Note: Dr. Lee and Dr. Breslow have submitted joint testimony. Dr. Breslow submitted written comments to the Commission in June, which also are attached.

TESTIMONY TO LITTLE HOOVER COMMISSION, October 24, 2002

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I. Introduction

In connection with its work and the January 2002 report on Preparedness for Terrorism and other Health Disasters, the Little Hoover Commission is to be commended for identifying and bringing to public attention the severe, decades-long deterioration of California's public health system and the consequences for combating terrorism as well as for confronting everyday threats to the public's health.

Despite the serious problems facing California in meeting its obligations to protect and promote the health of the public, the state has many strengths within its public health system reflecting a long history of leadership in public health. We will leave it to others to provide an overview of the current public health system, the services it provides, the legal structure and financing, as well as the system's capacity in such areas as trauma care. No doubt in part because we have expressed ourselves previously on the topic, we

have been asked to address the governance issue, particularly the potential role of a State Board of Health.

II. Nature of Public Health

The nature of public health is changing as the population grows, ages, becomes more diverse, and is confronted by the challenges of an increasingly complex environment. The scientific basis of public health has been strengthened in recent years, and there is far better understanding than formerly of the determinants of health (e.g., human biology, behavior, socioeconomic status, occupation, education, environment, and health care). The resources needed to protect and promote the public's health, however, have increasingly been re-allocated to providing acute medical care services rather than meeting the broader public health needs. Public health programs often get out-classed compared with medical services in popular health concern because:

1) Medical care of individuals is usually far more dramatic than care for populations.

2) Public health fulfills its functions mainly through "things that don't happen" (e.g., fluoridation to prevent dental caries, prevention of food or water borne disease outbreaks, immunization to prevent communicable diseases).

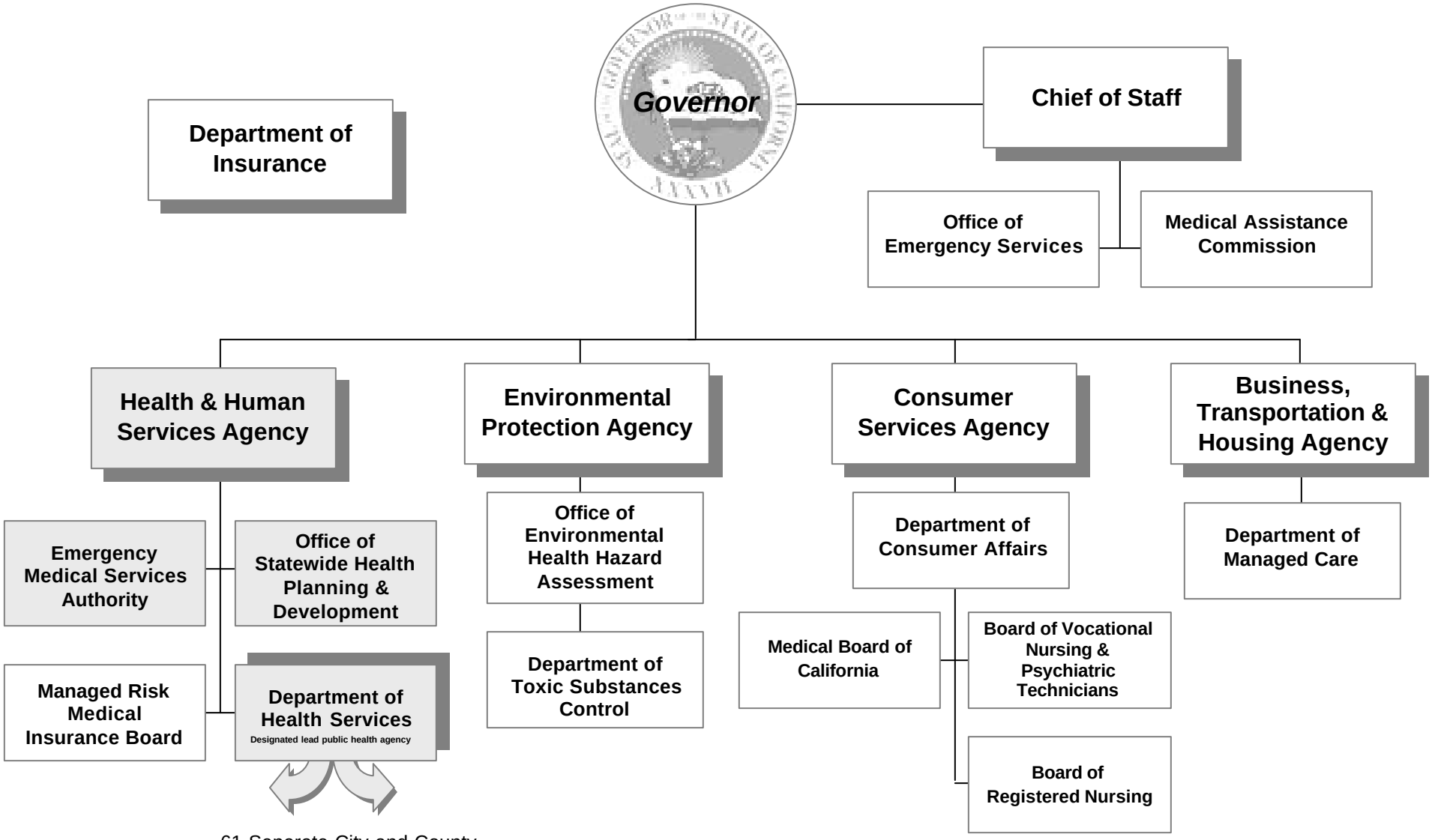
In the past, public health was considered the function exclusively of a government agency; but since the report to the Institute of Medicine in 1988, The Future of Public Health, there has been increasing recognition of the role of the whole community. Public health consists of all the ways in which communities organize to protect and advance their health. Organization through governmental action (health departments) is the

