Minnesota Public Health Association

Policy statements, endorsements and resolutions

1974 – 2015

August 2015

MPHA RESOLUTIONS

OVERVIEW

The advocacy actions of the Minnesota Public Health Association are grounded in resolutions passed by the membership. This handbook contains all resolutions passed by MPHA since 1974. It provides general information about the ways resolutions are used by MPHA and information about writing resolutions. This document will be updated annually to include new resolutions passed by the membership.

How are resolutions used by MPHA?

MPHA resolutions describe the organization's position on issues not otherwise covered in our by-laws or other governing documents. The resolutions passed by the membership guide the policy and advocacy work of the organization. When MPHA is approached to join a coalition, support a bill, or advocate for a particular public health issue, we first look to our resolutions for guidance. Final decisions about the actions the organization should take in regard to a policy issue are made by the Governing Council.

What information is included in a resolution?

Resolutions include two main components: a preamble (or "Whereas" statements) and resolving clauses (or "Therefore" statements). The preamble is the foundation of the resolution. It describes the issue and provides the rationale to support a specific bill/ public health policy issue. MPHA focuses on developing resolutions that include current, peer-reviewed literature in the preamble to provide a rationale for supporting a public health issue.

The resolving clauses outline the actions the MPHA membership believes the organization should take to support a particular issue. Often, these statements are written broadly so that MPHA can have the flexibility to support a number of specific bills that may be related to the policy topic. However, when the resolution is focused on a very specific issue, the "Therefore" statements may be much more narrowly defined. While the resolving clauses provide guidance, the final decisions about the steps MPHA will take to support a particular policy are made by the Governing Council.

How is a resolution passed?

Most resolutions are brought directly to the Policy & Advocacy (P&A) Committee for review. Resolutions can be brought to the committee by any MPHA member, or by an external organization looking for additional support on an issue. The committee will provide feedback and suggest revisions to the resolution author, as appropriate, and determine whether to recommend approval of the resolution to the Governing Council (GC). The GC may request revisions to the resolution prior to considering whether to recommend it is moved forward for a

membership vote.

Although resolutions can be brought to the committee at any time during the year for review, membership votes only occur at a maximum of two times each year (through a Fall online-survey vote or at the MPHA Annual Meeting). Resolution authors are encouraged to contact the committee co-chairs early in the writing process to identify whether any existing MPHA resolutions address the issue, develop a timeline for development of the resolution, and consider the most appropriate way to frame the issue.

Resolutions will be made available to the membership at least 15 days prior to a membership vote. Resolutions not reviewed by the P&A committee or Governing Council may also be presented at any meeting of the Association if it has been signed by 5 percent of the membership.

What process does the Policy & Advocacy Committee use to review resolutions?

All proposed policies, fact sheets, and resolutions should be submitted electronically as a Word document to the Policy and Advocacy Committee co-chairs. The co-chairs will introduce all documents submitted to the committee for discussion, and notify the Governing Council when new resolutions are being developed.

The committee will conduct an initial review of the resolution to determine whether the topic is: 1) relevant to the work of MPHA, 2) written from a public health perspective, 3) supported by current peer-reviewed sources, and 4) appropriate in regard to scope and breadth of the topic and "Resolve" statements. Although resolutions will likely be addressed in order of their relevance to MPHA's current policy agenda, MPHA will accept resolutions on new topics. The committee co-chairs will work with the resolution authors to address the concerns of the committee and develop a final resolution to be reviewed by experts in the field.

The review process guidelines are reviewed below:

- All proposals will be submitted to 3 experts for peer review; ideally, these reviewers will be representative of the University of Minnesota, the Minnesota Department of Health, and another organization that works specifically on the topic area. Experts may be identified by committee members, other MPHA members or through contacting experts in the field.
- Electronic copies of the draft resolution and Peer Review Comment Form will be sent to each reviewer. The reviewed document, with comment and recommendations, will be returned to the committee co-chairs.
- Committee co-chairs are responsible for collecting all reviewed proposals, sharing the reviewers' recommendations for changes with committee members.
    - Proposals recommended "Accepted As Is" may be passed to the MPHA Governing Council for final approval after being approved by committee members.
    - Proposals that require changes will be submitted to the author and may be resubmitted following revisions.
- Committee co-chairs will keep copies of reviewed proposals and peer review comment

forms that may be referred to if a proposal is rewritten and submitted to the committee.

How do I write a resolution?

An effective resolution describes the policy issue, provides an explanation or justification for the particular proposed solution, gives the reader enough background to understand the proposal, and makes it clear for members to vote to approve the resolution.

An example of a current MPHA resolution is included below.

MPHA Policy Resolution
Freedom to Breathe, May 2006

WHEREAS, tobacco-related disease is the number one cause of death to Minnesota residents[1]; and
WHEREAS, worksites and public places are locations where both members of the community and employees of those establishments are exposed to secondhand smoke; and
WHEREAS, secondhand smoke kills 38,000 nonsmoking Americans every year from cardiovascular disease and lung cancer[2]; and
WHEREAS, secondhand smoke can cause asthma attacks in those who suffer from asthma[3]; and
WHEREAS, employees should not be forced to risk their health through exposure to dangerous and deadly toxins in their workplace; and
WHEREAS, much of this important health risk is preventable by the implementation of comprehensive smoke-free policies[4]; and
WHEREAS, members of the Smoke-Free Coalition have come together to create the Freedom To Breathe Coalition with the express purpose of advocating and lobbying for the adoption of a statewide comprehensive smoke-free law – the Freedom to Breath Act.

Therefore, be it resolved that the Minnesota Public Health Association:

1. Supports the passage of the proposed state Freedom to Breathe Act, which provides smoke-free protections for all Minnesota workers.

2. Supports the continued right of local governments to further strengthen local laws to protect workers from secondhand smoke exposure.

References

[1]Minnesota Department of Health, "The Human and Economic Costs of Tobacco in Minnesota," *Minnesota Department of Health Fact Sheet*, April 2, 2002, http://www.health.state.mn.us/divs/hpcd/tpc/tobcosts.pdf.

[2]Centers for Disease Control and Prevention, "Tobacco Information and Prevention Source: Secondhand Smoke," *Centers for Disease Control and Prevention Fact Sheet*, February, 2004.
http://www.cdc.gov/tobacco/factsheets/secondhand_smoke_factsheet.htm.

[3]Minnesota Department of Health, "Educate Yourself about Asthma," *Minnesota Department of Health Fact Sheet*, http://www.health.state.mn.us/divs/hpcd/cdee/asthma/documents/fact05.pdf.

[4] DP Hopkins and others, "Reviews of Evidence Regarding Interventions to Reduce Tobacco Use and Exposure to

Environmental Tobacco Smoke," *American Journal of Prevention Medicine*, no. 20, suppl. 2 (2000): 16-66.

Writing Tips

- Contact the committee co-chairs as soon as possible to ensure the resolution can be reviewed and developed in time for a MPHA membership vote.
- The first "whereas" statements should include broad information to introduce and frame the issue. "Whereas" statements should become increasingly specific, current, and relevant to the issue. Sources should be cited using numerical superscript endnote notation at the end of the relevant "Whereas" statement, placing references at the end of the document. Most resolutions are approximately 2 pages in length.
- When writing the resolution, describe how the issue aligns with key public health principles, using peer-reviewed journal articles and other sources to support each statement. There should be a clear connection between the evidence used in the preamble of the resolution and the resolving clauses. It may be useful for the author to refer to the questions asked in the MPHA Decision Tree when framing the "whereas" statements.
- "Therefore, be it resolved" statements are actions MPHA supports/opposes. Begin these statements with action words such as supports, calls, opposes, encourages, urges. Include solidified MPHA positions, stances, or roles on the issue.

MINNESOTA PUBLIC HEALTH ASSOCIATION

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ADOLESCENT HEALTH AND SCHOOL HEALTH EDUCATION

Minnesota Public Health Association Resolution: Endorsing Prevention and Early Treatment of Sexually Transmitted Infections in Minnesota 2009

Passed June 18, 2009 at the MPHA Annual Meeting

WHEREAS, the American Public Health Association acknowledges sexually transmitted

infections (STIs) pose a significant risk to the public health of young people in the United States [i, ii]; and

WHEREAS, overall rates of STIs in Minnesota have increased dramatically over the past 10 years and, in particular, chlamydia rates have doubled between 1995 and 2007 [iii]; and

WHEREAS, youth, women and communities of color are disproportionately harmed by STIs, such as chlamydia [iv, v, vi] ; and

WHEREAS, many STI cases go undetected since three out of four women and one out of two men infected with chlamydia have no symptoms; and in the case of gonorrhea, four out of 10 men and nearly eight out of 10 women who are infected have no symptoms; and these individuals are unlikely to pursue clinical screening services [vii]; and

WHEREAS, untreated STIs result in serious public health consequences such as Pelvic Inflammatory Disease, infertility and a three to five times greater likelihood of contracting HIV compared to individuals without STIs; and

WHEREAS, primary prevention, screening, and early treatment of STIs are cost-effective public health strategies [viii, ix]; and

WHEREAS, in a national survey of U.S. physicians, only 1 in 3 reported routinely screening for common STIs among female patients, and fewer than 1 in 7 reported routinely screening males; and the CDC recommends that all sexually active females 25 and under should be screened at least once a year for chlamydia, even if no symptoms are present [x;] and

WHEREAS, among sexually active individuals, consistent condom use is effective in preventing many STIs, including HIV, chlamydia, gonorrhea, herpes, and syphilis [xi]; and

WHEREAS, assuring treatment of infected person's sex partners is a core element of prevention and control of bacterial sexually transmitted infections; and

WHEREAS, in studied populations, expedited partner therapy [xii] (EPT) has been shown to be a useful option for partner management of acquired gonorrhea and chlamydial infections [xiii;] and

WHEREAS, the Centers for Disease Control and Prevention (CDC) recommends that EPT should be available to clinicians and public health departments for managing partners of specific patients with sexually transmitted infections [xiv].

Therefore, be it resolved that the Minnesota Public Health Association:

1. 1. Urges that funding for chlamydia prevention and control be adequate to assist local health departments and community agencies to develop comprehensive STI control programs to improve screening and treatment of at-risk populations, with attention to asymptomatic infections and partner management, and
2. 2. Urges policy makers, health care payers, and medical providers to develop universal policies that assure confidentiality of patients seeking screening and treatment for STIs, and
3. 3. Urges payers and providers to incorporate CDC screening criteria for STI infections in medical insurance reimbursement plans and as a key component of preventative health care standards for medical practice, and
4. 4. Urges all providers caring for sexually active adolescents and young adults, as well as the general population, to implement CDC screening criteria in their standards for medical practice, and collaborate with local STI control programs to develop methodologies for patient-based sex partner treatment, including the implementation of EPT.

References

[i] Bauer, Heidi M.; Wohlfeiler, Dan MJ,; Klausner, Jeffrey D.; Guerry, Sarah; Gunn, Robert A.; Bolan, Gail. California Guidelines for Expedited Partner Therapy for Chlamydia trachomatis and Neisseria gonorrhoeae. Sexually Transmitted Diseases: Volume 35(3) March 2008pp 314-319.

[ii] APHA Policy 2005-10 Sexuality Education As Part of A Comprehensive Health Education Program in K-12 Schools.

[iii] Centers for Disease Control and Prevention. Chlamydia - CDC Fact Sheet, February 2008.

[iii] St Lawrence JS et al. (2002). STD screening, testing, case reporting, and clinical and partner notification practices: a national survey of US physicians. American Journal of Public Health, 92, 1784-1788.

[iii] Minnesota Department of Health, Annual Summary: 2007 Minnesota Sexually Transmitted Disease Statistics. Minnesota Department of Health, 2006 MN Sexually Transmitted Disease Statistics.

v Centers for Disease Control and Prevention. *CDC Trends in Reportable Sexually Transmitted Diseases in the U.S., 2005*, December 2006.

vi American Social Health Association, *STD/STI Statistics: Fast Facts.*

vii Centers for Disease Control and Prevention. *Chlamydia - CDC Fact Sheet,* February 2008.

viii Centers for Disease Control and Prevention. *CDC Trends in Reportable Sexually Transmitted Diseases in the U.S., 2005*, December 2006.

ix Minnesota Department of Health. *MDH Fact Sheet: Children and Adolescents Preventing Pregnancy and Sexually Transmitted Infections* . September 2004.

x St Lawrence JS et al. (2002). STD screening, testing, case reporting, and clinical and partner notification practices: a national survey of US physicians. American Journal of Public Health, 92, 1784-1788.
xi Crosby RA et al. (2003). The value of consistent condom use: a study of sexually transmitted disease prevention among African American adolescent females. American Journal of Public Health, 93, 901-902. Holmes KK, Levine R, Weaver M. (2004). Effectiveness of condoms in preventing sexually transmitted infections. Bulletin of the World Health Organization, 82, 454-464.
xii Expedited Partner Therapy is the clinical practice of treating sex partners of patients diagnosed with chlamydia or gonorrhea by providing treatment to the patient to take to his/her partner without the health care provider first examining the partner.
xiii Centers for Disease Control and Prevention. *Expedited partner therapy in the management of sexually transmitted diseases*. Atlanta, GA: US Department of Health and Human Services, 2006.
xiv Centers for Disease Control and Prevention. *Expedited partner therapy in the management of sexually transmitted diseases.* Atlanta, GA: US Department of Health and Human Services, 2006.

Minnesota Public Health Association Resolution
Physical Activity and Nutrition in the School Environment 2007

WHEREAS, schools ought to provide a consistent environment conducive to teaching and modeling healthful eating behaviors and regular physical activity;
WHEREAS, in 2000, 53.2 million students were enrolled in public and private elementary and secondary schools in the United States, providing prime opportunity to educate and prevent against obesity[1];
WHEREAS, the Minnesota Public Health Association recognizes that obesity and overweight among children and adolescents is a concern among all age, race, and ethnic groups;
WHEREAS, early childhood overweight is significantly associated with later childhood and adult obesity and related morbidities in adults[2];
WHEREAS, 16 % of children and adolescents in the U.S. ages 6-19 are overweight, a number that has doubled for children and tripled for adolescents since 1980[3];
WHEREAS, type 2 diabetes due to overweight is the fastest-growing childhood disease in the United States [4,5,6];
WHEREAS, 43% of elementary schools, 74% of middle schools, and 98% of high schools have vending machines, school stores, or snack bars where students can purchase food or beverages that are in competition with federally supported child nutrition programs[7]; and
WHEREAS, the childhood obesity epidemic has been linked to multiple factors including increased access to and consumption of calorie-dense foods and sugar added beverages, decreased daily physical activity, and increased sedentary behavior.

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:

1. Supports prevention efforts to reduce the prevalence of overweight and obesity in children and adolescents through policy, education, and environmental changes;
2. Supports efforts to implement and improve the vending, school lunch, and wellness policies of schools in Minnesota;
3. Supports the integration of food and nutrition education into school curricula;
4. Supports limits on the availability of high-calorie, nutrient-poor foods and beverages in school stores, vending machines and a la carte offerings;

5. Supports efforts to increase the availability of drinking fountains in schools with quality water;
6. Supports and encourages schools to develop, implement and enforce school policies to encourage healthful food and physical education messages and marketing practices to children;
7. Supports legislation and policies that increase the quantity and quality of physical education programs offered in grades K-12; and
8. Encourages schools to expand opportunities for physical activity to include intramural sports, activity clubs, after-school programs, other non-team based physical activity and, where possible, safer biking and walking paths to and from schools.

References:

[1] Institute of Medicine. Preventing Childhood Obesity: Health in the Balance. National Academy of Sciences, 2005.

[2] U.S. Department of Health and Human Services. The Surgeon General's Call to Action to prevent and decrease overweight and obesity, 2001.
[3] A Nation at Risk: Obesity in the United States, A Statistical Sourcebook. Robert Wood Johnson Foundation, 2006.

[4] Rosenbloom AL, Joe JR, Young RS, Winter WE. Emerging epidemic of type 2 diabetes in youth. Diabetes Care. 1999; 22:345-54.
[5] Dabelea D, Pettitt DJ, Jones KL, Arslanian SA. Type 2 diabetes mellitus in minority children and adolescents. An emerging problem. Endocrinol Metab Clin North Am. 1999, 28: 709-29.
[6] American Diabetes Association. Type 2 diabetes in children and adolescents. Diabetes Care. 2000; 23:381-9.
[7] CDC School Health Policies and Programs Study, 2000.

American Heart Association Physical and Health Education – Resolution for Endorsement 2004

BECAUSE physical education class is one reliable opportunity for all students for physical activity within the school day;
BECAUSE physical education helps children become and remain physically active for a lifetime , which may help them achieve better weight control and lower their risk of cardiovascular disease and chance of acquiring certain types of cancer and diabetes;
BECAUSE regular physical activity is thought to stimulate various regions of the brain and may have favorable effects on academic achievement;
BECAUSE a child completing grades K-12 in Minnesota schools could do so without taking a single health education course;
BECAUSE children who take health education classes are more capable of making informed decisions when faced with challenging lifestyle choices;
BECAUSE health classes provide a safe environment for children and adolescents to ask questions and gain support from adults.
BECAUSE the 2003 Minnesota Legislature made physical and health education an elective academic standard for the first time in decades.

BE IT THEREFORE RESOLVED that MPHA endorses:
• Legislation that includes physical education as a core required academic content area to assist in ensuring healthier development of our youth.
• Legislation that includes health education as a core required academic content area and ensures curriculum and instruction consistent with the National Health Education Standards.

Minor Consent 1999

Whereas, the Minnesota Public Health Association was instrumental in the passage of the emancipated minors consent law (Chapter #544) during the 1971 Minnesota Legislative Session; and

Whereas, the Minnesota Public Health Association supports access to health services for all, regardless of economic status, race or age; and

Whereas, certain individuals and organizations have attempted to restrict or eliminate this law;

Therefore, the Minnesota Public Health Association will work to preserve this law through community education and coalition building with other organizations; and

Be it further resolved that a priority for the Minnesota Public Health Association is to preserve the integrity and intent of the minors consent law.

School-based Health Services and Clinics 1987

Realizing that school-based health services and clinics are an innovative means for delivering medical and social services to youth;(1) and

Recognizing that youth, particularly those in low-income communities, often do not have available to them access to traditional medical providers; and

Noting that young people aged 11-20 have a lower rate of visits to physicians' offices than any other age group, even though they have a higher incidence of acute conditions;(2) and

Realizing the extreme severity of the teen pregnancy problem, where fully one million adolescents become pregnant each year, and 40% of all 14 year old girls become pregnant before they turn 20;(3) and

Understanding that school-based health services and clinics provide comprehensive health services that seek to meet urgent adolescent health needs in areas such as substance abuse, adolescent pregnancy, mental health, and general primary health care;(4)

Recognizing that the evidence of success in school-based health services and clinics across the county provides encouraging data with respect to clinic utilization, school dropout, detection of untreated health problems, and adolescent pregnancy prevention;(5) therefore:

1) Encourages health providers and communities to consider locally appropriate school-based health services and clinic programs which coordinate with existing services, where such a need for services exists.

2) Encourages local, state and federal governments as well as the private sector to continue and expand funding of school-based health services and clinics.

3) Reaffirms its 1985 resolution on comprehensive school health services.

4) Opposes restrictions of funding for school-based health services, including but not limited to Community Health Services and Maternal and Child Health Block Grant funds.

5) Recommends continued evaluation of school-based health services.

References

1. Kirby D: School-Based Health Clinics: An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy. Washington, D.C., Center for Population Options, 1985.
2. Johnson K and Rosenbaum S: Building Health Programs for Teenagers. Washington, D.C., Children's Defense Fund, 1986.
3. Alan Guttmacher Institute: Teenage Pregnancy: The Problem That Hasn't Gone Away. New York, Alan Guttmacher Institute, 1981.
4. Hadley EM, Lovick S, and Kirby D: School-Based Health Clinics: A Guide to Implementing Programs. Washington, D.C., Center for Population Options, 1986.
5. Center for Population Options: The Facts: School-Based Clinics. Washington, D.C., Center for Population Options, 1987.

This resolution is based on a resolution submitted to APHA for 1987 by Jodie Levin-Epstein, Center for Population Options (202-347-5700) on behalf of the Population and Family Planning Section, APHA (as approved February 25, 1987)

Comprehensive School Health Programs 1985

The Minnesota Public Health Association supports a comprehensive school health program for children which enhances personal health through the dissemination of health information, the teaching of healthy lifestyle behaviors, provision of appropriate health services, and a healthy environment. School health policies should be formulated to facilitate maximum cooperation and coordination within each school and school system, and between the school and the community.

The Comprehensive School Health Program encompasses School Health Education, School Health Services, and Healthful School Living. The purpose of Health Education is to impart health knowledge and cultivate desirable attitudes, habits and practices. School Health Services support the total educational program by identifying and securing correction of, or compensation for individual health problems. School Heath Service includes health promotion and health maintenance activities for all students. Healthful School Living includes the provision of a safe and healthful school environment.

MPHA realizes that the health of school age children is an essential to effective learning and that students' capacity to take full advantage of their educational opportunities contributes to their future adult health productivity.

The appropriate roles of the Minnesota Department of Education (MDE) and the Minnesota Department of Health are to provide technical consultations to local school districts and to assist them in the development and the implementation of comprehensive school health programs.

MPHA also recognizes the role of state and local government in appropriating funds to school districts for comprehensive health programs including health education, health services, and a healthy environment for all students.

In addition, local school districts have the responsibility to develop and implement comprehensive school health programs through the support of government agencies, voluntary organizations and other professional and community groups.

Action Proposals

1. MPHA recommends that local school districts recognize the need for comprehensive school health programs and take the necessary action to implement these programs, through the use of qualified, professional staff.

2. MPHA encourages the state legislature and local governments to support comprehensive school health program for all students throughout the state.

3. MPHA encourages parents, educators, and community health providers to work together to provide comprehensive school health programs.

Approved April 26, 1985 Annual Meeting.

Minor's Rights 1980

MPHA supports the concept that minors have rights, increasing with age, to control their own bodies, except if such control may cause them harm; this support includes advocating resources and programs, regulations and legislation which enable minors to better exercise these rights.

Comment
The Minnesota Public Health Association has historically advocated several resolutions for programs and funding to support minors in both the family and the school setting. These resolutions have included, from 1974 to 1979, support of health education (both generally and, more specifically, for optional family planning curricula), and general support of measures to strengthen families.

The purpose of this position is to continue to advocate measures to promote the health and well-being of minors and their families. With increasing national attention focused on the status of the family, MPHA should have opportunity to make an impact on this area.

MPHA advocates school health education, including education about sexuality and family planning. We support programs and regulations which promote safety and health in all child care settings. We support measures to control child abuse and neglect, and other programs which help families cope with increasing pressures and fragmentation of family units.

MPHA Resolutions Related to this Position:
Children Measures to Strengthen Families - 1979
Minors Consent Law - 1978
Venereal Disease Control - 1975
Resolution Relating to Comprehensive School Health Education Programs - 1974
School Health - 1978
Approved September 26, 1980 Annual Meeting.

Comprehensive School Health Education Program 1978

WHEREAS, The Minnesota Public Health Association recognizes that our present technological and social environment is concerned with individual and community health problems and issues; and

WHEREAS, There is increased public awareness and concern for health problems such as mental and emotional health, safety and emergency care, nutrition and food management, dental health, chronic diseases and disabilities, aging and other types of health problems; and

WHEREAS, There is adequate strong evidence that sound foundations for development of skills and abilities to cope with today's health problems are best achieved by a systematic progression of acquiring health education concepts and practices during childhood and youth; and

WHEREAS, Comprehensive health education programs should be integral parts of the total school health curriculum and health care delivery system; and

WHEREAS, The interests of the citizens of the State of Minnesota would be best served if comprehensive school education programs were developed in Minnesota's elementary and secondary schools; and

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association support national, state and local efforts to plan and implement comprehensive school health education programs.

BE IT FURTHER RESOLVED that such programs include enabling appropriations for local school districts to employ qualified health education specialists to incorporate health education concepts in the entire school curriculum.

BE IT FURTHER RESOLVED that comprehensive health education programs emphasize full and adequate preparation and continuing education for those personnel directly involved in, or responsible for, such programs.

Adopted by the Governing Council, June 21, 1974.
Approved September 22, 1978 Annual Meeting.

Minors Consent 1978

WHEREAS, The Minnesota Public Health Association was instrumental in the passage of the emancipated minor's consent law (Chapter #544) during the 1971 Minnesota legislative session; and

WHEREAS, The Minnesota Public Health Association defended and supported the same law during the 1973 Minnesota legislative hearings; and

WHEREAS, The Minnesota Public Health Association supports access to health services for all, regardless of economic status, race or age; and

WHEREAS, Certain individuals and organizations may work to restrict or eliminate this law during the 1979 legislative session;

THEREFORE, LET IT BE RESOLVED that the Minnesota Public Health Association work to preserve this law through community education and coalition building with other organizations;

BE IT FURTHER RESOLVED that a priority for Minnesota Public Health Association is to preserve the integrity and intent of the minors consent law.

Approved September 22, 1978 Annual Meeting.

ALCOHOL, TOBACCO, AND OTHER DRUGS

Minnesota Public Health Association Resolution

Addressing Public Health Concerns Regarding New Tobacco and Nicotine Products 2010

WHEREAS, more than 5,500 people in Minnesota die of tobacco-related diseases every year; and

WHEREAS, tobacco use results in more than $2 billion annually in excess health care costs; [1] and

WHEREAS, an estimated 85,000 public middle and high school students use tobacco products in Minnesota; [2] and

WHEREAS, the tobacco industry spends $196.6 million in Minnesota each year marketing its deadly products, with significant resources dedicated to targeting teens; [1] and

WHEREAS, the tobacco industry is developing and promoting new tobacco and nicotine products that appeal to teens and young adults and can be used in smoke-free environments; [1] and

WHEREAS, there are current loopholes in the taxing and fees of tobacco products including "youth friendly" candy flavored little cigars; [3] and

WHEREAS, there are an increased number of smokeless tobacco and nicotine products being test-marketed which are not covered by youth access laws [4] and

WHEREAS, the Minnesota Public Health Association has supported resolutions (1986, 1989, 1993, 1998) in the past to restrict the sale and use of tobacco products by minors, prevent illegal sales and limit access, and support increases in tobacco taxes.

THEREFORE BE IT RESOLVED, that the Minnesota Public Health Association
support legislation to modernize existing Minnesota tobacco laws, reduce tax evasion and reduce youth access to tobacco and nicotine products including:

1. Classify "little cigars" as cigarettes, subjecting them to existing regulations applicable to cigarettes,

2. Ensure that new tobacco products are covered by existing regulation, such as not allowing them to be sold on the counter next to candy and gum, and

3. Prohibit the sale of e-cigarettes to youth, which are electronic nicotine delivery devices that simulate smoking.

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[3] "Tobacco Products for the 21st Century/Tobacco Modernization and Compliance Act of 2010", flyer produced by Blue Cross Blue Shield of Minnesota, American Health Association, ClearWay Minnesota, Association for Non-Smokers—Minnesota, American Lung Association and the American Cancer Society (2010).
[4] Minnesota Public Health Association. *Minnesota Public Health Association Resolution Handbook 1974-2009*, Revised March 2010: pp 24-29.

Methamphetamine
May 2006

WHEREAS, the Minnesota Public Health Association (MPHA) has long been committed to preventing drug abuse and reducing the impact of drug addiction; and

WHEREAS methamphetamine is a "powerfully addictive stimulant associated with serious health conditions, including memory loss, aggression, psychotic behavior, and potential heart and brain damage; it also contributes to increased transmission of hepatitis and HIV/AIDS," [1] dental decay [2], hallucinations, violent behavior and psychiatric symptoms [3]; and

WHEREAS methamphetamine production creates hazardous waste and contaminates buildings, which can result in exposure to toxic and hazardous chemicals that may cause "severe and long-lasting health concerns" for responders, children and others in proximity [4, 5, 6]; and

WHEREAS the average methamphetamine laboratory produces 5 to 7 pounds of toxic waste for every pound of methamphetamine produced. Operators often dispose of this waste improperly, simply by dumping it near the laboratory via streams, septic systems and surface water run-off. This can cause contamination of the soil and nearby water supplies [7]; and

WHEREAS each methamphetamine lab or methamphetamine chemical dump is a potential hazardous waste site, requiring evaluation, and possibly cleanup, by hazardous waste (HazMat) professionals; and

WHEREAS treatment for those exposed to methamphetamine production is hampered by a lack of scientific information on which to base appropriate treatment plans [8]; and

WHEREAS approximately one-third of methamphetamine labs investigated by authorities involve children [9]; and

WHEREAS methamphetamine poses serious challenges to children's health and safety, playing a role in up to 81% of child protection cases reported in Minnesota [10] and causing a fourfold increase in the likelihood of physical or sexual abuse and a threefold increase in the likelihood of neglect [11]; and

WHEREAS the need for prevention efforts and effective treatment is increasing rapidly in Minnesota (the drug accounted for 2.9% of admissions to treatment in the Minnesota metro area in 1998; that figure has grown to 12.1% of admissions in 2005, which approaches the level of treatment sought for cocaine addiction) [12,13]; and

WHEREAS methamphetamine availability and production are being reported across the US, particularly in rural areas [14]; and

WHEREAS methamphetamine addicts represent a growing proportion of those incarcerated in Minnesota prisons, jumping from 139 people in January 2001 to 1,012 in July 2004 [15] and 1,127 in July 2005 [16]; and

WHEREAS, methamphetamine use as self-reported by high school seniors in metropolitan Minnesota was at 5% in 2004[17], reflecting the importance of drug education and early intervention; and

WHEREAS research indicates that methamphetamine users need about a year to start to recover from the cognitive damage to their brains, necessitating longer-term treatment programs and other adjustments specific to the impact of this drug [18]; and

WHEREAS methamphetamine is a particularly dangerous drug that includes a constellation of public-health, environmental, economic and safety consequences statewide, particularly in areas of the state where the necessary resources may not be in place; and

WHEREAS precursor ingredients used to make methamphetamine can be legally purchased at a wide variety of businesses; and

WHEREAS methamphetamine requires efforts by local and state governments to develop appropriate mitigation rules, mandate cleanup of meth labs and oversight of that process, restrict sales of precursor drugs and other chemicals, and ensure the safety of first responders and others exposed to former lab sites.

Therefore, be it resolved that the Minnesota Public Health Association:

1. Advocates for the efforts of local, state and national public health agencies and other organizations to prevent and reduce methamphetamine use.
2. Encourages efforts to develop, promote and fund effective existing and new prevention and treatment programs, including efforts to teach prevention in schools, to obtain insurance coverage and other support for individuals who may require longer treatment for physical, chemical and mental health issues related to the damage suffered from taking methamphetamine.
3. Supports research to prevent use and to develop and implement treatment for methamphetamine addiction.
4. Supports efforts of policy makers, courts and other agencies to safeguard children from the effects of drugs.
5. Supports adequate clean-up protection for responders and the environment.

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3. "Methamphetamine-Related Psychiatric Symptoms and Reduced Brain Dopamine Transporters Studied With PET," American Journal of Psychiatry, Sekine et al. 158 (8): 1206. 2001.
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7. National Drug Intelligence Center. January 1, 2006. http://www.usdoj.gov/ndic/pubs7/7341/index.htm#hazards
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9. Ibid.

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12. "Methamphetamine-related Treatment Admissions Continue to Rise in Minnesota," Hazelden Foundation news release December 2005, http://www.hazelden.org/servlet/hazelden/cms/ptt/hazl_7030_shade.html?sh=t&sf=t&page_id=30567
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17. "Drug Abuse Trends," Hazelden Foundation's Butler Center for Research December 2005. http://www.hazelden.org/servlet/hazelden/securefile/1205DAT.pdf?content_item_id=32080&content_item_version_id=32080&directory=docsDirectory&filename=1205DAT.pdf
18. Ibid.

Support of Using Tobacco Settlement Funds to Reduce Tobacco Use in Minnesota 1999

Whereas, the State of Minnesota has settled its lawsuit against the tobacco industry generating $6.1 billion for the state; and

Whereas, each year tobacco-related disease accounts for 6,400 (17 percent) deaths in Minnesota costing over $1.3 billion dollars in medical expenses; and

Whereas, secondhand smoke is a leading cause of asthma in children and responsible for 3,000 annual lung cancer deaths among non-smokers; and

Whereas, nicotine is a powerful, addictive substance which often leads to lifelong addiction; and

Whereas, smoking rates among Minnesota teens surpass the national average; and

Whereas, the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health called for the creation of an endowed foundation that would be directed by a board drawn mainly from scientific and public health organizations. The mission of that foundation would be to develop the world's largest and most comprehensive tobacco prevention and control program; and

Whereas, the Minnesota tobacco lawsuit settlement language recommends $650 million (less than 11 percent of the total settlement) to be used for tobacco prevention and control projects as proposed by the Koop-Kessler Committee; and

Whereas, opinion polls by leading research organizations in Minnesota indicate that 87 percent of citizens polled believed that tobacco settlement funds should be used for health and wellness programs; and

Whereas, the Minnesota Smoke-Free 2000 Coalition has identified that a minimum of $70 million per year is needed to adequately fund counter-advertising campaigns, research and evaluation, community-based programs, and tobacco-use cessation services; and

Whereas, public health research clearly indicates that successful smoking cessation and tobacco prevention programming requires long-term continuity insulated from changing political priorities, cooperative and coordinated community-wide input and evidence-based comprehensive intervention strategies; and

Whereas, a sustainable trust fund is a mechanism to accomplish these objectives;

Therefore, be it resolved, that the Minnesota Public Health Association actively supports creating a sustainable trust fund that yields at least $80 million annually for the development of a comprehensive tobacco use prevention and control program. The principle of the trust fund remains in control of the trust; and

Be it further resolved, that the Minnesota Public Health Association supports the remainder of the settlement funds to be dedicated to health care with an emphasis on prevention to address such issues as:

- accessible health care,
- state and local health department core functions,
- supporting public/private partnerships for prevention, and

- supporting immunization registries.

Felony Loophole in Alcohol Statute 1999

Whereas, alcohol use is associated with a number of major causes of injury and death among young adults; and

Whereas, youth who drink alcohol are more likely to die in a traffic crash; be a victim of murder, rape, or assault; commit suicide or drown; have an unplanned pregnancy; drop out of school; or face other physical or social problems; and

Whereas, alcohol is the major cause of all fatal and nonfatal crashes involving teenage drivers[1]; and

Whereas, too many communities are suffering the tragedies resulting from adults who knowingly supply alcohol to young people; and

Whereas, alcohol use is a social behavior that is heavily influenced by the social structures, norms and other dimensions of the environment in which people live[2]; and

Whereas, drinking patterns among young adults in the general population are often not reflective of addictive or psycho-pathological behavior, but rather are the results of social policies, institutional structures and social norms concerning alcohol in our society[3]; and

Whereas, alcohol remains readily available to young people because of the propensity of adults to supply alcohol to them and a person aged 21 or over was the most common source of alcohol for young people for their last drinking occasion[4]; and

Whereas, adults produce, promote and profit from alcohol; and

Whereas, adults are the primary source of alcohol to underage people illegally; and

Whereas, adults have the highest responsibility and accountability in this illegal act; and

Whereas, recent news of the Ramsey County Attorney office's inability to file felony charges against the alleged adult provider of alcohol in the death of Kevin Brockway left many communities and policy decision makers furious; and

Whereas, the failure to hold this adult accountable for this death is found in a "loophole" in the alcohol statutes; and

Whereas, correction of this "loophole" would allow county judicial systems to file felony charges against adult providers of alcohol to underage persons who suffered serious bodily injury or death;

Therefore, be it resolved that the Minnesota Public Health Association supports changing the alcohol statute to allow filing felony charges against adult providers of alcohol to underage persons who suffered serious bodily injury or death.

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[2] Akers, R. L. *Drugs, Alcohol, and Society*. Belmont, CA: Wadesworth, 1982

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Reducing Youth Alcohol Use and Access 1998

WHEREAS, alcohol use is associated with a number of major causes of injury and death among young adults and; and

WHEREAS, youth who drink alcohol are more likely to die in a traffic crash; be a victim of murder, rape or assault; to commit suicide or drown; have an unplanned pregnancy; drop out of school; or face other physical or social problems; and

WHEREAS, alcohol is the major cause of all fatal and nonfatal crashes involving teenage drivers(1); and

WHEREAS, more than one in three 12th grade males reports binge drinking (5 or more drinks in a row) at least once in the past two weeks(2); and

WHEREAS, binge drinking increased for 9th graders and 12th grade females between 1992 and 19952; and

WHEREAS, about two-thirds of young people who drink (about 7 million) buy their own alcoholic beverages(3); and

WHEREAS, in the 1992 Minnesota Student Survey, 63% of the ninth graders and 85% of the twelfth graders stated that alcohol was easy to obtain; and

WHEREAS, the economic cost of alcohol use problems in Minnesota totals $1.74 billion(4); and

WHEREAS, prevention efforts by parents, schools and community must be complimented by strong informal and formal norms, standards and policies to counteract the broad pro alcohol environment that teens are exposed to every day; and

WHEREAS, youth state that parents have a significant influence on the choices youth make; and

WHEREAS, adult role-modeling is critical to the development of our young people to live a chemically healthy life; and

WHEREAS, young people emulate the actions of adults in their community; and

WHEREAS, a University of Minnesota study indicates that teenagers appearing as young as age 18 can buy alcohol without showing age identification in at least 50% of their attempts at both on and off-sale alcohol businesses in Minnesota(5); and

WHEREAS, underage youth can also easily obtain alcohol from individuals over age 21; and

WHEREAS, alcohol industry practices such as the marketing of sweet alcoholic beverages called "alcopops" with cartoon characters - which industry insiders call "training wheels" - target youth and contribute to the problem of youth alcohol use(6); and

WHEREAS, research has found that systematic compliance checks are an effective way to reduce illegal alcohol sales(7); and

WHEREAS, a University of Minnesota research study has found that compliance checks encourage alcohol licensees to train and supervise their employees; and

WHEREAS, requiring server and manager training is also a valuable strategy to reduce youth access to alcohol and to limit adult intoxication which could lead to other alcohol-related problems; and

WHEREAS, we also know from law enforcement that beer kegs are widely used as a source of alcohol at parties that underage persons attend; and

WHEREAS. the longer underage persons are prevented from consuming alcohol, the less likely they will have subsequent alcohol-related problems;

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association supports:

- Appropriate funding for outcome based research for parent education programs.
- Appropriate funding for prevention programs.
- Appropriate funding for treatment programs.
- Positive adult role modeling campaigns.
- An on-going awareness campaign on the problem of youth alcohol use and access.
  Mandating at least one compliance check per year in each location where alcoholic beverages are sold.
- Graduated administrative penalties for licensee where there is a sale to an underage person.
- Requiring civil penalties for sale of alcoholic beverages to persons under 21 years of age by a licensee or the employee of a licensee.
- Forbidding the use of cartoon characters, caricatures or similar materials on labels of cordials and liqueur bottles.
- Mandating server and manager training programs for the licensee and all employees who sell or serve alcoholic beverages.
- Forbidding the retail sale of cordials and liqueurs in bottle sizes of less than 375 milliliters.
- Mandating tighter controls or a ban on home delivery of alcoholic beverages.

- Mandating keg registration.
- Improving state statute to hold adults civilly responsible for providing alcohol to underage persons where there is an injury or death.

