Testimony on
PUBLIC HEALTH GOVERNANCE

Presented to
THE LITTLE HOOVER COMMISSION
November 18, 2002

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Chairman Alpert and members of the Commission, thank you for the opportunity to speak with you about public health leadership and governance in California.

Based upon my experience of over 25 years as President and CEO of the Public Health Institute in Berkeley and its predecessor organizations and close working relationships with the State Department of Health Services and local health departments, I must concur with the statement that public health in California is still in “disarray”, “a term used by the Institute of Medicine in its 1988 report on the Future of Public Health”. This is not surprising, considering that 1948 was the most recent complete review and attempt at a rational reorganization of California’s government public health structure.

Obviously there have been enormous changes in California in the past 50 years. Many new public health campaigns and initiatives have been created in response to new diseases and challenges, and overall spending on health has increased significantly. The state of the public's health in California has improved steadily, as shown by many measures of health status. However the new programs have been piled, one on top of another, on the original 1948 structure, resulting in ever increasing complexity, redundancy and confusion of goals, roles and responsibilities.

The bioterrorism scare, coupled with public awareness of the threat of new emerging infectious diseases such as AIDS, West Nile Virus and Dengue, bring a new opportunity to review the public health system in California. Such a broad review needs to include the context of public health in the 21st century, to consider the roles of both government and non-governmental organizations in the public health system, and to provide a new template for how the many governmental departments and programs will work together in the future in the most effective and efficient way.

While this may seem like a large challenge, there are many good models for programs and structure within California and throughout the nation. The collaborative efforts in smoking and health, the California Cancer Registry program, and recent work in nutrition, genetics and environmental monitoring are success stories that provide examples for future work. There is also a dedicated workforce of public health professionals throughout our government agencies,

universities and non-profit organizations who, in spite of decades of underfunding and neglect, have maintained their idealism and dedication to creating a healthier California.

While I want to focus on the issues of governance and leadership, it is important to do this within the context of a vision for public health and the new roles that are expected for public health agencies in the future. It would be unfortunate to make recommendations for governance and leadership based on public health as it is today or based solely upon bioterrorism or a rather narrow definition of public health.

As part of our background work on this paper we agreed to synthesize for the Commission the models of governance in other states and to conduct several interviews to shed light on how these states are coping with the transition to new "public health". Those reports were distributed to you and I will make reference to them in my presentation.

I would like to provide my comments and observations in four areas: Health in the 21st Century; Restructuring Public Health; The Need for a System of Accountability; and Funding an Expanded Vision of Public Health.

I. Health in the 21st Century

The health of a population depends on the context in which people live, their health behavior and their ability to intervene with disease and disability. At the beginning of the 21st Century Californians live in an environment that has changed significantly in terms of health challenges. There are four areas where this is the case. First, technology and economic development have brought dramatic changes in global travel, global exchange of food and other goods, urbanization of populations throughout the world, extension of modern transportation into previously remote rural areas, large waves of migration of people into the developed world - all of which create opportunities for micro-organisms to spread throughout the world in hours or days, instead of years or decades, as was the case in the 19th century. In the United States we have made great progress against traditional infectious diseases, but this new context makes us extremely vulnerable to new ones.

A second concern for California is the increased recognition of the importance of risk factors as contributors to the burden of disease (smoking, poor nutrition, inadequate physical exercise, alcohol and drug use, sexual behavior and injuries). As much as we have made progress with traditional infectious diseases, we have great challenges ahead in dealing with cancer, heart disease, diabetes and other chronic conditions. Likewise, alcohol and drug use, sexual behavior, injuries and violence are other areas where lifestyle and personal behavior require a role for governmental leadership somewhat different than it has been in the areas of infectious disease.

A third area for consideration in the health of populations is that we now live almost entirely in "manufactured" environments, where exposure to chemicals, toxins and machinery are facts of daily life. The days of the family farm, or idyllic rural living are now past. Yet our public health structure has not created a comprehensive approach for both monitoring the environment for degradation and for monitoring the effects of environmental substances on human health.

A fourth area is improvement of the health care delivery system and accelerating its transition to a “health system” from a sickness system.

We have learned a lot in the last 30 years about how to prevent disease and promote health, especially how to address the risk factors that contribute so much to poor health. Likewise we better understand the strong – often causal connections between the broader determinants of health, e.g. poverty, education, and disease and are beginning to design interventions that encompass a broader healthy communities approach.