principal form; but in the United States, there is extensive collaboration with other agencies (e.g., non-government, non-profit, community-based organizations, universities, private businesses).

The focus of public health agencies at the local, state, national, and international levels, is often through categorical disease control programs (e.g., HIV/AIDS, diabetes), preventive services (e.g., immunization), and regulation (e.g., tobacco control). The fragmentation of programs at the federal level is unfortunately duplicated at the state and local levels, making a comprehensive approach to the whole population more difficult. This is illustrated by the attached chart which shows functions clearly related to the public's health scattered through eleven departments in four agencies. Somewhere there should be one unit concerned at least with the quality of what State government does to protect and advance the public's health. We believe that this should be in the Department of Health Services.

State Public Health Entities

(A Few Primary, Many Secondary Players)



Unshaded departments listed have important, but not primary public health roles.

At any one time, public health reflects knowledge of health problems, how to deal with them, and the determination to address them; e.g., during the first half of the last century public health practitioners responded to the situation at the that time. Communicable disease control then constituted the overwhelming health problem and means to combat such diseases effectively were being rapidly applied as they were accumulated. During the second half of the century, new problems (e.g., chronic diseases) have become prominent, the scientific base of public health has expanded, and public health practice has accordingly enlarged its scope. This expanded scope is evident in such programs as tobacco control that have developed in the last 40 years. As science advanced, the evidence related to nicotine addiction and the damage caused by secondhand smoke became known. This knowledge led to citizen and scientist-led initiatives at the local level (e.g., San Francisco), widespread ordinances that prohibited smoking in public places, increased taxes on cigarettes, education programs aimed at children and adolescents, as well as the State effort which Proposition 99 launched. Screening programs (e.g., Pap smears) to detect cancer and the growing number of vaccines to prevent a wide array of infectious diseases demonstrated how effective public health programs could be if provided adequate resources. The scope of public health has been the subject of a number of reviews by professional bodies since the 1988 IOM Report, most recently, the development of a list of essential public health functions by a Task Force convened by the Assistant Secretary for Health, U.S. Department of Health and Human Services in the mid-1990s. While this effort spelled out in more detail the essential public health functions, it was within the context of the three basic functions: assessment, policy, and assurance proposed in the 1988 Institute of Medicine National Academy of Sciences report The Future of Public Health.