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2Minnesota Student Survey: Perspectives on Youth, Minnesota Department of Children, Families and Learning, St. Paul, Minnesota, 1995.
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5Forster, J.D., Murray, D.M., Wolfson, M., Perry, C.L., and Anstine, P.S., (1994). The Ability Of Young People To Purchase Alcohol Without Age Identification In Northeastern Minnesota, USA, Addiction 89, 699-705.
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Adopted April 30, 1998

Opposing the Sale of Strong Beer, Wine and Distilled Spirits by Grocery & Convenience Stores as a Strategy to Reduce Youth Access to Alcohol 1998

WHEREAS, alcohol use is associated with a number of major causes of injury and death among young adults and; and

WHEREAS, youth who drink alcohol are more likely to die in a traffic crash; be a victim of murder, rape or assault; to commit suicide or drown; have an unplanned pregnancy; drop out of school; or face other physical or social problems; and

WHEREAS, alcohol is the major cause of all fatal and nonfatal crashes involving teenage drivers(1); and

WHEREAS, more than one in three 12th grade males reports binge drinking (5 or more drinks in a row) at least once in the past two weeks(2); and

WHEREAS, binge drinking increased for 9th graders and 12th grade females between 1992 and 1995(2); and

WHEREAS, about two-thirds of young people who drink (about 7 million) buy their own alcoholic beverages(3); and

WHEREAS, in the 1992 Minnesota Student Survey, 63% of the ninth graders and 85% of the twelfth graders stated that alcohol was easy to obtain; and

WHEREAS, the economic cost of alcohol use problems in Minnesota totals $1.74 billion(4); and

WHEREAS, a University of Minnesota study indicates that teenagers appearing as young as age 18 can buy alcohol without showing age identification in at least 50% of their attempts at both on and off-sale alcohol businesses in Minnesota(5); and

WHEREAS, compliance checks of alcohol outlets in Sherburne County in 1996 indicated that underage people could purchase alcohol an average of 45% of the time from all outlets - and the rates for grocery and convenience stores were 42%; and

WHEREAS, compliance checks in the City of Orono indicate that sales rates to underage persons was 99% at grocery and convenience stores(6); and

WHEREAS, the Minnesota Grocers Association stated that they are considering changing Minnesota law to allow grocery and convenience stores to sell strong beer and wine; and

WHEREAS, studies have indicated that in states that have allowed convenience and grocery stores to sell strong alcohol have resulted in overall increased sales of 48% to 150%(7); and

WHEREAS, research also indicates that increased availability of alcohol leads to increased consumption(8); and

WHEREAS, research has shown that it is easy for underage persons to purchased 3.2 beer in grocery and convenience stores; and

WHEREAS, police have reported that one reason compliance cheeks are not conducted to prevent illegal alcohol sales to underage people is a lack of resources(9); and

WHEREAS, increasing the number of alcohol establishments will stretch police resources and reduce the likelihood of doing compliance checks(9);

THEREFORE, BE IT RESOLVED that to reduce youth access to alcohol the Minnesota Public Health Association opposes the sale of strong beer, wine and distilled spirits by grocery and convenience stores.

References

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Adopted April 30, 1998

In Support of Local Control of Alcohol Ordinances to Reduce Youth alcohol Use and Access 1998

WHEREAS, it is crucial that cities maintain the ability to enhance state laws or regulations of alcohol in order to strengthen efforts at the municipal level to control alcohol sales to minors; and

WHEREAS, communities in Minnesota should have local options in controlling and enforcing the distribution and sale of alcohol; and

WHEREAS, pre-emption is a real threat as indicated by the national movement by tobacco and alcohol industries to take away local control of tobacco and alcohol sales; and

WHEREAS, Minnesota communities have begun to recognize the serious problem it is when young people gain access to alcohol and have begun to implement greater restrictions on alcohol sales beyond current state laws; and

WHEREAS, youth who drink alcohol are more likely to die in a traffic crash; be a victim of murder, rape or assault; to commit suicide or drown; have an unplanned pregnancy; drop out of school; or face other physical or social problems; and

WHEREAS, alcohol is the major cause of all fatal and nonfatal crashes involving teenage drivers(1); and

WHEREAS, the economic cost of alcohol use problems in Minnesota totals $1.74 billion(2); and

WHEREAS, in Minnesota, both the tobacco and alcohol industry attempted pre-emption during the 1995, 1996 and 1997 legislative sessions;

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association supports maintaining local control and enforcement of the distribution and sale of alcohol as a strategy to reduce youth alcohol use and access.

References
1Morbidity and Mortality Weekly Report, 1990.
2Alcohol Use In Minnesota: Extent and Cost, Minnesota Department of Health Report, 1995.

Adopted April 30, 1998

Lowering the Blood Alcohol Concentrate (BAC) From .10% to .08% 1998

WHEREAS, drinking and driving in Minnesota poses a serious health threat to public safety; and

WHEREAS, in Minnesota in 1996, there were 205 motor vehicle fatalities that were classified as alcohol-related1; and

WHEREAS, during that same year, there were 38,925 DWI arrests(1); and

WHEREAS, the economic cost of alcohol use problems in Minnesota totals $1.74 billion or $400 per person annually(2); and

WHEREAS, lowering the blood alcohol concentrate (BAC) from .10% to .08% for driving while intoxicated (DWI) offenses is a critical strategy to reduce the incidence of drunk driving because it does have a deterrent effect on the broader population(3); and

WHEREAS, impairment of important physical skills necessary for driving begins at approximately .04 BAC for nearly everybody(4); and

WHEREAS, at .08% BAC, a person's fatal crash risk is at least 10 to 15 times higher than a person who has not been drinking alcohol(5); and

WHEREAS, at 10% BAC, the risk rises to nearly 32 times higher than a non-drinking driver; and

WHEREAS, studies of the first five states that lowered the BAC to .08% experienced a 16 percent reduction in the proportion of fatal crashes with a fatally injured driver whose BAC was .08% or higher, as well as an 18 percent reduction in such crashes with a fatally injured driver whose BAC was .15% or higher(5); and

WHEREAS, a study published in the American Journal of Public Health concluded that nearly 690 alcohol related highway deaths could be prevented annually if all states lower the legal blood alcohol limit to .08%(5);

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association supports lowering the blood alcohol concentrate from .10% to .08% for DWI offenses.

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Adopted April 30, 1998

Position on any Proposed Tobacco Settlement 1998

The Minnesota Public Health Association strongly supports President Clinton's decision to oppose the tobacco settlement and the right of the State of Minnesota and BlueCross BlueShield of Minnesota's lawsuit to go to trial. Because tobacco use causes over 400,000 deaths in our county every year, any settlement discussion must consider public health as its highest priority. Improvement of the public health will be achieved only through reduced consumption of tobacco products by all people, especially youth. Long term change must come through fundamental changes in the way that the tobacco industry does business.

Historically, the tobacco industry has been very successful at circumventing regulations that, on their surface, appear to affect the industry negatively. Their most recent legislative success, would have credited the revenue raised by the increase federal tobacco tax to the financial commitment of the previously proposed settlement. This proves that the tobacco industry will do anything it can to ultimately undermine any deal made which they view not to be in

their best interest. Therefore, local, state, and federal policy makers must retain their right to enact legislation that is more restrictive than any tobacco industry driven settlement proposal.

The Minnesota Public Health Association recognizes the following provisions as most critical to any tobacco settlement:

FDA Authority - The FDA must retain full and unfettered authority to regulate tobacco products currently and in the future. There should be no limitations on, or special exceptions to, the FDA's authority to regulate nicotine or other ingredients in tobacco products.

Look Back Penalties* - Recently unveiled internal tobacco industry documents reveal what the general public has long suspected, that the tobacco industry intentionally targets children to maintain a customer pool that becomes addicted to their product. The penalties proposed for not meeting the "performance standards" established to reduce teen tobacco use rates are not large enough to significantly change the corporate behavior of the tobacco industry. Look back penalties must be substantial enough to be an effective deterrent: they must exceed the profit the tobacco industry could gain from selling tobacco to youth under 18.

Liability - The legal precedent that the settlement sets is dangerous because it protects the tobacco industry from paying damages caused by their harmful products. No other corporate entity is granted this immunity. All currently available avenues of litigation, both civil and criminal, must be fully preserved.

Document Disclosure - All internal tobacco industry documents that bear upon public health should be disclosed. Documents that have already been released in the states of Florida and Minnesota begin to reveal the extent to which the tobacco industry has lied to the public and Congress. Federal legislation should not be adopted without a close examination of all the documents.

Advertising/Promotion Restrictions - A federal agency needs to preserve flexibility and authority to comprehensively deal with tobacco advertising and promotion. Local, state, and federal policy makers must be able to enact legislation that places appropriate restrictions on tobacco advertising and promotion.

Industry Payments - The dollar amount offered in the proposed settlement is far too low. Any payment must be punitive and commensurate with the damages that the tobacco industry has caused or may cause in the future. Fines, punitive damages, and other payments imposed on the tobacco industry should not be recognized as ordinary business expenses and should not be tax-deductible or given other special tax treatment.

Funding for Tobacco Control Programs - A portion of the money paid by the tobacco industry must be allocated to programs designed to reduce tobacco use, such as research on and development of cessation programs, provisions of cessation classes, enforcement of statutes governing tobacco manufacturing and sales, state and local projects to reduce tobacco use, school-based education programs, and public education campaigns delivered through radio, newspaper, and television.

Environmental Tobacco Smoke - Legislation should be enacted and enforced by local, state and federal governments to eliminate exposure to secondhand smoke, including a public education and awareness program detailing the dangers of environmental tobacco smoke.

International Policy - The United States should actively promote tobacco control worldwide. Any settlement legislation adopted must include provisions that deter the manufacturers of tobacco products from promoting their products in global markets.

*Look Back Penalties (term used by Koop-Kessler Report) indicates that the industry would be subject to penalties if youth cigarette use fails to drop by 30 percent in 5 years, 50 percent in 7 years and 60 percent in 10 years.

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2. Smokeless States Evaluation Analysis on the Proposed Global Settlement, 1997
3. Evaluating the Proposed Settlement, The Advocacy Institute, Washington, D.C.

Adopted April 30, 1998

Minimal Provision to be Included in a National Comprehensive Tobacco Policy 1998

WHEREAS, legislation is currently being considered at the federal level that seeks to enact comprehensive national tobacco policies and potentially settle dozens of lawsuits pending against the tobacco industry by state attorneys general; and

WHEREAS, any federal legislation enacted would have far reaching implications for states, including in Minnesota;

THEREFORE, BE IT RESOLVED, that the Minnesota Public Health Association, in order to secure changes to the tobacco industry's behavior and protection of public health, support the following provisions to any national comprehensive tobacco policy:

•The Food and Drug Administration (FDA) must retain complete and unfettered authority to regulate tobacco products without special limitations or exception.

•Substantial penalties must be assessed against the tobacco industry for its past behavior and to deter future efforts to market tobacco products to teenagers. Those penalties must exceed industry profits from teen tobacco sales.

•The tobacco industry must not be granted immunity from future criminal or civil litigation.

•All internal tobacco industry documents that have a bearing upon public health should be disclosed.

•A federal agency must be vested with the authority to comprehensively regulate tobacco industry advertising and promotion, and local and state policy makers must not be preempted from regulating tobacco advertising and promotion at the state and local level.

•The tobacco industry must be required to pay fines and penalties commensurate with the damage done by the industry and those fines and penalties should not be given tax deductible or other special tax treatment.

•Penalties for failing to meet standards for reducing teen tobacco use rates (lookback penalties) must be truly effective and must significantly exceed current and expected profits from industry teen tobacco sales.

•A portion of the payments made by the tobacco industry must be allocated to education, cessation and enforcement programs designed to reduce tobacco use.

•In conjunction with passage of a tobacco industry settlement, legislation should be enacted and enforced by local, state and federal authorities to eliminate exposure to secondhand smoke.

•In conjunction with the passage of any tobacco industry settlement, the Congress must adopt provisions that effectively deter the tobacco industry from promoting their products worldwide.
Adopted April 30, 1998

Policies to Reduce Illegal Tobacco Sales to Youth 1998

WHEREAS, the average smoker is already addicted to nicotine by the age of 18; and

WHEREAS, on average, kids try their first cigarette at the age of 14; and

WHEREAS, each day, nearly 3,000 children and adolescents begin smoking; and

WHEREAS, more than 1 in 4 high school seniors in Minnesota smoke daily; and

WHEREAS, throughout Minnesota, teenagers are able to purchase tobacco 40-60% of the time, even though its illegal to do so; and

WHEREAS, research has found that systematic compliance checks are an effective way to reduce illegal tobacco sales to underage youth; and

WHEREAS, education programs in school are not enough to prevent youth from using tobacco;

THEREFORE, BE IT RESOLVED, that the Minnesota Public Health Association supports the 1997 Youth Access Law and especially the provisions to:

- Conduct compliance checks at least once per year.

- Enforce current state law which eliminates vending machines in all establishments except those that cannot be entered, at any time, by persons under the age of 18.

BE IT FURTHER RESOLVED that the Minnesota Public Health Association supports policies to:

- End direct or indirect payment, of "slotting fees," from tobacco companies to retailers for the display of tobacco products.

- Fully eliminate self-service displays or other forms of tobacco purchasing that do not require face-to-face interaction with an employee.

Adopted April 30, 1998

Support for Special State Appropriated Funding To Reduce the Overall Harm Caused by the Use of Tobacco Products in Minnesota 1998

WHEREAS, cigarette smoking is the single-most avoidable cause of death in our society, and the most important public health issue of our time; and
WHEREAS, tobacco kills 440,000 Americans every year - causing more death than alcohol, cocaine, crack, heroin, homicide, suicide, car accidents, fires and AIDS, combined; and
WHEREAS, smoking is known to cause eight different kinds of cancer and is the leading cause of death from lung cancer; and
WHEREAS, smoking contributes to heart disease, stroke, and chronic obstructive pulmonary disease - all leading causes of death today; and
WHEREAS, environmental tobacco smoke is responsible for 3,000 lung cancer deaths annually in American nonsmokers and is a leading cause of asthma in children; and
WHEREAS, tobacco related costs in Minnesota exceed a billion dollars and result in 17 percent of all deaths, annually, in the state; and
WHEREAS, state costs related to tobacco have risen sharply since 1985 and outweigh the revenue generated by the tobacco tax seven times over; and
WHEREAS, the tobacco industry has targeted children and adolescents as a source of replacement smokers in addition to targeting communities of color through their marketing and promotion of tobacco products; and

WHEREAS, 3,000 young people being smoking everyday, one-third of who will suffer from a disease and die more than a decade prematurely as a result of smoking; and
WHEREAS, Minnesota youth are smoking at increased rates. Between 1992 to 1995, weekly smoking among 9th grade students increased by 50 percent; and
WHEREAS, the tobacco industry spends $6 billion annually to attract new users, retain current customers, increase current tobacco consumption, and generate favorable long-term attitudes toward smoking and tobacco use; and
WHEREAS, states with comprehensive tobacco-use prevention programs have experienced a decline in youth smoking rates, for example California and Massachusetts have seen youth smoking fall by 23 percent and 20 percent respectively; and
WHEREAS, Minnesota, once revered as a leader for efforts to confront smoking, now has youth smoking rates that surpass the national average, a tobacco tax that has fallen to 17th in the nation - 52 cents away from the top, and a pioneering clean indoor air law that has not been strengthened since the early 1970's.

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association support the dedication of state appropriated funds for broad-based initiative designed to reverse these discouraging trends and revitalize efforts to prevent and reduce tobacco use in Minnesota. Sources for this special appropriation include, but are not limited to, revenue from a settlement or jury award from the state's tobacco lawsuit, a substantial increase in the state tobacco tax, or proceeds resulting from national tobacco legislation.

BE IT FURTHER RESOLVED that such an appropriation should be funded at a level that will sustain efforts to prevent children from beginning a lifelong addiction to tobacco products, help smokers who want to quit, and protect nonsmokers from the documented dangers of second hand smoke. Likewise, the funding level should reflect the economic and societal costs inflicted by tobacco upon our state each year.

Adopted April 30, 1998

Support of Increase State Tobacco Excise Tax 1993

Whereas, Tobacco Taxes Reduce Tobacco Use Because:
- An increase in tobacco taxes acts as a disincentive to smoke; and
- Increasing tobacco taxes is particularly effective in preventing smoking among teenagers;

And Whereas, Reducing Tobacco Use Will Save Lives and Reduce Health Care Costs Because:
- In 1990, 6,100 Minnesotans died from tobacco-related causes; and
- Minnesota's estimated health care costs for tobacco-related diseases were $335 million in 1990, or $.90 for every pack of cigarettes sold, and $81 per Minnesota resident for that year alone; and
- Income lost as a result of premature death or disability related to tobacco use was $641 million in 1991 in Minnesota, or $1.63 per pack sold;

And Whereas Tobacco-related Death and Disability Are a Special Burden on Low Income People:
And Whereas Excise Taxes as a Proportion of the Retail Cost of Cigarettes Have Declined:

- to 31% of retail cost in 1992 compared with 57% in 1972;

BE IT RESOLVED

That the Minnesota Public Health Association supports increases in the state tobacco excise tax to prevent and reduce tobacco use.

Resolution to Increase the Alcohol Excise Tax 1990

WHEREAS, Health problems associated with excessive alcoholic beverage consumption are major contributors to morbidity, mortality, and social conflict in the United States and Minnesota, and
WHEREAS, The population rates of alcohol-related problems have been shown to be reduced by increasing price, and

WHEREAS, The price of alcohol has not kept pace with inflation, and thus the cost of alcohol in real dollars has gone down over the last 20 years;

THEREFORE, BE IT RESOLVED that MPHA supports legislation to increase the state alcohol excise tax, and that those funds be used to support programs to prevent and treat problems associated with alcohol use.

Resolution Opposing Penalties for Minors who Purchase Tobacco 1990

Whereas, It is the responsibility of adults to protect vulnerable populations such as children from dangerous substances, including tobacco. And
Whereas, A penalty against children who attempt to purchase cigarettes would criminalize children, instead of recognizing that they are victims of the tobacco industry's advertising and selling practices, and
WHEREAS, Such a penalty would be unenforceable, and thus add nothing to our ability to limit access of minors to tobacco, and
WHEREAS, Such a penalty would put an end to monitoring efforts by community groups and research which evaluates the impact of measures to limit children's access to tobacco, because child confederates could not be sent into stores to attempt to purchase tobacco;

THEREFORE BE IT RESOLVED that MPHA opposes state or local legislation to impose a penalty on minors who purchase or attempt to purchase tobacco.

Tobacco Billboard Advertising 1989

WHEREAS, MPHA supports the development of a smoke-free society, and
WHEREAS, Almost 90% of adult smokers begin smoking before the age of 18, and
WHEREAS, Billboard advertising of tobacco products continuously exposes children to messages that promote smoking, and
WHEREAS, Children cannot avoid these messages and adults cannot control or prevent children from being exposed to them;

THEREFORE, BE IT RESOLVED that MPHA support legislation prohibiting billboard advertising of tobacco products.

Access of Young People to Tobacco 1989

WHEREAS, MPHA supports the development of a smoke-free society; and
WHEREAS, Almost 90% of adult smokers begin smoking before the age of 18; and
WHEREAS, The current law regarding age of sale of tobacco is not enforced; and
WHEREAS, The ready availability of tobacco to teenagers contradicts the educational programs regarding smoking, and sends a conflicting message to young people regarding the social norms around teenage smoking, and
WHEREAS, Barriers to access have been shown to be effective in discouraging young people during the period of trial and initiation to smoking;

THEREFORE, BE IT RESOLVED that MPHA support legislation designed to limit young people's access to tobacco. Such measures might include banning the sale of tobacco through vending machines, mandatory licensure of tobacco vendors, linking tobacco licensure to compliance with the tobacco age of sale law, prohibiting the sale of tobacco by those under 18, increasing the penalty for tobacco sales to minors, and/or requiring a sign in all retail outlets.

Smokeless Tobacco 1986

WHEREAS, MPHA supports prevention of illness, disease, and injury; and
WHEREAS, Smokeless tobacco products have been proven to be a major cause of oral disease and pharyngeal cancer and associated with cancer in other sites; and
WHEREAS, Smokeless tobacco is associated with periodontic disease and acute elevations of blood pressure; and
WHEREAS, Smokeless tobacco is an addicting substance;
THEREFORE, BE IT RESOLVED that MPHA support all legislation restricting the sale and use of smokeless tobaccos by minors.
BE IT FURTHER RESOLVED that MPHA support legislation at the state and federal levels restricting advertising of smokeless tobacco products and imposing requirements for warning labels on all smokeless tobacco products.

Smoke Free Society 1983

WHEREAS, Tobacco is a health hazard both for smokers and their surroundings, and

WHEREAS, Continuous use damages the heart, blood vessels, circulatory system, lungs and respiratory tract, and causes cancer of the lung, throat and urinary bladder, as well as damage to the fetus, and

WHEREAS, Phasing out the consumption of tobacco is an important step toward improving the health of the nation,

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association urge the public health community, the medical community, related groups, educational institutions and government agencies to more effectively demonstrate the health hazards inherent in the use of tobacco products and work toward promoting a smoke-free society by the year 2000, and

BE IT FURTHER RESOLVED that MPHA prohibit smoking by participants at all MPHA meetings.

Approved October 20, 1983 Annual Meeting

Criminal Penalties Related to the use of Prescribed THC among Cancer Patients 1979

MPHA believes that provisions should be made by the Minnesota State Legislature whereby Minnesota cancer patients who follow their physicians' advice regarding marijuana use will not be subject to existing criminal penalties for such use, and further believes that the Minnesota State Legislature should designate and fund a state agency to develop a protocol with the FDA and other federal regulatory agencies establishing a research program that would permit access to marijuana compounds for cancer patients.

Approved September 20, 1979 Annual Meeting.

Drunk Driving 1978

State Legislature and Governor take appropriate action to alleviate the costly epidemic of death and disability from drunk driving.

Chemical Abuse and Dependency 1975

MPHA shall form a section committee on Chemical Abuse and Dependency who shall work with non-public health agencies to infuse public health concepts into the area of chemical dependency.

September 3, 1975

Marijuana Reform 1974

MPHA supports reducing penalty for possession of 1.5 oz. or less from a misdemeanor to a petty misdemeanor.

ANIMAL AND VECTOR BORNE ILLNESS PREVENTION

Minnesota Public Health Association Policy Resolution Encouraging Foodstuffs Produced Without the Use of Medically Important Antibiotics, May 2015

WHEREAS, recent reports from the White House and the Centers for Disease Control and Prevention (CDC) confirm the public health threat from growing antibiotic resistance;[1,2]

WHEREAS the CDC, World Health Organization and Food and Drug Administration (FDA) all acknowledge that antibiotic use and overuse in food animal production contributes to the human threat from antibiotic resistance;[3,4,5]

WHEREAS, the American Public Health Association passed a Policy Statement "Addressing the Problem of Bacterial Resistance to Antimicrobial Agents and the Need for Surveillance" in 1999, which acknowledged the unnecessary and harmful usage of antibiotics in animals;[6]

WHEREAS, it is fundamental to microbiology that use of antibiotics provides the selection pressure that tends to select for the emergence and propagation of antibiotic resistant strains of bacteria;

WHEREAS, data collected from the pharmaceutical industry by the FDA since 2009 indicate that sales of antimicrobials for use in food animals are more than 4-fold higher, by volume, than sales for human usage, and increased by 16% from 2009 to 2012.[7]

WHEREAS, classes of antibiotics that are "medically important", including cephalosporins, tetracyclines, penicillins, macrolides, aminoglycosides and sulfa drugs accounted for 61% of total antibiotic sales for use in food animals in 2012;[8]

WHEREAS, current FDA proposals to the pharmaceutical industry to voluntarily restrict the sale of medically important antibiotics for use in food animals apply only to the use of antibiotic products in animal feed or water for so-called "production uses", i.e. growth promotion, feed efficiency and weight gain, but would not address ongoing and routine use of many of these same products in animal feed at similar or identical dosages for disease prevention and/or control, so long as they were ordered via a veterinary feed directive (VFD) or veterinary prescription;[7,8]

WHEREAS, FDA's voluntary proposals in any case, do not take effect until December 2016 or, in the case of its to-be-revised VFD, is not yet final;

WHEREAS, recognizing the limitations in the FDA approach, a bipartisan bill called the Prevention of Antibiotic Resistance Act has been re-introduced in the U.S. Senate that would require FDA to withdraw its approval for uses of medically important antibiotics for disease prevention or control that are at high risk of abuse, unless the producer of the drug can demonstrate that its use in agriculture does not pose a risk to human health.[9]

WHEREAS, McDonald's USA announced March 4, 2015 that it would no longer allow use of medically important antibiotics by its chicken suppliers, and would seek to discourage similar uses in beef, pork and egg supplies in the future.[10]

Therefore, be it resolved that the Minnesota Public Health Association:

Encourages bulk purchasers of foodstuffs, including restaurant chains, school and hospitals, to adopt policies encouraging and, where feasible, requiring procurement of foodstuffs from animals raised with no medically important antibiotics or, alternatively, from animals only given such antibiotics on a non-routine basis and for a diagnosed disease.

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[8] Ibid, page 26, Table 3 of 2012 Summary Report.

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[10] McDonald's Corporation website, Press release, dated March 4, 2015, "McDonald's USA Announces New

Antibiotics Policy and Menu Sourcing Initiatives", Available at http://news.mcdonalds.com/US/releases/McDonald%E2%80%99s-USA- Announces-New-Antibiotics-Policy-an.

Minnesota Public Health Association Resolution:
Preserving Antibiotic Effectiveness by Stimulating Demand for Meats Produced Without Excessive Antibiotics 2005

Whereas, the effectiveness of many antibiotics, depended on by doctors to treat illness caused by bacteria from pneumonia to meningitis to other life-threatening situations, has begun to wane due to antibiotic resistance; and

Whereas, resistance is driven by antibiotic use and overuse, which exists in both human medicine and in agriculture; and.

Whereas, a major source of overuse is the routine use of antibiotics feed additives for livestock and poultry, not necessarily to treat disease, but to promote growth and to compensate for crowded, stressful, or unsanitary conditions.[1]

Whereas, antibiotic use in animal agriculture has been linked definitively to human bacterial infections resistant to antibiotics.[2]

Whereas, the American Public Health Association[3,4] and America Medical Association[5] are on record opposing the routine feeding of medically important antibiotics to livestock and poultry;

Whereas, meat, fish and dairy products produced without routine antibiotic use are widely available to consumers,[6] as well as to major wholesale purchasers;[7]

Whereas, the purchasing practices of hospitals and health care facilities, with a mission to heal the sick, create an opportunity to reduce overall antibiotic use by stimulating market demand for foodstuffs produced without the use of excessive antibiotics;

Now, **therefore,** be it resolved that the Minnesota Public Health Association help assure that existing antibiotics remain effective for treating infections by:

5. 1. Urging hospitals and health care facilities to adopt and use food purchasing and procurement policies that support meat, fish and dairy producers who are not routinely using medically important antibiotics for non-therapeutic purposes.

6. 2. Informing consumers that they too may help preserve antibiotic effectiveness by preferentially purchasing such products, thereby stimulating market demand for less antibiotic use.

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Human Health? Australian National University and the University of Sydney. Also, The 2003 National Academy of Sciences' Institute of Medicine report, *Microbial Threats to Health*, states that "Clearly, a decrease in antimicrobial use in human medicine alone will have little effect on the current situation. Substantial efforts must be made to decrease inappropriate overuse in animals and agriculture as well."[2] And, an expert consultation of the World Health Organization concluded in December 2003, "There is clear evidence of the human health consequences due to resistant organisms resulting from non-human usage of antimicrobials. These consequences include infections that would not have otherwise occurred, increased frequency of treatment failures (in some cases death) and increased severity of infections." (Joint WHO/FAO/OIE Expert Workshop on Non-human Antimicrobial Usage and Antimicrobial Resistance, Geneva, 1-5 December 2003, Executive Summary. Available at: http://www.who.int/foodsafety/micro/meetings/nov2003/en/. Accessed Jan. 30, 2004.)

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[4] APHA Resolution 9908: Addressing the Problem of Bacterial Resistance to Antimicrobial Agents and the Need for Surveillance. Available at: http://www.apha.org/legislative/policy/99policy.PDF. Accessed Jan. 30, 2004.

[5] American Medical Association, Resolution 508 - Antimicrobial Use and Resistance.

[6] Numerous such suppliers, for example, are listed at www.EatWellGuide.org.

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ENVIRONMENTAL HEALTH/OCCUPATIONAL HEALTH

Minnesota Public Health Association Resolution: Protecting Children from Harmful Effects of Lead in the Environment Passed June 18, 2009 at the MPHA Annual Meeting

WHEREAS, the toxic effects of excessive lead exposure on the brain and nervous system have been recognized for centuries[1]; and

WHEREAS, during the second half of the 20th century, it became increasingly evident that lower exposures to lead can also cause lasting intellectual and behavioral impairments, even when the dose is not immediately life-threatenining[1-3]; and

WHEREAS, over the past 40 years, science has repeatedly shown that blood lead concentrations once believed to be safe are actually toxic to children's developing brains and nervous systems[4]; and

WHEREAS, since the 1960s, the Centers for Disease Control and Prevention (CDC) has reduced its blood lead "level of concern" four times, due to scientific evidence of harm: In 1971, from 60 µg/dL to 40 µg/dL; in 1978, to 30 µg/dL; in 1985, to 25 µg/dL; and, in 1991, to the current limit of 10 µg/dL[4]; and

WHEREAS, a large and growing body of scientific evidence published since 1991 demonstrates adverse effects among children whose blood lead concentrations do not exceed the current CDC

exposure limit ("level of concern"; "elevated blood lead level") of 10 µg/dL[5-15]; and

WHEREAS, studies have found that intellectual impairment, quantified as significant loss of points on IQ tests, is associated with blood lead concentrations under 10 µg/dL[5-7]; and

WHEREAS, researchers have evaluated effects of lead on brain function through the use of a variety of other tests of cognitive ability, academic aptitude, and neurodevelopment, and have reported adverse effects at blood lead concentrations below 10 µg/dL[8-10]; and

WHEREAS, a recent study of the impacts of lead on children's academic performance found that blood lead concentrations below 10 µg/dL were correlated with lower reading and math scores on standardized tests that school systems administer to assess children's academic achievement[11]; and

WHEREAS, lead exposure has been identified as a risk factor for attention deficit/hyperactivity disorder (ADHD) and conduct disorder (CD) even when blood concentrations do not exceed 10 µg/dL[12-15]; and

WHEREAS, a no-effects threshold for blood lead concentration has not been found, yet studies have reported more serious neurocognitive effects of lead among children whose blood concentrations are between 5 µg/dL and 10 µg/dL, compared to children with levels below 5 µg/dL[2,6,8,11]; and

WHEREAS, the majority of children exposed to lead paint today are already disadvantaged, mainly living in poverty-stricken areas of our cities; and

WHEREAS, African-American children as a group and children from lower-income families (of any racial or ethnic background) are subject to disproportionately high exposures[16]; and

WHEREAS, in 2005, the American Public Health Association (APHA) published a resolution urging the CDC to "substantially lower its current 'blood lead level of concern' because the current action level is set too high and does not adequately protect children from the toxic effects of lead" [17]; and

WHEREAS, the CDC acknowledges that "research conducted since 1991 has strengthened the evidence that children's physical and mental development can be affected at [blood lead levels] < 10 µg/dL" [18]; and

WHEREAS, investment in lead exposure prevention can yield great economic returns: Decades after the phaseout of lead from gasoline, children's lead exposure from other sources still costs the U.S. economy over $40 billion per year in lost productivity when children become adults of working age[19]; and

WHEREAS, the State of Vermont, the City of Chicago, the City of Cincinnati, and the City of Cleveland have each successfully established a blood lead exposure limit of 5 µg/dL, demonstrating that this standard is both cost-effective and achievable[20-23]; and

WHEREAS, policy requiring thorough family education and follow-up venous blood testing at an exposure limit of 5 µg/dL would not change or supersede higher regulatory thresholds already in place (e.g., 15 µg/dL, 45 µg/dL, 60 µg/dL) that trigger more intensive interventions[24, 25].

THEREFORE, BE IT RESOLVED, that the Minnesota Public Health Association:

I. Recommends the following actions be conducted in accordance with existing state guidance[24, 25], when a child's blood lead level exceeds 5 µg/dL: 1) thorough family education on potential sources of lead and on ways to avoid exposure, and, 2) at least one follow-up (venous) blood test after 3 months for the exposed child and for all other children ≤ 5 years of age living in the residence.

II. Urges Minnesota state and local government agencies to promulgate policy, as resources become available, adjusting the children's blood lead exposure limit ("level of concern"; "elevated blood lead level") from 10 µg/dL to 5 µg/dL.

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Minnesota Public Health Association Resolution
Reform of Chemicals Policies to Protect Public Health[1], 2008

WHEREAS, The American Public Health Association has established policy in the area of chemical safety for workers and the general public,[2,3,4,5,6,7] and the need for reform of U.S. industrial chemical regulation; [8] and

WHEREAS, the U.S. chemical industry is a critical economic sector that designs, produces, and imports 42 billion pounds of chemical substances per day – substances that constitute the material base of society,[9] with global production growing a projected 4-fold by 2050;[10-11] and

WHEREAS, many of these chemicals ultimately found in toys, everyday consumer or industrial products also are known to be hazardous to human biology and ecological systems;[12-13] and

WHEREAS, hundreds of these same chemicals are now found, in studies by the CDC and others, to be accumulating in human tissues, including breast milk and the cord blood of infants;[14-15] and

WHEREAS, the Toxic Substances Control Act (TSCA) of 1976 (P.L. 94-469) – the federal statute broadly intended to enable regulation of chemicals both before and after they enter commerce – has fallen short of its objectives, according to multiple independent analyses by the National Academy of Sciences,[16] the Government Accountability Office,[17 -18] the U.S. Congress, [19] the U.S. EPA,[20] the University of California,[21] and others;[22-23] and

WHEREAS, TSCA consequently fails to serve as an effective vehicle for the public, industry, or government to *assess* the hazards of chemicals in commerce or *control* those of greatest health concern, and TSCA therefore also fails to motivate U.S. industry to innovate or invest in cleaner technologies, such as "Green Chemistry" – a term and approach well-defined in the scientific literature and endorsed by the American Chemistry Society;[24] and

WHEREAS, the U.S. chemicals market consequently operates primarily on the basis of economics (chemical price, function and performance), with much less attention to health (human and eco- toxicity); and

WHEREAS, these market conditions have failed to safeguard health and have instead produced a set of chemical problems for children,[25] for workers, the public, ecosystems, government, businesses, and industry[26] that will deepen, concomitant with expanding global chemical production; and

WHEREAS, these problems include not only body fluid contamination but also development of chronic diseases and premature death related to chemical exposures in the workplace; disproportionate chemical exposure risks visited upon members of minority, immigrant, and

low-income communities, as residents and workers; and the projected need for cleanup at enormous cost of an estimated 600 new hazardous waste sites appearing each month in the United States over the next 25 years;[27] and

WHEREAS, sweeping changes in public European environmental health policy[28] are driving global interest among manufacturers in cleaner technologies, including Green Chemistry, that reduce chemicals risks; and

WHEREAS, the U.S. federal government to date has not acted to reform the failing U.S. chemical regulatory system, thereby creating a unique opportunity within Minnesota state government to correct long-standing chemicals policy weaknesses and implement a modern, comprehensive approach to chemicals policy that better protects the public from exposures to toxic chemicals while building the foundation for new productive capacity in Green Chemistry; and

WHEREAS, increasing capacity in Green Chemistry will serve to prevent injury and disease – a cornerstone of public health policy and practice – since the twelve basic principles of Green Chemistry[29] include: reduced toxicity of final and intermediate products to human health and the environment; avoidance of substances that persist in the environment; and utilization of safer manufacturing processes to protect workers and prevent accidents.

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:

1. Supports and urges Minnesota to become a leader among states in innovation and education in the area of cleaner technology, such as Green Chemistry; and

2. Supports and urges the Minnesota legislature to take action to protect the health of Minnesota citizens from unnecessary exposures to toxic chemicals by requiring the phase out of toxic, persistent, bioaccumulative chemicals in products and production processes when safer alternatives are available.

References:

1 APHA Policy 20077 Calling on the U.S. Congress to Restructure the Toxic Substances Control Act of 1976.

2 APHA Policy 200011 The precautionary principle and children's health.

3 APHA Policy 20008 Affirming the importance of regulating pesticide exposures to protect public health.

4 APHA Policy 20009 Support for International Action to eliminate persistent organic pollutants.

5 APHA Policy 2002-5 Preserving Right-to-know information and encouraging hazard reduction to reduce the risk of exposure to toxic substances.

6 APHA Policy 2005-5 Protecting human milk from persistent toxic chemical contaminants.

7 APHA Policy 9606 The Precautionary Principle and Chemical Exposure Standards for the Workplace.

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MPHA Policy Resolution
Freedom to Breathe
May 2006

WHEREAS, tobacco-related disease is the number one cause of death to Minnesota residents; and
WHEREAS, worksites and public places are locations where both members of the community and employees of those establishments are exposed to secondhand smoke; and
WHEREAS, secondhand smoke kills 38,000 nonsmoking Americans every year from cardiovascular disease and lung cancer; and
WHEREAS, secondhand smoke can cause asthma attacks in those who suffer from asthma; and
WHEREAS, employees should not be forced to risk their health through exposure to dangerous and deadly toxins in their workplace; and
WHEREAS, much of this important health risk is preventable by the implementation of comprehensive smoke-free policies; and
WHEREAS, members of the Smoke-Free Coalition have come together to create the Freedom To Breathe Coalition with the express purpose of advocating and lobbying for the adoption of a statewide comprehensive smoke-free law – the Freedom to Breath Act.

Therefore, be it resolved that the Minnesota Public Health Association:

1. Supports the passage of the proposed state Freedom to Breathe Act, which provides smoke-free protections for all Minnesota workers.

2. Supports the continued right of local governments to further strengthen local laws to protect workers from secondhand smoke exposure.

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Minnesota Public Health Association Resolution:
Preventing Human Exposure to Polybrominated diphenyl ether (PBDE) Fire Retardants to Protect Public Health, 2005

Whereas, polybrominated diphenyl ethers (PBDEs) are commonly used flame retardants found in foam products, textiles, electrical equipment, building materials and transportation, with three of the most common commercial classes being penta-BDE, octa-BDE and deca-BDE.

Whereas, PBDEs are chemically similar to polychlorinated biphenyls (PCBs), which were banned in 1976 due to their high toxicity, persistence,and evidence that they cause neurodevelopmental problems in children.[1]

Whereas, PBDEs are potent toxins that persist in the environment and bioaccumulate in the food chain and in human tissues, [2] are lipophilic and have been found in fish, bird eggs and marine mammals as well as in human milk, fat and blood.

Whereas, PCB levels in fish and breast milk have slowly declined since being banned, while total PBDE levels in human milk, blood and tissues have increased by a factor of 100 during the past 30 years, doubling about every 5 years. [3]

Whereas, animal studies document that PBDEs are toxic to the brain, reproductive system and liver and disrupt thyroid function. [6,7,8,9,10,11,12,13,14]

Whereas, PBDE levels in U.S. women's breast milk are typically 10 -100 times higher than levels in European women [4,5] and are now approaching concentrations at which health effects have been observed in laboratory animals.