What does this mean for the future of the public health system in California? It means that much like the rest of the country, public health in California must transition into a dramatically different role than it has had in the past.

The Institute of Medicine began the call for this transition in 1988 with its Future of Public Health Report, which called on public health to embrace the core functions of assessment, assurance, and policy development. More recent reports and other efforts of the federal government have emphasized that the public health system is more than just governmental public health but includes many other organizations in society (cities, schools, communities, private sector providers, nonprofit organizations, etc.). These and many of the recommendations in the new IOM report “The Future of the Public’s Health” are consistent with our recommendations in this report.

How do we design an effective governance system and re-energize leadership for this complex public health system? First it may be helpful to look into the future and understand what the system may be doing.

1. The traditional role of health departments in infectious disease control, environmental health, laboratory services and health education will be strengthened.

2. State and local health departments will dramatically improve public health data systems to be able to communicate the health of the population in understandable language. States will provide more reports on statewide health trends and local health departments will use the data to develop community report cards, which will point out the wide variations in disease patterns that exist at the community level. This data will be available on the internet.

3. Public health will focus much more on prevention than the delivery of health services and ways will be developed to prevent cuts in these prevention resources.

4. Many public health issues will be addressed through collaboratives designed for the particular issue and involving appropriate players from many sectors. Public health department staff will be better equipped to assist these collaboratives.

5. Some current functions carried out at the county level may be regionalized for economies of scale and because some health issues may be better addressed on a regional level.

6. Collaboration between public health agencies and managed care will increase to address those issues that are better solved on a community rather than individual patient level.

7. The public health system will see dramatic increases in funding to tackle risk factors that contribute to diseases. With a growing understanding of how chronic disease can be prevented there will be campaigns equal to the world-renowned tobacco control program in California. We expect major attention in areas like nutrition, physical exercise, alcohol, drug use, injuries and violence prevention. These campaigns like tobacco will have roles for all of the players in the public health system and will be adequately funded.

8. Social marketing and health education will expand significantly - hopefully as joint programs between the public and private sectors.

9. Tools for early diagnosis of disease will become cheaper and faster making early detection and treatment a reality.

10. The field of genetics will continue to expand increasing the role for public health in establishing standards for screening and treatment and providing guidance on key ethical issues raised by the new science.

11. Communities will become more active and sophisticated in addressing their local health problems through stable funding.

12. The health care system will continue its efforts to improve quality and reduce excessive on inappropriate utilization.

13. Funding for research on effective prevention and health promotion strategies will expand with public support.

14. We will become more knowledgeable about the linkages between the environment and disease, and design new policies and interventions to ameliorate problems.

15. Pharmaceuticals will play an increasing role in prevention strategies.

II. **Restructuring Public Health**

Whether or not this new vision for public health moves quickly, it is imperative that some of the structural, administrative and system barriers that currently exist be removed to recreate the type of leadership role that California needs. My recommendations for creating a new reorganized leadership and effective governance system include:

1. Create Public Health as a Cabinet Level Department
   The importance of public health as a leader in prevention requires access to the Governor and a bully pulpit not buried in a larger bureaucracy. It is worth noting that all three state health departments (Washington, Illinois and Minnesota) profiled in the document submitted earlier to the Little Hoover Commission have public health as cabinet-level positions, and each has been able to establish strong and visible state leadership in public health.

   While there is great debate in the field about whether Medi-Cal should remain within or separated from the department, we must preserve the prevention focus of public health and protect those functions from budget cuts due to shortages in medical care dollars. It was argued in a previous panel that the deficits from the health care delivery system would still affect public health whether or not they are part of a combined agency. However, the decision-making process about how to resolve the deficit would be more open and subject to greater public participation and debate if public health had cabinet representation.

2. Recreate a State Board of Health
   As described in the written report submitted earlier, other state's Boards of Health (BOH) are a mixed blessing. One BOH that has policy authority is largely confined to traditional areas of public health and cannot lead it into the broad sphere of activity outlined in the recent Institute of Medicine report. Another BOH that is advisory does not always have the clout that is needed, and it is most effective only when taken seriously by key parties.

   Perhaps we should not focus so much on whether a Board of Health should have policy-making authority or be advisory, but rather on what the proper scope of a Board of Health should be. I am convinced, however,

that an appropriately structured and staffed Board of Health could be a major asset in California.

