STATE PUBLIC HEALTH GOVERNANCE IN THE UNITED STATES

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By
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PREFACE

During the course of its deliberations, the Little Hoover Commission has raised the issue of the relationship between state public health leadership and governance. Commission staff requested a review of options for state public health governance as part of a presentation to be made at its November 18, 2002 advisory committee meeting by Joe Hafey, President and CEO of the Public Health Institute. This document summarizes that review.

The results of the review are divided into two sections. The first is an overview of state public health governance throughout the United States. It focuses on key dimensions of state public health governance.

The second section looks more closely at a selected sample of states in order to consider some of the actual dynamics of governance. The states were chosen for their ability to illuminate themes that are central to the review of public health governance in California.

It should be noted that surveys of state governance are limited. Some information has been compiled by the Association of State and Territorial Health Officials (ASTHO) and, more recently, a survey was conducted as part of a review of state public health performance management by Turning Point, an initiative funded by The Robert Wood Johnson Foundation and The Kellogg Foundation. Other information must be gleaned from isolated sources that do not provide the breadth of information of national surveys. An in-depth review of state public health governance, and the associated issues, would require more extensive research than either time or resources presently allow.

AN OVERVIEW OF STATE PUBLIC HEALTH GOVERNANCE IN THE UNITED STATES

This overview section examines three dimensions of state public health governance:

- Whether authority for public health is centralized in a state agency or decentralized among local public health agencies;
- Whether public health is free-standing or is part of a larger agency; and,
- Whether public health reports to a governor or to a board of health (or similar statutory body).

Centralized vs. Decentralized

Ten states have centralized authority, which means that public health services at both the state and local levels are provided by staff and administrative units of the state (see Figure 1). Its obvious advantage is that the state can make policy and administrative decisions that directly affect local public health, including the creation of regional authorities when there is insufficient capacity in small, rural counties, or when public health functions are redundant among local public health departments. It is important to point out that most of the 10 states with centralized authority are small and/or rural, and that the rationale for centralized authority is often based on the lack of capacity of local governmental entities to administer public health agencies.

Twenty-one states have decentralized authority, which means that public health services are provided by agencies that are organized and operated by units of local government. Local public health departments are generally regarded as being more responsive to local conditions and more subject to community participation in decisions.

Eighteen states, including California, have mixed authority, which means that some jurisdictions provide public health services operated by state agencies, while others are operated by units of local government. Mixed authority is most commonly the result of small, rural counties in diverse states lacking the capacity to operate local public health departments on their own. California, for example, is mixed because 11 counties with 50,000 people or less (1990 census)—Alpine, Amador, Calaveras, Del Norte, Glenn, Lassen, Mariposa, Modoc, Mono, San Benito and Sierra—contract back with the State to administer their local public health

FIGURE 1

States	State Health Department Freestanding or Part of Larger Organization		State Health Agency (SHA) Structure Re: Local Health Departments			Local Board of Health		State Board of Health or Health Council			
								Board of Health			
	F	L	Mixed	Centra-lized	Decentra-lized	State Associations	Number of Counties	Y/N	Policy	Advisory	Health Council
Alabama		X	X					Y	X		
Alaska	X		X					N			
Arizona	X				X			N			X
Arkansas	X			X				Y		X	
California		X	?					N			
Colorado	X		X			Inactive	48 cities/4multi-city	Y	X		
Connecticut		X	X					N			
Delaware		X			X			N			X
Florida		X	X					N			X
Georgia		X			X			N			
Hawaii	X			X		Yes, Point of CPHA	159 counties	Y		X	
Idaho		X	X					Y			
Illinois	X				X	Yes	7 districts (multi county)	Y		X	
Indiana	X				X	Yes	93 LHD's (city, town, etc)	Y	X		
Iowa	X				X			Y	X		
Kansas		X			X			N			
Kentucky	X				X			N			
Louisiana		X		X				N			
Maine		X	X					N			
Maryland	X		X					N			X