Whereas, PBDEs have been detected in household dust, [15] foods, and in air drawn from a warm TV, [16] and in Minnesota's environment in fish, landfill leachate, wastewater treatment plant sludge and sediments from major river basins.[17]

Whereas, concerns about rising levels of PBDEs in the breast milk of Swedish women, led to efforts by industrial users in both Sweden and Germany to phase out the use of these chemicals, with these actions leading to a decline in PBDE levels in breast milk of Swedish women.[18]

Whereas, the European Union has enacted a ban on penta and octa-BDEs and several U.S. states have enacted or are considering PBDE phase-outs.[19]

Whereas, alternatives to the use of PBDE flame-retardants are available and cost effective. [20,21]

Whereas, some computer, electronics and furniture manufacturers are phasing out the use of

PBDE flame-retardants. [22]

Whereas, in light of the emerging science on the inherent toxicity and persistence of PBDEs; evidence of adverse health effects on animals; prevalence and rising levels in fish, biota and human breast milk; and identification of the need for immediate action to prevent further environmental contamination and to protect public health, the American

Public Health Association adopted Resolution 2004-05, *Preventing Human Exposure to Polybrominated diphenyl ether (PBDE) Fire Retardants to Protect Public Health.*

Now, **therefore,** be it resolved that the Minnesota Public Health Association, urges:

18. 1. The U.S. Congress and the Minnesota Legislature to enact phase-outs of the use of PBDE flame retardants in all products manufactured and sold in the U.S. by a date certain; and

19. 2. The U.S. Congress and the Minnesota Legislature to provide financial incentives for development and use of alternative flame retardants or preferably changes in product design to increase fire resistance without use of chemicals, to assure fire safety, while protecting the public from toxic exposures; that alternative flame retardants be adequately tested for toxicity; and that environmental and health safety must be assured prior to use; and

20. 3. The U.S. Congress and the Minnesota Legislature to require labeling of chemical flame retardants used in products; and

21. 4. State, federal and local governments to regulate the safe disposal of products containing PBDE flame retardants and to prohibit land application of sewage sludge until testing can assure that such material does not contain measurable levels of PBDEs; and

22. 5. State and local governments to adopt purchasing policies which phase-out the use of products containing PBDEs; and

23. 6. The U.S. Centers for Disease Control and Prevention to expand the national biomonitoring program to include PBDEs and to increase the number of people studied; and

24. 7. Congress to increase funding for research on PBDE flame retardants, including monitoring levels of PBDEs in fish, sediments, human milk, blood and tissue, and additional research into exposure routes and human health effects from these exposures.

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Minnesota Public Health Association Resolution:
MERCURY IN FOOD AS A HUMAN HEALTH HAZARD 2003

WHEREAS, methyl mercury is a well-documented toxic substance that has posed a problem wherever it has been encountered; and

WHEREAS, because of methyl mercury's known toxicity, especially to the developing brain, no controlled trials using children or other human subjects have been carried out; and

WHEREAS, a recent study of over 200 patients in a community setting – eating retail fish and seafood under jurisdiction of the Food and Drug Administration (FDA) and no fish from local or non-commercial waterways – revealed symptoms indicative of mercury exposure, and many patients incurred significant health bills in pursuit of finding a cause of their symptoms (National Institutes of Health, *Environmental Health Perspectives,* November 1, 2002, "Mercury Levels in High-End Consumers of Fish"); and

WHEREAS, some study subjects, including children, consumed fish within current FDA consumption guidelines but nevertheless exceeded current Environmental Protection Agency (EPA) and National Academy of Sciences guidelines for mercury levels; and

WHEREAS, approximately eight percent of reproductive-age women in the U.S. have total mercury concentrations in blood considered unsafe for the developing fetus, according to the first

U.S. population-based estimates from National Health and Nutritional Survey using 1999-2000 data recently published in Journal of the American Medical Assn. (JAMA) ("Blood Mercury Levels in US Children and Women of Childbearing Age, 1999-2000," JAMA 2003; 289:1667-1674); and

WHEREAS, mean mercury levels in the JAMA study were almost four-fold higher among women who ate three or more fish or seafood servings in the previous 30 days compared to those with no fish consumption; and

WHEREAS, forty percent of Minnesota's mercury emissions are generated by coal-fired power plants and non-mercury generating renewable energy sources are readily available; and

WHEREAS, Minnesota Public Health Association passed a resolution in 1999 in support of eliminating environmental releases of mercury, better labeling of mercury in products and reduction of anthropogenic sources of mercury pollution, and which urged health professionals to warn the public of dangers of consuming mercury-contaminated fish and encouraged healthcare institutions to avoid mercury-containing products; therefore be it

RESOLVED: That testing of mercury content in fish be continued by appropriate agencies, and laboratory reporting of results of mercury testing be updated and consistent with current EPA and National Academy of Sciences standards; and be it further

RESOLVED: That the results of any mercury testing of fish, and advisories based upon them, should be labeled on packaged/canned fish; and be it further

RESOLVED: That the results of any mercury testing of fish, and advisories based upon them, should be readily available where fish are sold and through food distribution programs, including food shelves, in appropriate languages; and be it further

RESOLVED: That the Minnesota Public Health Association encourage collaboration among relevant public agencies and encourage public health professionals who work with women of childbearing age to educate them about the dangers of mercury toxicity from ingestion of food items, especially fish, and especially to advise pregnant women, parents and children to review and revise fish consumption habits to maximize the nutritional benefits while avoiding fish higher in mercury and other contaminants; and be it further

RESOLVED: That the Minnesota Public Health Association support increased funding for the Minnesota Department of Health to educate the public about safe fish consumption; and be it further

RESOLVED: That federally funded programs such as the Women Infant and Children program and free school lunch programs for children offer foods that are lower in mercury and provide appropriate fish consumption advice; and be it further

RESOLVED: That the Minnesota State Legislature promote through regulation and financial incentives the development of renewable energy sources, as an alternative to mercury-generating coal plants; and to set statewide goals for phased elimination of mercury emissions; and be it further

RESOLVED: That the Minnesota Public Utilities Commission continue and expand the Metro Emissions Reduction Plan (MERP) and aggressively pursue statewide goals for phased elimination of new mercury emissions; and be it further

RESOLVED: That this matter be referred for national action.

Public Health Risks of PVC Pipes 2003

Author: Jamie Harvie, PE, Institute for a Sustainable Future
Introduced by: Kathleen Schuler, MPH
Date: August 12, 2003

Whereas, a fundamental principle of public health practice is the prevention of the use and release of harmful substances as the preferred means of controlling pollution and disease; and

Whereas, the Association of Metropolitan Water Agencies supports pollution prevention as a major component in ensuring that the nation's drinking water supplies are safe and of high quality; and

Whereas, the EPA recognizes that pollution prevention is recognized as the most effective waste management strategy; and

Whereas, the origins of public health practice involve the distribution of potable water and the collection of human waste; and

Whereas, more than half of polyvinyl chloride (PVC) plastic produced is used in the manufacture of PVC pipe; and

Whereas, dioxin is a toxic waste byproduct that occurs when chlorinated waste is burned and when other organic chemicals that contain chlorine are manufactured and which in itself has no commercial or industrial use;[i] and

Whereas, PVC pipe is manufactured using lead, organotin, and/or cadmium stabilizers; and

Whereas, the toxic substances vinyl chloride, lead and organotins have been found to leach into drinking water supplies ; and

Whereas, organotins are readily absorbed through the skin ; and

Whereas, organotins are toxic to the live, bile duct, immune system and reproductive tract are powerful metabolic inhibitors and are also potent teratogens; and

Whereas, a variety of cost effective alternative piping materials are available on the marketplace for both water and wastewater applications; and

Whereas, PVC has the highest relative environmental risk ranking of six plastic resin alternatives based on comparative fuel, materials use, and emissions from production, and that this risk is twice that for the alternative plastic pipe resins polyethylene and polypropylene; and

Whereas, respected expert associations and agencies including the Minnesota Medical Association, the Minnesota Public Health Association (MPHA), the American Public Health Association, the Chicago Medical Society and the International Joint Commission[15], comprised of the governments of Canada and the U.S., have agreed upon the need to reduce or eliminate dioxin in the environment through the use of PVC and organochlorine alternatives; and

Whereas, disparate organizations such as the respected trade publication Environmental Building News and the International Fireman's Association support minimizing risk to human health and the environment through the use of PVC-free building materials; and

Whereas, international cities including Toronto , Barcelona , San Francisco , and Oakland , have adopted resolutions and/or ordinances to reduce and eliminate PVC and chlorinated products from building construction and other uses; and

Whereas, MPHA passed a resolution in 1998 that healthcare institutions adopt and implement purchasing policies which reduce the use of PVC products, inform others of its purchasing policies, label PVC products and avoid incineration of PVC products.

Now, Therefore, be it resolved that the Minnesota Public Health Association:

Will work with interested persons and organizations to inform municipalities and publicly owned wastewater and water utilities of its PVC Pipe Resolution and recommend the use of piping materials which are PVC-free.

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17 Chicago Medical Society, Resolution, 1998.
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20 Toronto City Council Resolution, 1996
21 Barcelona City Council Resolution, May 1997
22 San Francisco County Resolution, 1999
23 City of Oakland, Resolution, 1999

Mercury Reduction to Protect Public Health 1999

Understanding that human activity has fundamentally altered the global biogeochemical cycling of mercury, and

Noting the conclusion of the U.S. Environmental Protection Agency that anthropegenic emissions of mercury to the air are 50 to 75% of the total input from all sources; (1) the Minnesota Pollution Control Agency found that virtually all of the mercury in Minnesota's lakes, rivers and streams comes from releases to the atmosphere, (2) and

Understanding that when mercury is released into the environment, microbial biotransformation of inorganic mercury, especially in aquatic environments, produces methylmercury, and that this bioaccumulative compound undergoes biomagnification in the food chain, (3) and

Understanding that most mercury exposure in humans and wildlife which consume fish is attributable to methylmercury and that it is likely that a considerable portion of methylmercury concentrations in freshwater fish result from anthropogenic mercury emissions, (4) and

Understanding that methylmercury adversely affects the nervous and reproductive systems of humans and some wildlife and that methylmercury crosses the placental barrier to produce developmental deficits (5); that methylmercury penetrates the blood-brain barrier readily in children and interferes with normal development (6); and that methylmercury exposure on a per body weight basis among fish-consuming children is likely to be higher than that for fish-consuming adults; (7)

Recognizing that fish are an important food source, that there are health benefits associated with eating fish and that fish are a source of high quality, low-fat protein; and,

Recognizing that the MN Department of Health issues public health warnings advising the public to limit consumption of fish that may contain mercury at levels exceeding state advisory levels, and that of the 779 lakes tested to date, all have advisories to limit consumption for the most sensitive populations; (8) and,

Recognizing that fish advisories are an inadequate risk management tool in that one fifth of the fish consumed in the U.S. are harvested by recreational and subsistence fishers and are therefore exempt from federal health-based controls (9); fish advisories issued under various regulations by states, tribes, and territories are often confusing to the public, (10); adherence to fish advisories is not universal (11); some women of childbearing age continue to consume at-risk fish (12); and fish advisories do not protect fish and wildlife, and

Recognizing that data on fish ingestion rates by some subpopulations which rely upon fish as a subsistence resource indicate that these subpopulations, including Native Americans practicing traditional life ways, ingest approximately 10 times the human reference dose by EPA estimates (13) and that this constitutes a significant and an inequitable distribution of health risks on the public; and,

Understanding that a prudent approach to eliminating the release and discharge of mercury waste and consequent mercury exposure is to avoid incineration of all mercury-containing waste and to adopt alternative mercury-free products; and,

Understanding that appropriate alternative mercury-free products are currently available for many mercury-containing consumer and healthcare products, and,

Understanding that many sources of mercury emissions are facing increasingly stringent regulation but the largest sources of mercury pollution, coal-fired power plants, are not required to control or limit mercury emissions.

Therefore, be it resolved that the Minnesota Public Health Association supports:
1. A comprehensive approach to managing mercury use and eliminating environmental releases is required in order to protect this and future generations of children from this hazard.
2. Product manufacturers should clearly and publicly identify products which contain mercury and label them accordingly, to facilitate recycling of mercury-bearing products, and to work toward elimination of non-essential uses of mercury wherever possible.

3. Physicians and other health care professionals work to inform patients and the public about the potential dangers of consuming mercury-contaminated fish, and the potential impacts of over-consumption of fish on children's health.
4. Health care professionals encourage health care institutions with which they are associated to adopt policies that will lead toward the eventual elimination of the use of mercury-containing products, except florescent lamps (for which a more environmentally-protective alternative has yet to be developed.)
5. Federal and state regulators identify sources of anthropogenic mercury emissions and take the steps necessary to substantially reduce those emissions with the goal of their virtual elimination.

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Universal Primary Seat Belt Legislation 1999

Whereas, motor vehicle crashes are a leading cause of death and disability among Minnesotans; and

Whereas, in 1997, 600 people were killed in motor vehicle crashes in Minnesota. This is a substantial increase from 462 deaths in 1996. Among the victims for whom seat belt status could be determined, 55% were not wearing a seat belt at the time of the crash(1); and

Whereas, when seat belts are worn correctly, they reduce the chances of occupant death in a crash by nearly 50%.(2) In addition to protecting occupants from death, seat belts protect people from paraplegia, quadriplegia, traumatic brain injury, and disfigurement; and

Whereas, in 1997 Crash Facts, published by the Department of Public Safety, reports that 65% of Minnesotans wear seat belts while in rural areas, seat belt use is lower (59%) compared to metro areas (68%)(1); and

Whereas, primary enforcement of seat belt laws is the most effective way to increase use rates; and

Whereas, national averages show that 77% of motorists buckle up in states that allow primary enforcement4 and where adequately promoted and enforced, mandatory seat belt laws increase seat belt use and in turn, save lives.(5-6)

Whereas, Minnesota law (Statute 169.686) currently requires seat belt use among all front seat occupants and all children between ages 3 and 11 years old but, the law's effectiveness is limited because law enforcement officials can address seat belt violations only when they stop drivers for other reasons (speeding, etc.); and

Whereas, a primary seat belt law would allow enforcement officials to stop a vehicle solely on the basis of a seat belt violation; and

Whereas, a comparison between states with secondary and primary enforcement demonstrated that fatality rates declined by almost 10% among states with primary enforcement, compared with 7% in states with secondary enforcement policies(7);

Therefore, be it resolved that the Minnesota Public Health Association supports Universal Primary Seat Belt Legislation.

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Environmental Tobacco Smoke 1998

Whereas, tobacco use is the leading preventable cause of disease, disability, and death in the United States and Minnesota; and

Whereas, environmental tobacco smoke (ETS) is the combination of secondhand smoke and sidestream smoke; and

Whereas, ETS contributes to the toll of death and disease caused by tobacco, impacting smokers and non-smokers alike; and

Whereas, secondhand smoke is the third leading cause of preventable death in this country, killing 53,000 nonsmokers in the U.S. each year[1-2]; and

Whereas, research reviewed in the reports of the Surgeon General3, the National Academy of Sciences4, the National Institute of Occupational Safety and Health (NIOSH)5, and the Environmental Protection Agency6 have all found that environmental tobacco smoke was harmful, increasing the risk of lung cancer and possibly heart disease in nonsmokers; and

Whereas, the EPA has classified ETS has a Group A (known human) carcinogen, similar to asbestos and benzene. There is no safe level of exposure for Group A toxins[5]; and

Whereas, nonsmokers subjected to ETS are exposed to nicotine, carbon monoxide, and cancer-causing agents[7]; and

Whereas, both the Environmental Protection Agency and the National Institute of Occupational Safety & Health recommend that to protect nonsmokers in enclosed areas, smoking must be eliminated, or be restricted to rooms that have a separate ventilation system which is exhausted directly outside[8,9]; and

Whereas, a 1996 report issued by the U.S. Centers for Disease Control and Prevention and the American Cancer Society, found that eliminating ETS in the workplace and decreasing smoking by employees can reduce health care costs and increase years of productive life, and can also decrease maintenance costs and liability risks[10]; and

Whereas, Minnesota is no longer a national leader in clean indoor air regulation and currently lags far behind other states such as California and Utah in creating smoke-free workplaces;

Therefore, be it resolved that the Minnesota Public Health Association supports legislation that would strengthen and expand the Minnesota Clean Indoor Air Act to include all enclosed public and workplace locations where people might be exposed to tobacco smoke.

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PVC Purchasing Policy 1998

WHEREAS, the Healthcare Pollution Prevention Roundtable (Roundtable) was convened by the Minnesota Center for Environmental Advocacy (MCEA) in September 1996, being composed of materials managers and other key decision-makers from several Minnesota healthcare institutions, providers, representatives of a state physicians' association, a state hospital association, a plastics industry trade association, and other; and

WHEREAS, the Roundtable was convened as a forum for a voluntary, collaborative and open process based on the premise that healthcare institutions can collectively arrive at solutions to environmental problems which are more

effective and less costly than is often the case when such solutions are imposed by legislative and regulatory bodies; and

WHEREAS, the Roundtable held two formal meetings during which information was presented by experts in toxicology, medical plastics research and development, medical plastics incineration, and others regarding the environmental consequences of incinerating polyvinyl chloride (PVC) products, health risks posed by dioxins in the environment and pathways to human exposure, medical products made from non-PVC materials that are currently available for purchase and those which are being developed, and other topics; and

WHEREAS, at the conclusion of its second meeting, Roundtable participants completed a survey assessing whether the information presented indicated to them that the risks posed by incineration of PVC medical products warranted continued examination of non-PVC products, to which seven of the eight healthcare service providers and other Roundtable participants responded affirmatively and formed the Health PVC Working Group; and

WHEREAS, the Environmental Protection Agency has identified medical waste incinerators as among the nation's leading emitters of dioxins, and Minnesota has 25 operating medical waste incinerators, and many solid waste incinerators which may incinerate non-infectious medical waste; and

WHEREAS, research indicates that medical waste incinerators across large parts of the U.S. and Canada emit dioxins which are carried by wind currents and deposited in Minnesota; and

WHEREAS, numerous studies show that PVC constitutes the overwhelming proportion of chlorinated organics in the medical waste stream; and

WHEREAS, the weight of credible scientific evidence supports the conclusion that the removal of such materials from the waste stream will significantly reduce dioxin emissions; and

WHEREAS, dioxins are highly toxic, persistent and bioaccumulative pollutants that have been associated with a wide range of health effects at extremely low exposure concentrations in wildlife, including cancer, immune system suppression, reduced sperm production, feminization of males, development and behavioral problems in offspring, and research is being conducted to determine whether the increased rates of these conditions in humans may also be attributable to dioxin exposure; and

WHEREAS, the Environmental Protection Agency in its 1994 Dioxin Reassessment report has stated that the average U.S. body burden of dioxins is "at or near levels known to cause harm"; and

WHEREAS, recycling programs for PVC medical products do not currently exist in Minnesota, and many of those in other states suffer from quality control problems, unstable markets for recycled materials, rely on subsidies from PVC medical products manufacturers in order to remain economically viable, do no insure that products made from recycled materials will not themselves be incinerated, thereby merely delaying the production of dioxins, and do not address dioxins produced during the PVC production process; and

WHEREAS, a materials substitution approach, by removing from the waste stream materials which produce dioxins when incinerated, is likely to be more effective in reducing dioxin emissions from medical waste incinerators than costly pollution control technologies which capture only a portion of pollutants after they have been produced; and

WHEREAS, price-competitive non-chlorinated alternatives which are equivalent in function and performance to existing PVC products are being more widely available on the market for some PVC products, and more such products will be developed and will come onto the market as customer demand for them increases; and

WHEREAS, a fundamental ethical principle of health care is "First do no harm."

NOW, THEREFORE, BE IT RESOLVED THAT Minnesota Public Health Association adopt the recommendation of the Healthcare PVC Working Group that healthcare institutions in Minnesota adopt and implement the following purchasing policy.

1. It is the policy of the institution that it is committed to reducing harmful dioxin emissions from medical waste incinerators by minimizing the purchase of PVC medical products and packaging materials to the fullest extent possible, in favor of cost-effective non-PVC products and packaging which provide safe and effective patient care.
2. The institution will inform manufacturers, vendors and group purchasing organizations (GPOs) of its PVC purchasing policy, and will encourage them to identify and label products made from PVC and to offer products and packaging materials not made from PVC. As additional shipments of medical products currently under contract which may contain PVC are ordered the institution will also request its vendor of GPO to provide information of the PVC content of those products.
3. The institution will, to the maximum extent feasible, avoid incineration of those PVC products for which acceptable alternatives have not yet been developed by seeking out disposal technologies that do not have the potential to create dioxins.

Adopted April 30, 1998

Air Quality 1994

Whereas, 164 million Americans in 534 counties and cities are at risk for respiratory and other health problems from excessive air pollution, and the number of communities at risk has increased from 1988 to 1991(1); and

Whereas, Minnesota ranks 19th among states in the volume of mercury emitted into the atmosphere, and according to an estimate of the Minnesota Pollution Control Agency, at least 14,000 pounds of mercury have been emitted into the atmosphere each year from 1988 through 1991(2); and

Whereas, mercury in the human body can harm the development of fetuses and infants, and can cause tremors, impair vision, cause hearing loss, and kidney damage, thus having an adverse impact on the health of the public(3); and

Whereas, the Minnesota Public Health Association has passed a resolution (1982) opposing the relaxation of emission standards from sulfur dioxide and nitrogen dioxide, and promoting the study of acid deposition in the waters of Minnesota; and

Whereas, the net present value of national health costs are estimated to be between $2.7 billion and $10.0 billion annually for mortality, morbidity, and material damage effects from exposure to sulfur dioxide and related particulate matter in excess of the current federal public health standard(4); and

Whereas, State agencies are promulgating rules regarding ambient concentration limits for at least 80 toxic substances which will be important for protection of the health of Minnesotans, and will include standards for the emission of mercury, dioxins, and polychlorinated biphenyls (PCBs), for which no national air quality standards have been established; and

Whereas, the Minnesota Department of Health has stated that mercury, dioxins and PCBs have some of their most severe effects on fetal development and young children; and

Whereas, the Minnesota Department of Health has also stated that the promulgation of health-based* ambient concentration limits as part of air toxins rulemaking will be important for the protection of the health of Minnesotans, and total reliance on technology based standards may not be protective and may be needlessly costly(5); and

Whereas, State air toxin regulations will allow State agencies to regulate those sources emitting pollutants in a more systematic and efficient manner than under the current permit-by-permit approach,

Be it therefore resolved that the Minnesota Public Health Association supports the prompt development of State air toxic rules incorporating "health-based" standards, when evidence indicates that the standards are technically feasible, using the best available scientific data as well as a risk assessment policy which is sufficiently protective of the public health, and takes into account other possible routes of exposure to toxic substances, such as in food and water.

* "Health-based" standards are defined as levels which, according to the best available scientific data, have been shown not to cause unacceptable health effects in humans.

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Response to Core Proposal Concerning Environmental Health 1993

The Minnesota Public Health Association is opposed to the transfer of environmental health functions out of the Minnesota Department of Health into a new Department of Environmental Protection.

While we support the Governor's initiatives to streamline state government and make services more accessible to all citizens, we urge caution in making changes that would weaken the public health infrastructure in Minnesota. Support for an organized delivery system of basic public health services, including programs that ensure the safety of our drinking water, is critical to the maintenance of the quality of life we have come to all but take for granted in Minnesota.

1. The department of health is charged by law with protecting human health. Therefore, it employs staff who possess expertise and knowledge about human health and all the various activities and programs designed to maintain and protect it.

2. To separate the environmental health programs from this group of experts would have a negative impact on those health programs which are transferred. the loss of immediate contact with health program designers, epidemiologists, communicable and chronic disease specialists, health educators, and health promotion experts would significantly impair delivery of public health services in Minnesota.

3. While transfer of environmental health programs out of the Minnesota Department of Health would create some efficiencies, it would fragment the delivery of services and create inefficiencies. It would jeopardize existing effective working relationships. For example, the department of health has worked with local Community Health Service agencies for the past two decades to forge a strong state and local partnership that is the envy of the nation. This relationship has led to increased delegation of responsibilities to local health agencies, and increased local control of public health programs. It is unlikely that this state-local partnership would continue to thrive outside of the Community Health Service Delivery system.

4. The primary responsibility of the proposed Department of Environmental Protection is to protect the environment from the harmful impacts of human activities. On the other hand, the purpose of environmental health programs is to assure protection of human health from the negative impacts of the environment, whether naturally occurring or man-made. The goals of these two disciplines, although not inconsistent with each other, may sometimes result in conflicts. For example, fear of harming the environment with water to extinguish a fire may conflict with efforts to protect humans from the ill effects of toxic smoke. The goal of protecting the environment could support letting a fire burn itself out. The goal of human health protection might support extinguishing the fire quickly to protect residents from the toxic smoke. Separate agencies for both concerns supports a system of checks and balances.

5. While we agree that environmental protection serves the interests of all citizens, we feel strongly that human health protection should never have to compete for resources with programs to protect the environment, a strong likelihood if the environmental health programs were transferred to a new department. Gaining support needed to protect human health from the environment is often challenging because the relationship between cause and effect is often not obvious to the public. This may become a greater problem if environmental health is obscured in an environmental department.

Licensing Commercial Tanning Facilities 1992

SF1086 - Authors: Senators Pappas, Marty, Ranum, Spear, Waldorf
HF1171- Authors: Representatives Hausman, Wejcman, Milbert

Summary of the Bill

This bill requires that:

- All commercial tanning facilities be licensed, with fee to cover costs of inspections;
- Commercial tanning equipment meet specified standards;
- Goggles be provided to customers;
- Sign of specified size and wording be posted, warning of health hazards;
- Customers be required to sign a statement of health hazards;
- Facility keep a record of each customer's visits and duration of exposure;
- Facility keep a record of reported injuries or complaints resulting from use;
- Use by minors under 18 prohibited.

Why Is Licensing Needed?

- UV radiation from commercial tanning facilities is a serious health threat.
  UV radiation emitted from tanning equipment is associated with acute and chronic health problems:
  * allergic reactions, increased skin photosensitivity
  * eye problems: burns of the cornea, damage to the retina, cataracts
  * skin problems: rashes, burns, premature aging of the skin
  * compromised immune response
  * drug interactions: some oral contraceptives, some antibiotics, some antihistamines
  * malignant melanoma and other skin cancers

- Tanning produces no known health benefits.

Exposure to tanning equipment may make the skin more sensitive to cancer from natural sunlight. The natural sun protection factor from prior tanning in a tanning facility is only about 4, not significant protection from sunburn from natural sunlight. Tanning represents the skin's attempt to avoid further UV damage.

- Indoor tanning is NOT safer than the tanning in natural sunlight.

Most types of tanning equipment emit a mixture of UVA and UVB radiation. UVB radiation is more intense and burns the skin quicker. UVA is less energetic, and thus less likely to burn; but UVA penetrates deeply, thereby increasing many of the hazards.

- The risk of melanoma and other skin cancer is higher when exposure occurs during childhood and adolescence. Estimates indicate that up to 78% of the risk for skin cancer from UV radiation may be complete by age 18.

- High numbers of Minnesota teenagers use commercial tanning facilities. Estimates from a survey of a local suburban high school are that 50% of high school juniors and 20% of ninth graders have used tanning facilities.

- Many states currently regulate commercial tanning facilities. Over 25% of states require that commercial tanning facilities be licensed. Licensing legislation includes provisions to protect both adult and minor users, and many place severe restrictions on use by minors. Minnesota is negligent in not protecting consumers against this serious health hazard. The U.S. Food and Drug Administration requires a small warning on the beds or bulbs, but has not taken more restrictive action.

- Medical organizations have taken strong positions in favor of regulation of commercial tanning facilities.

The American Medical Association, the Minnesota Medical Association, the American Academy of Dermatology, and the American Academy of Pediatrics warn patients against use, state that there is no such thing as a safe tan, and urge regulation of the facilities.

A Resolution Urging the Minnesota Delegation in the Congress of the United States to Sponsor and to Support Measures to Expedite for Recycling of Plastics 1990

WHEREAS, The current mix of solid waste management practices is producing widespread pollution problems of such a magnitude that they constitute a crisis; and

WHEREAS, Sanitary landfills are proven sources of groundwater pollution and new solid waste incinerators may pollute the air; and

WHEREAS, Responsible actions to address this dilemma are those which reduce the amount of solid waste buried in landfills and processed in incinerators; and

WHEREAS, To accomplish these objectives, measures need to be taken to maximize the recyclability and reusability of materials; and

WHEREAS, Plastics are materials which constitute a significant component of the solid waste stream, and are among the most voluminous wastes generated; and

WHEREAS, Plastics are used in ever-increasing amounts but only a small percent are reused or recycled; and

WHEREAS, Overall waste management strategies will be more effective if plastics can be easily recycled and reused; and

WHEREAS, As the presence of plastic products and manufacturers is ubiquitous in the nation, the ability to establish uniformity and to encourage the reuse and recycling of plastics is most effectively addressed on a national level during the inception of handling post-consumer waste plastics;

THEREFORE, BE IT RESOLVED by the Minnesota Public Health Association that the Association urges the Congress of the United States to enact measures to expedite the recycling of plastics:

1. Mandate a uniform system to identify resin types in plastic products to more easily separate for recycling and reuse; the system devised by the Society of Plastics Industry should be used as the model.

2. Changes should be made in the federal Tax Code which will provide incentives for recycling and reuse in manufacturing processes and consumer purchasing patterns.

3. Regulations and practices should discourage the use of virgin resins for products other than uses related to food and health.

The Minnesota Congressional Delegation should continue to demonstrate its leadership in this area to safeguard our precious environment.

Reduce Toxic Chemical Use 1990

WHEREAS, Health problems associated with toxic chemicals are major contributors to increased morbidity and mortality in Minnesota and,

WHEREAS, New toxic chemicals are introduced every year, and

WHEREAS, Annually more of the population are being exposed to the long-term effects of toxic chemicals;

THEREFORE, BE IT RESOLVED that MPHA support legislation mandating decreased usage of toxic chemicals.

Groundwater 1985

MPHA supports efforts to protect and preserve the state's groundwater supply, particularly from potential threats to human and animal health when groundwater contamination occurs. Residents of Minnesota should accept the caretaker status which accompanies living in a state with high quality groundwater. MPHA supports a strong, coordinated federal, state, and local effort to assure that groundwater problems are adequately addressed.

Comment

Two-thirds of Minnesota's population relies on groundwater for their drinking water supply. Public water supplies are routinely monitored under the state and federal safe drinking water act regulations. Some 800,000 residents used private wells, generally in the rural areas of the state. In the case of both the public and private water supplies, to protect groundwater quality from degradation, local use decisions should reflect a groundwater protection policy.

Since State programs do exist which can assist counties with many aspects of groundwater protection, local units of government should be encouraged to include groundwater-related responsibilities in their environmental programs and to educate the citizenry on the local importance of groundwater. Well owners should be encouraged to test their wells and be provided with assistance in the interpretation of the results of the sampling. Counties should also consider adoption of new well and on-site sewage disposal inspection responsibilities and ordinances.

Approved April 26, 1985 Annual Meeting.

Health Risks Related to Lead Exposure 1985

Recognizing that lead is pervasive throughout the human environment as a result of industrialization and that abnormal absorption of lead is one of the most prevalent and preventable health problems in the United States today(1,2,3); and

Realizing that new epidemiologic, clinical and experimental evidence suggests that lead is toxic at levels previously thought to be nontoxic and that lead toxicity is a widespread problem that is neither unique to the inner city nor limited to one area of the country(2,3); and

Noting that the Centers for Disease Control has lowered its definition of an elevated blood level for lead from 30 to 25 g/dl in whole blood and for lead toxicity to an elevated blood lead level with an erythrocyte protoporphyrin (EP) level in whole blood of 35 g/dl or greater(2); and

Acknowledging that numerous clinical and pathological effects of lead in humans and animals have been identified affecting the blood, central nervous system, kidneys, skeleton, gastrointestinal tract, cardiovascular system, endocrine system, reproductive system and the peripheral neuromuscular system(4,5,6,7); and

Realizing that all members of the population experience exposures to man-made sources of lead from the air, drinking water and foods(8,9) and that current lead levels in Americans are between 100 and 1,000 times higher than in pre-technological humans(1,2,10,11); and

Observing that young children have been identified as being at greatest risk of lead exposure and toxicity through exposure to leaded paint, soil, dust, food, folk medicines, water and air(1,12,13,14,15,16,17,18); and

Noting that environmental levels alone can not account for some children developing elevated blood lead levels and that a number of sociodemographic variables (e.g., education, income, parental supervision) are associated with elevated blood lead levels(19,20); and

Considering that lead in gasoline is a major source of elevated blood lead levels in both children and adults(21,22); and

Recognizing that many drinking water supplies are conveyed through plumbing systems containing lead-based solder, which produce excessive lead levels in the water,(23,24) and that these levels may threaten health;(24) therefore

1. Recommends that researchers continue to undertake prospective epidemiologic studies to ascertain the effects of low-level lead exposures on humans, especially children.

2. Recommends further research on quantitative assessment of social, demographic, and family risk factors related to elevated blood lead levels in order to identify high risk target populations and to facilitate development of prevention strategies to protect those populations from environmental lead hazards.

3. Recommends that the use of lead-based solders should be prohibited and that control measures to minimize the presence of lead in drinking water due to the corrosion of lead solders be instituted.

4. Suggests that state and local housing codes be reviewed to assure that they consistently address lead hazards in existing residential dwellings. State/local procedures for enforcement of such standards should be reviewed and improved as necessary.

5. Recommends development of childhood lead poisoning prevention programs incorporating a screening program that enrolls the maximum number of children of high risk populations, ensures a comprehensive diagnostic evaluation of every child with a positive screening test, thoroughly identifies all possible sources

(e.g., paint, soil, dust, food, water, air and folk medicines) and addresses the sources of the exposure, and monitors the adequacy of the treatment and the follow-up of each lead toxicity case, including abatement of the environmental problem.

6. Encourages continued efforts by the Environmental Protection Agency to reduce and eventually eliminate the lead added to gasoline.

7. Encourages the dissemination of information and education of the public, especially high risk populations, health professionals, and public officials, with regard to the sources of lead exposure, the potential health effects of lead and the means of reducing exposures.

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Approved April 26, 1985 Annual Meeting

Occupational Health 1983

MPHA supports efforts to ensure a safe working environment through educating the employer and workers about occupational health hazards and supporting planning, legislation, regulatory measures, research and rule-making at the federal, state, regional and local level. We respect the worker's right to know and the responsibility of employers to adjust processes to insure safety.

Comment

The MPHA has consistently supported the concept of prevention and education as effective means of ensuring a safe working environment. The responsibility for a safe worksite rests with the employee as well as the employer.

The purpose of this position is to continue to advocate measures to promote health and well-being in the workplace and to focus attention on the problem.

MPHA advocates the right of workers to know about, and be protected from, actual and potentially hazardous processes, materials and products at the worksite. We support education programs and regulations which promote health and safety on the job.

Approved October 20, 1983 Annual Meeting.

Drinking Water Quality 1983

MPHA supports efforts to ensure that a healthful source of drinking water is available to all Minnesotans. Both urban and rural water supplies must be protected from contamination and should be treated, when necessary, to meet Safe Drinking Water Standards.

Comment

The current understanding of traditional water quality problems such as common pathogens and inorganic chemicals is generally good to excellent. The biggest gap in knowledge about water quality involves trace contaminants, such as viruses and organic chemicals.

The health effects of hundreds of compounds detected in water are either unknown or well debated, focusing on the question of the possible carcinogenicity of these compounds when consumed in small amounts over long periods of time.

Rural supplies are generally only sampled for nitrate-nitrogen and coliform bacteria. The additional water quality problems such as the presence of agricultural chemicals in wells are not routinely addressed, partly because of the high cost of organic chemical analyses.

In order to assess the long-term public health impact of drinking water, accurate records of readily retrievable water quality data for both ambient and treated, urban and rural water supplies must be maintained at the state and county levels.

Approved October 20, 1983 Annual Meeting.

Hazardous Water Management 1983

MPHA recognizes the importance of public and private hazardous waste management programs for protection of public health, safety and the environment, and supports ongoing efforts to identify and implement appropriate hazardous waste management programs. Efforts should be made to minimize the need for hazardous waste disposal by the use of other methods of management, such as recycling, processing, reduction of wastes, and by a large and continuing commitment to research into all of these components of waste management.

Comment

In response to public health and environmental problems associated with solid and hazardous wastes, the Resource Conservation and Recovery Act (RCRA) was enacted by the U.S. Congress in 1976. That legislation called for a system to identify and track hazardous wastes, established standards for waste generators and transporters, outlined requirements for hazardous waste facilities and provided guidelines for state waste management programs.

The Minnesota Waste Management Board is in the process of identifying specific and appropriate methods for hazardous waste disposal and recycling. This process will also recommend specific sites. Citing hazardous waste disposal areas is a very difficult process and requires citizen education and participation.

Approved October 20, 1983 Annual Meeting.

Environmental Hazards 1982

MPHA supports the funding of activities to assess the long and short-term effects of recognized and potential environmental hazards in order to provide accurate information to the public and to develop preventive programs at the National, State and Local levels.

Comment

This position is consistent with MPHA positions on the prevention of disease and the provision of environmental health services. The provision of such services and the setting of standards and policies to protect public health require the availability of research findings on the short and long-term health effects of environmental problems. Because health problems from environmental hazards may have a long latency period, the risk assessment requires that consistent data be collected and analyzed over many years.

MPHA recognizes the pressure, when funding is decreasing, to eliminate or cut back on environmental studies in order to continue providing direct services. However, both services and studies are needed to protect public health in the future. Thus MPHA opposes the elimination or disproportionate reduction of funding for environmental studies.

Approved September 30, 1982 Annual Meeting.

Acid Deposition 1982

MPHA opposes the relaxing of the emission standards of sulfur dioxide and nitrogen dioxide and should promote the study of acid deposition to determine health and environmental risk.

Comment

Acid deposition does present a serious potential for health effects in Minnesota through the introduction of toxic metals in drinking water supplies and from the ingesting of contaminated fish. Acid deposition is now causing serious damage to the environment through acidification of the soil, long-term loss of forest productivity, acidification of surface waters, and interference in the normal reproduction of fish, amphibians, and other organisms.

The chief precursors of acid deposition are sulfur dioxide and nitrogen dioxide expended through the worldwide burning of coal, oil, and natural gases, forming sulfuric and nitric acid, which falls to earth in the form of rain or snow. Much remains to be learned about acid deposition to determine the long-range impact of acid deposition on the aquatic ecosystem, forests, crops, soils, wildlife, groundwater, man-made materials and human health.

Approved September 30, 1982 Annual Meeting.

Accident Prevention 1981

MPHA supports planning, regulatory measures and educational programs at the state, regional and local levels to reduce the incidence and severity of accidents.

Comment

The MPHA has consistently supported policy positions for the prevention of accidents. Accidents are the leading causes of death among persons between the ages of one and forty in Minnesota and the U.S. with motor vehicle accidents responsible for about half the deaths. Millions of people are injured each year as a result of accidents and the estimated cost of these accidents in the U.S. in 1975 was $27.5 billion. In Minnesota alone the economic loss resulting from motor vehicle accidents alone in approximately $400 million. MPHA believes that the majority of accidents are preventable and a strong educational and regulatory program will greatly reduce the total number of accidents.

MPHA Resolutions Related to This Position:
Position Paper on Prevention - 1977
Comprehensive Recommendation for Preventive Programs - 1978
Motorcycle Helmets - 1977
MPHA Position on Prevention - 1980
Approved October 1, 1981 Annual Meeting.

Prevention 1980

MPHA supports the concept that prevention of illness, disease, and injury is generally more effective in maintaining and improving people's health than attempts to correct the impact of personal, societal, and environmental problems.

Comment

Since the natural processes inherent in the human organism tend toward healing and health, society should strive to enable each person to maintain and restore health by promoting healthy lifestyles.

The MPHA has historically supported legislation which assures the planning and provision of preventive health services for people of all ages. This includes support for private, local, state, and federal initiatives to develop prevention-oriented health services in a variety of settings. While MPHA encourages the individual to assume responsibility for his or her own health, the organization also encourages strategies to promote preventive measures in situations where the individual has little control, such as in the work-place, school, or in the environment at large.

MPHA Resolutions Related to This Position:
Comprehensive Recommendations for Preventive Programs - 1978
Position Paper on Prevention - 1977
Approved September 26, 1980 Annual Meeting.

Environmental Cooperative Planning and Service Provision 1980

MPHA supports cooperative planning and service provision efforts among statewide, regional and local, public and private health organizations to provide for the management and control of the environment.