To build on the proposal of my esteemed colleague Lester Breslow, I would like to suggest that a Board of Health capable of overseeing a broad range of public health functions cannot have jurisdiction that is limited to the Department of Health Services, but must also be able to assess the public health impact of actions undertaken by the Department of Education, Mental Health, Alcohol and Drugs, the Environmental Protection Agency, the Office of Traffic Safety, the Department of Managed Care, etc. Such a Board of Health would necessarily be advisory because of its broad scope. Several additional considerations could help assure that an advisory Board of Health would be credible and could strengthen public health leadership in California. 1) the composition of the Board of Health must include respected public health professionals from a range of fields that represent the breadth of contemporary public health practice; 2) there must be representation from local public health departments to foster state/local planning; 3) there must be public participation; and, 4) there must be sufficient autonomy to protect the Board of Health from political constraints.

The Board of Health should select its own staff and have resources to carry out its role.

The opportunity a Board would create to have open public debate on critical issues would help to re-energize public health in California.

3. Study the Restructuring of Local Public Health

We feel that the independent county health department decentralized model that exists in California is still the core for the future of a viable public health system. But we should be mindful of the comments of Chris Gates of the National Civic League who said, “most of our challenges are at the community and regional levels where we do not have appropriate governmental structure.” Therefore it is important that we look at how regional and community structures could improve the effectiveness of public health.

It is striking to note that in the three states profiled in the written materials submitted earlier, all were forced to confront the adequacy of local public health capacity in bio-terrorism and emergency preparedness planning. All either implemented, or are considering, regional solutions to limited capacity in some local jurisdictions. More generally, public health functions that have been considered as possibly lending themselves to regional efforts are data, laboratory services, media/health education, communicable disease, and emergency preparedness (bioterrorism). It may be that many of these functions would exist at both the county and

regional level. The best regional groupings and the governance of those regional efforts (joint powers, lead county, etc.) need further study. To date, these options have not been formally explored in California.

Likewise community level interventions are the future frontier of public health. As PHI's Partnership for the Public's Health program funded by The California Endowment has pointed out, well organized and resource supported communities are a major asset to improving the efforts of health improvement. We will be happy to share more with you about the successes of this demonstration effort. Finding a way to institutionalize and fund this experiment is critical.

4. Improve State/Local Planning

When examining state/local planning in the states profiled in the submitted written materials, it is difficult not to notice the contrast. California's attempt to create a statewide Public Health Improvement Plan akin to Washington's 4-5 years ago dissolved before it was completed. Unlike Illinois, we have no certification or accreditation of local public health departments and no statewide capacity assessment or performance standards process. There is no statewide collaboration, similar to Minnesota's, that can support broad public health goals.

It is also evident from the examples cited, that good state/local planning provides a platform from which additional public health improvement activities can be undertaken. While the recent bio-terrorism planning process was a good example of state/local collaboration, it needs to broaden its participation and the scope of its concerns.

The State Department of Health Services and key partners should establish a committee to explore mechanisms for improving this planning relationship and articulating a vision for public health in the future. The release of the Institute of Medicine's report on the Future of the Public's Health in the 21st Century should serve as the framework and guide for state/local planning for public health improvement.

5. Eliminate Administrative Barriers

The increasing importance of partnerships in public health has been recognized by many national organizations, including the Institute of Medicine. Indeed, they are essential for the future of public health. Both the Department of Health Services and local public health departments partner with many nonprofits, associations, community groups, universities, community clinics and other provider groups and both provide funding to these groups.

But there are many impediments to the current contracting process caused by the State budgetary process, contracting rules, and reimbursement policies.

The State should convene these parties to identify ways to eliminate these barriers and strengthen the parties ability to maximize the potential of these essential partnerships.

Similarly, the State pay scales for DHS professionals have been or become a barrier to attracting people of national stature. A salary survey should be done and pay scales increased where geographically and professionally appropriate.

III. **The Need for a System of Accountability**

There is a major movement in society to make our institutions more accountable particularly if they receive public funding. Even if the public health system does not expand exponentially, we need to devise systems for evaluating the effectiveness of what they do. These systems must hold all of the players accountable. So like the report cards measuring the quality of HMO's we should expect that our health departments, schools, cities, as well as other public and private sector partners will have appropriate systems of health accountability.