States	State Health Department Freestanding or Part of Larger Organization		State Health Agency (SHA) Structure Re: Local Health Departments			Local Board of Health		State Board of Health or Health Council			
								Board of Health			
Massachuesetts		X	X					N			X
Michigan	X				X	Yes	359 LBH's	N			X
Minnesota	X				X	Yes	45 city/city districts HD's	N			X
Mississippi	X			X				Y	X		
Missouri	X				X			Y		X	
Montana	X				X			N			
Nebraska	X				X			Y		X	
Nevada		X	?					Y			
New Hampshire		X			X			N			
New Jersey	X				X			Y	X		
New Mexico		X		X		Yes	115 LH jurisdictions, (14 counties, 19 cities, 82 town/townships)	N			
New York	X		X					N			X
North Carolina		X			X			N			X
North Dakota	X				X	Yes,	86 LHD's (79 city, 7 multi-community)	Y	X		
Ohio	X		X					N			X
Oklahoma	X		X			Yes	143 Public Health Agencies, 23 Counties, 56 Combo, 9 Contracting, 55 City	Y	X		
Oregon		X	X					N			X
Pennsylvania	X		X			Yes	Local Public Health Advisory Boards	N			X

States	State Health Department Freestanding or Part of Larger Organization		State Health Agency (SHA) Structure Re: Local Health Departments			Local Board of Health		State Board of Health or Health Council			
								Board of Health			
Rhode Island	X			X				N			X
South Carolina	X			X				Y	X		
South Dakota	X			X				N			X
Tennessee	X		X					N			X
Texas		X	X					Y	X		
Utah	X				X			N			X
Vermont		X		X				Y		X	
Virginia	X		X			Yes	12 LHD's, include 5 County/City and 7 Multi-City	Y	X		
Washington	X				X			Y	X		
West Virgina		X			X			N			X
Wisconsin		X			X	Yes	97 Public Health Agencies, 7 City, 25 Cityor Village, County/City	N			X
Wyoming	X		`					N			X

services, most for public health nursing and environmental health. Although California has mixed authority, it functions much like a decentralized state, since even the decisions of small counties to contract back with the State are local rather than mandated by the State; in a similar vein, three of those small counties pool their funds to have a single State employee regulate solid waste dumps on a regional basis, as opposed to regionalization being initiated by the State.

It is important to acknowledge that, in diverse states such as California, where local environments range from the large-scale complexities of Los Angeles to the challenges of providing basic public health protections and services in small counties such as Del Norte or Modoc, a pure centralized or decentralized model might be impractical, since public health functions must be carried out in a manner that both covers the entire population and still allows for adaptation to unique local circumstances. Moreover, it is unlikely that a state whose strength in public health is largely local could change to centralized authority. Instead, it would seem prudent to look to states that have demonstrated strong state leadership in an environment characterized by decentralized or mixed authority.

Free-Standing Public Health vs. Part of a Larger Agency

National data on how many state public health departments are free-standing as opposed to being part of a larger agency are hard to come by, since the only existing survey was based on the role of the participant in the Association of State and Territorial Health Officials (ASTHO), which is an imprecise measure at best. Available data do indicate that 30 states have health departments that are not part of a larger agency, although the questions were not asked in a manner that makes it possible to determine the extent to which public health specifically is free-standing.

In California, it is clear that one of the great challenges to asserting public health leadership is that public health is part of a Department of Health Services that also administers the Medi-Cal program, where recurring deficits and the size of the budget make it a constant priority; public health, for example, accounts for only about 10% of the total budget for the Department of Health Services. In addition, the Department of Health Services is part of a larger Health and Welfare Agency, whose director nominally represents public health in a cabinet-level position. The

practical constraints against a strong voice for public health emerging from such broad organizational responsibilities are considerable.

Reporting to a Governor vs. a Board of Health

Twenty states have a board of health, twelve of which have policy-making authority while the remainder are advisory. An additional seventeen states have a health council or similar body that provides opportunities for public input into state health agency policies and practices. It is interesting to note that California is alone among large, urban states in not having either a board of health or a health council.