Comment

MPHA support for this position has been consistent with its support of advocating the Clean Indoor Air Act, its support for energy conservation without the sacrifice of environmental and public health, and the coordination of comprehensive environmental health programs. It is important to recognize the pressures that are focused on environmental health programs because of the current economic conditions. These conditions demand quick solutions to the competing issues of expensive energy, high unemployment, inflation, etc. While MPHA recognizes the importance of developing solutions to these problems in the immediate future, these solutions must address the long and short-term environmental impacts on communities through special coordinated planning among all levels of government. In addition, planning and training are encouraged for the emergency management of environmental hazards and accidents.

MPHA Resolutions Related to This Position:
CHS - 1979
Energy Conservation - 1979
Environmental Health - 1976
CHS - 1978
CHS - 1976
Approved September 26, 1980 Annual Meeting.

Solid and Hazardous Waste Management 1979

RECOGNIZING that many landfill sites, and remaining dump sites, in the state are soon going to be filled; and

RECOGNIZING the difficulty in citing waste handling facilities due to local opposition; and

RECOGNIZING that the handling of waste materials is of regional and statewide concern and that often regional facilities are more advantageous; and

RECOGNIZING that the pollution potential of waste handling facilities must be alleviated by thorough planning and development; and

RECOGNIZING that some industries may refuse to locate or remain in Minnesota due to their inability to dispose of waste materials; and

RECOGNIZING that the fate of large quantities of waste, including hazardous waste, is unknown; and

RECOGNIZING also that the disposal of wastes in landfill sites represents a great waste of energy and resources; and

RECOGNIZING the multiplicity of regulatory agencies with conflicting views and overlapping authority,

The Minnesota Public Health Association recommends:

1. That the State of Minnesota establish legislation supporting a comprehensive program of waste management. This would include laws and tax incentives which would promote resource recovery, waste reduction, materials reuse, materials recycling and appropriate management of hazardous waste.

2. That any attempts to plan, site, develop and implement a regional and statewide waste management system have strong representation and input from environmental health specialists.

Approved September 20, 1979 Annual Meeting.

Energy Conservation 1979

RECOGNIZING that oil, coal, nuclear fission and synthetic fuels for electrical power generation are non-renewable resources; and that the mining of these materials is associated with high rates of occupational injuries and illness; and that the mining of these products often scars the land in such a way as to cause erosion and water pollution;

ALSO RECOGNIZING that the refining of oil, coal, nuclear fission materials, and synthetic fuels contributes to air, soil and water pollution;

RECOGNIZING further that the consumption of oil, coal, nuclear fission materials and synthetic fuels also contribute to air, soil and water pollution;

REALIZING that erosion, air, soil and water pollution degrade our environment and contribute to excess morbidity and mortality;

THE MINNESOTA PUBLIC HEALTH ASSOCIATION expresses concern for both public health, and the quality of our environment, and recommends:

1. Energy conservation should be encouraged through tax legislation, direct subsidies and the development of energy standards for the production, service and consumer segments of our society, and other methods.

2. Emphasis should be placed on promoting renewable energy sources such as solar and wind power.

3. Standards for environmental/public health protection should not be compromised and should be strictly enforced.

Approved September 20, 1979 Annual Meeting.

Anti-Laetrile 1978

WHEREAS, It has been demonstrated that laetrile (amygdalin) does not control cancer, and is identified as a poisonous compound; and

WHEREAS, No clearly documented cases of cancer patients who have responded to their regimen of laetrile treatment have ever been submitted for scientific review; and

WHEREAS, The Food and Drug Administration, and American Medical Association, and National Cancer Institute, and the American Cancer Society have banned laetrile as an ineffective substance for the treatment of cancer; and

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association oppose legalization of the dispensing of laetrile in Minnesota.

This resolution conforms with similar resolutions and/or statements of the American Cancer Society, American Medical Association, and the National Cancer Institute.

References

1. Cancer Quackery-Laetrile, American Cancer Society, Minnesota Division, 1977.
2. "Laetrile, the Political Success of a Scientific Failure," Consumer Reports, August 1977.
3. "Retrospective Evaluation of Laetrile Anti-Cancer Activity in Man," National Cancer Institute, January 1978.

Approved September 22, 1978 Annual Meeting.

Motorcycle Helmets 1977

MPHA supports use of helmets.

March 18, 1977

Environmental Health 1976

MPHA recognizes that health is a state of physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO definition). Furthermore, it is a fundamental principle of public health that prevention is the only way to reduce the incidence of disease and that reducing the incidence of disease is more cost-effective and humane than curative medicine.

Environmental health applied on a community level provides a vital role in promoting health and preventing disease. To implement an environmental health program, local public health agencies should receive proper funding and authority for service delivery.

Summary for Action

1. MPHA supports the establishment of local environmental health units in all counties except where there are existing City Environmental Health Units as part of the Community Health Services implementation plan. Such local environmental health units should involve a unification of all duplicative environmental health services provided by the State Department of Health, Agriculture, Natural Resources and Pollution Control Agency.

2. MPHA urges the Minnesota Legislature to provide additional funding to the State Department of Health for environmental health research, epidemiology, training and for technical assistance to local agencies in the development and maintenance of their programs.

3. Furthermore, MPHA urges the Legislature to adopt a State policy for removal of State agencies from direct delivery of environmental health services and to transfer authority and funding for delivery to local public health agencies. Appropriate mechanisms for the transfer of these service responsibilities shall be provided and implemented. The State agencies' role will be to provide technical assistance, standard setting, training and general supervision of the local agencies.

Approved October 8, 1976 Annual Meeting.

Clean Indoor Air Act 1975

MPHA supports designation of non-smoking areas in public places.

GERIATRICS/HOME HEALTH CARE

Position Paper on Long Term Care Reform 1995

MPHA supports the reform of the Long Term Care (LTC) system within the context of Minnesota's Health Care reform effort. The steadily increasing population of people at risk of long term care has begun putting pressure on the current LTC system that necessitates change, and projections show the trends continuing. For example:

- In 1980 11% of Minnesota's population was 65+ years of age and the elderly population was projected to increase by 13% by 2000.

- In 1980 1.2% of Minnesota's population was 85+ years and by 2010 this "oldest old" population would increase to 2.4% of the population.

- As the baby boomers age, the elderly population will swell so that by 2020 about 22% of Minnesota's population will be 65+ years of age.

- Additionally, long term care is needed by many persons under 65. Approximately 40% of persons needing long term care are under 65 years of age and that segment of Minnesotan's population is also increasing in number each year.

Long term care services cannot, however, simply be folded into the reform of the acute care system because they are so different from medical services. Donna McDowell, Director of the Wisconsin Bureau of Aging, has nicely summarized LTC in the following terms:

"Long term care is a term which describes a range of supports and services for elderly persons, as well as adults and children with disabilities, who experience chronic conditions which interfere with their abilities to carry out essential life tasks. Long term care is often equated with nursing home care, because that is its most visible (and costly) location, but most long term care is delivered at home by spouses and children. Long term care usually consists of lots of small, ordinary tasks performed for a person of limited capacity - things like help getting in and out of bed, toileting, bathing, etc.

From a customer's perspective, long term care is necessary to enable individuals to live where they choose, to maintain important relationships and roles, and to carry on activities which give pleasure and purpose to their lives. Autonomy and choice are the central values which must guide long term care, in order to preserve the consumer's dignity and encourage the interdependence of consumers and their families and communities. The quality of long term care can thus best be judged by how well its participants are able to experience the valued aspects of their lives."

Therefore, MPHA recommends that LTC Reform in Minnesota be designed to assure that the following principles are met:

1. By the year 2005, Minnesota will have uniform comprehensive long term care benefits available to all Minnesotans who need them, regardless of age or income. Eligibility should be based on functional, cognitive or behavioral limitations, or the need for supervision, support or training because of risk to safety or health.

2. Minnesota's long term care system should be customer focused, i.e. attends to the needs and wants of people with disabilities with a goal of optimizing each person's functional ability. The system should offer individual choice and respect autonomy, and should include a variety of alternative care options and living situations for functionally limited people, within the constraints outlined in item 7 below. In this new system people will be able to make their own decisions and take some risks in terms of living alone, controlling the type and amount of services they receive, etc.

3. Minnesota's long term care system should involve the community. To strengthen the long term care system and provide needed resources, the system should build and maintain community leadership and "ownership" in providing support and care, decision making, and contribution of resources. For example, the home delivered meals service system is built on a volunteer network that needs to be maintained in a reformed system.

4. The new Minnesota long term care program should assist, not replace, families and other informal caregivers. Families and friends should be an integral part of care coordination and should have access to supportive services to lighten the burden of care giving.

5. Minnesota's long term care system should be user friendly and more flexible than the current system of fragmented programs in order to meet the variable and changing needs of people. To provide for people's changing needs, long term support and housing services must be integrated with each other and work closely with acute and rehabilitation services. Individual service and care management are necessary for people with multiple needs.

6. Minnesota's long term care system should distribute the costs equitably. To fairly and equitably distribute the costs of long term care, financing policies should build on partnerships among the person, their community, and state and federal programs. Consumers' assets and resources and family contributions should be used for long term care when they have the capacity to do so. Payment strategies need to recognize taxpayers' interests concerning overall public costs and that private long term care insurance has a role in funding the services. These overall costs should be contained, not merely shifted.

7. Minnesota's long term care system should maintain a defined standard of quality in terms of outcomes and consumer satisfaction. As resources are limited, the long term care provided through our system needs to include both cost and quality as determining factors. Cost containment should emphasize the use of the least costly package of services that equals or exceeds the defined standard of quality, taking into account the appropriateness of setting and the choice of consumer.

8. The financial risk for long term care should be spread as broadly as possible, through a social insurance program like Social Security or Medicare. Public programs should provide a base of coverage for all and should be supported through progressive sources of financing.

9. The new comprehensive Minnesota long term care program should be phased in to ensure orderly development of the new system and all of its services. Training of providers, including family caregivers, should be integral to the program.

10. Long term care programs should provide for research on the adequacy of services to meet family long term care needs and on more accurate measures of disability. An information system needs to be created that drives the quality improvement effort and also provides consumers with information that will improve their ability to make informed decisions.

Resolution in Support of the Living at Home/Block Nurse Program Model for Providing Long Term Care Services to the Elderly at Home 1991

WHEREAS, The Block Nurse Program began in the St. Anthony Park neighborhood of St. Paul, has successfully operated there since 1981 and has been replicated in the Highland Park neighborhood in St. Paul, North End-South Como neighborhood in St. Paul, Prospect Park neighborhood in Minneapolis, and the rural community of Atwater, Minnesota, and

WHEREAS, The Living at Home Program has successfully operated since 1987 in the Macalester-Groveland and West Seventh neighborhoods in St. Paul, and

WHEREAS, Both programs have joined together to develop a new Living at Home/Block Nurse Program model that combines the strengths of both programs, and

WHEREAS, The Living at Home/Block Nurse model centers on the needs of the individual elderly person and that person's family, and is supported by neighbors and health care professionals who wok as partners to meet the independent living and health needs of the individual, and

WHEREAS, The development of the Living at Home/Block Nurse Program strengthens and enriches communities by encouraging residents and local organizations to work together and build a commitment to serve the needs of the elderly, and

WHEREAS, The Living at Home/Block Nurse model enables the elderly person to remain part of their community, contribute economically and socially and live as independently as possible with appropriate use of services, and

WHEREAS, Community professionals and volunteers function as partners as they provide care and support for their elderly neighbors, and

WHEREAS, The population 65 and over in Minnesota is projected to grow to nearly 600,000 by the year 2000 and to over 675,000 by 2010, and

WHEREAS, No one disputes that, given a choice, elderly people usually prefer staying in their own homes as long as possible, and

WHEREAS, The Wilder Foundation Survey of Older Minnesotans in 1989 found that about 5 percent of the sample, because of a health or physical problems, have difficulty doing personal care for themselves, such as dressing, grooming, bathing, using the toilet, and eating; and that about 13 percent of the sample report having difficulty with at least one of the other activities of daily living, such as grocery shopping, meal preparation, light housework and managing money, and

WHEREAS, Current public payment programs do not provide funding for long term care at home, and

WHEREAS, Minnesota has a history of placing higher percentages of the elderly population in nursing homes than other states - about 8 percent of the elderly are in nursing homes in Minnesota compared to about 5 percent throughout the U.S., and

WHEREAS, There is a need to continue efforts to keep elderly persons out of nursing homes, and

WHEREAS, The Block Nurse Program model has demonstrated the providing of long term care services in the home for about $300 per month for persons assessed as Case Mix A as compared to total nursing home costs of about $1,670 per month in Ramsey County and care related costs of about $660 per month in Ramsey County, and

WHEREAS, The community based organization contracts with an organization that uses a public health nursing philosophy of service delivery to hire the nursing and allied health professional staff, and uses other existing service agencies and resources, provided they complement the philosophy of the model,

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association supports the development and the expanded availability of the Living at Home/Block Nurse model of providing long term care for the elderly at home, and supports additional ongoing public funding to provide the opportunity for communities throughout Minnesota to implement the model.

Adult Health Care Decision 1989

WHEREAS, Many adults want to ensure that their own wishes about health care are followed even if a time comes when they no longer are able to speak for themselves.

WHEREAS, State laws like the adult health care decision act can provide simple voluntary ways for adults to state their preferences in a health care declaration.

WHEREAS, State laws like the adult health care decision act can address the concern of many senior citizens that unwanted medical technology will be forced on them.

WHEREAS, State laws like the adult health care decision act can also help assure appropriate health care for those who have no close relatives to speak for them.

THEREFORE, BE IT RESOLVED that MPHA supports efforts by the Minnesota Legislature to protect the right of competent adults to make their own decisions about their health care.

Home Health Care Licensure 1986

WHEREAS, MPHA supports the development of public policy at all levels of government to protect vulnerable individuals; and

WHEREAS, Over the past several years community awareness of the lack of accountability among home health care agencies has increased; and

WHEREAS, Current law does not provide any standards of care, training, or quality assurance for home health care agencies;

THEREFORE, BE IT RESOLVED by the Minnesota Public Health Association that it support the passage of legislation establishing a state-wide home health care agency licensure law that builds on a state and local partnership for implementation.

BE IT FURTHER RESOLVED that this resolution be communicated to all members of the Minnesota Legislature, the Governor, the Commissioner of Health, and the Commissioner of Human Services.

Long-term Care 1985

MPHA supports the development of public policy at all levels of government to ensure that functionally impaired individuals have access to a comprehensive range of prevention, supportive and rehabilitation services. These services are designed to enable families to assist the impaired individual to remain independent over an extended period of time.

Comment

MPHA has consistently approved support for the systematic development of a coordinated continuum of services, which will enhance the health status of people in the aggregate. Promotion of health and prevention of illness are of first order priority.

A coordinated, community-based services system emphasizes coordination via the function of case management to ensure appropriate placement, monitoring and transition of clients among many potential long-term care settings, both institutional and non-institutional.

Services coordination activities implemented by local government further ensure that clients and their families receive services based on standards for quality assurance and cost-effectiveness.

MPHA supports community health practices, which include responsible management of costs and organization necessary for the fulfillment of government's responsibility to protect its citizens.

Approved April 26, 1985 Annual Meeting.

Home Care 1980

MPHA supports the promotion of planning the orderly development of a comprehensive, coordinated and cost effective system of home care services available for all persons which builds on the existing Community Health Services Structure.

Comment

The Minnesota Public Health Association has consistently supported policy positions for the development and provision of home care services.

A comprehensive system of home care provides equal access for every person to a complete range of home care services. A complete range of services extends from prevention to pre and post institutional care.

A coordinated system of home care supports and extends the care provided by the natural network of family, friends and community. It builds on the existing Community Health Services structure.

A coordinated system is also the result of balanced development and growth of services. This is assured by continued State level planning and control and is based on participation and determination of need by local government authority.

A cost effective system of home care provides methods for assessing need, allocating services, assuring accountability and assuring quality. It also continues to develop a system of improved alternatives. A cost effective system utilizes the full range of resources for developing these methods and their standards as well as for developing and evaluating improved alternatives.

MPHA Resolutions Related to This Position:
Home Health Agencies - 1979
Home Health Care - 1979
Public Health Nursing - 1974
Long Term Care - 1975
Approved September 26, 1980 Annual Meeting.

Home Health Agencies 1979

MPHA supports Home Health Agencies, however, opposed licensing of such.

Home Health Care 1979

RECOGNIZING that the Minnesota Public Health Association aims to stimulate improvement in the delivery of personal health services, and has seen promotion of community based services including home health and supportive services as a means to that objective; and

RECOGNIZING that there are complex problems with the present system of home care; and

RECOGNIZING that there is a lack of consensus about the scope of services, and the optimal organization of home health care; and

RECOGNIZING that there are adequate support services to meet the needs of ill and/or functionally impaired individuals who wish to remain at home; and

RECOGNIZING that there are inadequate funds for support services and for maintenance home health services; and

RECOGNIZING that there are no programmatic and fiscal incentives for home health services to encourage maximal individual independence; and

RECOGNIZING that there is a lack of consensus as to accepted standards for home health care and a lack of consistency in their interpretations; and

RECOGNIZING that there is a lack of consumer education and protection in home care; and

RECOGNIZING that there are regulations which create barriers such as restricted eligibility, to meeting individual and family needs;

THEREFORE BE IT RESOLVED by the Minnesota Public Health Association that it will form a task force to

1. Define and analyze program, system and funding issues in home health care in the State of Minnesota, and

2. Recommend appropriate actions and roles for MPHA.

Approved September 20, 1979 Annual Meeting.

Long-term Care 1975

MPHA supports a comprehensive program to promote deinstitutionalization to include:

a) coordinated planning process
b) education program
c) development of legal resources
d) programs to increase individuals' independence
e) develop community supports

Public Health Nursing 1974

MPHA supports state grants to counties, cities or groups of counties to provide public health nursing and home health services.

ELIMINATING HEALTH DISPARITIES

Health Benefits of Legal Recognition of Same Sex Relationships 2012

WHEREAS, the American Public Health Association passed a resolution in 1975 deploring public and private discrimination based on sexual orientation, citing infringement on the right to health care, among other civil and human rights[1]; and

WHEREAS, the U.S. Census for 2000 indicated that families headed by or consisting of same-sex couples reside in every county of Minnesota[2] and the number grew between 2000 and 2010[3];

WHEREAS, Minnesota college students identifying themselves as gay, lesbian, or bisexual, report they are less likely to be insured, higher rates of mental illness, more days physically sick in the last 30 days, higher rates of alcohol problems, higher rates of sleep difficulties, higher rates of marijuana use and many other health difficulties than their heterosexual counterparts[4] and

WHEREAS, the lack of legal recognition for same-sex relationships undermines the State's role in promoting families by excluding same-sex couples from 515 state statutes conferring rights and responsibilities to married couples[5]; and

WHEREAS, states have an interest in promoting family units as a means toward achieving social stability, private economic interdependence, and healthier home environments in which both children and adults may prosper; and

WHEREAS, the lack of legal recognition for same-sex relationships effectively devalues cultural diversity and promotes an environment of discrimination against gay, lesbian, bisexual, and transgendered citizens; and

WHEREAS, legal recognition of a spouse can increase the ability of adult couples to provide and care for one another and fosters a nurturing and secure environment for their children[6]; and

WHEREAS, children who grow up in stable, two-parent families have a higher standard of living, receive more effective parenting, experience more cooperative co-parenting, are emotionally closer to both parents, and are subjected to fewer stressful events and circumstances[7]; and

WHEREAS, the lack of recognition for same-sex relationships reduces health care access for gay and lesbian individuals and their families by limiting access to health insurance, including coverage for dependent children, hospital visitation rights, bereavement privileges, and health care decision making[8 9]; and

WHEREAS, intolerance toward homosexual behavior results in increased rates of stress- related psychiatric disorders for gay, lesbian, bisexual, and transgendered individuals[10 11 12], and, when using same-sex marriage and civil union bans as a proxy for intolerance, intolerance is positively though not always significantly associated with HIV rates[13]; and

WHEREAS, bans on same sex marriage result in higher rates of mood disorders for lesbian, gay, and bisexual populations[14]; and

WHEREAS, institutional support for committed relationships such as domestic partnerships may be associated with lower risk behaviors for sexually transmitted disease, including HIV[15], and is associated with lower rates of syphilis.[16]

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:

1 Supports same-sex relationships and their legal recognition because of the positive health effects it would have on Minnesotans and their families, including improved health outcomes and decreased health care costs due to increased access to health care.

25. 2 Supports policies recognizing same-sex relationships, including, but not limited to, same-sex civil marriage and the extension of employment benefits to same-sex couples.

26. 3 Opposes any proposed state amendment limiting civil marriage.

27. 4 Specifically opposes the ballot question, which will appear on the Minnesota 2012 ballot, that seeks to define marriage as solely between "one man and one woman" in the Minnesota Constitution.

References:

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Approved by MPHA members September 28, 2012

MPHA Policy Resolution
Promoting Health Equity 2012

WHEREAS, the 2005 Minnesota Public Health Association Resolution on Eliminating Racial and Ethnic Health Disparities was appropriate for the time [i]; and

WHEREAS, as of May 2012, the American Public Health Association has 46 policy statements related to eliminating health disparities and achieving Health Equity [ii]; and

WHEREAS, health inequities are becoming more important in U.S. and Minnesota society with changing demographics, economics, health status and health policy [iii, iv]; and

WHEREAS, a National Partnership for Action to End Health Disparities has released a National Stakeholder Strategy for Achieving Health Equity [v]; and

WHEREAS, Health People 2020 has included "Creating social and physical environments that promote good health for all" as one of the four overarching goals for the decade [vi]; and

WHEREAS, Promoting Health Equity is a focus reflected in both of the 2011 U.S. health initiative [vii], and by the World Health Organization [viii].

Therefore, the Minnesota Public Health Association:

1. Supports the efforts of community initiated and driven action projects, private, non-profit and academic sectors independently and in collaboration with government to eliminate racial and ethnic disparities in health;
2. Supports reaching out to diverse communities to assist them in addressing health disparities.
3. Supports the goal of addressing social determinants of health

Resolution recommended for approval by MPHA Governing Council on 5/17/2012.

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Minnesota Public Health Association Resolution: Eliminating Racial and Ethnic Health Disparities 2005

Whereas, while on average Minnesota is one of the healthiest states in the nation, populations of color [1] and American Indians in Minnesota suffer substantially and disproportionately from adverse health conditions and inadequate access to quality health care services, as described in detail in "Populations of Color in Minnesota Health Status Report"; [2] and

Whereas, as recognized in MPHA's 2004 Resolution concerning Principles on Universal Health Care Coverage, populations of color and American Indians have uninsurance rates that are three to four times higher than the rate for white Minnesotans.[3]

Whereas, these health related disparities are ethically unacceptable and indefensible, and

Whereas, there are many efforts in public, private, nonprofit and academic sectors underway in Minnesota to reduce racial and ethnic disparities in health, including the Eliminating Health Disparities Initiative,[4] but much more work is needed over time to eliminate such disparities; and

Whereas, the public health community needs continued and expanded support for innovation and for understanding and replicating interventions that are successful in reducing disparities in health; and

Whereas, the public health community needs continued and expanded support for research into the causes of health disparities, including adverse social and environmental conditions; and

Whereas, including community members as equal partners in community-based participatory research has the potential to bridge cultural gaps and address health disparities, as more fully stated in the American Public Health Association's Policy on "Support for Community Based Participatory Research in Public Health"[5];

Whereas, the collection of data on race and ethnicity is essential to the elimination of health disparities, even though "race" is not a biological measure reflecting innate differences, but a social construct capturing the social classification of people in a race-conscious society.[6]

Whereas, data on race and ethnicity are needed at local and state levels in social, economic and health sectors to understand not only who is most affected by diseases, environmental hazards and other health threats, but why they are affected, and how to create prevention and treatment programs that are effective with the variety of cultures represented in Minnesota.

Therefore, the Minnesota Public Health Association:

1. Supports the efforts of the Minnesota Department of Health and local public health agencies to eliminate racial and ethnic disparities in health, particularly activities to identify existing interventions and programs effective in eliminating health disparities and to nurture new strategies by expanding our knowledge of intervenable risk factors for eliminating disparities;

2. Supports the efforts of private, non-profit and academic sectors independently and in collaboration with government to eliminate racial and ethnic disparities in health;

3. Supports continued research into the causes of health disparities, including community- based participatory research;

4. Supports the continuation and expansion of successful programs such as the Eliminating Racial and Ethnic Health Disparities Initiative;

5. Urges the Minnesota Department of Health to continue to provide to the public summaries and updates of effective strategies for eliminating health disparities.

6. Urges the public health community to promote effective strategies through presentation, publication, and implementation; and

7. Supports the collection of racial and ethnic data for public health purposes and opposes initiatives that would eliminate or compromise the collection of such data.

References:

1As used here and by the Minnesota Department of Health's Office of Minority and Multicultural Health,

the term "populations of color" includes African/African Americans, Asian Americans and Pacific Islanders, Hispanics/Latinos, and other racial/ethnic groups. See http://www.health.state.mn.us/ommh/index.html, accessed Feb. 15, 2005.

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Health and Poverty 1986

Recognizing the inter-relationship of poverty and poor health and that people in poverty have higher rates of infant mortality, higher death rates generally, and higher rates of illness than do people in better circumstances; and

Recognizing that poverty results from and contributes to poor health; and

Realizing that some current trends in the State indicate failure to recognize the plight of those in poverty as a serious State problem;

Therefore, be it resolved that the MPHA:

1. Supports the principle that a healthful life is a basic human right must be available to all persons and that a sufficient share of the nation's and the State's resources should be devoted to the assurance of this right.

2. Supports the development of public policy at all levels of government to ensure access to adequate resources to those in need.

3. Encourages decision makers to actively support budgets of programs and funds designated for low income people.

HEALTH POLICY AND ADMINISTRATION

MPHA Resolution
Principles on Universal Health Care Coverage

Passed June 23, 2004 at the MPHA annual mtg

WHEREAS the Minnesota Public Health Association (MPHA) has long been committed to ensuring access to high quality, appropriate, and continuous health care for all; and

WHEREAS over 43 million US residents, nearly one in six Americans under the age of 65, lack health coverage; and

WHEREAS lack of health insurance causes roughly 18,000 unnecessary deaths every year in the US; and

WHEREAS although America leads the world in spending on health care, it is the only Western industrialized nation that does not ensure that all citizens have coverage; and

WHEREAS current estimates of uninsurance in Minnesota range from 5.4 percent of the population to 8.2 percent, and rising health care costs, coupled with recent economic downturns, portend health care coverage cutbacks and/or rising uninsurance; and

WHEREAS populations of color and American Indians in Minnesota have uninsurance rates that are three to four times higher than the rate for white Minnesotans; and

WHEREAS underinsurance also presents significant barriers to timely, appropriate and high quality care; and

WHEREAS Minnesotans are strongly supportive of a health care system where everyone has access to needed health care; and

WHEREAS a set of principles to evaluate health care reform proposals would be useful to support MPHA's continued advocacy of universal health care coverage; and

WHEREAS the American Public Health Association (APHA) has developed such a set of principles;

WHEREAS MPHA is Minnesota's exclusive affiliate to APHA;

NOW THEREFORE be it resolved that MPHA support policies that are congruent with the 14 principles on universal health care articulated by APHA:

1. Universal coverage for everyone in the United States and in Minnesota.[10]
2. Comprehensive benefits including health maintenance, preventive, diagnostic, therapeutic, and rehabilitative services for all types of illnesses and health conditions.
3. Elimination of financial barriers to care.
4. Financing based on ability to pay.

5. Organization and administration of health care through publicly-accountable mechanisms to assure maximum responsiveness to public needs, with a major role for federal, state, and local government health agencies.
6. Incentives and safeguards to assure effective and efficient organization of services and high-quality care.
7. Fair payment to providers using mechanisms which encourage appropriate treatment by providers and appropriate utilization by consumers.
8. Ongoing evaluation and planning to improve the delivery of health services with consumer and provider participation.
9. Inclusion of disease prevention and health promotion programs.
10. Support of education and training programs for all health workers.
11. Affirmative action programs in the training, employment, and promotion of health workers.
12. Non-discrimination in the delivery of health services.
13. Education of consumers about their health rights and responsibilities.
14. Attention in the organization, staffing, delivery, and payment of care to the needs of all populations, including those confronting geographic, physical, cultural, language, and other non-financial barriers to service.

Minnesota Public Health Association Resolution:
Supporting the use of Health Impact Assessments (HIAs) to guide policymaking 2011

WHEREAS, many of the policies and decisions made by local, county, state, and federal government influence health directly or indirectly; and

WHEREAS, many policy decisions impacting health and well-being are made outside of the public health and health care sectors; and

WHEREAS, a comprehensive approach to assess health is needed, as environmental impact assessments are well-established as a tool used to guide policy decisions, but have not included a systematic process to assess health[1]; and

WHEREAS, a health impact assessment (HIA) is a tool that helps policy makers and the public understand how a proposed project, program, plan, or policy could affect the health of the people in a community[2]; and

WHEREAS, HIAs view health holistically, including not only physical health effects, but also the broader social, economic, and environmental influences that occur upstream; and

WHEREAS, the information provided by an HIA assists policy makers to weigh the pros and cons of their decisions and puts in place practical strategies that minimize adverse health effects and maximize potential benefits[3]; and

WHEREAS, HIAs incorporate a number of qualitative and quantitative methods to identify the health effects of public policy decisions and provide opportunities for community residents, public health professionals, and other stakeholders to be involved[4]; and

WHEREAS, HIAs have been widely adopted by European nations, as well as Canada and Australia, and are emerging as a policy planning tool in the United States[5,6,7,8];

Therefore, be it resolved that the Minnesota Public Health Association:

1. Supports efforts to train public health professionals and others to conduct comprehensive health impact assessments.

2. Encourages public health professionals to collaborate with community stakeholders to plan and implement health impact assessments.

3. Urges policymakers to request health impact assessments to ensure policy and planning decisions promote, protect, and improve the health of communities; supports efforts to make HIAs routine in decision making when appropriate; and urges policymakers to follow HIA recommendations.

4. Encourages the Minnesota State Legislature to adopt legislation that encourages and funds the use of health impact assessments to guide community development and policy decisions at all levels of government (local, county, and state).

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Minnesota Public Health Association Resolution: Promoting a Health In All Policies (HiAP) Framework to guide policymaking

2013

WHEREAS, Health in All Policies is a systemic and sustained approach to taking into account the impacts of public policies on health determinants and health systems across sectors, at the levels the decisions are made, in political, legislative and administrative processes, in order to realize health- related rights and to improve accountability for population health and health equity.[1] and

WHEREAS, the American Public Health Association has adopted a policy of Promoting Health Impact Assessment to Achieve Health in All Policies[2] and collaborated with multiple partners to produce *Health in All Policies: A Guide for State and Local Governments*; [3] and

WHEREAS, the Institute of Medicine recommended that federal, state, and local decision-makers adopt a Health in All Policies approach; [4] and

WHEREAS, Health in All Policies is reflected in both the National Prevention Strategy [5] work across seventeen Federal departments, agencies and offices, and the Healthy People 2020 [6] approach to social determinants of health; and

WHEREAS, the National Association of County & City Health Officials [7] and the Association of State and Territorial Health Officials [8] all published materials describing, guiding, and supporting Health in All Policies approach; and

WHEREAS, the California Health in All Policies Task Force [9] and the Texas Health in All Policies Project [10] have established websites including resources such as reports, presentations, meeting agendas and minutes describing decisions taken and examples of HiAP in action; and

WHEREAS, Health in All Policies has been promoted by the World Health Organization,[11] and practiced more extensively in other parts of the world[12, 13] with promising results in improving health [14] and

WHEREAS, the Healthy Minnesota Partnership is a statewide partnership group looking to enlist multi- sector leadership to implement a statewide health improvement framework, and Healthy Minnesota 2020 is a guide for creating and improving health throughout the state of Minnesota [15] ; and

WHEREAS, "Healthy Communities"[16] is just one example of this type of Health in All Policies partnership between the Federal Reserve Bank of Minneapolis, Wilder Research, the Blue Cross Blue Shield of Minnesota Foundation, and the Robert Wood Johnson Foundation; and

WHEREAS, a call for a Health in All Policies approach with short and long-term recommendations was included as testimony for the Prevention and Health Promotion Work Group as part of the Governor's Health Care Reform Task Force [17] and;

WHEREAS, Public Health responsibilities in support of a Health in All Policies approach include:

- Understanding the political agendas and administrative imperatives of other sectors;
- Building the knowledge and evidence base of policy options and strategies;
- Assessing comparative health consequences of options within the policy development process;
- Creating regular platforms for dialogue and problem solving with other sectors;
- Evaluating the effectiveness of intersectoral work and integrated policy-making;
- Building capacity through better mechanisms, resources, agency support and skilled and dedicated staff; and
- Working with other arms of government to achieve their goals [18]; and

WHEREAS, tactics to implement Health in All Policies include: Clear mandates for intersectoral collaboration, mediation across interests, accountability and transparency, stakeholder participation, and practical projects to build partnerships and trust. Ultimately, health sectors must learn to work in partnership with other sectors and jointly explore opportunities for collaboration and innovation. [19]

THEREFORE, be it resolved that the Minnesota Public Health Association:

1. Supports reaching out to diverse partners and communities to advance a shared view of health that crosses all levels and sectors of society to address the origins and the distribution of the social determinants of health .

2. Supports the efforts of global, national, state, local and community partners in learning about, sharing ideas, reaching agreement, and applying tools, concepts and principles from a Health in All Policy framework to improve population health.

References

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Community and Individual Rights 1980

MPHA supports the concept that both communities and individuals have rights and responsibilities to make informed health care decisions about health behavior, health problems, and health services. This support includes advocating legislation and programs which encourage the increased availability of health resources, health education and democratic decision making.

Comment

The MPHA has regularly advocated resolutions which support these rights and responsibilities. These include support for Community Health Services, Home Health Care, Prevention, Reproductive freedom, family planning and public health nursing. This support has been based on several basic ideals:

• That individuals should know about their own bodies and health, should understand the impact of various behaviors on their health, should know options for correcting health problems, should have knowledge of and access to health care services at a reasonable cost, and should participate in planning and policy making for health care services. These ideals will best enable individuals to carry out their rights and responsibilities.

• That with regard to communities, decisions affecting health care should be made at the closest possible governmental level to the city, county, set of counties, state that will be affected by the decision. This approach demonstrates respect for the rights of each citizen and emphasizes personal and community responsibility for health.

MPHA Resolutions Related to This Position:
Reproductive Freedom - 1978
Family Planning - 1974
CHS - 1979
CHS - 1976
Environmental Health - 1976
Corrections Health Services Policy - 1975
Public Health Nursing - 1974
Approved September 26, 1980 Annual Meeting.

INFECTIOUS DISEASE/CHRONIC DISEASE/PREVENTION

MPHA Policy Resolution
Asthma
May 2006

WHEREAS, asthma is a major public health issue, resulting in excess hospitalizations, school and work absenteeism, lost productivity, disability, and increased health care costs; and
WHEREAS, asthma is a serious, chronic disease of the respiratory system, the lungs and the system of air tubes that lead to the lungs; and
WHEREAS, asthma occurs when the tiny air passageways in the lungs (bronchioles) become narrowed when they react to an irritant or an allergen in the environment; and
WHEREAS, numerous studies have demonstrated an association between air pollutants and respiratory diseases, including childhood asthma[1, 2, 3]; and
WHEREAS, asthma symptoms are exacerbated by several factors such as colds/flu, cold air, exercise; environmental triggers including irritants (e.g. tobacco smoke, perfumes/paints, ambient air pollution from auto exhaust and industrial emissions) and allergens (e.g. pollens, animal dander, cockroaches, dust mites, foods); and
WHEREAS, asthma affects 300 million people worldwide[4]; about 20 million people in the U.S., including over 6 million children (2003)[5]; and
WHEREAS, 10.5% of adults in Minnesota have had asthma at some point in their life and 6.8% currently have asthma, with the highest rates in the Twin Cities Metro Area[6]; and

WHEREAS, various asthma data sources show differences for adults across racial and ethnic groups as presented in a recent study (2002, Hennepin County), rates varied, with U.S. born Black (12.5%); American Indian (10.1%); Hispanic/Latino (5.0%); White (7.7%) [6]; and

WHEREAS, asthma ranks nationally within the top ten prevalent conditions causing limitation of activity that resulted in 12.8 million lost school days in children and 24.5 million lost work days in adults[5]; and
WHEREAS, asthma is costly, annually contributing $16.1 billion in health care costs in the US, with prescription drugs as the largest single direct medical expenditure at $5 million[5]; and
WHEREAS, asthma resulted in 484,000 discharges from the hospital; 12.7 million physician office visits; 1.2 million hospital outpatient visits; and 1.9 million emergency visits in the U.S. in 2002[7]; and 4,500 hospitalizations of Minnesotans in 2003[6]; and
WHEREAS, the initial onset of asthma cannot yet be prevented and asthma cannot be cured[7]; asthma can be managed through early detection and identification, avoidance of triggers, such as second-hand smoke, and using appropriate medications;
WHEREAS, stakeholders throughout the public health community have developed a strategic plan to address asthma in Minnesota[8].

Therefore, be it resolved that the Minnesota Public Health Association:
Supports implementation of the strategic plan for addressing asthma in Minnesota, including policies which:
Promote good coordination between health care and public health systems;
Promote the use of evidence-based guidelines by Minnesota providers, such as the National Institute of Health (NIH)/National Heart, Lung, and Blood Institute (NHLBI) and Institute of Clinic Systems Improvement (ICSI);
Promote the use of asthma action plans by Minnesota health care providers;
Promote asthma education for students in schools;
Promote coordination among all organizations and systems that work with people with asthma;
Promote training and education for professions who provide care for people with asthma, such as physicians, nurses, school nurses, and pharmacists;
Promote training and education for those who interact with people with asthma such as families, teachers, day care providers, and coaches;
Include asthma in state and local initiatives focused on reducing health disparities.
Promotes the enhancement of the existing statewide asthma surveillance system for collecting, analyzing and reporting health outcomes and risk factor data.

Supports actions, legislation, and regulations that will ensure people with asthma have access to healthy environments that are free of secondhand smoke and other asthma triggers, especially those that reduce air pollutants.

Raises public awareness about the identification and reduction of asthma triggers for people with asthma.

Promotes the effective evaluation of existing prevention and intervention strategies to determine and advance the most effective population-based approaches.

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MPHA Policy Resolution
Pandemic Influenza
May 2006

WHEREAS, every 30 years (on average) a novel flu virus emerges and develops the ability to cause widespread infection and death among human populations that have no immunity to this virus [1]; and
WHEREAS a virus now circulating among domestic and migratory birds has developed the ability to directly infect people, leading to 176 cases and 97 deaths [2] in several countries since 2003, and sparking increased concern that a pandemic may be imminent [3, 4]; and
WHEREAS, a pandemic virus can negatively affect human health, civil society and global economies [5, 6]; and
WHEREAS all levels of government and sectors of society, including health systems, hospitals/clinics and businesses, must be actively engaged in preparing to respond to pandemic influenza [7, 8]; and
WHEREAS there is currently no approved vaccine for a pandemic flu strain [9] and vaccines and antiviral drugs that may be effective in treating a pandemic flu strain are in extremely short supply worldwide [10]; and
WHEREAS the World Health Organization notes: "Given the seriousness of the present situation, all countries need to undertake preparedness activities." [11]; and

WHEREAS national officials have indicated that preparedness and response to pandemic influenza must begin at the local level[12]; and
WHEREAS the President of the United States has said that "preparing for a pandemic requires the leveraging of all instruments of national power, and coordinated action by all segments of government and society. … The next pandemic is likely to come in waves, each lasting months, and pass through communities of all sizes across the nation and world. While a pandemic will not damage power lines, banks or computer networks, it will ultimately threaten all critical infrastructure by removing essential personnel from the workplace for weeks or months." [13]; and
WHEREAS appropriate local response to pandemic influenza will be determined by adequate preparation, sufficient local public health infrastructure, and appropriate public health staff levels [14, 15]; and
WHEREAS pandemic influenza planning is a timely and important endeavor at all levels of public health; and
WHEREAS the role of local public agencies and partners in collaborating to respond to pandemic influenza is key; and

WHEREAS it is important to have sufficient federal and state funding to meet staff and supplies needs; and
WHEREAS communication plays a crucial role at all levels of public health infrastructure to facilitate planning and response to a pandemic; and
WHEREAS communicating disease and surveillance information globally is necessary in order to respond appropriately at the local level.