With the leadership of the Center for Disease Control there is a significant movement in the country to identify performance standards for local health departments. While these are still very general and not very measurable, several states have moved to establish formal systems of accountability including Certification and Accreditation. I would suggest that you look at Illinois (certification) and Michigan (accreditation) to understand how a similar approach in California might strengthen public health.

Michigan's process has recently resulted in the disaccrediting of 4 local health departments. The process likewise was used by the Detroit Health Department to get an additional $5 million dollars to bring itself up to acceptable standards.

No such system exists in California and there has been little interest in establishing one. Because of the subvention mechanism for funding local health departments there is no reporting back to the State on the performance of local public health functions. While this subvention mechanism does facilitate the rapid flow of monies to the counties, it does not encourage collaborative State/local planning nor collaborative efforts between counties.

While there are some State standards that are legislated, we have no way of knowing if and how they are being met.

I would recommend that the State Department of Health Services provide leadership in establishing an accountability system for local health departments in California. Bioterrorism infrastructure monies can be used to study, design, and implement such a system. In addition, a similar set of standards should be developed to measure State DHS performance.

Likewise similar efforts should be undertaken to measure the substantially funded public health programs in the schools, hospitals, nonprofit sectors, and other partners.

IV. **Funding an Expanded Vision of Public Health**

If the public health system is inadequately funded to carry out the traditional public health roles, how can we expect to both support additional resources to strengthen those traditional programs and also sell the need for dramatic increases in funding for the "new public health".

The answer: increased investment in prevention and public health will yield better health at lower cost.

Here are a few arguments which make this case:

1. Changes in reimbursement for health care in the 1980's dramatically shifted incentives to prevent hospitalizations. A result was the reduction of hospital days in California from 1200 to 200 per thousand population. The cost savings to government, employers, and individuals has been substantial.

2. An article by McGinnis, et al, in a recent issue of Health Affairs estimates that 50% of the deaths in the United States are preventable if we could address the risk factors that cause them (see chart on What Really Kills People). Last year there were 232,000 deaths in California.

3. The tobacco control program in California reduced cigarette consumption by 51% during the 1990's. The future impact on reduction in lung cancer and other diseases is enormous as is the cost savings for the medical care system. The annual cost of $150,000,000 from Prop. 99 funding is an estimate of what it will cost to take on some of the other risk factors.

4. The attached chart on preventable hospitalizations (through primary prevention, early primary care, and chronic disease management) in California shows that charges were almost $7 billion dollars in 1998 for these 30 diagnoses. Add emergency room and primary care costs (some of which are preventable). Add other diagnoses that may be preventable (automobile accidents, occupational injuries, etc.) the potential cost savings are impressive.

So, how much are we talking about to build a public health system capable of addressing the current and future challenges?

I would suggest that initially an additional 1 billion dollars annually should be invested in government, private sector, and community partnerships to realize the potential to improve the public's health and reduce unnecessary expenditures. I want to emphasize that this money is not solely for governmental public health but to support the important work of all the partners in the public health system.

1. Traditional Public Health Programs
   Annual budget of $100 million dollars to build and maintain the infectious disease control system including laboratories, communications network, epidemiologists and to sustain environmental health programs and food safety.

2. Assessment Functions
   Annual budget of $100 million to begin integrating medical record systems into state public health data bases, improving current data systems, creating new data systems, and registries (e.g., immunizations, asthma, diabetes, heart disease) and building an epidemiology and surveillance system in California that can provide accessible information to California on their health and a broad array of health issues.

3. Prevention Funds
   $500 million to expand programs to focus on reducing the risk factors that contribute to so much death and morbidity. A major focus should be in reducing chronic diseases through a tobacco level campaign on nutrition and physical fitness. Other risk factors like alcohol and drugs, injuries and violence and environmental and occupational hazards should also be addressed.

4. Health Systems Improvement
   $100 million to focus on improvements in the health care delivery system that will improve quality, reduce unnecessary utilization, and create incentives for prevention.

5. Research and Evaluation
   $200 million to build a California Institutes of Health (CIH) modeled on the peer review National Institutes of Health (NIH) that would augment current research efforts supported by California taxpayers currently in the areas of cancer, AIDS, and tobacco.

V. **Conclusion**

In order to improve governance and public health in California there needs to be a clear vision of the scope of public health. The expanded roles called for by the IOM should be the basis for creating such a vision in California. The challenges for designing a balanced system are daunting but no where is it more possible than in California.