Unfortunately, the limited surveys of state governance do not include information on important characteristics of boards of health, such as their scope, function, accountability and composition. Although there are some sources of information that reflect on those questions, they are isolated and do not create a complete profile of state governance. Among the key considerations related to state boards of health that deserve further research are the following:

- The scope of programs and responsibilities within their purview;
- The specific scope of their policy or regulatory authorities, and/or if they are advisory, to whom;
- Who has the authority to appoint members, or to confirm appointments;
- The composition of the board, and the competencies that are required;
- Their relationship to other state agencies, local public health agencies and state/local planning activities;
- How public participation is structured into their decision-making processes; and,
- How they operate, including whether members are compensated and whether they have staff.

SAMPLE PROFILES OF STATE PUBLIC HEALTH GOVERNANCE

The following profiles of state public health governance were created based on extensive interviews with key state public health officials. The states—Washington, Illinois and Minnesota—were selected because they illuminate important issues in governance and leadership. All three states have decentralized authority for public health. One has a policy-making board of health, another has an advisory board of health and the third has a health council.

The State of Washington was chosen because it is widely regarded as the model state for producing comprehensive public health improvement plans through collaborative planning between state and local public health departments.

The State of Illinois was chosen because it has been certifying local public health departments for nearly a decade, and has recently based that certification on public health performance standards.

The State of Minnesota was chosen because it has launched a high-profile, ambitious campaign, *A Call to Action: Advancing Health for All Through Social and Economic Change,* which moves public health into the realm of addressing health disparities and the broad determinants of health.

State of Washington

Overview

The current Department of Health was created in 1989 as a separate department in the Governor's cabinet. It covers all population-based public health services including Environmental Health and Licensure of Health Professions and Facilities (excluding nursing homes). Other health services, including Medicaid, reside in the Department of Social and Health Services. Other health-related departments include a Health Care Authority, Agriculture and Ecology and Labor and Industrial/Occupational Health. One of its strengths is that it is a department with its core purpose being population-based public health; its challenge is that it is dwarfed in size and budget by the Department of Social and Health Services and the Health Care Authority.

Department Director

The Secretary of Health (department director) is appointed by the Governor and reports to the Governor as a member of the cabinet. There is no term appointment, so there is no assurance that a director will stay when Governors change. The current Governor is known for strong cabinet member appointments and for delegating policy-making authority to them. He expects them to collaborate, and they do. They have developed strong collaborative relationships, which are evident in bio-terrorism planning (see below).

State Board of Health

The Board of Health is a separate agency from the Department of Health. It has been in existence since the State was formed, approximately 150 years ago. Its nine members, including the Chair, are appointed by the Governor. The members represent various constituencies. They are not paid a salary, but their expenses are reimbursed for attending monthly meetings. The Secretary of Health is a member of the Board.

The Board has an Executive Director and a small staff. The Department provides in-depth research and staff support, as well as space in its building, to the State Board of Health. The Board has recently increased its staff and has a new Executive Director (a former legislative staffer appointed two years ago) who is trying to move the Board toward becoming more engaged in key policy issues. He is trying to increase the Board's staff and visibility.

The Board has statutory authority and can make rules and regulations, particularly related to traditional public health areas such as communicable disease control and sanitation. Other public health rules are made by the Department of Health, which has diminished the importance of the Board, especially in relation to local government. The Board can hear appeals in state and local rule enforcement, but rarely does.

The Board balances citizen concerns with government enforcement. For example, the Board of Health became involved in the politically sensitive issue of names reporting in HIV cases. The Department of Health had not made a final recommendation, so the Board decided to hold a series of public forums to discuss the issue. It served a valuable role in providing for citizen views and input into public policy making. The Department of Health let the Board decide through this deliberative process, which was staffed by the Department. The policy result, requiring names reporting, garnered more

support because of the public process, and the Department was better able to carry out its enforcement responsibilities.

Local Health Jurisdictions

Authority for public health is decentralized in Washington. There are 39 counties and 34 local health departments, with some districts being multi-county. They are separate jurisdictions, but highly dependent on, and approved by, County government. They are independent local health departments from the State. Approximately 50% of the funding for local public health comes from local government (fees and taxes), 25% from the State, and 25% from the Federal government via the State.