Therefore, be it resolved that the Minnesota Public Health Association:
Calls on public health agencies, hospitals, clinics, government units, businesses and other partners to collaborate, develop and practice pandemic response plans.
Calls on the federal government and its agencies to lead in coordinating development, expanding production, and ensuring the safety and availability of vaccines and antivirals, and other products appropriate to public health interventions.
Advocates for adequate federal and state funding to prepare for pandemic flu, that is proportionately distributed to local public health agencies and other local health organizations.

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Antibiotic Resistance and the Overuse and Misuse of Antibiotics 2002

Understanding that antibiotic resistance is a widespread problem, resulting in infections that are difficult, or impossible to treat, and that the overuse and misuse of antibiotics greatly accelerates the proliferation of resistant bacteria, thus speeding the demise of antibiotics as effective treatments. (APHA Policy #9908)

Recognizing that fluoroquinone antibiotics are the treatment of choice for some human gastrointestinal infections, particularly severe food-borne illness caused by Campylobacter or Salmonellae bacteria; and that fluoroquinolones also are used to treat urinary tract infections, bone and joint infections, some types of pneumonia, and other human illness; and

Further recognizing that Campylobacter, as the most common cause of food-borne illnesses in the U.S., accounts for nearly two million illnesses and about 100 deaths each year, according to estimates by the Centers for Disease Control;[1] while Salmonellae bacteria are the leading cause of food-borne disease in many other countries,[2] and in the U.S. account for an estimated 1.3 million food-borne illnesses and around 550 deaths each year.[3]

Understanding that fluoroquinolones closely related to those used in humans are also used in poultry, which are a leading source of human food-borne illnesses,[4] and that use in poultry has contributed to the generation of fluoroquinolone-resistant Campylobacter,[5] as well as resistant Salmonellae.[6]

Therefore, be it resolved that the Minnesota Public Health Association:

Supports efforts to curb the growing public health threat of antibiotic resistance by reducing the overuse and misuse of antibiotics in both agriculture and human medicine.

Support efforts to educate patients and doctors about the prudent use of antibiotics, including the importance of prescribing them only for bacterial infections and of taking the entire course of the drug.

Supports the ongoing collection of data at the state and federal levels on antibiotic residues and antibiotic resistance, including antibiotics and antibiotic-resistant bacteria on food, and in surface and ground waters.

Urges the Center for Veterinary Medicine of the U.S. Food and Drug Administration to work for regulations eliminating the non-medical use of antibiotics, and limiting the use of antibiotics in animal feeds, including the FDA's proposed withdrawal of remaining uses of fluoroquinolones in poultry.

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Keep Antibiotics Working Campaign 2002

Antibiotic resistance is reaching crisis proportions, resulting in infections that are difficult, or impossible, to treat. Resistant bacteria can evolve even after careful use of antibiotics. But the overuse and misuse of antibiotics greatly accelerates the proliferation of resistant bacteria, thus speeding the demise of antibiotics as effective treatments.

The Campaign's Mission

Keep Antibiotics Working: The Campaign to End Antibiotic Overuse includes concerned health, consumer, environmental and agricultural groups, all working to reduce the growing public health threat of antibiotic

resistance. Our primary goal is to end the overuse and misuse of antibiotics in animal agriculture, though we also support efforts to limit overuse in human medicine. Current estimates indicate that agriculture accounts for more than 80 percent of antibiotic use in the U.S.

The Campaign focuses on three areas:

•Phasing out use in healthy animals of antibiotics that are or may become important to human medicine; •Restricting use in sick animals of antibiotics essential for treating sick humans, notably fluoroquinolones; •Ensuring policymakers and the public will have adequate data at their disposal to track antibiotic use and the development of antibiotic resistance.

Health professional organizations and public interest groups are invited to endorse the Campaign's Principles. Such endorsement does not constitute joining the Campaign - it is simply an indication of support for the

Principles:

1.We support efforts to curb the growing public health threat of antibiotic resistance by reducing the overuse and misuse of antibiotics in both agriculture and human medicine.

2.We support a ban on the use in healthy farm animals of antibiotics used in human medicine or closely related to human drugs.

3.We support efforts to promote sustainable agricultural production methods that provide alternatives to the use of antibiotics in healthy farm animals.

4.We urge companies involved in the production and marketing of meat, poultry and fish (livestock producers, supermarkets, restaurants, etc.) to voluntarily agree to stop using, buying, or selling products produced using antibiotics other than for the purpose of treating sick animals.

5.We support efforts to educate patients and doctors about the prudent use of antibiotics, including the importance of prescribing them only for bacterial infections and of taking the entire course of the drug.

6.We support the creation of a nationwide system to collect objective, verifiable data on the production and use of antibiotics in both human medicine and animal agriculture, and to make that information available to the public.

7.We affirm the importance of ongoing collection of data at the state and federal levels on antibiotic residues and antibiotic resistance, including antibiotics and antibiotic-resistant bacteria both on food and in surface and ground waters.

Organizations of health professionals and public interest groups are invited to endorse these principles. Endorsing them does not entail joining the Campaign, but rather simply indicates support for the principles as stated. To endorse the principles, contact Jessica Nelson, 612-870-3422.

Keep Antibiotics Working · 2120 L St NW Ste 400, Washington DC 20037 · 202-478-6168.
e-mail: information@KeepAntibioticsWorking.com
www: KeepAantibioticsWorking.org

Tuberculosis Control Legislation 1993

Tuberculosis is a serious public health problem in Minnesota and nationally. The Minnesota Public Health Association supports the tuberculosis control measures contained in S.F.521/H.F. 818.

After declining during the 1980's, the number of tuberculosis cases is on the rise. In 1991, 102 cases of tuberculosis were reported to the Minnesota Department of Health. In 1992, this number increased to 165 cases, and is expected to continue to increase unless more aggressive prevention and control strategies are implemented.

Recent public health investigations in jail and school settings have underscored the need for additional tuberculosis control authorities. Tuberculosis screening conducted in several St. Paul secondary schools following three cases of active tuberculosis reported from these schools identified an undetected infection rate of 4.3 percent. During 1991, state and local public health officials undertook a contact investigation surrounding a case of multidrug-resistant tuberculosis incarcerated in a county jail which required attempts to locate more than 400 contacts who had potentially been exposed to tuberculosis. In addition, difficulties in dealing with carriers of tuberculosis who pose a health threat to others have been identified.

This bill allows the Commissioner of health to require tuberculosis screening of students and staff in school settings when there is a public health threat from tuberculosis as evidenced by cases of disease or greater than expected infection in a school population. The bill also requires tuberculosis screening of staff and inmates of facilities operated, licensed, or inspected by the Commissioner of Corrections, and extends the health threat procedures law to cover individuals who are infected with tuberculosis, and are unwilling to complete drug therapy which will cure them of their disease.

Minor Consent Revision

Additionally, the bill allows minors to consent to receive hepatitis B vaccine. Currently minors can consent for sexually transmitted disease (STD) testing and treatment. Hepatitis B can be transmitted sexually; hence efforts are underway to immunize minors who receive services from a public health STD clinic. Requiring parental consent for the receipt of hepatitis B vaccine in an STD clinic would preclude many minors from obtaining this vaccine. The Minnesota Public Health Association supports this provision.

Mandatory HIV Testing of Health Care Workers 1992

Risk of Health Care Workers Transmitting AIDS Is Very Low

"Current data indicate that the risk of HIV transmission from health care workers to patients is extremely low," said an article published in the New England Journal of Medicine.

No medical or dental patient in Minnesota has been infected by a health care worker while undergoing a medical procedure. The case of a Florida dentist who infected five patients is the only reported incident in the United States.

Only one health care worker in Minnesota is known to have been infected with HIV by a patient.

A major study of patients of an HIV-infected physician in Minnesota found that while the physician was infected with extreme dermatitis and performed procedures on 336 patients which put them at potentially greater risk of infection, none of the patients was found to be infected.

Experts Do Not Recommend Mandatory Testing

The American Public Health Association and the Centers for Disease Control (CDC) are not recommending mandatory testing of health care workers. The CDC recommends voluntary testing and recommends that HIV-infected health care workers not perform "exposure-prone procedures" unless they have sought counsel from a review panel of experts.

The Minnesota Commission on Health has recommended against mandatory testing indicating that "voluntary testing of health workers doing certain procedures can provide reasonable assurance of patient safety, without creating a false sense of security." (Minneapolis Star Tribune, October 4, 1991)

The Minnesota HIV/HBV Joint Task Force recommends against mandatory testing. They encourage all health care workers to assess their need for HIV testing based on personal risk assessment, undergo testing on a voluntary basis, and report results to an expert review panel.

Recommendation of the Minnesota Public Health Association

MPHA supports the HIV/HBV Joint Task Force report that recommends incentives for voluntary testing, mandatory reporting of HIV reactive status by infected individuals to the Department of Health, and the convening of an expert review panel to review practices and recommend restrictions and monitoring as necessary to prevent transmission of HIV in the health care setting.

Position Statement on Prevention and Management of HIV Infection and AIDS 1988

Adopted April 1988

Introduction

Responding intelligently, effectively and sensitively to the growing AIDS crisis is one of the crucial public health problems facing our nation and the state of Minnesota. It is estimated that there are approximately 51,000 cases of AIDS nationwide and 315 cases of AIDS in Minnesota as of February 1988. At present there is no known cure for the disease. It is essential that efforts to deal with the spread of the Human Immunodeficiency Virus (HIV) obtain a judicious balance between concern for the well-being of HIV-infected patients and for protection of public health.

The Minnesota Public Health Association, as an umbrella organization for public health professionals in Minnesota, is dedicated to providing leadership in promoting and protecting public health through advocacy of public health policy, provision of professional and consumer education and promotion of a strong scientific basis for public health practices.

In August 1987, the AIDS Task Force of the Association was appointed to define what role MPHA should play regarding AIDS. The Task Force was co-chaired by Terry Hill, President of MPHA and Malcolm Mitchell of the Governing Council. The other eleven members were:

Martha Arnold, Minnesota Department of Education
Richard Dinella, Minnesota Department of Health
Erik Engstrom, The Minnesota AIDS Project
Gayle Hallin, Bloomington Public Health
Susan Kjeer, Governing Council MPHA
Ruth Luehr, Consultant, Health Service/Health Promotion in the School and the Community
Steven R. Moscow, Health Futures Institute
Deborah A. Plumb, Governing Council MPHA
Sherri Rollnick, Group Health, Inc.
Stan Shanedling, Minnesota Medical Association
Mary K. Sheehan, Minnesota Department of Health

The Association, through its AIDS task force, has developed a policy statement on the prevention and management of HIV infection and AIDS. This policy statement, outlined below, is based on the best information and data presently available and is designed to help in successfully confronting the AIDS challenge. The Association will

continuously monitor and analyze developments in HIV infection and AIDS and update this position statement as dictated by advances in knowledge.

The Minnesota Public Health Association presents this policy statement as a basis for:

1) informing policy makers of the position of the Association regarding HIV infection and AIDS,

2) informing and educating health professionals throughout Minnesota, particularly Association members, and

3) providing encouragement for local public health professionals to participate and provide leadership in local activities to prevent and treat HIV infection and AIDS.

General Principles

To provide a framework for the development of more specific policy statements the following beliefs or tenets on individual rights and responsibilities, community rights and responsibilities, governmental responsibilities, and finance are presented.

Individual Rights and Responsibilities

- The individual right of confidentiality and responsibility for personal protection are held central with restrictions based on compelling scientifically based evidence that information or action is necessary to protect those who cannot otherwise take action to protect themselves from HIV infection. Those at increased risk for HIV infection should receive appropriate support and education to minimize their risk of exposure. Those infected with HIV should be provided with access to quality care, protected from discrimination, and treated in a manner affirming their quality of life.

- Individuals have the primary responsibility for adopting behaviors which minimize their risks of exposure to or transmission of HIV infection.

Community Rights and Responsibilities

- Communities have a right to respond to situations which, based on scientifically based information, pose a health threat to their members.

- Collaboration among diverse groups and organizations is essential to solve the problems of HIV transmission and AIDS care. Community groups have the responsibility to work and act cooperatively in developing and implementing programs to prevent and treat HIV infection, to take a leadership role in preventing AIDS hysteria, and to encourage a supportive environment for persons with HIV infection and AIDS.

Governmental Responsibilities

Government has the responsibility of preventing disease and protecting the public health through:

- Surveillance and reporting of the incidence and prevalence of HIV infection and AIDS.

- Design and implementation of strategies that facilitate the development of local responses to HIV infection and AIDS.

- Organization and/or provision of services where there is:

    * An immediate or potential health threat not being dealt with through any other responsible entity.

* A need for enforcement or coordination.

* A potential to prevent unnecessary health problems in a cost- effective manner for populations which may not otherwise receive services.

* Promotion of public health policies and related designation of funding for HIV.

Finance

To effectively deal with HIV infection with AIDS multiple funding sources are essential. When faced with resource limitations, balance should be achieved in financing prevention, treatment and research.

Funds for prevention programs should be allocated to those programs which have the greatest cost-benefit potential.

Funds for care and treatment should be allocated for cost-effective services provided through the least restrictive setting.

Funds for research should be allocated to address all aspects of HIV infection and AIDS.

Policies

Based on the general principles stated above, specific policy statements have been developed regarding the prevention and management of HIV infection and AIDS in the following areas:

1) Prevention
2) Discrimination
3) Testing
4) Support services
5) Financing
6) Evaluation

PREVENTION

Background

The fact that AIDS cannot be cured points to the urgent need to develop available and effective strategies for prevention as a primary focus of public health and community action. Prevention must encompass obtaining accurate information, disseminating that information and providing support systems that encourage appropriate actions beneficial to the public health. Prevention must include efforts focused at the individual, community, and the health care delivery system.

The major initiatives to prevent and reduce the risk of transmission of HIV infection must be accomplished through education and must promote behaviors that prevent and/or reduce the risk of HIV infection. Such initiatives should include:

a) Influencing beliefs by helping individuals realize their personal responsibility in terms of reducing or eliminating risk behaviors.

b) Promoting specific behavioral actions that prevent transmission of HIV infection.

c) Building cultural and/or community support for sustaining behavioral change.
Educational Initiatives

It is important that educational initiatives regarding HIV infection and AIDS occur in a variety of settings and focus on the specific needs and understandings of the audiences addressed.

Policies

Health Care Providers

1. The professional care giver is regarded as an authority and has the ethical responsibility to provide factually and scientifically accurate and current information. It is essential that providers at all levels be trained and continually educated on prevention of HIV infection and AIDS. This education should incorporate the values of sensitivity and responsiveness to the HIV infected individual, family and community.

General Population

2. It is essential that educational approaches address individuals at varying degrees of risk.

    a) For those not at risk for HIV (persons who have not yet developed high risk behaviors - not sexually active or sharing needles), developmentally appropriate education should be directed toward understanding high-risk behaviors.

    b) For those at risk (persons who have adopted high risk behaviors but who are not yet infected with HIV), developmentally appropriate education should be directed toward understanding the transmission of HIV and toward adopting behaviors to prevent infection. Where persons have decided to cease high risk behavior, adequate medical and social support services should be available to help ensure their continued cessation.

    c) For those at risk (persons who are practicing high risk behaviors and who are infected with HIV), developmentally appropriate education should be directed at eliminating high-risk behaviors and preventing transmission. For those persons with HIV infection, adequate medical and social services are necessary to help ensure elimination of transmission and timely care and treatment.

Media

3. The media has the responsibility to develop and maintain factually sound and current resource information on prevention and treatment related to HIV infection and AIDS. Members of the media are encouraged to solicit and report expert opinions.

School

4. Developmentally appropriate curriculum should be implemented beginning in grade school. Where appropriate, special emphasis should be placed on peer education which includes explicit information on HIV transmission, and on building decision-making skills regarding high-risk activity.

Work Place

5. Job-appropriate educational content should be made available in the workplace for individuals to a) protect them from high-risk exposure, and/or b) prevent further transmission of HIV infection from infected employees to their clientele.

Community Organizations

6. Community organizations such as churches, social clubs and other groups should discuss issues related to HIV infection and AIDS to ensure public awareness and provide support regarding prevention and risk reduction of HIV infection.

Other Preventive Initiatives

7. Every effort must continue to assure adequate supplies of safe blood and blood factor products.

8. Efforts should be encouraged to develop an agent (vaccine) to prevent HIV infection.

9. Infection control procedures should be developed based on current recommendations of the Centers for Disease Control in Atlanta and job appropriate equipment should be made available at all worksites for individuals to protect themselves from significant exposure to blood and body fluids.

10. Governmental bodies should exercise their responsibility to implement environmental measures that are consistent with our democratic system to decrease the incidence of HIV infection.

DISCRIMINATION

Background

AIDS is more than a public health issue; it is a symbol upon which several of our cultural anxieties have been projected.

These anxieties include:

1) Sexuality in general and homosexuality in particular.
2) Attitudes about drug abusers.
3) Racial or ethnic prejudices.
4) Intensive fears of death associated with AIDS.

Anxieties such as these are reflected in various forms of discrimination which infringe upon a person's civil liberties. Discrimination against HIV positive persons has or may occur in health and social services, educational systems, health facilities, day care centers, criminal justice systems, housing, worksites, employment opportunities, insurance coverage, religious organizations and should not be permitted.

Policies

Protection from Discrimination

11. The presence of HIV infection in a person is not an acceptable rationale for deprivation of that person's civil liberties. Special efforts, including public and professional education and enforcement of anti-discrimination laws, must be made to assure that those individuals who are infected with HIV, or suspected of being infected, are protected from discrimination.

Health Care Worker Responsibility

12. It is especially important for public health and health care workers to advocate against all types of discrimination. In particular, health workers and facilities have an ethical responsibility to: 1) provide services and/or care to HIV-infected persons in consort with professional practice standards, and 2) be cognizant of attitudes that would compromise the treatment of infected persons and make adjustments to assure appropriate service delivery.*

HIV ANTIBODY TESTING

Background

Researchers have determined that acquired immunodeficiency syndrome (AIDS) is caused by the retrovirus, HIV (human immunodeficiency virus, formerly referred to as human T-cell lymphotropic virus type III/lymphadenopathy-associated virus, or HTLV-III/LAV. Antibody to the virus has been detected in a high proportion of persons with AIDS and clinically associated conditions such as AIDS-related complex (ARC).

To date, the U.S. Food and Drug Administration has licensed several manufacturers to sell a laboratory test for detecting HIV antibody which is an enzyme-linked immunoassay (EIA) test. In addition, the Western blot technique has been widely used for confirmation of EIA results. Our State Department of Health (MDH) considers a serum specimen to be positive only after it has been demonstrated to be repeatedly reactive by EIA and subsequently positive by Western blot testing.

Since screening and confirmatory testing for the antibody to HIV have only recently been developed, many issues on the use of this test are unresolved. Nevertheless, there are some basic tenets of testing that should be followed.
Policies

Need for Testing

13. Since the aim of public health is ultimately prevention, testing, regardless of HIV infection status, should always be accompanied by counseling that includes health education. Testing and counseling should be viewed as a tool to help health professionals identify and educate individuals most likely to further transmit HIV. To this end individuals must not be deterred from testing due to cost, availability, discrimination and/or confidentiality concerns.

    * In a few situations employees or students may be relieved of responsibility for care of an AIDS patient. Situations warranting relief of responsibility may be as follows: 1) a pregnant employee or student, 2) an employee or student with an infection that can be communicated to an AIDS patient, 3) an immuno-suppressed employee or student.

Confidentiality

14. Anonymous testing and counseling should be made available to individuals who perceive a potential threat to their individual rights if client identifiers are obtained by the test provider. Records and materials should be handled in the most protected way so as to respect the patient's rights of privacy.

Counseling

15. Counseling should be provided by trained individuals with current knowledge about HIV infection and AIDS. Health care providers need to assess individual risk on a case-by-case basis and offer counseling and education to those whose behaviors place them at increased risk of transmitting or receiving the virus.

    a) Counseling should be provided to individuals before testing to educate them about effective behaviors to avoid the risk of HIV infection for themselves and others.

    b) For individuals who are found to be HIV infected, counseling should focus on: (i) the infection; (ii) strategies for health protection with a compromised immune system; and (iii) the necessity of alerting sexual contacts, past (5-10 years) and present, regarding their possible HIV infection. Long-term emotional support should be provided or arranged for seropositive individuals.

Testing

16. Testing should be voluntary.

17. The HIV antibody test should only be performed after: 1) the patient or person designated to be responsible for the patient's medical decisions is consulted and permission obtained to have HIV antibody testing done;

2) the patient is informed of the limitations of the test and the implication of results; 3) each person is informed of how the results will be recorded (or be given a clear understanding that results will be part of the permanent medical record) and that positive results will be reported to the MDH. If the patient or persons responsible for the patient's medical decisions declines HIV antibody testing, it is recommended that testing not be done.

18. HIV antibody tests should not be routinely used for involuntary screening of any individual or group. Use of serologic testing is not appropriate, for example, as a precondition for employment, admission to hospitals or admission to schools.

19. Under certain very limited conditions, mandatory testing may be considered appropriate. In such instances, there should be documentation of probable cause to suspect a compelling public health threat.

SUPPORT SERVICES AND FINANCE

Background

The anticipated large number of persons with HIV infection and AIDS and related conditions point to the urgent need to develop new and/or expanded services for this population. The challenge to the state of Minnesota is to provide services and pay for them in a way that is most cost effective and at the same time provide care that is accessible and acceptable to HIV-infected persons, AIDS patients and their informed support group of friends and relatives. The following policies relate to support service and the financing for prevention an management of HIV infection and AIDS.

Policies

Willingness to Treat

20. All health care professionals, and health care institutions and organizations should provide competent and humane care to all patients regardless of their HIV status, socioeconomic position, racial or ethnic origin and sexual preference. Denying appropriate care to sick and dying patients is unethical.

Volunteer Care

21. Informal care to persons with HIV infection and AIDS provided by volunteers should be maintained. Care providers should make use of volunteer services to the degree possible to protect and enhance support networks and maximize cost efficiency.

Housing and Home Care

22. To the greatest possible extent, existing financial mechanisms should be utilized to keep people with HIV infection and AIDS in their own homes as long as possible. When these mechanisms are not available, subsidized housing should be provided in a home-like and cost-effective setting.

23. Home health care should be a primary service available to persons with HIV infection and AIDS.

Health Care Facilities

24. Every care facility should address the policy management issues raised by the treatment of patients with infectious agents. Health care facilities should be careful to balance the need to ensure appropriate precautions to prevent spread of disease with the need to ensure appropriate confidentiality for their patients.

Mental Health

25. Comprehensive outpatient and inpatient mental health services should be available in facilities which are geographically convenient and financially affordable to individuals with HIV infection and AIDS. Staff in these programs should be educated about HIV infection and AIDS, if possible, before HIV-infected patients are admitted.

Comprehensive Case Management

26. There should be a comprehensive community case management system, independent of any care giver, available to persons infected with HIV and AIDS. Such a system would work with HIV infected and AIDS patients to conduct overall needs assessments (including review of financial, medical, legal, housing, psychosocial and spiritual needs) at intervals based on severity of symptoms. As these assessments were completed, the system would assist individuals in locating and arranging the necessary service. This would serve to coordinate the services of numerous providers, assist providers in improving their ability to render services and also assist in identifying service gaps and strategies for filling them.

Financing

27. Reimbursement for home health care and home support services should be expanded. Where feasible and appropriate, resources now being spent by Medicaid and third-party payers on inpatient hospital stays should be shifted to home health care and home support services. Where gaps continue to exist, funds should be made available by direct government subsidy, as has been done in other parts of the country. Additionally, we support the extension of the Medicaid waiver to provide expanded home care services.

28. Funding should be made available for comprehensive medical and psycho social case management. Alternative funding options such as direct government subsidies, funding through Medicaid and involvement by third party payers should be explored.

29. There should be an organized approach to funding hospice care by Medicaid and other third-party payers. Any approach to coordinated hospice funding should be flexible enough to account for different types of hospice philosophies, individual needs, and other social policy goals, as well as to address cost containment.

30. The state of Minnesota should continue to work toward a comprehensive health insurance program that would ensure access to appropriate health care for all citizens.
31. Persons with HIV infection who quality because of income asset guidelines should be given the same presumptive eligibility for Medicaid as are individuals with AIDS.

EVALUATION AND LONG RANGE PLANNING

Background

New information on the care and management of HIV infection and AIDS is occurring almost daily. The longer term impacts are only now beginning to be identified and analyzed. It is essential that ongoing efforts be developed and maintained to understand the impact of HIV infection and AIDS on Minnesota and its economy.

Policies

32. There should be ongoing monitoring and system-wide evaluation of prevention efforts, discrimination, testing, support services and financing regarding HIV infection and AIDS.

33. A community and statewide process should be developed to study the longer term impact of HIV infection and AIDS on regional and statewide demographic trends, the economy and the health services system for the period beyond 1990.

Mandatory Premarital Testing for AIDS 1987

Being deeply concerned that the Minnesota House of Representatives voted to amend the Omnibus Health, Human Services and Corrections Bill to include a provision for mandatory premarital testing for AIDS; and

Recognizing that the House of Representatives was well-intentioned in its action, although misinformed regarding the effectiveness of premarital AIDS testing as a public health intervention measure for AIDS; and

Noting that an issue as important as mandatory testing of any residents of Minnesota warrants public hearings within the legislative process which allows for expert and balance testimony; and

Acknowledging that mandatory AIDS testing did not receive a public hearing prior to passage; and

Recognizing that the Centers for Disease Control conclude after public hearings held in February 1987 that mandatory premarital AIDS testing was not a prudent intervention activity for AIDS; and

Noting that since passage of this amendment, the Minnesota Department of Health has shared with the leadership of the House & Senate and the full Senate the rationale for why this amendment was ill-conceived; therefore

*Requests that the Minnesota Legislature's Conference Committee assigned to the Omnibus Health, Human Services and Corrections Bill delete the mandatory premarital AIDS testing provision in its Conference Committee Report.

*Asks that the Minnesota Legislature provide adequate public hearings through its committee process for major policy initiatives.

*Asks that the Minnesota Legislature seek public health and medical expertise in consideration of public health measures and refrain from politicizing AIDS by developing AIDS legislation that is inconsistent with public health practice and scientific evidence.

Chronic Disease Risks 1982

MPHA supports efforts to increase knowledge about the preventable risks associated with chronic diseases and to direct resources at and disseminate information about preventing or eliminating those risks. MPHA supports efforts to develop and maintain an ongoing capability to monitor the occurrence of chronic disease, particularly cancer.

Comment

Federal reductions in environmental protection and risk reduction activities place a greater burden on the state to monitor disease patterns in the population and to ascertain risk factors or exposures which are associated with those diseases, particularly for diseases with long latency periods. The State of Minnesota needs to develop the capability to efficiently detect changes in chronic disease patterns as those changes occur, in order to more effectively identify risk factors or exposures, which may be associated with those diseases.

Using only death certificate data to monitor chronic disease occurrence delays significantly our ability to detect changes in disease patterns. Death certificates do not contain enough information to support detailed examination of exposures and risk factors which may have been associated with development of the disease.

Approved September 30, 1982 Annual Meeting.

MATERNAL AND CHILD HEALTH

Minnesota Public Health Association Resolution: Endorsing Doula Care for All Birthing Women, Especially Those Receiving Medical Assistance and Minnesota Care 2009

Passed June 18, 2009 at the MPHA Annual Meeting

WHEREAS, doulas provide continuous physical and emotional support to women during labor and birth, including support for self-advocacy and informed consent[1]; and

WHEREAS, doulas often meet with mothers prenatally and postpartum in their homes and offer support and resources for all aspects of a woman's individual perinatal needs and experience[1, 2]; and

WHEREAS, women who have a doula have up to 50% fewer cesarean sections [3,4,5,6,7] ; and

WHEREAS, cesarean sections have been shown to contribute to maternal mortality and morbidity [8] and also to preterm birth [9] ; and

WHEREAS, the cesarean rate has increased every year in Minnesota and the United States for the last 13 years, to rates of 25.5 % and 31.4% respectively [10] ; and

WHEREAS, cesarean rates are increasing for all groups of birthing women, regardless of age, the number of babies they are having (multiples), the extent of health problems, their race/ethnicity, or other breakdowns[2] ; and

WHEREAS, babies of high risk women supported by a doula prenatally have better birth weights [11], and fewer NICU admissions [5,6] ; and

WHEREAS, women who have doula care are less likely to give birth with vacuum or forceps, have regional analgesia (e.g., an epidural), have any analgesia (e.g., narcotic pain medication), [7, 12] or be induced[13] thereby reducing the risks, side effects, and expense of those interventions; and

WHEREAS, postpartum depression (PPD) is the number one complication of childbirth affecting an estimated 12-15% of all postpartum women[2] (8,000-11,000 Minnesota women annually); and

WHEREAS, PPD impacts maternal adjustment, attachment and bonding [14,15,16,17], and breastfeeding [18], while infants whose mothers are suffering from PPD are more likely to have behavioral, language, and developmental deficits as well as display an increase in depressive symptomology such as irritability, prolonged crying, and poor weight gain [19] ;and

WHEREAS, doula support during pregnancy and labor has been proven to decrease rates of PPD [20,21] ; and

WHEREAS, women who receive doula care have an enhanced birth experience and self-image [15,18,22];

and

WHEREAS, in nearly every culture throughout history women during childbirth have been surrounded and cared for by other women familiar to them [23] ; and

WHEREAS, doctors, midwives, and nurses have demonstrated appreciation for the extra attention given to their patients and the greater satisfaction expressed by women who were assisted by a doula [24] ; and

WHEREAS, in the State of Minnesota women have a statutory right to doula care if they choose [25] ; and

WHEREAS, low-income women and those without family support benefit most from doula support and benefit most from support persons who are not hospital employees [7]**.**

Therefore, be it resolved that the Minnesota Public Health Association supports legislation and policies to increase access to and funding for doula care.

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Community Immunization Registries 1999

Whereas, community immunization registries are an effective and efficient tool to assist parents, health care providers and public health agencies assure all children receive the necessary vaccines; and

Whereas, community immunization registry information systems reduce the cost of producing complete immunization records when they are needed for enrollment in child care, schools, camps or other programs; and

Whereas, the increasing complexity of the immunization schedule (including new vaccines), as well as the mobility of many families and the frequent changes in a family's health care coverage has made assembling immunization records difficult; and

Whereas, community immunization registries benefit everyone by maintaining complete and accurate immunization records no matter where the shots were given; and

Whereas, complete immunization records in a geographic region also enables timely population-based assessments of immunization rates and the ability to identify pockets of under-immunization which could result in a disease outbreak; and

Whereas, a registry can help improve the quality of health care by highlighting where clinical practice is not meeting national immunization standards and by preventing over-immunization of children due to incomplete or missing records;

Therefore, be it resolved that the Minnesota Public Health Association supports funding community immunization registries as a tool to assure that all children receive necessary vaccinations, to address the low rates of immunizations for some children and to protect the public from outbreaks of serious infectious diseases.

Resolution Regarding Service to Preschool Handicapped Children 1991

WHEREAS, PL99-457 mandates comprehensive, coordinated, multidisciplinary interagency systems of early intervention services for young handicapped children and children at risk for handicapping conditions and their families; and

WHEREAS, Minnesota Statute 120.17 requires collaboration between health, human services and education in developing the early intervention systems; and

WHEREAS, The status of a child's health in the prenatal period and early childhood years is a critical factor in determining developmental outcomes; and

WHEREAS, infants, toddlers, and young children are at known risk for nutritional, medical, health, environmental and educational problems; and

WHEREAS, Public Health has a commitment to family-centered, community-based coordinated care;

Therefore, be it resolved that Minnesota Public Health Association supports public health as a partner in the collaboration and coordination of services provided to handicapped infants, toddlers and young children and their families.

Be it further resolved that the Minnesota Public Health Association supports funding for public health preventive services for handicapped and at risk infants, toddlers and young children and their families.

Be it further resolved that the Minnesota Public Health Association establish a statewide task for to develop a position paper on the role of public health in early intervention services.

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Maternal and Child Health Federal Block Grants 1985

The Minnesota Public Health Association supports the distribution of federal Maternal and Child Health Block Grant funds for the primary purpose of improving and maintaining statewide direct service delivery, emphasizing prevention, to mothers and children This should be accomplished through the allocation of a minimum of funds for state administration and a majority of funds for local agencies providing direct services and through a partnership including State technical support and local delivery of direct services. The distribution of funds to local agencies should be on a non-competitive formula method based on need. The agent for distribution of funds at the local level should be the Community Health Services Boards.

The Minnesota Public Health Association supports the expansion of the resource base for maternal and child health services to assure adequate funding of local services and adequate funding of State technical support functions.

Comment

The Minnesota Public Health Association recognizes that the provision of maternal and child health services is the responsibility of both public and private providers, that the Community Health Services system was established by the Minnesota Legislature to coordinate local, state and federal services and funding for community health services, and that maternal and child health services are an important component of the Community Health Services system.

MPHA acknowledges that a maximum amount of funds in any granting process should be assigned to direct service delivery in order to be most effective in achieving target population outcomes. Appropriate technical assistance should be made available to providers in development and operation of effective programs.

In addition, MPHA recognizes that the direct delivery of health services should be provided by local agencies rather than by the Minnesota Department of Health when economies of scale are appropriate. If a service has been the responsibility of a State agency supported by federal block grant funds and those service responsibilities are shifted to a local agency, then the funds should also be redirected to those agencies.

Approved April 26, 1985 Annual Meeting.

Health Risks and Infectious Diseases Associated with Child Day Care 1984

The Minnesota Public Health Association,

Realizing that the number of children receiving non-parental child day care has increased rapidly from 1950, when 11 percent of two parent households and 50 percent of single parent households with children under six years of age worked, to 1980 when 50 percent of two parent households and 70 percent of single parent households with children under six years of age worked;(1) and

Noting that approximately 11 million children in the United States are receiving some form of non-parental child day care;(2) and

Realizing that child day care is an essential service and that well-designed and operated day care programs can promote the physical, mental and emotional development of children; and

Recognizing that children attending child day care, close family members, and child day care staff are at a potential increased risk of infectious diseases(3) due to close physical contact;(4,5) inadequate personal hygiene associated with age-related need and behaviors;(6-8) age-related immune status (e.g., Haemophilus influenzae, type b infections);(9,10) and ill children attending centers because of parental inability to provide or locate alternative care;(3) and

Acknowledging that child day care environments may also contribute to other health-related problems; and

Noting that there has been virtually no unified approach by experts in different disciplines to define the scope of health problems in child day care or to define specific areas requiring further research;(3)

Observing that there are varying requirements and qualifications for child day care providers and no uniform health and safety standards for child day care facilities;(3) therefore

1. Encourages child day care and health care providers and child day care regulators to increase efforts to characterize the epidemiological features of infectious diseases and other health and safety problems in child day care and to develop more effective strategies of control and prevention in these settings;

2. Encourages efforts to create an awareness of the potential health risk implications for children in child day care settings and actions to address these potential risks directed at our membership, other health professionals, child day care providers, elected officials, and the general public;

3. Recommends promulgation of uniform and acceptable local and state government regulations as well as the development of guidelines for health and safety management in child care programs formulated through the efforts of health professionals and agencies of federal, state, and local governments.

4. Supports the development of new safe and effective childhood vaccines to prevent common causes of infectious diseases in children attending child day care;

5. Encourages increased funding to support both research and implementation of child day care health and safety; and

6. Encourages efforts to ensure that all children have access to child day care which promotes their health.

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Approved May 11, 1984 Annual Meeting

Infectious Diseases in Child Day Care 1983

WHEREAS, The increase in the number of children attending day care in the United States and the potential for transmission of infection in that environment suggests a problem of substantial magnitude; and

WHEREAS, To date there has been virtually no unified approach by experts in different disciplines to define the scope of the problem of infectious diseases in day care or to define specific areas requiring further research; and

WHEREAS, Current recommendations for prevention of many diseases in child day care are based on incomplete information and did not take into consideration economic realities of child day care or the day care environment. Therefore,

THEREFORE IT BE RESOLVED that the Minnesota Public Health Association supports the efforts being taken by the Minnesota Department of Health and the University of Minnesota regarding a symposium on "Infectious Diseases in Day Care: Management and Prevention" to be held June 21-23, 1984, in Minneapolis.

Approved October 20, 1983 Annual Meeting.

MEDICAL CARE AND CLINICAL SERVICES

Endorsement of Health Care Without Harm - Campaign Goals 1998

WHEREAS, Health Care Without Harm: The Campaign for Environmentally Responsible Health Care is an international non-profit coalition of 75 organizations, with participation by health care professionals, public health advocates, scientists, religious institutions, labor representatives, environmental justice activists, health-impacted individuals and environmental groups; and

WHEREAS, the mission of Health Care Without Harm is to transform the health care industry so it is no longer a source of environmental harm by eliminating pollution in health care practices without compromising safety or care. This mission will by accomplished by:

- promoting comprehensive pollution prevention practices;
- supporting the development and use of environmentally safe materials, technology and products; and
- educating and informing health care institutions, providers, workers, consumers, and all affected constituencies about the environmental and public health impacts of the health care industry and solutions to its problems; and

WHEREAS, the goals of Health Care Without Harm are:

1. To work with a wide range of constituencies for an ecologically sustainable health care system;
2. To eliminate the non-essential incineration of medical waste and promote safe materials use and treatment practices;
3. To phase out use of polyvinyl chloride (PVC) and persistent toxic chemicals, and to build momentum for a broader PVC phase-out campaign.
4. To phase out the use of mercury in the health care industry;
5. To develop health-based standards for medical waste management to recognize and implement the public's right to know about chemical usage in the health care industry;
6. To develop just siting and transport guidelines that conform to the principles of environmental justice: "no communities should be poisoned by medical waste treatment and disposal."
7. to develop an effective collaboration and communication structure among campaign allies; and

WHEREAS, this mission statement and these goals are in keeping with MPHA's mission to protect public health.

THEREFORE, BE IT RESOLVED THAT the MPHA formally support the mission and goals of Health Care Without Harm.

Adopted April 30, 1998

Improving Health Care Coverage 1998

WHEREAS, Minnesota has taken steps throughout the 1990s to improve access to health care coverage including the creation of an insurance program for the uninsured, MinnesotaCare; and

WHEREAS, the MinnesotaCare program together with expanded eligibility for Medicaid and small group insurance reform have created an environment that has allowed Minnesota's rate of uninsured residents to remain essentially stable at six percent while rising nationally; and

WHEREAS, in 1997 Congress enacted the State Children's Health Insurance Program (SCHIP) which makes available Federal dollars for states, including approximately $27 million for Minnesota, to use to increase the number of children who are insured in a state; and

WHEREAS, the are approximately 72,000 uninsured Minnesota children; and

WHEREAS, Minnesota has not yet been able to access SCHIP funds due in part to the recent addition of an asset test to the MinnesotaCare program; and

WHEREAS, Minnesota has yet to achieve a measurable decrease in the number of uninsured residents; and

WHEREAS, since its creation in 1992, it has gotten administratively more difficult to enroll in the MinnesotaCare program; and

WHEREAS, in a study conducted by the University of Minnesota one-third of the uninsured knew nothing about MinnesotaCare and another third did not know enough about it to know if they were eligible.