III. Key Health Role of the State

In the United States, the states rather than the federal government have the primary responsibility in public health. American federalism grants the national government specific, limited powers while the states retain "the powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people" (10th Amendment to the Constitution).

The Congress is granted certain powers-- the power to tax, the power to spend, and to regulate interstate commerce. These powers have provided Congress with the authority to greatly expand the role of the federal government in public health in the past 70 years; but that expansion has not limited the basic power of the states. Gostin has noted: "Two specific powers-- the police power (protecting health, safety, and morals of the community) and the parens patrias power (protecting the interest of minors and incompetent persons)-- express the state's sovereignty to safeguard the community's welfare" (Gostin, L. Public Health, Power Duty Restraint. UCPress, Berkely CA 2000). There are many areas of public health where the federal government acts concurrently with the states and local governments, often providing funds for the states and local governments to implement federal policies (e.g., immunizations, community health centers, heart disease control). There are, however, a number of areas where the federal government has pre-empted state public health regulation, even if the state is acting within its police powers. Among the most important of these have been in food, drug, medical devices, and cosmetic health and safety regulations by the FDA; and food (meat and poultry) safety regulation by the Department of Agriculture. There are many other areas of federal regulation, including air pollution (EPA), auto

and highway safety (Department of Transportation), occupational health and safety (Department of Labor), and consumer products (Consumer Product Safety Commission).

By far the largest allocation of federal funds for health has been in the area of medical care, including Medicare (a federal program that replaced a federal-state program of medical care for the aged); Medicaid (a federal-state program); medical care, for Veterans, the armed forces, and military dependents; Indian Health Service; and federal employee health insurance.

As in other states, California public health has depended mainly on government as its principal bulwark. During the 1940s, 1950s and 1960s, there was a substantial augmentation of State resources for public health, including funding for hospitals (shared with the Federal government), laboratories, personnel, and service programs. The State Department of Public Health was then considered one of the best in the nation, and it had a strong State Board of Health having authority to adopt regulations and otherwise guide the Department.

As has occurred generally across the country, the State has passed considerable responsibility for public health to the 61 units of local government, in particular to the county (and three city) governments. During the 1950s, the State Department of Public Health developed a unique relationship with these local governmental health authorities whereby the state allocates funds to them provided that they maintain a standard of service upon which the State and the California Conference of Local Health Officers (CCLHO) agree. Unfortunately, because State funding for public health has declined so greatly relative to the population growth and the needs of the population, the State's support for local public health has declined as well. During the 1970s, 1980s and 1990s, there has been considerable deterioration in the public health infrastructure; programs (e.g., pollution control) were fragmented; an increasing share of public dollars for health

were allocated to the medical programs; the State Board of Health was abolished and its functions absorbed into politicized machinery of State government. The State Department of Health was seriously weakened, especially by deprofessionalization which began in 1968. Recently retiring professional staff have still been largely replaced by generic "managers," and essentially all health policy decisions kept in the Governor's office. California's public health infrastructure at both the state and local levels fits the 1988 Institute of Medicine's report, which described public health as in "disarray." This leaves Californians very vulnerable to the threat of bioterrorism when the state and local government resources are weakened in responding. In addition to strengthening the public health infrastructure at both State and local levels, their interrelationship should be enhanced. One way to accomplish this would be to deputize local health officers from the State. That would invigorate the possibility of enforcing the current requirements of local health officer qualifications, now neglected to a considerable extent. Also, regionalization of public health authority among some rural counties could be helpful.