The local health director is appointed by three county commissioners, who in statute function as a local board of health. (Technically, there must be a board of health in every county which has responsibility for local public health.) The State Department of Health is trying to work more closely with the strong statewide group of local commissioners. The State Department of Health does, however, have the authority to take control of a local health department that fails to meet its responsibilities.

County commissioners run for re-election every three years in staggered terms, so there is constant turnover of local board of health members. They run as members of political parties. Because they appoint the local health director, there is also considerable turnover of the local public health directors, although that appears to be less true in larger jurisdictions.

State Health Initiatives

The State of Washington Public Heath Improvement Plan (PHIP) process has been a model for the rest of the country. This process has resulted in a set of standards and goals agreed upon by state and local government. It has strengthened the state/local relationship. There are seven active committees working on various issues, including policy development (see the Department of Health website, www.doh.wa.gov).

Another factor that has strengthened state/local relationships is the position of Local Health Liaison, which is now complemented by a Director of Public Health Systems and Planning & Development, who oversees the Public Health Improvement Plan process and work.

Bioterrorism Planning

The cabinet-level status of the Secretary of Health made it easier to engage in collaborative bio-terrorism planning with other State agencies, which was evidenced immediately after the anthrax scare in the Fall of 2001. The Secretary of Health and Chief of the State Patrol jointly developed a plan within 2-3 days following the anthrax scare that defined roles and responsibilities of public health and law enforcement.

The relationship between the State Department of Health and local public health departments developed and reinforced through public health improvement planning served as a foundation for bio-terrorism planning in Washington. They jointly developed a regional framework for bio-terrorism preparedness in the State. The plan calls for the largest local health department in a region to be granted funding and responsibility for providing support for that region. Each local health department also received some direct funding based on population. The State Department of Health has a Bio-terrorism Coordinator and new staff in epidemiology, training and communications.

The State of Washington, like California, is considered high risk because of its international border with Canada, its military bases and storage facilities and its international water boundaries.

State of Illinois

Overview

The Illinois State Department of Public Health began as a Board of Health 125 years ago. Today the Department of Public Health is a freestanding public health department, which is not part of a larger agency. It includes an Environmental Health Program and Licensure of Health Facilities (including nursing homes), but it does not include Medicaid. When a new super agency, the Department of Human Services, was created about seven years ago, two key programs—Maternal/Child Health and the Women, Infants and Children's (WIC) Program—were taken out of the State Department of Public Health and placed in the new agency.

Department Director

The Director of Public Health reports directly to the Governor and is a member of the Governor's cabinet. The Director of Public Health must undergo a review by the State Senate every two years. The current Director of Public Health has served for 12 years. As required by statute passed in 1993, the Director of Public Health must be a physician.

Local Health Jurisdictions

There is a decentralized public health structure in Illinois. There are 94 local health jurisdictions. These local entities are units of municipal or county government, although some are multi-county jurisdictions. There is some tension in the state right now about local governance and the capacity of local health departments, with the larger public health jurisdictions calling for a study to assess the need for the number of small, rural public health departments. This has been exacerbated by the new controversial bio-terrorism plan by the State Department of Public Health to place State employees (one emergency response coordinator and an epidemiologist) in each of 10 regions—otherwise used only for perinatal hospital services and trauma systems—and to distribute a core amount of bio-terrorism funding to all rural health departments in order to help keep them viable.

State Board of Health

There is currently a State Board of Health. It was re-established in 1993, after having been abolished in the early 1970s. Its return was part of a package of reforms promoted through a state/local assessment and planning process.

The State Board of Heath is advisory only, and reports to the Governor. It has a statutory authority to prepare an annual report on the Department of Public Health and to report it to the Governor. The Board of Health has 15-20 members, with four-year staggered terms. It is technically non-partisan, but is still subject to political pressures. The composition of the Board of Health is specified in statute. The current Director of Public Health is working with the Governor's office to encourage new appointments that will shift the Board of Health's composition more toward professional and technical representation (e.g. schools of public health, medical schools and physician groups), which they hope will increase its credibility.