THEREFORE, BE IT RESOLVED THAT MPHA support efforts to move Minnesota closer to a goal of universal coverage by supporting the following policy changes:

1. Remove the asset test from the MinnesotaCare program;

2. Make other administrative changes so that Minnesota can use the State Children's Health Insurance Program (SCHIP) funds that have already been set aside;
3. Simplify the enrollment process for MinnesotaCare:
4. Improve affordability by decreasing premium costs; and
5. Conduct an in-depth study of the remaining uninsured so that their needs may be more clearly understood.

Adopted April 30, 1998

Eliminating Cost Sharing for Preventative Care Services 1995

Be It Resolved That: The Minnesota Public Health Association supports the Minnesota Commissioner of Health's recommendation to not have cost sharing applied to primary and secondary preventive care services covered by the Universal Standard Benefits Set to be adopted under the 1994 MinnesotaCare Act.(1) It is believed this policy will move Minnesota closer to assuring equal access for all to the opportunity to avoid illness, will lead to improvements in the overall health of the population, and would probably be achieved without increasing health care costs. This policy is in agreement with previous Minnesota Public Health Association resolutions supporting universal access, equal accessibility, and encouragement of preventive care.(2-8)

For the purpose of this resolution primary preventive care is defined as services intended to delay or prevent the onset of disease or a health problem. Secondary preventive care is defined as services to detect a disease or condition before it is clinically recognizable to avoid or delay further progression.

Background to Statement:

Our current health care system is oriented to treating illness. It is desirable to have a system that is focused instead on health promotion. The key advantage to a health promotion orientation is it reduces the level of illness and disability in the population. Rather than caring for people after they have become sick, steps are taken to prevent them from becoming ill in the first place. This reduces both the number of days people are sick and the likelihood of permanent disability or death. Classic examples of preventive care are immunizations, prenatal care, and Pap smears for the early detection of cervical cancer.

A probable second advantage to an emphasis on preventive care would be a reduction in health care costs. As a general rule it is less expensive to prevent a given illness or treat it early than to provide care once someone has become acutely ill with a disease. Here are some examples of the potential cost savings from preventive care services. Nationally it is estimated giving measles, mumps, and rubella vaccine saves $1.3 billion per year.(9) Screening for Chlamydia infections is estimated to annually save from $100-$400 million.(10) Every dollar spent on smoking cessation counseling to pregnant women is expected to save three dollars.(11) There is calculated to be an overall savings of 50% from the early detection of breast cancer.(12) However, even if health care costs remained at about the same level we will still have "purchased" more days of health for the population than under our current health care system.

As Minnesota advances in its health care reform efforts it is designing incentives for health care providers to focus on prevention and health promotion. At the same time, incentives for consumers to focus on health promotion need to be designed into the system. These incentives should enable all consumers to use those health care services aimed at preventing them from becoming ill. Eliminating out of pocket fees for preventive care would help achieve this objective.

In the debate on health care financing there may be reasonable arguments for having co-payments or deductible fees for some medical care services. However, the Minnesota Public Health Association believes it is counter productive to the population's health to have consumers pay for preventive care. Avoidance of cost sharing for preventive care services is also seen as a key requirement in achieving the Minnesota Health Care Commission's goals of universal access to services and equal purchasing power.(13) It is known the more one relies on out-of-pocket fees to finance

health care the greater the relative burden on low income individuals, who are also disproportionately those at higher risk of illness.(14) These fees are a strong disincentive to limited income people seeking basic health promoting services. The effect then of having co-payments and deductibles for preventive care services is to discriminate against lower income individuals, who are usually those most in need of such care. Instead our current system now steps into help them only after they have become so ill that medical care has become an inescapable necessity.

It may be many years before the Nation or Minnesota achieves universal coverage for health care. Further, it is likely that the financially well off will always be able to purchase better care. Yet Minnesota can at least move towards the achievable state of assuring that everyone has an equal opportunity to prevent the onset of serious diseases. By removing financial barriers to getting preventive care we would in a sense be giving people equal purchasing power for protecting their health and avoiding illness.

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State and Local Public Health Agencies in Health Reform 1994

I. Statement of the Problem

The United States is focusing on health reform as a means of controlling the costs of and expanding access to health services. The Federal and state governments are in various stages of re-structuring the health system in the United States. Health reform represents both an opportunity and a threat to population-based health activities and the public health system. The opportunity lies in the recognition that prevention is essential to a cost-effective system. To the extent that this recognition is translated into priorities by resource allocation, public health's goals are served.(6) The threat is that a less than optimum investment in clinical prevention will be considered sufficient, and that the needs for population-based activities --those public services and interventions which protect entire populations from illness, disease and injury--will neither be considered nor adequately funded.(6,11) Thus, a common understanding

of the future role of public health, especially state and local public health agencies, in health reform needs to be clearly articulated and communicated to policymakers.

The Minnesota Public Health Association has traditionally played a role in advocating public health policy. With health reform occurring in Minnesota and nationally, MPHA needs to mobilize its resources, including public health professionals, to articulate and advocate the appropriate role of public health at the state and local level as a part of health reform.

II. Description of the Problem

Health is determined by a complex of factors that are outside the control, interest, and responsibility of physicians, hospitals, and other components of medical care, because medical care's main purpose is to help people through acute illness.(14) A variety of actions that can be taken outside the common sphere of medical care has great potential to alleviate suffering and contain costs. These actions are public health in nature. By changing environmental conditions, assuring adequate housing and nutrition, providing educational programs, and pursuing population-based strategies such as screening and immunization programs, significant reductions can be made in the need for expensive therapeutic interventions after disease is established.(7)

The medical care system has demonstrated its ability to absorb every dollar that is made available to it with marginal impact on the population's health status. The separation of financial support between population-based services that are largely supported by taxation and clinical medicine activities that are supported largely by insurance mechanisms has contributed to the huge disproportionate societal investment between these areas. As funding sources shift with health reform implementation, the infrastructure for providing population-based functions will erode unless a stable source of funding is maintained.(7)

Expanding access through the medical care delivery system, however necessary, will not be sufficient in itself to improve the health of Americans. Through better access to medical care, only 10% of premature deaths among Americans would be avoided. In contrast by changing individual behaviors, 50% of premature deaths would be avoided. Another 20% of the premature deaths are attributable to environmental factors. Both behavioral and environmental issues require population-wide strategies and interventions. Nearly one-half of the U.S. deaths in 1990 were due to causes that were behavioral in nature and substantially outside the purview of the traditional medical care system.(10)

Under current reform proposals, health plans and health providers will be encouraged to emphasize prevention and health promotion, but the services they will provide (primarily medically-oriented diagnosis, treatment, and prevention) are not the only factors that determine individual, family, and community health. Issues of public health significance such as unstable family environments, unhealthy lifestyles, community violence, and environmental pollutants will not be mitigated by universal insurance and managed competition.

The true causes of most preventable health problems in our society are related to individual behavior and environmental conditions such as tobacco use, improper diet, lack of physical activity, alcohol, microbial and toxic agents, firearms, unsafe sexual behavior, motor vehicle crashes, and illicit use of drugs. For example, population-based preventive programs are largely responsible for the recent changes in tobacco use, blood pressure control, dietary patterns (except obesity), automobile safety restraint, and injury control measures that have fostered declines of more than 50% in stroke deaths, 40% in coronary heart disease deaths, and 25% in overall death rates for children.(10) The public health system with its emphasis on population-based health promotion and protection, offers the greatest hope for making substantial inroads into the true causes of preventable health problems.

Public health also has had responsibilities related to the delivery of personal health services to high risk groups. The delivery of effective and economic personal care services for high-risk, hard-to-reach populations must be addressed in the reformed health system.(8) Because these populations experience above average incidence of disease, disability, and death, they need special assurance that they will receive primary health care, health promotion, and social services to improve their health status. They frequently require extensive outreach to initiate care,

coordination to integrate delivery of required services, follow-up to ensure compliance and return visits, linguistically- and/or culturally-appropriate services, and assistance to modify high risk behaviors.(7)

The public health system works to identify these populations and assure that needed medical, social, and personal health promotion services are provided. Personal health promotion services are frequently provided through home visits and are designed to prevent future health problems and costs. These services can ultimately influence community norms.

As health reform is implemented, the new system is likely to enhance its capacity to serve a greater proportion of these clients. But a segment of the population with multiple psycho-social and health risks are difficult to reach and will require public health intervention.

Four major reports by the Academy of Sciences find that a stronger, more responsive public health system is needed to better meet its responsibilities. The findings specifically note the need for(10)

- strengthened public health leadership;
- enhanced professional competence among public health leaders and staff;
- revision of outdated statutes and ordinances;
- filling gaps in data collection;
- improving the system's analytic capability to use data effectively; and
- ongoing links between public health and private sector health care for population-wide responsibilities of public health.

Currently less than 1% of aggregate national health expenditures support population-based public health functions.(10) Yet, public health measures have been responsible for a proportionately higher percentage increase in the longevity of the U.S. population. Continuous and greater resource support for the population-based functions best performed by state and local public health agencies must be assured.

The most effective prevention strategies come from population-based public health initiatives. Because health reform seeks not only to expand access but also to contain health costs, the public health investment in prevention becomes ever more compelling. Unless this is recognized by policymakers by increased financial support for public health under health reform, the country will fail to realize the potential sought from reform.(10)

III. Purpose and Objectives

If a fundamental purpose of health reform is to cost effectively enhance the health status of Americans, then public health and population-based programs play an essential role in producing an effective reformed health system.

Public health should be a critical element in any health system and should be included in any reform proposal. Population-based services--those public services and interventions which protect entire populations from illness, disease and injury--are essential in any effort to address spiraling health care costs, lack of access to care, and poor health status. Population-based services focus on health promotion, community health protection, personal prevention and assistance in gaining access to care.(11) Public health programs are conventionally defined as governmental programs, although non-governmental entities also can conduct similar activities. Some specific activities are performed by governmental entities outside the designated public health agency or by private, usually non-profit, organizations.(6)

In pursuing the mission of public health, local and state public health agencies must have sufficient capacity to fulfill the three core functions of public health: assessment, policy development and assurance. The core public health

functions serve as the system's infrastructure, are unique to public health, and would not be a part of any other organization. Each jurisdictional level has a key role to play as described below.

1. Assessment - is the ability to continuously measure and monitor health, diseases, injuries, air and water quality, food safety, other local conditions, and community resources through regular systematic collection, analysis and dissemination of information. The assessment function identifies trends in morbidity and mortality and causative factors, available health resources and their application, unmet needs, and community perceptions about health issues.(8,9,11)

The State Role: The state is responsible for establishing and maintaining surveillance systems, collecting and assembling health status and utilization information, and performing analysis. Expertise is needed for comparative analysis and forecasting regional and state treads. This data should be shared with local government in a useable form. The state should also provide technical assistance to local health departments for local forecasting and interpretation of data.(8,11)

The Local Role: Local health departments are responsible for local data collection to use for their own services and to provide to the state for statewide analysis. They also assess citizen's perceptions of community health status and the importance of health issues facing their community. With state assistance, local health departments provide interpretations and forecasts of health status and other related information, and serve as the repository and disseminator of this information for the community served.(8,11)

2. Policy development - builds upon the data from assessment activities to develop local and state health policies. Policy development considers political, organizational, and community values. Good public policy development includes information sharing, citizen participation, compromise, and consensus building in a process that nurtures shared ownership of the policy decisions. Policymakers review the recommendations and decide appropriate actions and/or implementation. Policy development incorporates issues related to funding of public health programs. (8,9,11)

The State Role: The state is responsible for assembling and providing periodic state health reports identifying statewide priorities and goals that reflect local community planning efforts. In partnership with local agencies, the state initiates and/or develops policies on health issues, including funding, that require statewide action or standards. Regional or state policy development efforts ought to occur only when local leaders agree that such centralized policy development is more efficient and effective, and then only with active participation of local communities.(8,11)

The Local Role: Local health departments are responsible for providing a leadership role in developing local priorities and plans in partnership with the entire community. With the authority of local boards of health to initiate, develop and draft local ordinances or rules for health-related issues that require a specific local response, strong public health policy can be developed and owned by citizens locally.(8,11)

3. Assurance- translates established policies into services. These activities must assure that basic public health capacities and essential population-based services are available in all communities. Part of that capacity includes the ability to respond to critical situations and emergencies and requires monitoring the quality of health services provided in both public and private sectors. The assurance function does not mean that the public health agency always provides the service; provision of health services can come from a variety of sources.(8,9,11)

The State Role: The state requires adequate legal authority (in some instances waivers from federal constraints), resources and trained leadership and staff to provide a range of services, including maintenance of emergency response capacity, enforcement of standards and laws, and maintenance of quality assurance in the service delivery system. The state must also assure that core public health functions are provided throughout the state. Under reform, state government has assumed additional responsibilities to assure quality and access to care.(8,11) These include monitoring health expenditures; setting, enforcing and adjusting spending limits; increasing access to primary care providers in rural areas; compiling and analyzing outcomes data; and, supplying

purchasers, consumers and providers with information on cost, quality and value to improve decision-making and simulate appropriate competition.(7)

The Local Role: Local health departments need the capacity to advocate, serve as catalysts, coordinate and organize responses to priority local needs, respond to major regional or local emergencies, enforce regulations, and provide population-based health promotion, health protection and preventive health services to the community. They must assure that essential outreach functions, including transportation and foreign language assistance, are available to people experiencing barriers to obtaining access to necessary health services. Where no other resources are available in the community, local health departments need the financing to purchase or directly provide those personal health care services identified locally as priorities.(8,11)

Currently too few resources are allocated to state and local public health agencies for meeting the three core public health functions. Most available resources are spent on assurance and are limited to specific programs. Assessment and policy development are neglected.(11) When the system and resources are available to support core functions, public health science and expertise combine with an organized community effort to:(4)

- identify priority health problems, develop strategies and secure resources to address the priority health problems;
- ensure compliance with public health laws and ordinances; and
- assure the availability of appropriate health services maximizing the efficient use of public and private community resources.

A stronger government health system--working actively to protect and promote health, and prevent disease and injury--will ultimately result in cost savings and less demand for more expensive illness care.(10)

IV. Actions Desired and Methods

Public health must reassess its current role and functions and pursue its interests within the health reform movement. The public health community must reach a common understanding of population-based health services and the critical role such services play and assure an emphasis on both population-based and clinical preventive approaches in the reformed system.

Health reform requires a well-functioning public health system that operates in concert with the medical system. To accomplish this, the public health system must have the capacity and resources to fulfill its responsibilities. For those public health functions that are essential, the public health community should:

1. Articulate governmental public health functions and the division of these between the State and local public health agencies.
2. Recommend a level of dedicated funding for public health that does not supplant existing funds and distributes funds locally.
3. Determine those services that will be purchased through a set aside of health expenditures created for public health activities.
4. Institute a phased redistribution of resources from illness care to preventive programs by establishing a target investment in prevention with a timeline to achieve that target in a time certain.
5. Collaborate with purchasers and providers of care to assure that health benefit plans are appropriate to population needs.

6. Define standards for personal care services to assure that effective personal care services for hard-to-reach and high-risk populations can be cost justified and managed with a clear understanding of appropriate services, expected outcomes, and responsibility for providing services.

7. Assure that government public health agencies have a specific role in monitoring health effects and advising policymakers on the effectiveness of programs in meeting agreed upon health objectives.

8. Define standards for the provision of public health activities that improve the health of the population overall and provide a strategy for achieving health system cost containment.

9. Support innovative and effective public health programs by an ongoing, well-conceived research agenda and require a systematic approach to program evaluation.

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Position on the Cost Containment Plan of the Minnesota Health Care Commission 1993

The Minnesota Public Health Association (MPHA) commends the Minnesota Health Care Commission for its excellent work in drafting the Cost Containment Plan. The Plan reflects a solid foundation on which to build health reform in Minnesota under the goal of universal access to care. The public health components of the Plan are to be

applauded for their emphasis on prevention and their acknowledgement of the role of the Community Health Services system in the provision of health services in Minnesota.

MPHA supports the Health Care Commission's Plan because it provides a foundation for the integration of the medical and public health service delivery systems. MPHA encourages the further development of this model for health care delivery and offers its expertise to help accomplish this goal. MPHA can also offer assistance as the Health Care Commission prepares to resolve some of the issues surrounding minimum basic health care benefits and long term care.

Integrated Service Networks

MPHA supports the concept of the Integrated Service Networks (ISNs) and incentives that encourage integration of the public health and medical models of health care delivery. Health reform needs to address a blending of these approaches of providing health services into one delivery system within the ISN. The public health approach looks at the individual in the context of the larger community with an emphasis on prevention and health promotion. According to the Plan, the ISN is to be responsible for the health status of its member population; therefore, it needs to look at the aggregate of its population, not just the individual client. As the ISN develops a systematic community approach to improved health status for its population, working relationships with Community Health Service agencies and other existing community-based health agencies need to be strengthened. Care should be taken to ensure the continued development and existence of community-generated, community-based health programs.

To be effective, health reform in Minnesota needs to re-package the current method of delivering medical services. The physician plays a key role in the medical model. In the public health model, many other health professionals (a term preferable to mid-level practitioners) play a significant role as well in improving and maintaining good health. Active and extended use of nurses, nutritionists, health educators, trained counselors and others for appropriate services should be expanded to better use their health expertise and educate consumers to a broader array of health providers. Also, the inclusion of volunteers and the voluntary health agencies in the health system should not be overlooked.

The non-profit health system in Minnesota should be maintained by having the ISNs incorporate as non-profit entities. The ISN incentives should be designed so that ISNs are accountable for the health of their enrolled populations. This accountability should be elucidated to both the individual and to the community. Accountability should stress outcomes for the population served; but, it is critical to provide accommodations for the high risk individuals in the ISN. To ensure that high risk populations will be included in ISNs, risk adjustment factors are essential.

Growth Limits and Payment Systems

MPHA suggests that the Plan acknowledge that short-term increases in expenditures for prevention-oriented health services may be necessary to gain long-term health cost savings. For example, the costs of a wide-spread immunization effort must be accounted for before the long term savings from disease prevention can be achieved. When establishing growth limits, the initial costs of preventive efforts should be incorporated especially for health organizations whose primary mission is prevention. The incentives in the ISN system should encourage expansion of prevention-oriented services such as prenatal care, family planning, and support for behavior change for healthier lifestyles.

Collaboration

MPHA supports collaboration that will promote efficiencies in the system. Specifically, collaboration should be encouraged in the development of products for consumer education. These products should be made widely available and be part of the public domain.

Technology and Major Expenditures

Promoting efficient planning and utilization of health care facilities and technology is essential to ensure that consumers benefit from the billions of dollars spent annually in health care. Technology assessment and related practice guidelines should be tied to provider accountability for health outcomes and patient satisfaction as identified in the Plan.

Practice Parameters

MPHA encourages those involved in the review and determination of practice parameters to continually assess the use of parameters across all appropriate disciplines. The health system and the population will benefit by broader practice applications with a multi-disciplinary approach.

Administrative Costs

MPHA strongly supports changes in the health care system that produce administrative efficiencies. The Commission's continued investigation of administrative cost reductions through the streamlining of administrative activities and coordination of services is encouraged. MPHA encourages the Commission to promote collaboration where administrative efficiencies can be achieved.

Consumer Education and Incentives

MPHA supports the recommendation for greater consumer education and empowerment as they encourage consumers to take a more active role in their health care. Allocation of adequate resources including personnel and access to material and support programs is essential to enable people to make informed decisions regarding their health and to achieve behavior change. As part of the overall health network, the Community Health Services system can play a key role in this (as indicated in the Plan) if adequate resources are made available for initial development. Although the responsibility for consumer education and incentives is broader than the ISNs, these elements should be incorporated into the ISN structure as a part of a "full continuum" of services.

Prevention

MPHA supports the Plan's strong emphasis on prevention strategies. Specifically, MPHA endorses 1) increased subsidized family planning services, 2) reduced smoking among pregnant women, 3) repeal of laws requiring reporting of pregnant, cocaine using women, 4) providing culturally sensitive, culturally competent prenatal care, 5) incentives for low income women to use early and continuous prenatal care, 6) improved nutrition of women, infants, and children, 7) requiring mandatory helmet use, 8) increased excise tax on tobacco (not just cigarettes!), 9) restricting of advertising on tobacco products, 10) increased excise tax on alcohol, and 11) improved adherence to immunization standards and funded immunization efforts.

MPHA supports the recommendation that the revenue generated by the increase in the tobacco excise tax be dedicated to fund preventive health activities. The proposed list of prevention strategies represent only a beginning and will be expanded as the Commission proceeds. Additional suggestions for this list include: violence and abuse prevention, expansion of school-based clinics, elimination of smokeless tobacco, further development of comprehensive school health programs, enhancement of nutrition education, and injury prevention.

Public Health

MPHA supports using the Minnesota Department of Health's "Charting the Course: Minnesota Health Goals and Objectives for the Year 2000" as admirable goals for the entire health system of the State to be pursued by ISNs and non-ISN providers. The financial reimbursement and incentives for all health care providers should be structured to reflect performance in meeting these health goals.

MPHA strongly supports the coordination and collaboration of the private and public health systems. MPHA also recognizes that the current public health system provides a governmental "public good" function that does not translate into the ISN system. Those areas are adequately defined in the Plan.

The text of the Plan should explicitly acknowledge the ability of the public sector to form its own ISN and provide the regulatory structure necessary to accomplish this goal.

Targeted Strategies

Clarification of the terminology "short-term" could enhance the understanding of this portion of the Plan. Disregarding the "public commitments" issue, most of the other strategies can be implemented short-term with legislation or program enhancement. However, the health care cost impact of implementing these strategies run the gamut from short-term to long-term. MPHA supports these strategies and acknowledges their importance in improving the health of Minnesota's citizens, but understands that behavior change takes time and available resources to accomplish. This needs to be recognized in the Plan.

Information and Technical Assistance

MPHA supports the creation of a clearinghouse for the collection and dissemination of information on health care costs and quality through a private-public arrangement. The information that is dispensed should be consumer friendly in its configuration. The clearinghouse should be aggressive in targeting its dissemination of information to various sectors of the public. A passive availability of information will not produce the needed consumer education function for the system to work effectively.

Regional Coordinating Boards (RCBs)

The Plan calls for an extension of the expiration date for the RCBs to "provide an opportunity for regional input to the state Commission and the Commissioner of Health and facilitate local collaborative efforts to improve access, quality, and affordability". MPHA supports the extension of the RCBs and suggests an expansion of their roles to include the coordination of high cost technology distribution, the dissemination of practice parameter information, and the promotion of ISN development.

Concern exists regarding the distribution of the RCBs membership within the region. Some of the RCBs are not representative of the geography of their regions. For example, Region 2 has 8 of its 15 members from the city of Duluth, while some of the eleven counties lack representation. Reforms in the membership structure should be made to assure a geographically balanced representation in the RCBs so that they can truly provide regional input.

MPHA strongly supports community involvement in planning and implementing health services and the Plan's suggested use of the Community Health Boards as a resource to the RCBs. A review of the staff support for these boards indicates inadequate staff support. Once the RCBs responsibilities are more clearly defined appropriate staff support should be appropriated.

Rural Health Issues

MPHA recognizes the need for expanded study of the needs in rural areas for health delivery reform and supports the Plan's intent to tailor the reform strategies to the special needs and conditions in rural areas. A suggested strategy is to use multi-disciplinary practice parameters to provided greater access to health services for rural populations.

Concluding Comments

MPHA encourages the Minnesota Health Care Commission during its 1993 deliberations to allocate time to address cost containment strategies for long term care services.

(NOTE: The text of this position was presented as testimony at the Public Hearing conducted by the Minnesota Health Care Commission on Friday, March 5, 1993.)

Position on the Integrated Service Network Act 1993

The Minnesota Public Health Association (MPHA) supports the concept of the Integrated Service Networks (ISNs) accompanied by incentives that encourage integration of the public health and medical models of health care delivery. Health reform needs to address a blending of these approaches to support comprehensive health services through one delivery system. The Act provides a foundation for the integration of the medical and public health service delivery systems within the ISN.

The public health approach looks at the individual in the context of the larger community with an emphasis on prevention and health promotion. Within this context, public health has both a service delivery component and a public safety and protection function.

A greater emphasis on prevention and health promotion in health service delivery is needed to ensure true system reform and cost containment. MPHA supports a comprehensive set of health services within the ISN standard benefit set. Essential to this comprehensive array of services is the inclusion of prevention-oriented services and support services that enhance access to and availability of services.

Therefore MPHA recommends that the Act define the benefit set to assure that:

- ISNs offer a full array of prevention-oriented services that encompass the lifespan of their members and provide incentives to encourage their use. The prevention-oriented services include but are not limited to:

Reproductive Health - prenatal/postnatal care and education, confidential comprehensive family planning, positive/effective parenting education;

Health Screening and Assessment - routine hearing and vision, well child services, services presently available through EPSDT (consisting of screening for hearing, vision, development, lead and anemia), preventive dental services, early disease detection, monitoring of chronic conditions and activities of daily living; and

Disease Prevention and Health Promotion - confidential STD/HIV prevention and education, tobacco use prevention, chemical health promotion, nutrition services, injury prevention, immunizations, personal preventive health services.

- ISNs provide support services and appropriate mechanisms for service delivery (e.g., home visits) for high-risk individuals and families. Support services should increase access and include services such as:

outreach to foster appropriate utilization of services, transportation services, child care, services to address cultural barriers to service, care coordination, and access to and availability of injury prevention equipment such as helmets and child auto restraints.

- ISNs provide and reimburse health education services including individual health promotion and education counseling provided by qualified personnel whether in an office or home setting.

Health reform in Minnesota needs to remodel the current method of delivering medical services. The physician plays a key role in the medical model. In the public health model, many other health professionals play a significant role as well in improving and maintaining good health. Active and extended use of nurses, nutritionists, health educators, psychologists, trained counselors and others for appropriate services should be expanded to better use their health expertise and educate consumers to a broader array of health providers. MPHA endorses the Act's encouragement and facilitation of the participation of mid-level and allied health care practitioners and elimination of inappropriate barriers to their participation.

Those involved in the review and determination of practice parameters should continually assess the use of parameters across all appropriate disciplines. The health system and the population will benefit by broader practice applications with a multi-disciplinary approach.

MPHA endorses the Act's continuation of the non-profit health system in Minnesota.

The use of Minnesota Department of Health established goals for the State's entire health system including both ISN and non-ISN providers is necessary to assure positive health outcomes for the citizens of the State. Financial reimbursement and incentives for all health care providers should be structured to reflect performance in meeting these goals. In addition, reaching these goals should form the baseline for ISN accountability for the health of its enrolled population with appropriate accommodations for high risk enrollees. This accountability should be actively elucidated to both the individual and the community through the information clearinghouse.

MPHA supports collaboration that will promote efficiencies in the new system. This includes the coordination and collaboration of the private and public health systems. As the ISN develops a systematic community approach to improved health status for its population, working relationships with Community Health Service Agencies and other community-based health agencies are imperative. Care should be taken to ensure the continued development and existence of community-generated, community-based health programs.

MPHA also recognizes that the current Community Health Services (CHS) system provides a governmental "public good" function within a State-local partnership that does not translate into the ISN system. These public functions include:

- a statewide decentralized system of community assurances that basic public health capacities and essential population-based services are available in all communities and that accountability for population-based health outcomes based upon public health goals is achieved,

e.g., health emergencies such as disease outbreaks, enforcement of regulatory measures to protect personal and environmental health, quality of personal and population-based health services, and provision of "safety net" services;

- community assessment and response to community health needs and the adequacy of resources,

e.g., trends in illness and death plus causative factors, unmet needs and citizens' perceptions about their health, availability of resources and their application, abatement of environmental sources of lead and public health nuisances;

- public health research and development initiatives to improve public health practice; and

- assessment data is used for policy development at the local level that supports the health of the community;

  e.g., community priorities and plans, public agency budgets, and local ordinances.

Incentives for developing effective collaboration between CHS Agencies, non-ISN providers, and ISNs are necessary. This requires a level playing field for all participants. The Commissioner of Health and the Legislature must assure that the CHS system is adequately funded to perform its State mandated and public protection functions and to support the Commissioner's role in collecting and analyzing community-specific public health date, in determining state and regional public health goals, and in coordinating local funding allocations. The Minnesota Health Care Commission and the Commissioner of Health should develop specific plans for CHS and ISN collaboration with ample representation from the Community Health Services system.

MPHA recommends inclusion of a strong emphasis on prevention strategies in the Act. Specifically, MPHA endorses activities that 1) improve birth outcomes including reduction of smoking among pregnant women, provision of culturally sensitive, culturally competent prenatal care, and incentives for low income women to use

early and continuous prenatal care; 2) improve access to nutrition for women, infants, and children; 3) increase adherence to immunization standards and funded immunization efforts; 4) increase access and availability to subsidized family planning services; and 5) study the impact on the use of prenatal care services due to the required reporting of pregnant, cocaine using women.

MPHA supports the extension of the Regional Coordinating Boards (RCBs). However, concern exists regarding the distribution of the RCBs membership within the region. Some of the RCBs are not representative of the geography of their regions. Reforms in the membership structure should be made to assure a geographically balanced representation that they can truly provide regional input.

MPHA is an advocate of community involvement in planning and implementing health services and recommends designing more definitive relationships between the RCbs and the Community Health Boards.

Other MPHA Position Statements and Resolutions apply to this health reform proposal follow:

- Health Care Reform - 1992
- Position Statement on Universal Access to Efficient and Effective Basic Health Services - 1989
- Perinatal Substance Abuse - 1989
- In Support of a Minnesota Health Plan - 1988
- Prevention - 1980
- Alternative Health Insurance - 1980
- Community Health Services - 1979
- The Planning and Provision of Preventive Health Services – 1978

Health Care Reform 1992

Health Care Access and Cost are Major Problems in Minnesota

- 370,000 Minnesotans are uninsured for all or part of the year - 8.6 percent of the state's population

- 11,000 Minnesotans were refused health care last year because they lacked health insurance

- The current health care system is unaffordable for many Minnesotans. One in three uninsured Minnesotans have unpaid medical bills, averaging $826. One in four individually insured Minnesotans has unpaid medical bills, averaging $1,207. These unpaid bills cause additional burdens and pressures for the individual and often lead to collection agency involvement.

- People who live in greater Minnesota are harder hit by the health care access problem. Health insurance is more expensive for small business and self-employed people, such as farmers, the mainstays of rural economies. Many rural residents are underinsured; 40 percent of farmers spend 10 percent or more of their incomes on health care.

The Minnesota Public Health Association Recommends that the Following Are Incorporated as Essential Components of Effective Health Care Reform

Universal
- Basic level of health care for all without excessive burden to the individual
- Policies aimed at financial accountability for "unhealthy behavior" or own ill health should be prohibited

Accessible
- Equal opportunity to attain and maintain good health

- Focus needs to be on the removal of all types of barriers, including financial, cultural, and geographic

Efficient
- Reform must include a planned, coordinated approach to health care that is based on research and responsive to consumers
- There should be specific strategies to contain costs, such as enhancing administrative efficiency and incorporating managed care techniques

Basic Health Services
- Basic services should include preventive care, family planning, maternal/child health, early detection, and primary care and treatment
- Should focus on psychological, social, and physical aspects of health
- Health education should focus on risks and consequences

Minnesota Constitutional Amendment Guaranteeing Access to HealthCare 1990

The MPHA Public Affairs Committee passed the following resolution based on our commitment to and policy on access to health care for all Minnesotans. We also considered the policy we formed in support of a state constitutional amendment even though we opposed a national constitutional amendment.

We recommend to the Governing Council that MPHA support the concept of a State Constitutional Amendment guaranteeing access to health care for all Minnesotans.

Resolution to Improve Access to Prescription Medication 1990

WHEREAS, Physicians' Assistants have shown that mid-level providers can achieve excellence in health care, and have done so in a wide range of practice settings for the past 20 years; and

WHEREAS, Physicians' Assistants are registered with the State Board of Medical Examiners and certified by a national certifying organization; and

WHEREAS, Physicians' Assistants have been shown to increase access to primary care both in the inner city and rural areas; and

WHEREAS, Physicians' Assistants having the authority to prescribe serves the goals of efficiency, cost effectiveness, and quality primary health care:

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association support the delegation of prescription writing authority to health care professionals not currently processing that authority who:

Have the education and training necessary to safely and effectively prescribe medications, are registered or licensed by the State of Minnesota,

Are part of a comprehensive primary care program of which a physician is a component,

Follow a drug use protocol approved by a physician.

Are supervised in their prescription writing activities by a physician.

THEREFORE, BE IT FURTHER RESOLVED that the Minnesota Public Health Association support legislation establishing delegated prescription writing authority consistent with these principles.

Prescription Writing Privileges: Certified Nurse Practitioners 1990

WHEREAS, Certified nurses practitioners have been providing quality health care in a wide variety of settings for the past twenty years; and

WHEREAS, Certified nurse practitioners are licensed by the State of Minnesota as registered nurses and certified by their national specialty certifying organizations; and

WHEREAS, Studies have documented that, historically, certified nurse practitioners have prudently and appropriately recommended medications within the parameters of their practice; and

WHEREAS, Nurse practitioners have been shown to increase access to primary care for underserved populations; and

WHEREAS, Providing efficient, cost-effective and quality primary health care is dependent on the authority to prescribe medications and devices for the patients they serve;

THEREFORE, BE IT RESOLVED that MPHA support legislation establishing delegated prescription writing authority consistent with the method used for nurse midwives for certified nurse practitioners.

Position Paper on Universal Access to Efficient and Effective Basic Health Services 1989

Approved at the Annual Meeting on April 14, 1989

Introduction

While the United States has the highest per capita expenditure for health services among industrialized nations, it fails to apply to those resources in a way which maximizes the health benefits for the entire population. As a result, significant health indicators, such as our infant mortality rate, are worse than in countries that expend far less per capita. Momentum is gaining for developing a system which ensures access to health care for all citizens, not just those who can pay or who are covered through the employment based and special interest coverage systems. Eventually, it is believed that a revised method of making health care available to all citizens must be national in scope. Presently, the position of the Minnesota Public Health Association is that progress which can be made at the state level will also influence progress at the national level. To guide the shape and dimension of legislative action, MPHA formed a task force to develop an Association position paper on the elements of "universal access to efficient and effective basic health services."

The task force was formed during the fall of 1988 and presented its position statement for approval at the annual meeting of the Association in April of 1989. The task force gave consideration to significant documents on health care access as well as the viewpoints of individuals representing various health disciplines, work sectors, and geographical areas of the state. Task force participation included:

Leadership: Gayle Hallin, MPHA President
Sue Kjeer, Chair

Carol Solie, Student Intern
Barbara Eaton, Student Intern

Participants: Pat Bartschler, Lori Beaulieu, Ward Edwards, Edward Ehlinger, Jean Forster, Marilyn Hoy, Linda Kohn, Carolyn McKay, Todd Monson, Kathy Montgomery, Steve Mossow, Gretchen Musicant, Charles Oberg, Ray Olson, and K.C. Spensley.

The position statement developed by this task force is intended to be used in:

1) Influencing the development of state and federal legislation through providing information to policy makers;
2) Educating health professionals throughout Minnesota, particularly Association members;
3) Providing a reference for Association members in leadership activities to promote support for health care access.

Key Component: Universal

Principle:

Society has an ethical obligation to ensure equitable access to health care for all. In light of the special importance of health care, the largely undeserved character of differences in health status, and the uneven distribution and unpredictability of health care needs, society has a moral obligation to ensure adequate care for all people. (President's Commission, 1983).

Problem Statement:

The United States spends more on health care than virtually any of the advanced industrial democracies of Western Europe. There is no reason to believe that we cannot achieve the level of equity that exists in those societies. The question is not cost, but rather whether we have the moral imagination and political will to strive for justice. (Bayer, et al., 1988: Reinhardt, 1987).

Our health care economy is a paradox of excess and deprivation where over 11% of the GNP goes toward health care costs while more than 35 million Americans are uninsured. (Enthoven & Kronick, 1989).

Patchwork reforms succeed only in exchanging old problems for new ones. In public health work we are frustrated in the face of plenty: the world's richest health care system is unable to ensure such basic services as prenatal care and immunizations. (Himmelstein, et al., 1989). Partial "categorical" approaches leave people out and create enormous complexities as people change categories. They can treat unequally people who appear similar but who actually fall into different categories. (Enthoven & Kronick, 1989).

Our current system presents financial barriers to care, promotes economic incentives for both excessive and insufficient care, encourages administrative interference and expense, and allows uneven distribution of health facilities and escalating costs.

The need for health care is distributed very unevenly and its occurrence at any particular time is highly unpredictable. While individuals' behavior has a significant impact on their health, health care should be available to all people regardless of their choices. (President's Commission, 1983).

Employers who do not participate in health insurance, but whose employees receive care, are taking a "free-ride" at the expense of other employers and taxpayers -- as are their uninsured employees. (Enthoven & Kronick, 1989). For the insured, co-pays and deductibles endanger the health of poor people who are sick. They decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones, they discourage preventive care, and are unwieldy and expensive to administer. (Himmelstein, et al., 1989). Lower income insured families

pay premiums similar to those paid by higher income families thus spending a higher percentage of their income. (Enthoven & Kronick, 1989).

Policies:

1. As a nation, it is our collective responsibility to provide all individuals with a level of care necessary to maintain and restore health. It is our obligation to eliminate the undue anxiety, and risk, of future health problems. (Bayer, et al., 1988). A single comprehensive program should be enacted to ensure equal access for all. (Himmelstein, et al., 1989).

2. Equitable access to care should be assured so that all citizens are able to secure a basic level of care without excessive burdens. This basic level should be thought of as a floor below which no one ought to fall, not a ceiling above which no one may rise. (President's Commission, 1983; Reinhardt, 1987).

3. Policies aimed at institutionalizing financial accountability for "unhealthy behavior" or holding individuals responsible for aspects of their own ill health should be prohibited as they are likely to involve significant injustices and other undesirable consequences. (President's Commission, 1983).

Key Component: Access

Principle:

Equal opportunity to attain and maintain good health must be the central goal which guides all arrangements for the provision of health care. (APHA Policy #6922) the right to health care provides access to medical care services which may or may not lead to health. (President's Commission, 1983).

Problem Statement:

Inadequate access to health care is a public health problem. It imposes costs on society as a whole, such as the cost of medical services for conditions that could have been prevented or controlled at an earlier stage, and the cost of lessened productivity and participation in the community. It also imposes personal costs--diminished health and quality of life, increased or prolonged disability, and in some cases, premature death. (MN Department of Health, 1987).

The present arrangement of financing health care in the U.S. is inequitable. It provides most people with coverage either at no cost or at prices subsidized by the employer and the tax system. The system denies the opportunity of coverage to millions of others, in spite of the fact that over-insuring the well-to-do without considering systems costs is much more inflationary than being conscious of costs and covering the poor.

Not all uninsured people are poor or unemployed. In fact, nearly two-thirds of them are members of families with incomes above the poverty level. More than two-thirds of the uninsured adults belong to the labor force. (Enthoven & Kronick, 1989).

In addition to economic barriers, accessibility limits are a result of any or all of the following:

- Distance and travel time to sources of care.
- The length of time it takes to locate an appropriate source of care, the waiting time for an appointment, and the time spent in the facility.
- Complexity of the system.
- Race, ethnic and cultural background, knowledge of the health care system, level of education, and ability to communicate. (President's Commission, 1983).

Measures designed to contain health care costs that also exacerbate existing inequities or impede the achievement of equity are unacceptable from a moral standpoint. Moreover, they are unlikely by themselves to be successful since

they will probably lead to a shifting of costs to other entities, rather than to a reduction of total expenditures. (President's Commission, 1983).

Policies:

1. A system of universal coverage which eliminates financial barriers to care and achieves distributional equity in health care services should be available to all persons without exception of income or employment status.