We thank the Little Hoover Commission for creating this first forum on public health infrastructure and encourage you to recommend the use of the Federal bioterrorism/infrastructure funds to further address some of these important issues.

Thank you for the opportunity to testify. We are more than willing to assist you as your deliberations continue.

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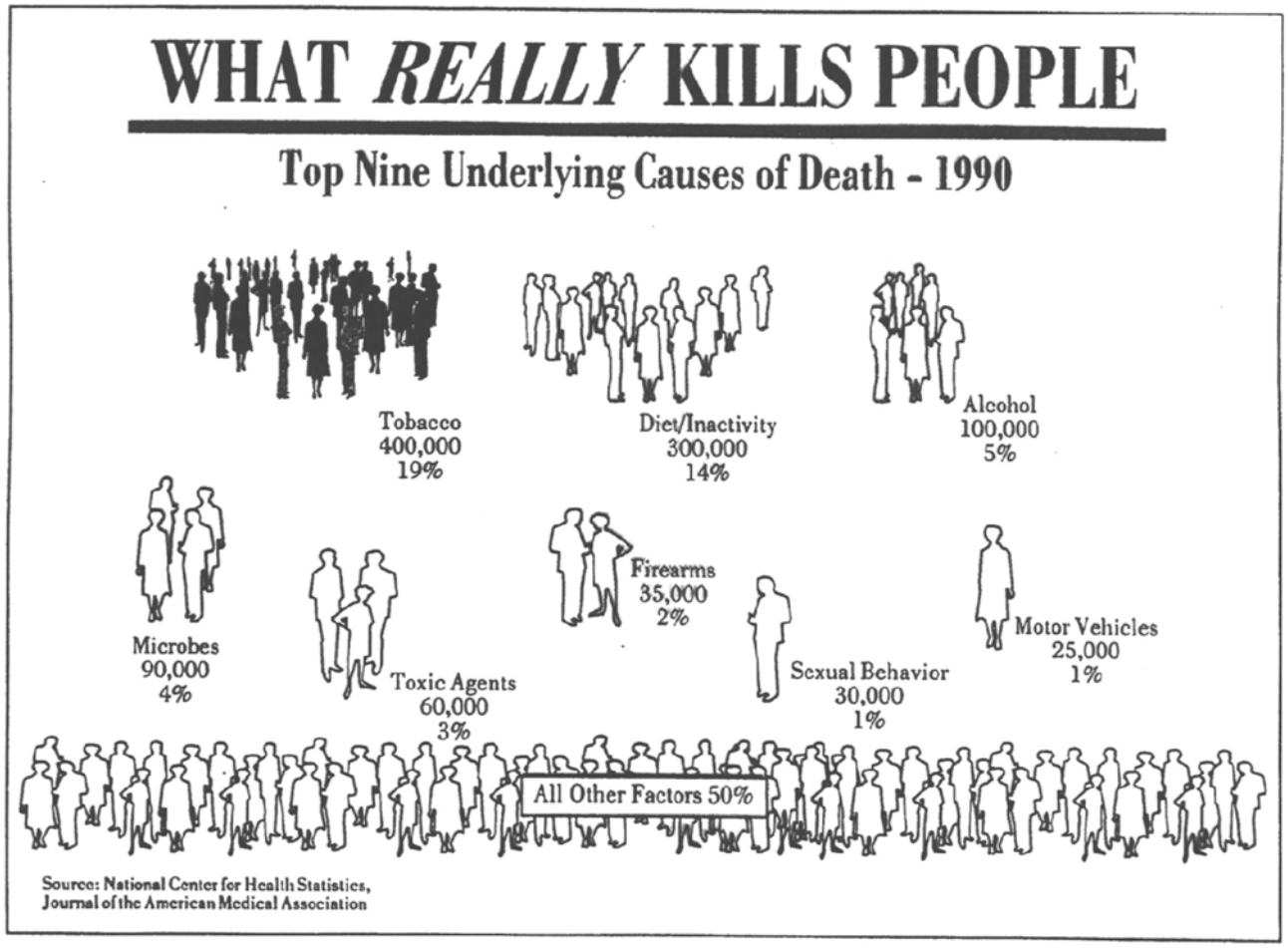
WHAT *REALLY* KILLS PEOPLE
Top Nine Underlying Causes of Death - 1990
Tobacco
400,000
19%
Diet/Inactivity
300,000
14%
Alcohol
100,000
5%
Microbes
90,000
4%
Toxic Agents
60,000
3%
Firearms
35,000
2%
Sexual Behavior
30,000
1%
Motor Vehicles
25,000
1%
All Other Factors 50%
Source: National Center for Health Statistics,
Journal of the American Medical Association