Since the Board of Health is advisory, it does not have authority over health policy or regulations. At its best, it can promote public understanding and discussion of public health policy decisions. In 1997-98, for example, the Board of Health conducted a series of citizen forums around the state regarding immunization issues, specifically the proposed requirement of Hepatitis B vaccination for school entry. Its activities diffused a highly political issue and resulted in a policy decision by the executive and legislative branches. The Board of Health, on the other hand, was unable to secure tobacco settlement funding for public health. More generally, the Board of Health is not viewed as strong, particularly by local health departments, in part due to its limited statutory authority and the fact that it has no dedicated staff.

State Health Initiatives

The State Department of Public Health demonstrated its leadership during the early 1990s when three major policy initiatives emerged from a collaborative state/local assessment process undertaken to determine the states' capacity to perform the core functions of public health. They collectively concluded that there were weaknesses in the state public health system and simultaneously proposed three policy initiatives that passed the legislature with executive branch support: 1) The requirement that the Director be a physician; 2) re-establishment of a State Board of Health; and, 3) establishment of the Illinois Project for Local Assessment of Needs (IPLAN). IPLAN in particular has distinguished Illinois by providing for state review of local community health assessments and plans that are coupled with a certification process for performing the core functions of public health. The State began with Assessment Protocols for Excellence in Public Health (APEXPH) and is now moving toward Mobilizing for Action through Planning and Partnerships (MAPP), both of which are public health improvement processes supported by the Centers for Disease Control and developed through the National Association of County and City Health Officials (NACCHO). The State has worked extensively with the University of Illinois School of Public Health in these processes.

Illinois has set the national standard for certifying local public health departments based on their ability to carry out the core functions of public health.

Bioterrorism Planning

The Department of Public Health established a first responder type of advisory committee to plan for bio-terrorism. The Board of Health was not involved. The City of Chicago, like Los Angeles, has its own direct bio-terrorism funding from the federal government.

The State did not do a lot of planning with the local public health jurisdictions and has developed some strategies that are getting resistance from some of the local public health departments, especially the larger ones. The State Department of Public Health is hiring local emergency response coordinators and epidemiologists to serve in state-administered regional offices in order to provide these services to local jurisdictions. This is leading the state to a mixed authority model for the first time, and there has been criticism of this new model from local public health jurisdictions. The State's bio-terrorism training programs may also use these regional structures. In addition, the State has distributed some funding to the local public health jurisdictions and has used a core funding approach in which the smaller, rural counties have received a disproportionate share of funding proportional to their population. The State has determined that each local community needs a core public health infrastructure and has used bio-terrorism funds to accomplish that objective, which has upset the larger counties. While the State's strong role in bio-terrorism planning has strengthened regional structures and supported a more uniform minimum standard for local public health throughout the state, there will need to be some major bridge building between the State and local public health departments to make the statewide bio-terrorism system function smoothly.

State of Minnesota

Overview

The Minnesota Department of Health is a cabinet-level agency that reports directly to the governor. It is a free-standing department that does not have responsibility for Medicaid, but it does include traditional public health programs as well as regulatory functions in health facilities and health professions. The Department of Health regulates health maintenance organizations, but health insurance more generally is regulated by the Department of Commerce. The Department of Health does have a fair

amount of policy authority, and it monitors health care costs and access to care. It was involved in access reforms in the state.

Department Director

The Commissioner of Health is appointed directly by the Governor, with confirmation by the Senate. Some administrations have filled more levels of the health agency with political appointees, but the current governor has generally taken a hands-off approach and allowed the Commissioner of Health to make more senior appointments. There have been generally good working relationships between the Commissioner of Health and other cabinet members, in part because the current governor has encouraged collaboration and programmatic work across organizational boundaries. Since the Governor has announced that he will not seek re-election, there is some concern that a new governor and most likely new political party will result in substantial changes.