2. Geographic, cultural, informational, and time barriers should be eliminated to allow equitable access to care for all people.

3. Equitable access to care requires that all citizens be able to secure an adequate level of care without excessive burdens. (President's Commission, 1983).

Key Component: Efficient

Principle:

Efficiency is not an end in itself; it must be pursued in relation to the fundamental goal and immediate priorities for developing a more effective and more equitable system for the delivery of personal health services.

Problem Statement:

The present system is wasteful in many respects. We have spent little on evaluating medical technology, and there is much uncertainty about its efficacy. Much care appears to be of unproved value (Enthoven & Kronick, 1989) and there is evidence that physician practice styles and use of technology vary greatly. There is an excess capacity of physician specialties (Fuchs, 1988) and inadequate numbers of primary care practitioners. These variances are part of the reason for cost differences, with little or no difference in the outcome to the patient.

There is considerable duplication and excess capacity in our medical facilities. The uninsured obtain much of their primary care in the outpatient departments and emergency rooms of public hospitals, instead of in the much less costly setting of a primary care provider's office. (Enthoven & Kronick, 1989).

Whereas other countries have stabilized the share of their GNP that is spent on health, ours has accelerated in recent years. Inflation-adjusted per capita spending for health care grew by four percent per year from 1970 to 1980, and by 4.6 percent per year from 1980 to 1986. The Health Care Financing Administration recently projected that according to present trends, health care spending would reach 15 percent of the GNP by 2000. (Enthoven & Kronick, 1989). The more than 1500 private health insurers in the U.S. now consume about eight percent of revenues for overhead, Whereas both the Medicare program and the Canadian National Health Program have overhead costs of only two to three percent. (Himmelstein, et al., 1989; Evans, et al., 1989).

The American voter has never been inclined to respond to ideology and analysis and usually has waited until coming face to face with reality before supporting a major deviation from established policies and practices. (Ginzberg, 1987). The spiraling inflation of health care costs and growing disparity of services within our society is testimony to the need for change. Instituting a new pattern of universal health care coverage will thus be integral to any effort to create efficiency within a just health care system. (Bayer, et al., 1988).

Policies:

1. Single source payment has been the cornerstone of cost containment and health planning in Canada. (Himmelstein, et al., 1989). We should develop a comprehensive, unified system of health care financing and delivery that will:

- Promote administrative efficiencies.
- Promote efficient planning and utilization of health care facilities and technology.
- Promote and encourage use of a continuum of health care personnel, with cost-effective distribution by specialty and geographic location.
- Provide for technology assessment and practice guidelines.
- Establish provider accountability for efficient practice styles and technology use based on measures of health outcomes and patient satisfaction.

Key Component: Effective

Principle:

A coordinated, planned approach to providing health services that assimilated the findings of health sciences and is responsive to health consumers will promote delivery of effective health services.

Problem Statement:

Fragmented and inadequate medical programs have failed to meet the health care needs of the population and resulted in escalation of costs. (Sanders, 1988). The system has produced economic constraints without a great deal of analysis or a conscious policy choice. (Himmelstein, et al., 1989).

Systematic analysis of technology assessment, risk adjusted monitoring of outcomes and outcomes management are mechanisms of evaluating the effectiveness of interventions. (Enthoven & Kronick, 1989; Himmelstein, et al., 1989; Reinhardt, 1988; Thurow, 1984).

Policies:

1. The nation's practitioners, hospitals and academic medical centers must launch a major effort to identify the benefits patients receive from the billions of dollars spent annually in health care. (Fuchs, 1984; Thurow, 1984).

2. Health care policy experts must continue to push for reforms in organization, finance, and consumer education that will lead patients to recognize, and health care professionals to deliver, more cost effective care. (Fuchs, 1984).

3. Health care providers must solicit feedback from consumers and increase the responsiveness of the system to meet consumers' needs.

Key Component: Basic Health Services

Principle:

No system of care in the world is willing to provide as much care as people will use, and all such systems develop mechanisms that ration services in one way or another. (Doing Better, 1977; Fuchs, 1984). Society has an obligation to ensure equitable access to a basic level of health services to all people.

Problem Statement:

Basic Health Services include health care and those services provided to entire populations that promote a level of health which will permit them to lead a socially and economically productive life. (Children's Defense Fund, 1980). Poverty and its concomitant effects result in a lowered level of health for many people. Few people understand that the standard of living is one of the main determinants of health. (Terris, 1988).

Potential for maximizing the health of the people is to be found in what they do and do not do for themselves. (Fuchs, 1974). Individual decisions about diet, exercise, smoking and substance use are of critical importance. As it was in the past when infectious diseases were the major focus of concern, rapid and dramatic improvements in the health of the public today will not result from medical care, but from preventive measures. (Sanders, 1988).

The poor, and to even greater extent, the near poor, who lack even the limited access to private physicians Medicaid provides, have no continuing relationship with an individual health care provider. Preventive care, early disease detection, and early treatment of health problems are the types of health care most often delayed or forgone by the uninsured. The uninsured more frequently obtain primary health care services at a hospital emergency room where costs are higher and where a relationship with a primary care provider is not established. (President's Commission, 1983).

In 1932, the Final Report of the Committee on the Costs of Medical Care took note of wide variations in medical services received by different population groups in our country. (U.S. Department HEW, 1932). Then, as now, no nation is wealthy enough to supply all the care that is technically feasible and desirable. No nation can provide "presidential medicine" for all its citizens. (Fuchs, 1984). However, in 1989 we still do not provide an adequate level of care which universally provides a basic floor of health care protection below which no one may fall. (President's Commission, 1983).

Policies:

1. A basic floor of primary care services provides for preventive care, family planning services, maternal and child health services, early disease detection and treatment. (Children's Defense Fund, 1980). Primary care should be the point of first contact for an individual with a health care provider who has a continuing relationship with that patient. This care should be concerned with the psychological and social as well as physical aspects of an individual's health. This care should be compatible with the life, culture, and needs of the people who receive it. (Doing Better, 1977).

2. The next major advance in the health of the American people will be determined by what the individual is willing to do for him or herself and for society at large. (Doing Better, 1977). Basic health services should provide public health promotion information regarding self care and the risks and consequences of lifestyle choices across all ages and social groups.

3. The provision of basic health services should include efforts toward achievement of full employment, adequate family income, decent housing, good nutrition, access to affordable education, freedom from violence, and freedom from the threat of nuclear war. (Sanders, 1988).

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In Support of a Minnesota Health Plan 1988

WHEREAS, The MPHA is committed to ensuring access to early, adequate and continuous health care for all Minnesotans; and

WHEREAS, The MPHA is committed to eliminating financial barriers to health care for all Minnesotans; and

WHEREAS, MPHA realizes it is necessary to effectively and efficiently use health care resources to provide high quality care; and

WHEREAS, The American Public Health Association is on record in support of states searching for solutions to the challenge of universal access to health care;

THEREFORE, BE IT RESOLVED that the MPHA supports the development and implementation of a Minnesota health access plan, that is based on the principles that:

* Coverage should be universal and mandatory, regardless of income, age, or health status;

* Benefits should include at least health screening, and assessment, health education, care of acute and chronic illness and disability, rehabilitation, personal preventive health services, and case management of long term health problems;

* Financing for the health plan should be sufficient and equitably derived;

* Premiums should be affordable;

* Public subsidies should be available for low-income persons;

* Cost sharing should not be imposed on preventive services or low income persons;

* Health care cost containment should be pursued through a variety of strategies;

* The health plan should be administered by the Minnesota Department of Health with mechanisms in place to assure public accountability;

* Administration must include consumer education and outreach, consumer protection and consumer grievances including a specified appeals process;

* Quality assurance systems should be developed to assure quality services and access to care;

BE IT FURTHER RESOLVED that the MPHA stands ready to assist in the implementation of such a plan in Minnesota and that the efforts be used to advocate for a National Health Program.
Approved April 15, 1988 Annual Meeting.

Alternative Health Insurance 1980

MPHA supports the availability of alternative health insurance plans which share minimum standards and provide the public with an informed opportunity to choose the type and source of their coverage.

Comment
With the growth of alternative health insurance plans, employers, unions, individuals, and researchers, have been gathering information and assessing the advantages and disadvantages of the different plans and the effects of such plans in the field of insurance. Both traditional health insurance plans and the newer plans, such as the health maintenance organizations, differ in benefits, delivery, and policy, which provide the consumer with a number of varying market choices. The public should be given a greater participatory role in their own health care. They should be able to choose and pay for those plans that best meet their needs. The availability of alternative plans can stimulate competition and provide incentives and methods for controlling costs, and promoting consumer

participation. Basic benefits must be included to provide quality care. An educational component is essential in selecting among appropriate health insurance plans.

MPHA Resolutions Related to This Position:
Catastrophic Health Insurance, Minnesota -1976
National Health Policy, MPHA Position - 1975
Approved September 26, 1980 Annual Meeting.

Community Health Services 1979

MPHA supports commitment of MDH to CHS philosophy after MDH reorganization and appoints a small delegation to express support to Commissioner.

Continued Funding For Community Health Services 1978

WHEREAS, Implementation of the Community Health Services Act throughout the state has provided Minnesotans an opportunity to receive a broad range of public health services; and

WHEREAS, The scope of community health services give emphasis and priority to those services which will contribute toward preventing disease, illness and disability in individuals, their families and the whole community; and

WHEREAS, The Minnesota Public Health Association has affirmed and promoted the concept and philosophy inherent in the Community Health Services Act since 1975 through active support at state and local levels; and

THEREFORE, BE IT RESOLVED that the Community Health Services Act as passed by the 1975-76 Minnesota Legislature, providing the first significant direct subsidy to local communities for community health services, receive continued full funding to maintain and further develop strong local health services delivery capabilities throughout the state.
Approved September 22, 1978 Annual Meeting.

The Planning and Provision of Preventive Health Services 1978

What Is The Nature Of Prevention?
To prevent something is to keep it from happening. What to do to prevent disease, illness, or disability has changed with the nature of health problems and with the scientific base for attacking these problems. During the 19th and 20th centuries, the major health problem of the United States was communicable disease. It still is the major health problem in many parts of the world, affecting people mainly in the early years of life. The means of dealing with the problem include immunization; breaking the chain of infection through environmental measures such as water sanitation; and finding and treating infected persons, for example, those with tuberculosis.

By the middle of the 20th century, however, the major health problem in the United States had come to be chronic diseases, such as heart disease and cancer, which typically and most heavily affect people after age 45.

Prevention strategies may be classified in a number of dimensions:

- Primary Prevention - Those measures which prevent the actual occurrence of disease or disability (for example, immunization against poliomyelitis and improved design of machinery and highways).

- Secondary Prevention - The detection of disease in its early stages and intervention to arrest the progress of disease (for example, venereal disease diagnosis and treatment; application of mammography for detection of breast cancer, followed by necessary treatment).

- Tertiary Prevention - The efforts to maintain a maximum level of independence and activity in the chronically ill (for example, the home visits to the ill by public health nurses).

What Are The Fundamental Principles?

Certain principles have begun to emerge concerning the planning and provision of preventive health services.

1. Periodic evaluation of the disease or disability problems in a community and the means for dealing with these problems in an optimally effective manner is necessary (for example, a considerable amount of disease still arises from occupational exposure; a considerable amount of disability occurs from automobile and motorbike accidents).

2. Increased attention should be given to the prevention of chronic illness in middle and later years through action during the early years of life (for example, the prevention of certain forms of chronic lung disease involves preventive measures starting in infancy. Alcoholism and cervix cancer, as well as lung cancer, appear increasingly to have their roots in the teenage period of life).

3. Health service providers must be kept informed about what is happening in the community as it affects prevention programs.

4. It is essential to examine the cost-benefits of prevention programs and to compare them with other health service programs.

5. It is the joint responsibility of the public health professionals and individuals to promote and practice preventive measures.

6. A single preventive measure may be effective against several conditions (for example, control of cigarette smoking can be effective not only against lung cancer, but also against coronary heart disease).

7. Preventive health services may be carried out in a variety of places: office, clinic, industry, school, health center, home, community, or neighborhood.

8. Public policy which emphasizes organizational mechanisms, financing, and tax incentives or constraints, is necessary for the development of effective preventive health services.

9. An essential preventive strategy is to encourage the individual to accept responsibility for his/her own health.

What Are The Priorities For Preventive Health Programs?

If we are to apply practical and cost efficient preventive programs to the entire population, high risk groups must be identified as a way to provide maximum benefits to the community as a whole. Considering various segments of the general population or the stage in the life cycle, goals for preventive programs can be identified.

- Mother and Fetus - Assure that the woman becomes pregnant on a planned basis and in a state of physical, mental, and social well-being; that this well-being is maintained through pregnancy and postpartum period; and that the mother has the knowledge and capacity to provide for the physical and emotional needs of the neonate.

- The Infant (newborn-1 year) - Detect and treat certain diseases before damage occurs; assure growth and development of the optimal potential of the child; provide for the prevention of specified infectious diseases through immunizations.

- Pre-School Child (1-6 years) - Assure growth and development to the optimal potential of the child; provide for the prevention of specified infectious diseases through immunizations.

- School-Age and Adolescent (6-16 years) - Assure sound foundations which determine good health or ill health; provide comprehensive health education, including sex-related problems, chemical abuse, smoking, and accident prevention.

- Young Adults (17-34 years) - Maintain sound health practices; provide for the prevention of specific communicable or chronic diseases.

- Middle Adult (35-64 years) - Maintain sound health practices; provide for the prevention of specific chronic diseases.

- Older Adult (65+ years) - Provide services to maintain a maximum level of independence and activity; provide counseling as it relates to preparation for retirement and the associated changes in lifestyle.

- Community - Provide services to protect the individual from various environmental contaminants, hazards, or conditions.

WHAT ACTIONS SHOULD MPHA TAKE
TO PROMOTE PREVENTIVE HEALTH PROGRAMS?

1. MPHA should actively support state and national legislation which assures the planning and provision of preventive health services. Specific attention should be given to:

- Secure full funding for the Community Health Services Act which supports the responsibility and accountability of state and local government.

- Secure passage of the school health education and health services legislation which would make available resources to local school districts to increase the level of preventive programs and services.

- Secure passage of accident prevention and safety legislation.

2. MPHA should support actions which provide for reimbursement for preventive services, especially through health insurance programs.

3. MPHA should support the development and implementation of public health educations programs as an integral component of preventive health services.

4. MPHA should coordinate efforts with other state affiliates and professional associations for use of its program and community expertise to promote and encourage the development of prevention programs.

5. MPHA should plan and sponsor a state-wide conference concerning public policy for preventive health services. This conference, to be held in Spring 1977, should be planned in cooperation with a broad base of health professionals and associations, public officials, educators and researchers and consumers. Resources to finance the conference should be sought from professional associations and private foundations.

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Approved October 8, 1978 Annual Meeting.

Implementation of the Community Health Services Act 1976

Implementation of Community Health Services Act throughout the State should assure all residents an opportunity to receive a broad range of public health services. To assist communities in this effort, membership should reaffirm the principles set forth in the last year's Policy Statement which was adopted at the Annual Meeting, September 1975.

Principles

1. Minnesota State policy now provides a single, comprehensive subsidy to local governments to plan and deliver community health services to residents of their geographical area.

2. This community health services policy defines new organizational and administrative responsibilities for the State Department of Health, regional organizations, and local governments.

State: the role of the State is to set statewide standards and regulations, provide technical consultation and assistance, review and approve local plans and programs, and allocate financial resources. These leadership and support functions are appropriately centralized at the State level.

Regional: consistent with regional plans, Health System Agencies (HSA's) and Regional Development Commissions (RD's) relate to local health agencies by provider review and comment on local community health service plans, within a designated period of time, and concurrent with state review. Regional agencies can also give local planning assistance.

Local Governments: broad authority is delegated to local governments, in single or multi-county arrangements, to develop practical service delivery plans, to establish priorities, and to develop a coordinated system for the delivery of community health services in their area. County boards have review and approval authority for all local plans within their geographic area.

3. The scope of community health services gives emphasis and priority to those services which will contribute toward preventing disease, illness and disability in individuals, their families, and the whole community. Local health plans should address all elements of the scope of services, regardless of their current degree of priority to the local area.

4. State subsidy for community health services is available to all geographic areas of the State, especially to those unserved or underserved areas. This subsidy includes a local matching requirement to provide a mechanism for state-local partnership in health service program development and provision of services. However, local governments have the option to determine their participation.

5. Local health boards should be composed of public officials, consumers, and health providers to provide advice and counsel in the development of the area plan.

6. A community health services advisory council, composed of representatives of local health boards, should be formed to assist the State in implementing the concepts of decentralization of planning and delivery of community health services.

7. In local areas where there are organized human services boards, community health services should be integrated into this planning and delivery system.

8. To assure the sound, systematic formation of multi-county health programs, regional planning bodies for human services programs should have single set of boundaries.

9. Local community health service plans should address the relationship of these prevention-directed services to the prevention programs of private agencies. Additionally, the plan should identify the linkages to treatment and rehabilitation services of public and private agencies.

10. The community health services subsidy should supplant, on an incremental or phased basis, the present system for allocating resources to local areas.

Summary For Action

1. MPHA should actively support State and national legislation which embodies these principles.

2. MPHA, through its Governing Council, should establish an ongoing Community Health Services Task Force, reporting to the Governing Council, to direct and coordinate statewide policy and information development concerning implementation of the CHS act.

This Task Force should be composed of:
*A Chairperson
*One person from each Regional Action Council (volunteer or appointed)
*Volunteers from Annual Meeting

The Task Force will:
* Be organized by October 31, 1976
* Develop a work program by December 1, with prior approval of Governing Council
* Implement work program by January 1, 1977

3. MPHA, through its Governing Council, should plan and implement ongoing educational efforts to inform State and local public officials regarding the need for full CHS funding. Additionally, consideration should be given to determination of appropriate methods for presentation and dissemination of information.

4. MPHA, through its Governing Council, should develop capabilities to provide technical resources to local communities to assist in implementing CHS.

Examples are: Assistance to define health problems to develop alternative programs and to develop local Board of Health and Community Health Agency organizational structures.

Approved October 8, 1976, Annual Meeting.

Catastrophic Health Insurance – Minnesota 1976

MPHA opposes appropriation of State funds to pay catastrophic medical expense favors giving highest priority to prevention and early detection.

National Health Policy 1975

MPHA needs to inform itself regarding the issue, and then to act to assure that whatever is done on the State and National levels contribute toward enactment of a rational national health policy.

September 3, 1975

Corrections Health Services 1975

MPHA should support legislative and Department of Correction's efforts to improve health services to their clients in institutions and community based programs

MENTAL HEALTH SERVICES

Minnesota Public Health Association Resolution

Increased Access to Mental Health Services 2007

WHEREAS, mental health is a key component of overall health and well-being across all age groups, and mental health disorders, which range in kind and severity, and can affect individuals of any age[1]; and
WHEREAS, effective and comprehensive prevention strategies should encourage screening and emphasize early identification of mental health needs among children and adults at greatest risk of developing serious mental health disorders[2]; and
WHEREAS, many mental health disorders are treatable when identified early[3], and individuals with diagnosed mental health disorders can reach recovery[4]; and
WHEREAS, over one-quarter of American adults experience a diagnosable mental disorder during their lifetime[5] and approximately six percent of adults are diagnosed with severe disorders (serious mental illness)[6]; and
WHEREAS, when compared with all other diseases (such as cancer and heart disease), mental illness ranks first in terms of causing disability in the United States, Canada, and Western Europe[7]; and
WHEREAS, the consequences of inadequate mental heath care affect individual recovery, and may also include: poor academic outcomes, high rates of unemployment, substance abuse, homelessness, and incarceration[8]; and
WHEREAS, there is growing evidence demonstrating that mental health disorders can be effectively treated using early identification and appropriate, evidence-based interventions, but only one-third of adults and youth with diagnosable mental disorders receive treatment[9]; and
WHEREAS, racial and ethnic minorities have less access to mental health services, are less likely to receive care, and less likely to receive high-quality mental health services[10]; and

WHEREAS, most rural areas of Minnesota are designated as a Mental Health Professional Shortage Area[11] and shortages of mental health services across the state limit accessibility; and
WHEREAS, the number of psychiatric beds available across the state has decreased since 1980 and discharges are delayed due to a lack of intensive community-based treatment options[12]; and
WHEREAS, in 2007 Minnesota took an initial step towards mental health parity by creating a uniform mental health benefit for publicly-supported state health care programs (Medical Assistance (MA), MinnesotaCare, General Assistance Medical Care (GAMC)) [Minnesota Statute Chapter 147], but full mental health parity has yet to be achieved through either state or national legislation.

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:
1. Supports policies that reduce stigma surrounding mental disorders and eliminate disparities that reduce access to culturally and linguistically appropriate mental health services;
2. Supports policies that encourage practitioners working in a range of professional fields, including education, social services, public health, mental health, and healthcare, to become increasingly involved in the prevention, early identification and treatment of mental health disorders;
3. Encourages policy makers to increase funding for services that increase public awareness about mental health, and support strategies to effectively prevent, identify, and treat mental health disorders;
4. Encourages insurers to adopt a consistent set of comprehensive mental health benefits, both in the commercial market and in publicly-funded health care programs;
5. Supports policies that increase access to comprehensive mental health services in all areas of the state, including housing and employment supports and case management to integrate and coordinate health care, public health and social services;
6. Collaborates with other organizations that are working to build a comprehensive system of care across the state that includes prevention, early identification, and effective treatment strategies; and
7. Advocates for State and Federal mental health parity legislation that ensures full physical and mental health coverage for all individuals insured by both public and private health insurance companies.

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Resolution to Maintain a Broad Spectrum of Mental Health Services 1990

WHEREAS, Comprehensive mental health services are a public health issue; and

WHEREAS, A broad spectrum of services is needed to treat the acute and recurring symptoms of mental illness regardless of source of payment or ability to pay; and

WHEREAS, Recent studies have indicated outpatient care alone is insufficient as the only treatment option for some serious and persistent mental illnesses, and active, inpatient treatment is periodically necessary for this population; and

WHEREAS, The DRG limits on the reimbursement rate and the length of stay for hospital treatment limits the time necessary to treat the acute and recurring symptoms of mental illness; and

WHEREAS, The consensus reached in the 1989 Regional Treatment Center Bill provides for the deinstitutionalization, quality community placements, and outpatient care of the mentally ill, and also provides for the recapitalization of three Regional Treatment Center facilities (Moose Lake, Anoka, and Fergus Falls) to deliver acute inpatient treatment and stabilization/medication readjustment, followed with good community placement whenever possible;

THEREFORE, BE IT RESOLVED that MPHA support the efforts to maintain a broad spectrum and continuum of Mental Health Services including the recapitalization of the Regional Treatment Centers.

NUTRITION/OBESITY PREVENTION

Minnesota Public Health Association Resolution
Healthful Food Options in Hospitals and Clinics 2007

WHEREAS, hospitals occupy a unique position in society as institutions charged with teaching and modeling healthy behaviors; and
WHEREAS, obesity is the 2nd leading preventable cause of death in the United States next to smoking[1]; and

WHEREAS, an estimated 120,000 deaths per year in the U.S. are attributable to obesity related illnesses[1]; and
WHEREAS, approximately $1.3 billion per year goes toward obesity-related medical expenditures in Minnesota alone[2]; and
WHEREAS, the average annual health care expenditures, for adults under 65 who are overweight or obese, are $450-$2500 more than their active and normal weight counterparts[2]; and
WHEREAS, numerous studies have linked the consumption of sugar-added soft drinks and juices to the epidemic of weight gain and obesity[3,4,5]; and
WHEREAS, higher consumption of sugar sweetened beverages has been associated with increased weight gain and body mass index and increased risk of type-2 Diabetes among young and middle-aged women[5]; and
WHEREAS, there have been multiple reports showing no loss in revenue due to removing sugar-sweetened beverages from school vending machines, and we can assume this would apply to health care settings, although limited research is available[6,7].
THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:

1. Supports hospitals and clinics by being role models in sending a consistent message that good nutrition is best for children and adults across the lifespan;
2. Supports prevention efforts to reduce the prevalence of overweight and obesity in the population through health policy, education, and environmental changes;
3. Supports efforts to improve the vending and wellness policies of hospitals and clinics in Minnesota;
4. Supports further exploration of healthy food policies and their impact on revenue for hospitals and clinics;
5. Supports removal of high-sugar beverages and high-fat foods from vending and cafeteria sales areas in hospitals and clinics;
6. Supports an increase in the quality and quantity of affordable, healthful options in vending machines and cafeterias throughout hospitals and clinics; and
7. Supports efforts to increase the availability of drinking fountains in hospitals and clinics with quality water.

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Minnesota Public Health Association Resolution

Public Health Approaches to Preventing and Reducing Obesity 2007

WHEREAS, the Minnesota Public Health Association recognizes that the United Nations has adopted a global strategy on diet, physical activity and health in response to a global epidemic threat of obesity[1], a chronic condition that increases the risk of other chronic diseases, such as type II diabetes, high blood pressure, stroke, myocardial infarction, heart failure, and cancer among other illnesses[2]; and
WHEREAS, obesity is defined as an excessively high amount of body fat or adipose tissue in relation to lean body mass, with a body mass index (BMI) greater than 30; and overweight is defined as increased body weight in relation to height, when compared to some standard of acceptable or desirable weight, with a BMI greater than 25[3]; and
WHEREAS, 17.1% of children and adolescents were overweight and 32.3% of adults were obese in the nation in 2002-2003[4], and high obesity prevalence disproportionately affects minorities and low-income communities[5]; and
WHEREAS, poor diet, physical inactivity, and obesity combined have negative health consequences comparable to tobacco use[6], and the combined factors are second only to tobacco use as potentially the most preventable risk factor for disease[7]; and
WHEREAS, $1.3 billion per year is spent on obesity-related medical expenditures in Minnesota[8], and about $78.5 billion spent on costs of obesity and related illnesses in the nation; and
WHEREAS, Minnesota is ranked 25th in the nation for the highest level of adult obesity in the nation, and 23% of Minnesotan adults are obese[9]; and
WHEREAS, obesity is a crucial problem facing today's generation of children and adolescents, because children may live shorter lives due to health-related issues[10]; and
WHEREAS, Minnesota is ranked the 13th highest in the nation for overweight levels for low-income children[11]; and 15-22% of all Minnesotan adolescents are obese, and 13% of children under the age of 5 are overweight in Minnesota[12]; and
WHEREAS, supporting healthy environments that offer nutritious foods, such as fruits and vegetables and low-fat milk, as well as opportunities for physical activity, help address the epidemic of overweight among children and adults[13]; and
WHEREAS, behavioral interventions, physical activity increases, and dietary adjustments play a role in preventing and treating obesity[14,15]; and
WHEREAS, many young children (one fifth of 0- to 2-year-olds and more than one third of 3- to 6-year-olds) have a television in their bedroom[16]; and
WHEREAS, the amount of time spent in front of televisions and computer monitors contributes to a lack of activity[17].

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:

1. Advocates for increased funding to develop, implement, and evaluate nutrition interventions that reduce levels of obesity in Minnesota;
2. Promotes the development of programs that support environmental and behavioral strategies that increase awareness and education of the importance of healthy lifestyle choices such as physical activity and diets high in fruits and vegetables;
3. Advocates for policy changes in school nutrition to provide children and adolescents with healthful options for food intake;
4. Supports requirements for physical education in schools;
5. Supports the provisions of healthy food options at low costs and fast accessibility for all Minnesotans;
6. Supports the development of health programs that target high-risk groups such as minorities and low-income populations;

7. Supports environmental infrastructure development that is conducive to healthy physical activity;
8. Encourages health practitioners in all settings to incorporate principles of obesity prevention and health promotion in their awareness, education and advocacy efforts.

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Nutrition 1978

Dietary Goals

WHEREAS, Recognizing that dental caries, diabetes, obesity, stroke and heart disease are among the most widespread health problems in the U.S.; and

WHEREAS, The Senate Select Committee on Nutrition and Human Needs recommends the U.S. adopt and institute nutrition goals that would maintain health and help prevent disease; and

WHEREAS, These goals indicate that directional changes in the American diet should be recommended; and

THEREFORE, BE IT RESOLVED the Minnesota Public Health Association, in cooperation with other professional, scientific, and governmental groups, knowledgeable in nutrition needs, work toward the implementation of the national dietary goals.

Sodium, Fat, Sugar Content

WHEREAS, The sodium, fat and sugar content of the diet is related to hypertension, degenerative diseases, obesity, tooth decay and may be related to other health problems; and

WHEREAS, The sodium, fat and sugar content cannot be determined by visual inspection; and

THEREFORE, BE IT RESOLVED that MPHA support legislation to require that the amount of sodium, fat and sugar be on all food labels.

Approved September 22, 1978 Annual Meeting.

POPULATION, FAMILY PLANNING, AND REPRODUCTIVE HEALTH

MPHA Policy Resolution
Earned Sick and Safe Time, May 2015

WHEREAS, having access to paid sick time is a social determinant of health in that it supports the financial stability of many families living on the edge of poverty; and
WHEREAS, safe time allows for time off for reasons related to domestic violence, sexual assault, or stalking;
WHEREAS, the American Public Health Association passed a Policy Statement in 2013 supporting comprehensive paid sick leave and family leave policies;
WHEREAS, 40% of all working Minnesotans in the private sector lack access to even one paid sick day; and
WHEREAS, being sick or having a child who is sick leaves many Minnesotan families unable to afford basic necessities and can result in not only the temporary loss of income, but also the loss of a job; and
WHEREAS, the United States is the only developed country that does not require employers to provide paid sick leave; and
WHEREAS, there is a disproportionate rate of people of color low income people who do not have access to this benefit making it a health equity issue; and
WHEREAS, access to earned sick time decreases health care costs by increasing preventive health visits and well-child visits while decreasing emergency room usage and resulting in improved management of chronic disease; and
WHEREAS, access to earned sick time slows the spread of infectious disease, especially influenza, when workers are able to stay home when sick causing more cases of disease and more instances of death related to infectious diseases; and

WHEREAS, members of the Minnesota Benefits Coalition; which includes labor, nonprofits, faith communities, worker centers and public health; have come together to support the "Earned Sick and Safe Time" bill in the Minnesota legislature; and
WHEREAS, the Earned Sick and Safe Time bill would allow workers in Minnesota to earn one hour of paid sick time for every 30 hours worked, therefore giving families the ability to care for themselves and their loved ones without losing valuable income or their employment.

Therefore, be it resolved that the Minnesota Public Health Association:
1. Supports policies that provide earned sick time benefits to all employees in the state, including the proposed Earned Sick and Safe Time bill.
2. Supports the right of local governments to strengthen local laws that give Minnesota families a paid sick time benefit.

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MPHA Policy Resolution
Paid Family Leave, May 2015

WHEREAS, having time to take care of loved ones when they are sick, and bonding with a new child without losing valuable income or employment is a social determinant of health; and
WHEREAS, the United States is the only industrialized country to not guarantee paid benefits to new parents; and
WHEREAS, the American Public Health Association passed a Policy Statement in 2013 supporting comprehensive paid sick leave and family leave policies;
WHEREAS, only 12% of the US workforce has paid leave to care for a new child or a sick loved one; and
WHEREAS, the number of employees without this benefit is disproportionately people of color, low income people, and women making this a health equity concern; and
WHEREAS, federal law (FMLA) only allows employees to take UNPAID time off for these events and has restrictions that mean less than 60% percent of the workforce have access to that unpaid leave; and
WHEREAS, the public health community has acknowledged for a long time now the importance of development and investment in the earliest part of life; and
WHEREAS, paid family leave would allow parents to bond with children, and therefore has been shown to: decrease infant mortality, decrease maternal depression (a known "Adverse Childhood Experience"), increase breastfeeding rates, increase use of well child visits, decrease stress for new parents, better management of chronic diseases in children, and there is evidence that shows there are a myriad of potential cognitive development benefits to bonding between a parent and child in the first few weeks of life; and
WHEREAS, allowing an employee to take paid time off when a loved one is sick decreases the stress of caregiving and also decreases health care costs by allowing familial caregivers to take the time to be present; and
WHEREAS, no family should have to choose between caring for a child or a loved one and being able to afford basic necessities; and
WHEREAS, no family should have to face the added stress of losing their job or struggling to make ends meet when their family is facing a crisis; and
WHEREAS, the Paid Family Leave Bill in Minnesota would allow all employees in Minnesota to take paid time off (up to 12 weeks) for the birth of a child or illness and/or death of a family member.

Therefore, be it resolved that the Minnesota Public Health Association:
1. Support policies that provide earned family leave to all employees in the state, including the proposed state Paid Family Leave Act, which provides all workers in Minnesota paid time off to care for loved ones in the event of a birth, adoption, illness or death of a family member.
2. Supports the right of local governments to strengthen local laws that give workers the right to paid family leave.

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Minnesota Public Health Association Resolution
Endorsing Prevention and Early Treatment of Sexually Transmitted Infections in Minnesota 2009

Passed June 18, 2009 at the MPHA Annual Meeting

WHEREAS, the American Public Health Association acknowledges sexually transmitted infections (STIs) pose a significant risk to the public health of young people in the United States [i, ii]; and

WHEREAS, overall rates of STIs in Minnesota have increased dramatically over the past 10 years and, in particular, chlamydia rates have doubled between 1995 and 2007[iii]; and

WHEREAS, youth, women and communities of color are disproportionately harmed by STIs, such as chlamydia[iv, v, vi] ; and

WHEREAS, many STI cases go undetected since three out of four women and one out of two men infected with chlamydia have no symptoms; and in the case of gonorrhea, four out of 10 men and nearly eight out of 10 women who are infected have no symptoms; and these individuals are unlikely to pursue clinical screening services[vii]; and

WHEREAS, untreated STIs result in serious public health consequences such as Pelvic Inflammatory Disease, infertility and a three to five times greater likelihood of contracting HIV compared to individuals without STIs; and

WHEREAS, primary prevention, screening, and early treatment of STIs are cost-effective public health strategies [viii, ix]; and

WHEREAS, in a national survey of U.S. physicians, only 1 in 3 reported routinely screening for common STIs among female patients, and fewer than 1 in 7 reported routinely screening males; and the CDC recommends that all sexually active females 25 and under should be screened at least once a year for chlamydia, even if no symptoms are present[x]; and

WHEREAS, among sexually active individuals, consistent condom use is effective in preventing many STIs, including HIV, chlamydia, gonorrhea, herpes, and syphilis[xi]; and

WHEREAS, assuring treatment of infected person's sex partners is a core element of prevention and control of bacterial sexually transmitted infections; and

WHEREAS, in studied populations, expedited partner therapy[xii] (EPT) has been shown to be a useful option for partner management of acquired gonorrhea and chlamydial infections[xiii]; and

WHEREAS, the Centers for Disease Control and Prevention (CDC) recommends that EPT should be available to clinicians and public health departments for managing partners of specific patients with

sexually transmitted infections[xiv].

Therefore, be it resolved that the Minnesota Public Health Association:

8. Urges that funding for chlamydia prevention and control be adequate to assist local health departments and community agencies to develop comprehensive STI control programs to improve screening and treatment of at-risk populations, with attention to asymptomatic infections and partner management, and

9. Urges policy makers, health care payers, and medical providers to develop universal policies that assure confidentiality of patients seeking screening and treatment for STIs, and

10. Urges payers and providers to incorporate CDC screening criteria for STI infections in medical insurance reimbursement plans and as a key component of preventative health care standards for medical practice, and

11. Urges all providers caring for sexually active adolescents and young adults, as well as the general population, to implement CDC screening criteria in their standards for medical practice, and collaborate with local STI control programs to develop methodologies for patient-based sex partner treatment, including the implementation of EPT.

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MPHA Policy Resolution
Emergency Contraception

May 2006

WHEREAS, nearly one-half of all pregnancies in the United States are unintended at the time of conception[1], which translates into as many as 47,000 unintended pregnancies annually in Minnesota[2]; and
WHEREAS, there is evidence that access to emergency contraception is not associated with risky sexual behavior[3]; there is evidence that advanced prescriptions are not associated with changes in usual contraceptive behavior[4], and evidence that over-the-counter access to contraceptives is associated with proper use[5]; and
WHEREAS, women who have unintended pregnancies are more likely to report depression and physical abuse, are less likely to receive adequate prenatal care, and are more likely to continue risk behaviors such as alcohol consumption and smoking that place the fetus at a health risk[6]; and
WHEREAS, women with unintended pregnancies may be less likely to have healthy pre-conceptional behaviors[7]; and
WHEREAS, children born of unintended pregnancies are at greater risk of low birth weight, and of not being breastfed[8]; and
WHEREAS, health care practitioners have been prescribing and dispensing high-dose estrogen since the 1960s to be used as emergency contraception, and there now exists a safe and effective medication (Plan B) packaged specifically to be taken orally within 120 hours after intercourse[9]; and
WHEREAS, emergency contraception poses no danger to an already established pregnancy[1], and the mechanism of action is to prevent ovulation, prevent fertilization, or prevent the implantation of a

fertilized egg, thereby being defined as contraception (not abortion), and whereby emergency contraception has no medical contraindications for women[10]; and

WHEREAS, ready access (within 120 hours) to emergency contraception is essential to effective use because of its time-sensitivity, thereby reducing the chance of pregnancy by up to 89%[11]; and

WHEREAS, there have been attempts by health care practitioners in Minnesota and across the United States to limit access to legally prescribed and dispensed contraceptives, based on personal beliefs and moral viewpoints, which have caused emotional trauma, endangering women's health and violating their legal rights; and

WHEREAS, each year, 25,000 American women become pregnant following an act of sexual violence and the prompt use of emergency contraception could prevent as many as 22,000 of those pregnancies[12]; and

WHEREAS, best estimates indicate that if emergency contraceptives were widely available in the United States, 1.7 million unintended pregnancies could be avoided and the number of abortions each year could be cut by as much as half[13]; and

WHEREAS, a larger percentage of women aged 18 to 44 (68%) are increasingly aware of emergency contraception, but only 6% of sexually active women have used emergency contraception, and whereby only 25% of gynecologists and 14% of family practitioners say that they always or usually include discussion of emergency contraception in routine patient counseling[14]; and

WHEREAS, Minnesota law allows for collaborative agreements between physicians and pharmacists to dispense emergency contraception; but there is no state-approved protocol for dispensing emergency contraception over-the-counter at this time[15]; and

WHEREAS, thirty-five other countries allow emergency contraception to be sold over-the-counter and eight states in the United States allow pharmacists to dispense emergency contraception without a prescription; and

WHEREAS, access to Plan B emergency contraception is determined in part by whether pharmacies stock the medication, and varies from as few as 35% of pharmacies in rural areas to 85% of pharmacies in urban areas[16]; and

WHEREAS, in December 2003, the Nonprescription Drugs and Reproductive Health Drugs Advisory Committee (NDRHD) of the FDA recommended overwhelmingly 23-4 to the FDA Commissioner, that Plan B be made available over-the-counter. However, the acting director of the Center for Drug Evaluation and Research, overruled the agency's advisory committees and staff scientists and denied the request[17]; and

WHEREAS, national professional organizations, including the American College of Obstetricians and Gynecologists, the American College of Nurse Midwives, [18]and the American Academy of Pediatrics, [19] have attested to the safety of emergency hormonal contraceptives and have advocated for over-the-counter availability; and

WHEREAS, the American Public Health Association (APHA) has already approved two policy statements, one regarding emergency contraception access to victims of sexual assault [20] and the other supporting public education about emergency contraception and reducing barriers to access [21].

<u>Therefore, be it resolved that the Minnesota Public Health Association:</u>

1. Opposes any efforts to restrict access to the provision of emergency contraception by individuals, organizations, groups or government.
2. Urges hospitals, hospital associations and health systems to adopt as the standard of care the requirement that emergency contraception be offered to any individual legally requesting a prescription, including, but not limited to victims of sexual assault.