Adding to this dismal picture, Federal funding for general and basic public health work has likewise decreased considerably as emphasis has shifted to literally hundreds of federal categorical grant in aid programs with extensive federal requirements, in effect "jerking around" State and local public health efforts. (Recently in the face of the terrorism threat, the Federal government has allocated some funds to help rebuild California’s woefully inadequate laboratory resources for public health).

Meanwhile, local governments in California have been strapped for funds and their local public health expenditures are increasingly limited because relatively more and more funding is

devoted to acute medical care in clinics, emergency rooms, and hospitals as the number of uninsured continues to rise (Los Angeles County is an example).

Thus, California's public health system has suffered severely enough to seriously endanger the health of the people, even to the point that a measles or flu epidemic could kill many children or perhaps thousands of elderly people because of limited immunization programs and response capacities.

IV. Historical Strength of Public Health in California (on which to build)

California established the nation's second State Board and Department of Health in 1871, following only Massachusetts in providing a statewide mechanism to protect the public's health. Over the years California has been a leader in many areas of public health. In the 1930's California was a leader in combating syphilis and gonorrhea. Later, public health advances in the state included policies and action on air pollution control, tobacco control, cancer registry, and migrant health which set models for the nation. California's leadership was also reflected in the 1951 classic textbook of public health (Maxcy, Preventive Medicine and Hygiene) that depicted the California State Department of Public Health as a model for state public health programs.

In addition, during the 1940s, 1950s, and 1960s, the three directors of the Department were elected to the presidency of the American Public Health Association. One lesson from this past is the importance of continuity of leadership, with the selection of the State Health Officer and other key personnel made on the basis of competence in the field and non-partisanship. The State Department of Health-- California Conference of Local Health Officers has also been a model for

other states in establishing policies to support quality local public health quality services with funding.

One final and highly significant element that provided stability and enhanced leadership in public health was the State Board of Health. We will focus on a recommendation concerning this aspect of governance.

V. Recommendations

1. For governance, reestablish the State Board of Health to provide a non-partisan body to promote and protect the health of all Californians.

a. Functions

1. Guide the State Department of Health

2. Advise the Governor and the Legislature on public health matters

3. Issue an annual report on the health status of the people of California and identify priority health issues.

4. Adopt regulations, with force of law, regarding public health.

5. Review and approve the budget for the Department of Health (or Health Services)

6. Provide a linkage to the private sector, including the achievement of the goals and objectives of the decennial federal document, Healthy People, now for 2010.

b. Membership specified to assure non-partisan and competency character of the Board.

The Board should consist of 7-9 members. The members should be appointed by the Governor, with staggered terms of four years, the initial members to be appointed for two, three, and four years. The chairman should be elected by the Board members. The members should be chosen from individual nominations by medical, public health, nursing, and other health professional organizations and institutions. They should not, however, represent these organizations but rather serve State interests as a whole. There should be at least four members selected from the health professions and three from the lay public. The organizations that should be asked to nominate candidates should include the schools of public health, the California Nurses Association, the Public Health Association, the California Medical Associations, the medical schools, nursing schools, and large multi-specialty group practices. The Director of the Department of Health Services should serve ex officio. The lay members should be nominated by the Secretary of the Health and Human Services Agency.

The Board should consider the steps necessary to reinvigorate public health professionalism, particularly in State Department of Health Services, by encouraging employment of personnel who are professionally highly qualified for positions. We believe that staffing should be augmented especially in epidemiology, information systems and communication, and health promotion.

The Board should review the state's health needs in relation to the budget, set priorities, and take steps to strengthen the public health infrastructure, including local health departments and the relationship of the State Department of Health Services to CCLHO. The Board should examine training needs and make recommendations for training an adequate public health work force for the State. We believe that the schools of public health should give greater emphasis to training of public health professionals for the State. This should include expanded public health training for health professionals and the training of volunteers and first responders (e.g. responding to bioterrorism).

California can and should regain its position in the forefront of public health, to be exemplified by leadership in meeting its residents' current health problems. To do so one key step is to reestablish the State Board of Health. We recommend that the Little Hoover Commission endorse that action.