Hospitalizations for Ambulatory Care Sensitive Conditions
1991, 1996 and 1998

Observed admissions: Hospital charges, not adjudicated claims
Total California for 1998, all ages

CASE TYPE	DISCHARGES			TOTAL CHARGES		
	1991	1996	1998	1991	1996	1998
ALL ACS CONDITIONS	**461,158**	**474,190**	**460,772**	**4,582,047,920**	**5,839,322,065**	**6,910,114,203**
ACS PREVENTABLE	**2,226**	**2,341**	**2,938**	**27,719,341**	**39,897,345**	**53,240,006**
Failure to Thrive	n/a	n/a	268	n/a	n/a	3,885,069
Immunization/Prevent Conds	686	735	700	11,700,735	18,021,099	19,737,954
Iron Deficiency Anemia	1,193	1,238	1,632	8,724,238	10,672,934	17,696,772
Nutritional Deficiencies	347	368	314	7,294,368	11,203,312	11,602,014
Congential Syphilis			24			318,197
RAPID ONSET CONDITIONS	**216,652**	**245,885**	**248,569**	**2,097,517,885**	**2,847,672,798**	**3,476,243,241**
Bacterial Pneumonia	78,319	87,779	95,703	982,221,779	1,261,045,231	1,765,559,894
Cellulitis	26,885	30,173	31,516	228,615,173	290,866,867	361,859,727
Convulsions	10,192	13,165	13,635	71,053,165	119,017,576	157,536,847
Dehydration-Volume Depletion	24,125	31,157	30,656	191,709,157	245,925,635	286,225,472
Diabetes A	9,197	25,633		104,406,633	421,877,552	
Diabetes w/Ketoacido	n/a	n/a	10,857	n/a	n/a	154,563,824
Gastroentertis	14,411	10,300	11,247	70,916,300	55,862,120	74,697,717
Hypoglycemia	2,820	452	8,526	21,594,452	4,026,798	135,884,533
Kidney/Urinary Infection	34,365	36,872	38,134	317,794,872	361,964,645	457,556,131
Pelvic Inflammatory Disease	8,276	5,708	3,988	74,055,708	60,887,287	52,825,792
Severe ENT Infection	8,062	4,646	4,307	35,150,646	26,199,087	29,533,304
CHRONIC CONDITIONS	**242,280**	**225,964**	**209,265**	**2,456,810,694**	**2,951,751,922**	**3,380,630,956**
Angina	48,533	24,527	16,290	286,067,527	245,265,916	149,997,135
Asthma	43,814	37,852	36,178	342,347,852	318,697,254	390,904,131
Chronic Obstructive Pulmonary Disease	37,910	47,785	44,808	460,183,785	707,392,951	825,421,370
Congestive Heart Failure	74,426	71,631	86,685	948,578,631	1,043,123,475	1,559,094,876
Dental Conditions	2,185	1,595	1,759	16,147,595	16,711,782	23,812,491
Diabetes B	14,207	7,676		122,182,676	87,907,542	
Diabetes C	768	5,383		4,229,383	41,260,200	
Diabetes with Complications	n/a	n/a	806	n/a	n/a	7,024,379
Diabetes w/o Complications	n/a	n/a	5,318	n/a	n/a	43,614,151
Grand Mal & Epileptic Convulsions	8,707	5,620	4,977	93,671,620	74,837,983	85,015,329
Hypertension	5,204	16,074	5,480	32,292,074	192,829,435	52,258,298
Other Tuberculosis	756	433	459	21,821,433	20,742,524	26,434,834
Pulmonary Tuberculosis	1,684	1,859	1,442	35,912,589	54,677,897	56,689,427
Skin Grafts with Celluitis	4,086	5,529	5,063	93,375,529	148,304,963	160,364,535

Source: California Works Foundation, from an AdvanceMed analysis

cp\phi\Ambulatory Care Conditions 12.7.01