3. Urges that prescriptions for contraception and emergency contraception are authorized and filled, and that timely access to these are not denied to individuals seeking to legally obtain them, by healthcare practitioners or pharmacists based on moral or ethical reasons.
4. Supports efforts to encourage pharmacies across Minnesota to stock emergency contraception in order to make it available when needed.
5. Supports state and national efforts to make Plan B emergency contraception available over-the-counter as recommended by the FDA's Non-prescription Drugs and Reproductive Health Drugs Advisory Committee.
6. Supports widespread public awareness campaigns and social marketing efforts to increase awareness about emergency contraception.
7. Supports widespread education of nurses, doctors, pharmacists, health educators and other health professionals working with adolescents and adult women on emergency contraception as a form of contraception, doing this via continuing education offerings and through pre-licensure education programs.
8. Encourages the implementation of collaborative agreements between pharmacists and health care practitioners who may prescribe drugs, as outlined in Minnesota Statute 151.01, Subdivision 27 (6), in order to improve access to emergency contraception.

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Women's Health Care 1994

Whereas, women comprise a majority of the population and initiate the majority of health care contacts; and

Whereas, an even larger proportion of those living after 65 years of age are women, producing a significant portion of the chronic illness and need for long-term care services.

Be it Resolved that health care reform should achieve a health system that:

- covers preventive and primary care for health risks of special relevance to women, including osteoporosis, family and sexual violence, substance abuse, mental health, nutrition issues, mammograms, and pap smears.

- provides full coverage for preventive and primary reproductive health care including sexual health education and counseling and services for family planning, infertility, pregnancy, contraception, abortion, sexually transmitted diseases, menstrual disorders, and hormone replacement therapy.

- ensure women have access to care in settings such as community, rural, and migrant health centers, family planning clinics, and school-based clinics that are concordant with the age, culture, privacy concerns and sensitivity to the needs of the consumer.

- cover services provided by a range of providers including physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, licensed social workers, and mental health professionals.

- cover long term care including home care and community-based services such as personal care, adult day care, respite care, home management, and nutrition services.

Women's Health Research 1994

Whereas, research on women's health is woefully inadequate and, recognizing this fact, public and private funders are making new commitments to support research on women's health;

Be it Resolved that women's health research should:

- involve women scientists, women's health care providers and advocates as key players in all stages of research, including elaborating the ethical guidelines and standards of research, defining priorities, developing requests for proposals, allocating funds, designing and implementing research, and analyzing and disseminating findings.

- involve research teams that are multi-disciplinary, including the social, public health, and biomedical sciences.

- use techniques that are sensitive to women subjects' situations. The intended beneficiaries of the research should have an active role in this process.

- should include, but not be limited to, community-based epidemiological investigations to assess the prevalence and incidence of certain problems; intervention research with emphasis given to preventive programs; health services research around key questions such as access and provider/client interaction; studies examining the socio-economic determinants of poor health in women; basic science research; and clinical trials.

- conceptualize women's health broadly and include reproductive health, work-related health concerns, substance abuse, mental health, family and sexual violence, and nutrition issues.

- recognize that although all women have received inadequate attention, emphasis should be given to the problems of disadvantaged and underserved women, taking into account issues of age, class, ethnicity, and geography.

- follow the highest ethical standards by honoring the principle of informed consent, doing no harm, and addressing the problems of disadvantaged women first.

Resolution in Opposition to proposed Legislation SF1688 1990

A bill for an act relating to health; preventing abortions for birth control purposes; requiring informed consent for abortions; proposing coding for new law in Minnesota Statutes, Chapter 145.

WHEREAS, The proposed legislation attempts to establish a compelling state interest in unborn life as the basis for prescribing abortion merely as a means of birth control; and

WHEREAS, The use of abortion as a preferred means of birth control over other means of birth control has not been established; and

WHEREAS, The State and Federal Court systems have consistently upheld the right of women to be free of state interference in choosing methods of birth control as well as abortion; and

WHEREAS, The proposed legislation attempts to establish in law an official state mandate as to access to and content of information which must be given to women considering abortion that is deemed lawful under this proposed statue; and

WHEREAS, Professional standards of ethical conduct as well as the United States and Minnesota Constitutions guarantee both freedom of speech and the right to privacy; and

WHEREAS, The law's intent is to outlaw abortion except in select cases of rape, incest, fetal non survivability or to save the life of the mother, and the information prescribed to be given to women considered under these exceptions by the State's official message is clearly detailed to discourage and dissuade rather to inform; and

WHEREAS, The mere discussion of the option of abortion except in these limited cases is defined as an attempt to perform an abortion and punishable under the law; and

WHEREAS, The proposed law's provision to permit suits for civil damages in a completed or attempted abortion from not only the pregnant woman, but the "father" and grandparents of the unborn child, is overly broad, punitive and designed to restrict and limit medical practice through fear of civil action; and

WHEREAS, The intent and provisions of this proposed legislation are in direct opposition to long-standing Minnesota Public Health Association policies which support a woman's right to reproductive choice, universal access to health care, and the right of minors to give consent for their own medical care.

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association reaffirms its support of a woman's right and ability to choose, and in full recognition of the privacy of the relationship between a woman and her physician and the accepted standards of good medical practice, stands in opposition to this proposed legislation to inject the state into this personal decision and to make abortion again illegal with all its negative consequences.

Perinatal Substance Abuse 1989

Recognizing that the problem of perinatal substance abuse, particularly use of cocaine, and crack, is becoming an issue of increasing concern in Minnesota.

Recognizing that substance abuse during pregnancy, particularly use of cocaine and crack, results in adverse outcomes for women during pregnancy and for infants born to them, ultimately affecting the entire family constellation.

Recognizing that perinatal substance abuse has a far-reaching impact on all sectors of the community, including the health care system, child protective services, foster care, educational system, chemical dependency services and legal system.

Recognizing the lack of solid epidemiological data documenting incidence and prevalence of substance abuse during pregnancy, lack of existing information regarding types of treatment which are most successful in addressing these problems, and the paucity of services designed to meet this need.

Recognizing that other Cities (i.e. Los Angeles) have, through many years of experience with this problem, learned that punitive approaches such as removal of children from mothers, have had deleterious long term effects.

Be it resolved that the MPHA:

1. Supports efforts to further document the incidence and prevalence of perinatal substance abuse and effects of such use.
2. Supports efforts to identify successful intervention strategies to address this problem, including information on treatment programs, which show promise of success.
3. Supports interdisciplinary prevention and intervention efforts which assure inter-system collaboration and coordination, including the development of innovative model community programs tailored to meet these needs.
4. Supports approaches which are therapeutic and supportive, rather than punitive in nature.
5. Supports the establishment of a perinatal substance abuse council to increase awareness of these issues, promote coordination of services, promote development of new model pilot programs to address this growing problem, and serve as a clearing house for funding efforts related to substance abuse.
6. Supports efforts to identify and implement methods of innovative financing which effectively coordinate categorical dollars linking a variety of needed services for clients.
7. Opposes proposed legislation or regulations that are punitive in nature, either proposing further legal penalties for use of illicit drugs while pregnant or parenting, or precipitous removal of children from mothers.

Family Planning Education Aids 1983

RESOLVED, that the Minnesota Public Health Association urge the Minnesota Department of Health to continue to make available a variety of educational aids on all health related topics including family planning.

Approved October 20, 1983 Annual Meeting.

Child and Family 1979

RECOGNIZING that 1979 is the International Year of the Child; and

RECOGNIZING that the children of Minnesota are its future; and

RECOGNIZING that children cannot speak for their own needs; and

RECOGNIZING that every child needs the nurturance which is most effectively provided by a loving, stable, and informed family; and

RECOGNIZING that most public decisions regarding health and welfare have an impact on children and their families;

THEREFORE BE IT RESOLVED by the Minnesota Public Health Association:

1. That it advocates that the needs of children be considered when public decisions are made, and

2. That it advocates measures to strengthen families.

Approved September 20, 1979 Annual Meeting.

Reproductive Freedom 1978

WHEREAS, The Minnesota Public Health Association supports the right of every citizen of Minnesota to have equal access to health services in order that they may exercise their right to freedom of choice; and

WHEREAS, The Association believes health services should not be restricted because of economic status, race, residential location, or age; and

WHEREAS, Preventing women from receiving reproductive health services is discriminatory and violates constitutional rights; and

WHEREAS, There is no 100% effective contraceptive method, abortion is a necessary backup to enable women to avoid unwanted pregnancy.

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association reaffirm the right of all women to control and make decisions about their reproductive rights for contraception, abortion, and sterilization.

BE IT FURTHER RESOLVED that the Executive, Legislative and Judicial branches of our state government be informed of this resolution. Part of the above policy is based on the APHA position policy supporting Medicaid payment for abortions.

Approved September 22, 1978 Annual Meeting.

Venereal Disease Control 1975

MPHA supports educational programs in junior and senior high schools, and state grants for local public and private agencies for VD detection and treatment services.

Family Planning 1974

MPHA supports state grants to local public and private agencies for family planning services, and for development of model family planning curricula for optional use by local school boards.

PUBLIC HEALTH INFRASTRUCTURE

Minnesota Public Health Association Resolution

Emergency Preparedness to Protect Public Health 2010

WHEREAS, in the United States and globally disasters and hazards disrupt hundreds of thousands of lives each year; and

WHEREAS, the Centers for Disease Control and Prevention (CDC) has identified emergency preparedness and response as a critical public health function;[1] and

WHEREAS, the Federal Emergency Management Agency (FEMA) recommends citizens should be self-sufficient for at least three days for shelter, first aid, food, water, and sanitation; [2] and

WHEREAS, The American Public Health Association (APHA) has developed the Get Ready campaign to educate all Americans about strategies to prepare themselves, their families, and their communities for all disasters and hazards;[3] and

WHEREAS, The Minnesota Department of Health (MDH) has developed a statewide all hazards emergency preparedness campaign, CodeReady.org, to educate the broader public with strategies to prepare for a major emergency;[4] and

WHEREAS, Minnesota has identified preparedness as an area of local public health responsibility and an essential activity; [5] and

WHEREAS, Minnesota has established leadership within the Department of Health to coordinate emergency preparedness activities with local public health agencies and inform the public when these situations arise;[6] and

WHEREAS, state and local public health agencies and collaborative partners have developed approaches that aim to improve public health preparedness response and reach culturally diverse communities throughout Minnesota.[7,8]

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:

1. Supports the emergency preparedness efforts that have been developed by MDH and APHA, and

0. Encourages the State legislature to continue to develop legislation supporting emergency preparedness activities, and

0. Supports funding for current and future federal and statewide emergency preparedness efforts.

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Minnesota Public Health Association Resolution

Livable Communities through the Built Environment 2007

WHEREAS, the built environment includes aspects of our environment that are modified by humans, such as urban and suburban spaces, workplaces, schools, housing, sidewalks, roads and public transportation infrastructure[1]; and

WHEREAS, the built environment is associated with factors that influence the health of the public, such as opportunities for safe physical activity, access to healthy foods, air quality, water quality, and psychosocial stressors[1]; and

WHEREAS, the relationship between the built environment and health is recognized by the Centers for Disease Control and Prevention, Institute of Medicine, American Public Health Association, National Association of County and City Health Officials and Minnesota Department of Health; and

WHEREAS, the United States is experiencing an obesity epidemic associated with decreased physical activity[2-5]; and

WHEREAS, Minnesota is not immune to the obesity epidemic and has seen obesity rates double in the last decade from 10-14% in 1991 to 20-24% in 2003[6]; and
WHEREAS, changes in transportation patterns, such as a greater reliance on cars and a decline in walking and bicycling, affect the public health factors mentioned above; and
WHEREAS, zoning, land use and housing density decisions have a direct impact on the quality of life and sustainability of neighborhoods, cities and towns[7]; and
WHEREAS, living in close proximity to roads aggravates chronic lung diseases[8-10]; and
WHEREAS, sidewalks and bike trails improve safety for pedestrians, especially children, older persons and people with special functional needs; and
WHEREAS, transit investment in the Twin Cities region lags far behind U.S. regions of similar size (we receive fewer federal grants for major transit projects), yet transit ridership was up by 5% in the Metro region (with increases of 11% on suburban routes) in 2006[11]; and
WHEREAS, access to affordable grocery stores can affect dietary choices, and chain grocery stores, which generally have lower prices, are more likely than non-chain stores to locate in the suburban and non-poor areas of the Twin Cities[12]; and
WHEREAS, improvements in the built environment that minimize environmental impacts, maximize public health benefits, and promote sustainable communities are expected ultimately to help decrease obesity, cardiovascular disease, and asthma while improving mental health and social cohesion[13].

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association:
1. Encourages state and local elected and administrative officials, local communities and public health departments to incorporate principles of a sound built environment into policies, programming and funding;
2. Advocates for the incorporation of universal and community design concepts into comprehensive planning for new construction and remodeling projects at state and local levels;
3. Advocates for the establishment of statewide access to improved public transit and pedestrian, walking and biking paths; and
4. Supports research and evaluation to examine the beneficial and harmful factors of the built environment that affect individual, family and community health.

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Policy in Support of University of Minnesota Academic Health Center 1999

MPHA supports the University of Minnesota's legislative request for increased funding in FY 2000-2001 for the Biomedical Library and a number of Academic Health Center Initiatives involving School of Public Health faculty and students. These initiatives involve ongoing study of managed care; increased student training in community settings; and a new Center for Disease Prevention and Health Promotion. Core support for salaries of faculty and staff at the School of Public Health are included in the University's main request.

Establishing a Nursing Scholarship Program 1990

WHEREAS, In order to be a certified public health nurse in Minnesota a baccalaureate or higher degree in nursing is required; and

WHEREAS, There is a current and projected shortage of nurses prepared at the baccalaureate and higher levels; and

WHEREAS, Assisting R.N.'s to continue their nursing education is an important aspect of retaining nurses in the profession and meeting the growing demand for baccalaureate nurses and advanced practitioners of nursing; and

WHEREAS, There is a need for grants and scholarships to assist R.N.'s who wish to continue their education in nursing, but who find that conventional financial assistance is not available to them or does not provide enough support to allow them to return to school; and

WHEREAS, Other states have successfully implemented nursing scholarship and loan programs using funds collected as part of licensure renewal fees; and

WHEREAS, Fees generated from licensed nurses would be used most appropriately to assist currently-licensed nurses to continue their nursing education;

THEREFORE, BE IT RESOLVED that MPHA support establishment of a scholarship program for R.N.'s who wish to continue their education in nursing and plan to practice in Minnesota.

BE IT FURTHER RESOLVED that, as an example of the kind of scholarship program MPHA would support, MPHA support legislation to raise R.N. licensure renewal fees (by $5.00) to support establishment of a scholarship program for R.N.'s licensed in Minnesota who wish to continue their education in nursing and plan to practice in Minnesota; and that this program be sunsetted after 6 years unless continued need is demonstrated.

Community Public Health Role of the University of Minnesota School of Public Health 1986

WHEREAS, The University of Minnesota School of Public Health (SPH) is a major state, regional and national resource for teaching, research, and community service activity; and

WHEREAS, The SPH has been a major resource for training new public health workers and providing continuing education for public health professionals; and

WHEREAS, The SPH has been a major source of technical consultation for public health agencies and programs, and

WHEREAS, The SPH has an historical tradition of preparing high quality leaders and practitioners for public health service in Minnesota and throughout the country;

THEREFORE, BE IT RESOLVED that the MPHA offers its support and cooperation to the SPH in its efforts to meet the new challenges in public health and urge that the SPH:

* Make every effort to preserve and strengthen the diverse and interdisciplinary nature of the SPH's programs in keeping with the broad needs of the State of Minnesota.

* Consider the needs of state and local agencies that depend upon the SPH for competent graduates and continuing educational opportunities.

* Remain responsive to the rapidly shifting needs of the public health community for technical consultation, research, and service assistance.

* Involve practicing public health professionals from the community in its long range planning process and include their input to assure inclusion of important data on community needs, trends, and activities.

Be sensitive to its historically unique educational mission as an institution serving a broad community role in addition to its academic role.

Professional Education 1982

MPHA believes that the optimum preparation of public health professionals should be considered a priority by health service providers, educators, educational administrators and public policy makers. This priority should be reflected in budget recommendations at the Local, State and National levels that promote training and research programs of quality and integrity across the breadth of public health practice.

Comment

Minnesota residents have always supported a high quality of life. A large part of any community's quality rests with public health programs which decrease morbidity and mortality rates. Many of the advances in public health in Minnesota are due to the high quality and the variety of public health programs. With technological advances and societal changes there will be an expanding need for the expertise of public health professionals to interpret public health issues and facilitate the development of public health policy. Vital and dynamic training and research

programs for public health professionals will be important to provide needed manpower and an environment that promotes interaction between providers and educators to develop policies and solutions for future challenges.

The School of Public Health at the University of Minnesota is a case in point. The School of Public Health has a long history of preparing public health professionals for service to the State and the Nation. It serves as a regional resource, being the only school of public health in the north central part of the United States and is nationally recognized for its educational and research programs. Adequate budgetary support from government and private sources is necessary to maintain the breadth and depth of public health training and research programs such as those in the University of Minnesota's School of Public Health thus to ensure maintenance of an adequate high quality pool of public health professionals.

Approved September 30, 1982 Annual Meeting.

Public Health Financing Policy Statement 1996

Background:

Historically, local public health in Minnesota has been supported through a combination of federal, state and local funds. State level health care reform and proposed federal health program changes could affect the adequacy of this funding for public health.

In March 1995 the Minnesota Health Department issued a report titled Building a Solid Foundation for Health: A Report on Public Health System Development. One of the findings of the report was that health care reform will affect the financing of the local public health system. As publicly funded health care programs are included in the state's health care reform efforts, some funds currently received by local governments may be redirected to managed care programs. Those funds might no longer be available to pay the costs of the core public health functions which local governments provide in their communities.

The report supported the need to assure a stable and adequate funding for local public health so that changes taking place in the health care system do not erode the ability of local governments to provide needed public health services in the community. The report also states that additional funding is needed to strengthen the ability of local governments to perform core public health functions and to implement transition strategies to further integrate the activities of the public and private health system.

Discussions about assuring stable and adequate funding to support local government core public health funding have continued since the report was issued. The Governor's 1996 budget recommended an additional general fund appropriation to support the local public health structure for the remainder of the biennium. The Legislature responded by allocating $1.5 million from the general fund for this purpose. Funding for future years will be dealt with next legislative session.

Balancing the financing of broader access to health care services, and the implementation of health care reform in publicly funded health care programs with assuring adequate funding for core public health functions is an ongoing challenge. As a guide for MPHA's role in this effort, the following principals were developed.

MPHA statement of principals related to public health financing:

1. MPHA supports the concept of integrated health delivery systems accompanied by incentives that encourage integration of public health and medical models of health care delivery.1
2. Within this context MPHA believes that a government sponsored public health infrastructure is needed to assure that the core public health functions of assurance, advocacy and assessment are achieved.
3. Adequate, stable and broad-based funding is needed to support this infrastructure and carry out the core functions.
4. Adequate public funds should be allocated both for public health for all, and for the provision of health care services for at risk populations and those who need financial assistance to purchase those services.

Recommended action:

MPHA advocate that state, national and local governments assure that, at a minimum, the level of funding outlined in the Minnesota Department of Health report, Building a Solid Foundation for Health: A Report on Public Health System Development, (equivalent to $41 per capita in 1992 dollars) be available for funding of local core public health functions.

Human Service Budget Reduction 1992

The Minnesota Public Health Association opposes across-the-board reductions in health and human services. We urge the Legislature to use reserve funds or other sources of revenue to ensure services are provided to underserved and low-income populations.

Public Health Funding 1982

MPHA supports the position that an implementation period, which allows for planning for efficient, effective budgeting of public health funds, be allotted for any National and/or State budget changes.

Comment

Changes in the availability of public health funds at the National and/or State level require adjustments in funding plans at the State and/or Local level. Without adequate time to consider the impact of changes in funds available and to assess the availability of alternate resources, agencies cannot make decisions that assure the most appropriate use of public health funds. If agencies are provided with notice of changes and an implementation period in which to consider and phase-in the changes, budget and service revisions can be made with due consideration of the health needs if the community.

Approved September 30, 1982 Annual Meeting.

Federal Block Grants 1981

MPHA supports a participatory process for determining the allocation of Federal Block Grants for Health Programs in Minnesota, which includes the early involvement of representatives of the affected communities, health services providers, consumers and other interested persons. In addition, the state should develop state health priorities, consistent with MPHA principles and the Surgeon General's Report on Health Promotion and Disease Prevention (1979), and allocate funds to achieve these goals. While it is recognized that there will be a reduction in Federal Funds, MPHA opposes a disproportionate cut in funding to public health and prevention programs.

Comments

MPHA has consistently supported the concept of prevention as a more effective means of maintaining and improving people's health.

With the elimination of categorical grants and the reduction of Federal Funding it is important that monies be allocated according to established public health goals. This will ensure that funding for preventive programs will not be disproportionately reduced because their impact is not immediately recognizable.

MPHA has also consistently supported citizen participation and community involvement in the development of public health policy. It is imperative that citizens be involved in the development of State health priorities and the allocation of Federal Funds. This input should occur as early as possible after the Federal regulations and the funding authorization levels have been determined.

MPHA Resolutions Related to This Position:
CHS - 1976
CHS - 1979
Prevention - 1978
Prevention - 1977
Approved October 1, 1981 Annual Meeting.

VIOLENCE, INJURY PREVENTION, AND SAFETY

Traffic Safety - Resolution of Endorsement 2003

The Minnesota Public Health Association ("The Association") endorses the work of the Minnesota Alliance for Safe Highways and the Coalition Against Bigger Trucks to make roads safe in Minnesota and reduce the number of highway deaths by fighting against efforts of bigger truck proponents to increase truck lengths and weights.

The Association is committed to protecting the safety of motorists and protecting the taxpayer's investment in our infrastructure.

WHEREAS, according to the National Highway Traffic Safety Administration's National Center for Statistics and Analysis, 5082 deaths and 131,000 injuries occurred as a result of large truck crashes in the year 2001,

WHEREAS, according to the US DOT, National Bridge Inventory, 2000 data 10% of Minnesota's bridges are considered to be "structurally deficient" or "functionally obsolete."

WHEREAS, the August 2000 United States Department of Transportation Comprehensive Size and Weight Study found that 1) double and triple trailer trucks are at least 11% more likely to be involved in a fatal accident, 2) heavier single trailer trucks are more likely to experience dangerous rollover and braking problems, and 3) longer and heavier trucks would mean $319 billion in national budget costs, and

WHEREAS, the Safe Highways and Infrastructure Preservation Act will be introduced in the United States House of Representatives to extend the federal truck size and weight limits to the National Highway System, cap trailer length at 53 feet on the National Highway System, and strengthen overweight enforcement on the National Highway System.

Therefore BE IT RESOLVED that the members of the Minnesota Public Health Association support establishing

common sense truck size and weight limits on the National Highway System and join in coalition with the Minnesota Alliance of Safe Highways to accomplish those goals.

Firearm Injury Prevention 1999

Whereas, firearms contribute to hundreds of deaths and injuries per year in Minnesota. Between 1992-1996, an average of 372 people died per year from firearm homicide, firearm suicide, and unintentional shootings. For every person who dies in Minnesota from a gunshot wound, two people are hospitalized and five people are treated in an emergency department[1]; and

Whereas, the presence of firearms in the home increases the likelihood of firearm injury or death among the residents of that home; and

Whereas, weak gun laws allow firearms to get into the illegal market where they are accessible by adolescents and others who are legally prohibited from possessing them; that few regulations control the manufacturing of firearms; and

Whereas, the prevention of firearm-related homicides, suicides and unintentional shootings are preventable through a comprehensive approach that requires action at all levels of government and by all sectors of society;

Therefore, be it resolved that the Minnesota Public Health Association supports state and federal legislation that would:

Limit access to handguns and limit handgun purchases, including those at gun shows.
Limit access to high-powered assault pistols with no legitimate sporting or hunting purpose.
Maximize ability to limit firearm permits to people who are legally permitted to own one.
Minimize the number of people with permits to carry loaded, concealed weapons.
Slow or prevent the flow of handguns from entering the illegal gun market where they are accessible by young people and others who are legally prohibited from possessing them.
Maximize the ability of law enforcement to identify and penalize people who provide firearms to young people and others who are legally prohibited from possessing them.

* Adapted from a draft of the American Public Health Association policy proposal.

Maximize gun owners' skills and knowledge regarding safe and responsible ownership of firearms.
Provide mechanisms for promoting and ensuring safe storage practices of gun owners.
Encourage funding for education activities that reduce weapon-carrying by youth; encourage school-based, public and professional education to reduce firearm injuries and death.

Reference:
1 Roesler, Jon M. Center for Health Promotion, Minnesota Department of Health

Universal Primary Seat Belt Legislation 1999

Whereas, motor vehicle crashes are a leading cause of death and disability among Minnesotans; and

Whereas, in 1997, 600 people were killed in motor vehicle crashes in Minnesota. This is a substantial increase from 462 deaths in 1996. Among the victims for whom seat belt status could be determined, 55% were not wearing a seat belt at the time of the crash(1); and

Whereas, when seat belts are worn correctly, they reduce the chances of occupant death in a crash by nearly 50%.(2) In addition to protecting occupants from death, seat belts protect people from paraplegia, quadriplegia, traumatic brain injury, and disfigurement; and

Whereas, in 1997 Crash Facts, published by the Department of Public Safety, reports that 65% of Minnesotans wear seat belts while in rural areas, seat belt use is lower (59%) compared to metro areas (68%)(1); and

Whereas, primary enforcement of seat belt laws is the most effective way to increase use rates; and

Whereas, national averages show that 77% of motorists buckle up in states that allow primary enforcement4 and where adequately promoted and enforced, mandatory seat belt laws increase seat belt use and in turn, save lives.(5-6)

Whereas, Minnesota law (Statute 169.686) currently requires seat belt use among all front seat occupants and all children between ages 3 and 11 years old but, the law's effectiveness is limited because law enforcement officials can address seat belt violations only when they stop drivers for other reasons (speeding, etc.); and

Whereas, a primary seat belt law would allow enforcement officials to stop a vehicle solely on the basis of a seat belt violation; and

Whereas, a comparison between states with secondary and primary enforcement demonstrated that fatality rates declined by almost 10% among states with primary enforcement, compared with 7% in states with secondary enforcement policies(7);

Therefore, be it resolved that the Minnesota Public Health Association supports Universal Primary Seat Belt Legislation.

References

1 1997 Minnesota Motor Vehicle Crash Facts. St. Paul, Minnesota: Minnesota Department of Public Safety, 1998.

2 Baker SP, O'Neill B, Karpf RS. The injury fact book. Lexington, Massachusetts: Lexington Books, 1984.

3 Seat belt use by high school students in Hennepin County. Minneapolis, Minnesota: Hennepin County Community Health Department, 1998.

4 Minnesota Safety Belt Coalition. Personal communication, September, 1997.

5 Petrucelli E. Seat belt laws: The New York experience—preliminary data and some observations. Journal of Trauma 1987; 27(7):706-710.

6 Williams AF, Preusser, DF, Blomberg, RD, Lund, AF. Seat belt use law enforcement and publicity in Elmira, New York: A reminder campaign. American Journal of Public Health. 1987; 77(11): 1450-1451.

7 Wagenaar A.C., Streff F.M., Sullivan K.P. Mandatory seat belt laws in eight states: A time-series evaluation. Journal *of Safety Research.* 1988; 19: 51-70.

Limiting Purchases of Handguns to a Maximum of One per Month 1998

WHEREAS, firearm homicide killed 165 Minnesotans under age 30 between 1993-1995(1); and

WHEREAS, homicide was the leading cause of death for teens, ages 15-19, in Hennepin County and 77% of deaths were caused by firearms(2); and

WHEREAS, studies estimate that the average cost of treating a hospitalized gunshot wound victim is $33,000(3) and approximately 80% of the medical cost for firearm injuries is paid for by taxpayers(4); and

WHEREAS, young people report that they have easy access to handguns despite state and federal laws that prohibit individuals under age 18 from purchasing or possessing them(5); and

WHEREAS, many guns travel to the black market through straw purchasers who legally buy large quantities of firearms for individuals who are prohibited from purchasing guns themselves (felons, minors, etc.) or who do not want to be traced(6); and

WHEREAS, data from a July 1997 report from the Bureau of Alcohol, Tobacco, and Firearms (ATF), indicated that a high percentage of guns with obliterated serial numbers (to impede tracing) were originally part of a multiple sale(6); and

WHEREAS, "one-handgun-per-month" legislation makes it illegal for anyone to purchase more than one handgun in any 30-day period; and

WHEREAS, three other states (South Carolina, Virginia and Maryland) have passed a "one-handgun-per-month" law; and

WHEREAS, evaluation of Virginia's law demonstrated a 67% reduction in guns that originated in Virginia and were later recovered in Massachusetts and a 38% reduction in guns that originated in Virginia and were recovered in New Jersey(7); and

WHEREAS, "one-handgun-per-month" legislation may be particularly effective at disrupting gun trafficking in Minnesota because more guns recovered in the state originated here(8).

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association supports the passage of a one-handgun-per-month law in Minnesota that would restrict the purchase or transfer of more than one pistol or semi-automatic military-style assault weapon within a 30-day period.

References

1Center for Health Statistics, Minnesota Department of Health, 1996.
2Childhood Injury in Hennepin County, Hennepin County Community Health Department, Minneapolis, MN, 1995.
3Rice, D.P., MacKenzie, E.J., Ad Associates. Cost of Injury in the United States: A Report to Congress. San Francisco, CA: Institute for Health and Aging, University of California and Injury Prevention Center, The John Hopkins University, 1989.
4Gun-related Mayhem and its Burden on the Health Care System. Minneapolis Star Tribune. February 3, 1994.
5Youth Access to Firearms; A Report of Focus Discussions with Youth Living in Minneapolis. Minneapolis Department of Public Health and Family Support. Unpublished report, 1997.
6The Crime Gun Trace Analysis Reports: The Illegal Youth Firearms Market in 17 Communities. The Bureau of Alcohol, Tobacco and Firearms, 1997.
7Mason J. Gun Straw Purchases Down. Richmond Times Dispatch, April 12, 1997.
8Trafficking the Traffickers. Minneapolis Star Tribune. April 2, 1997.

Adopted April 30, 1998

Limiting Carrying Handguns in Public 1998

WHEREAS, firearm homicides killed 165 Minnesotans under age 30 between 1993-1995(1); and

WHEREAS, studies estimate that the average cost of treating a hospitalized gunshot wound victim is $33,000(2) and approximately 80% of the medical cost for firearm injuries is paid for by taxpayers(3); and

WHEREAS, between 1996-1997, concealed handgun license holders in Texas were arrested for 946 crimes(4); and

WHEREAS, in the first six months of 1997, arrest rates for weapon-related offenses among Texas concealed handgun license holders was more than twice as high as that of the general population aged 21 years and older(4); and

WHEREAS, in 1997 the Texas Department of Public Safety revealed that 236 concealed handgun license holders were arrested on weapon-related offenses including deadly conduct/discharging a firearm, failure or refusal to display handgun license, failure to conceal a handgun, and unlawful carrying of a handgun(4);

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association opposes weakening of any existing gun control laws, especially those that would allow permits to carry concealed weapons in Minnesota.

References

1Center for Health Statistics, Minnesota Department of Health, 1996.
2Rice, D.P., MacKenzie, E.J., Ad Associates. Cost of Injury in the United States: A Report to Congress. San Francisco, CA: Institute for Health and Aging, University of California and Injury Prevention Center, The John Hopkins University, 1989.
4Gun-related Mayhem and its Burden on the Health Care System. Minneapolis Star Tribune. February 3, 1994.
4License to Kill: Arrests Involving Texas Concealed Handgun License Holders, Violence Policy Center, 1350 Connecticut Avenue, NW, Washington, DC, 1997.

Adopted April 30, 1998

Family Violence 1992

Who Are The Victims?

Spouses/Partners
Each year, 3-4 million U.S. women are victims of domestic violence.

From 1980 to 1984, 12,582 American women were homicide victims. Over half of these women were killed by their husband, boyfriend, or former partner.

Nationally, battering accounts for 20 percent of all medical visits by women and 30 percent of all emergency room visits.

Children
Approximately 1,727,000 children are abused or neglected each year in the U.S. Of these, 1,100 die due to abuse. In Minnesota, there were 16,903 reported cases of child abuse in 1990.

Nationally, as of 1986, 358,000 children were physically abused, 155,900 were sexually abused, and 211,100 were emotionally abused.

Elderly
In 1979, approximately 600,000 elderly were physically or psychologically abused. By 1988, approximately 2 million such incidents were being reported annually in the U.S.

Family Violence Has Serious Ramifications
for the Individual and Society

Family violence:
- can result in premature death, injury, and chronic disease
- threatens the well-being of the community and the social fabric of society

- cannot be attributed to a single cause
- cannot be entirely controlled, prevented, or managed through independent, individual action
- is expected to continue to spread, become more severe, and affect a large number of individuals, families, and communities - if not prevented.

The Minnesota Public Health Association
Offers the Following Recommendation

Because the impact of family violence is spread throughout our society, curtailing it requires a coordinated approach, with special emphasis on prevention at the community level. This will require an attempt to control, contain, or arrest its spread. MPHA recommends primary prevention activities to prevent family violence at all levels.

Responding: Social Violence Prevention (RSVP) Report of the Task Force for the Prevention of Family Violence 1991

Note: Due to space limitations, the full document is not printed. If you want a copy of the report, please contact Stanton B. Shanedling, PhD, MPH, at 853-8540.

Date: April 1991
To: Minnesota Public Health Association's Governing Council and Members
From: Stanton B. Shanedling, PhD, MPH, Chair
Task Force for the Prevention of Family Violence

As the Chair of the Task Force for the Prevention of Family Violence and on behalf of its members, I would like to present to you this final report in the form of a workbook. The charge given the Task Force was to examine carefully the child maltreatment issue in Minnesota, and propose creative solutions for its prevention. Since July, the Task Force has worked, discussed and deliberated at length on the magnitude of the maltreatment problem, its etiology, and cultural diversity. Given the complexity of child maltreatment and its interplay with family violence, the Task Force chose to address child maltreatment within the total context of family violence with the hope that the prevention strategies developed would be useful across the lifespan.

We are presenting you with a new approach to the prevention of family violence - a different strategy - that will provide a unique public health response to the maltreatment problem. The Task Force consistently focused on prevention in its truest form. The report is a beginning document that should stimulate more "action." In addition, the intent is that the report will become a working piece. We encourage comment, change, and adaptability.

Members of the Task Force:
Michael Baizerman, PhD, MS(Hyg.); Jeanne Morrison, RN, MPH; Ellen Benavides, MHA; Kathleen Montgomery, BSN, MPH; George Bowlin, MPH; Luanne Nyberg; Ann Ellwood; Cheryl Olson, MPH; Carol Fairbrother; Robert Schwanke, MPH; Deborah Hendricks, RN, MPH; Robert tenBensel, MD, MPH; Sandra Krause; Barbara Yawn MD; Larry Kutner, PhD; Oliver Williams, PhD, MPH; Molly Lester, RN, MPH

Resolution to Ban Fourteen Assault Weapons 1990

WHEREAS, Firearms rank as the second leading cause of fatal injuries in the United States, and

WHEREAS, The last two decades have witnessed a striking rise in homicides involving the use of assault weapons, and

WHEREAS, The present easy availability of assault rifles poses a threat to public health and safety, and

WHEREAS, Assault rifles are proving to be the weapon of choice of drug dealers, and

WHEREAS, The fourteen specific assault weapons are: Norinco, Mitchell, and Poly technologies Automat Kalashnikovs (all models); Action Arms Israeli Military Industrie UZI and Galil; Beretta AR-70 (SC-70); Colt AR-15 and CAR-15; Fabrique Nationale FN/FAL, FN/LAR, and FNC; MAC 10 and MAC 11; Steyr AUG; Intratec TEC-9; and Streetsweeper/Striker 12; and

WHEREAS, Assault rifles can be reasonably regulated without infringing on the rights of sportspeople.

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association supports legislation which bans weapons including, but not limited to the fourteen specific weapons named above.

Prevention of Child Maltreatment 1990

WHEREAS, In the State of Minnesota the frequency of child maltreatment is increasing rapidly; 1) In 1987, in Minnesota 17,894 cases of maltreatment of children were reported -189% increase since 1980. 2) Of those reported cases 6,599 were substantiated, 4504 were unsubstantiated and the rest were unable to be verified. 3) In 1988 an estimated 10 children died in Minnesota as a result of maltreatment. 4) In Hennepin County alone, 50% of all maltreatment cases are chemical related. 5) The nature of maltreatment in Minnesota is physical in 35% of the reports, sexual in 25% of the reports, and neglect in 40% of the reports. 6) Nationally, more than 1.5 million children experienced abuse or neglect in 1986 with physical abuse increasing by 58% since 1980 and sexual abuse more than triple the 1980 rate; and

WHEREAS, There exists many misconceptions about child maltreatment - e.g., abuse occurs only in poor families; abuse is an urban issue; most perpetrators of abuse are adults; etc.; and;

WHEREAS, There is a great need to coordinate the efforts of programs offering primary prevention of child maltreatment; and;

WHEREAS, There are limited financial resources for programmatic efforts in primary prevention of maltreatment;

THEREFORE, BE IT RESOLVED that the Minnesota Public Health Association will assemble a Task Force for the Prevention of Family Violence with specific attention drawn to child maltreatment whose purpose is to examine carefully the child maltreatment issue in Minnesota, propose creative solutions for its prevention, and formalize an official statement that MPHA can use to guide prevention efforts legislatively and within communities.

This Task Force will convene in May 1990 and conclude in November 1990 with a final report submitted to the Governing Council by January 1991.

Nuclear War 1982

MPHA supports the freeze on further testing, production and deployment of nuclear weapons and of missiles and strategic and tactical delivery systems designed primarily to deliver nuclear bombs. In addition, this nation should take part in mutual disarmament of nuclear weapons.

Comment
Nuclear war would kill or maim a large percentage of the world's population and render the environment unfit for life due to long-lasting radiation. The destructive power of current nuclear bombs has made nuclear war between superpowers obsolete. There is no circumstance that would justify nuclear warfare either in a first strike or in retaliation. If these weapons are going to be used only as a threat, it is a staggeringly expensive and civilization-threatening bluff. The best alternative is to negotiate a mutual nuclear disarmament treaty and adequate

surveillance measures with the other nuclear powers. Failing this, if unilateral freeze is the only option, it is a lesser risk than that of deadly escalation of arms and threats.

Approved September 30, 1982 Annual Meeting.

Accident Prevention 1981

MPHA supports planning, regulatory measures and educational programs at the state, regional and local levels to reduce the incidence and severity of accidents.

Comment

The MPHA has consistently supported policy positions for the prevention of accidents. Accidents are the leading causes of death among persons between the ages of one and forty in Minnesota and the U.S. with motor vehicle accidents responsible for about half the deaths. Millions of people are injured each year as a result of accidents and the estimated cost of these accidents in the U.S. in 1975 was $27.5 billion. In Minnesota alone the economic loss resulting from motor vehicle accidents alone in approximately $400 million. MPHA believes that the majority of accidents are preventable and a strong educational and regulatory program will greatly reduce the total number of accidents.

MPHA Resolutions Related to This Position:
Position Paper on Prevention - 1977
Comprehensive Recommendation for Preventive Programs - 1978
Motorcycle Helmets - 1977
MPHA Position on Prevention - 1980
Approved October 1, 1981 Annual Meeting.

Motorcycle Helmets 1977

MPHA supports use of helmets.

March 18, 1977

Prevention 1977

MPHA proposes position paper on prevention; priorities with regard to maternal, infant, school age; address cost-benefits; there is also an APHA policy statement.