Because the current governor ran as an outsider, he appointed people who were experts in their fields rather than political loyalists to head State departments. His cabinet was been more oriented to substance than to politics. He created a sub-cabinet on health policy that involved agencies meeting regularly and attempting to coordinate their activities, which is reported to have worked well. That approach has also been applied to preparing for potential terrorist attacks.

Local Health Jurisdictions

Minnesota has decentralized authority for public health. All counties in Minnesota must have a community health board. There are 87 counties and 50 community health boards, with several multi-county boards created through joint powers agreements. The community health boards have statutory responsibilities and a requirement to submit health plans and strategies every four years. Some portion of their funding comes through formula from the State general fund, although the local boards are independent and do not report to State. State funds account for 25-75% of local jurisdiction budgets, with the higher percentages typical of smaller counties.

The State Department of Health has influence over local health policy and agendas through its formula-based funding and categorical grants. There is current concern about a lack of minimum standards for local health jurisdictions, and an interest in developing state/local performance

standards. The State Department of Health does have the authority to step in if a local public health department is incapable of carrying out its responsibilities. With declining local funding, more financial responsibility for local public health is shifting back to the State, which will have to clarify its future role in assuring local public health capacity.

State Board of Health

There is no State Board of Health in Minnesota, although one did exist earlier in the history of the state. There is, on the other hand, a State Community Health Services Advisory Board (SHCSAB), which was created by statute and requires that each one of the 50 local community health boards elect someone to serve on the SHCSAB to advise the State Commissioner of Health on matters pertaining to health policy. The SHCSAB was created to enhance state/local working relationships.

When the current Commissioner of Health took office, the state/local relationship was frayed. She took time getting to know the members of the SHCSAB. The collaborative leadership approach has strengthened the state/local relationship and has served as the basis for jointly planning major statewide initiatives.

In addition to the SHCSAB, Minnesota has developed a health improvement partnership through their participation in Turning Point, a national grant-funded program focusing on state public health departments. The health improvement partnership involves broad stakeholder participation, including representatives from government-based public health, the health care delivery system, the medical profession, schools, labor unions, voluntary organizations, etc. and is led by a statewide steering committee that looks at the big issues to see how they can prepare a collaborative public health agenda. One impressive result of this process is *A Call to Action*, a statewide campaign to eliminate health disparities which is widely regarded to be the most ambitious initiative of its kind.

State Health Initiatives

The Turning Point health improvement partnership's *A Call to Action* establishes guidelines for identifying and eliminating health disparities in Minnesota. Local community health boards must incorporate those objectives into their local health plans.

The health improvement partnership has also been used for tobacco prevention initiatives targeting youth. Initial successes in youth tobacco

prevention shifted the focus of the partnership to more general efforts to improve adolescent health, including through school health programs. The latter focus has highlighted the elusive accountability for school health through the education system, and has begun discussions of how public health and education can work more closely and be held accountable for improving the health of children and youth.

Bio-terrorism Planning

Bio-terrorism planning has been carried out primarily through the SHCSAB. There was an agreement that for the first years investment would be weighted in favor of the State, but that in subsequent years additional funding would go more to local public health departments as they take on more responsibilities. There is a desire to sort out the most appropriate roles for state and local public health departments and to have funding reflect a reasonable division of labor.

The bio-terrorism planning process established a minimum grant size ($15,000) for all counties, but the State encouraged small counties to pool their dollars. Larger jurisdictions are getting additional funding based on population. The SHCSAB is attempting to determine minimum deliverables for all counties no matter how small, which will in all likelihood force the realization that some local jurisdictions will not be able to meet the minimum criteria and that other options will need to be explored. Possibilities include having the State take back some of the responsibilities or encourage multi-county jurisdictions. The State is trying to use public health performance standards to push the discussions.

Bio-terrorism planning has not yet engaged the Turning Point health improvement partnership, except for smallpox preparedness, but there is an intent to incorporate them into the discussions both to help them understand the design of the plan and to enlist them as allies. It is also likely that the statewide organization of local health officials, and the American Public Health Association affiliate in the state, will be included in future bio-terrorism planning.

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