Public Health Study Commission

Testimony of Russ Toal, MPH

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Thank you, Chairman Williams and all the members of the Commission for inviting me here today and for your service to the state on this important question of what is best for Public Health. I am appearing before you today wearing multiple hats: as a former Medicaid agency director, as a former DCH Commissioner, as Immediate Past President of the Georgia Public Health Association who served as the lead person from GPHA on the health reorganization bill, as Clinical Associate Professor at the Jiann Ping Hsu College of Public Health of Georgia Southern University, and as chair of the McIntosh County Board of Health. I have been fortunate to have many different opportunities to develop a perspective on Public Health in Georgia.

Before I address the specific charge of the Commission, permit me to thank DCH for the very good job it did in responding to the HB 228, the health and human services reorganization bill that passed in the 2009 session. The Department was given little time and little cooperation in transferring the Division of Public Health, and I think all agree that it was as smooth a transition as was possible. My thanks to the Commissioner and his staff.

I would like to begin my remarks on organizational placement by answering a question that is frequently put to me, namely: why wasn't Public Health made part of DCH when the department was created in 1999? There were several reasons this was not done.

1. The new agency was to be focused on the purchase and regulation of health care, and to do that in the best and cleanest manner possible there was a consensus that DCH should have no provider component. For that reason, only selected parts of Public Health (Rural Health and Minority Health) were made a part of DCH.

2. There was a concern that the general approach to doing business by DCH and Public Health were by necessity quite different. As a payer and regulator and health plan administrator, DCH had to do its business in a top-down, centralized manner. Nearly all the DCH staff was in Atlanta focused on the business to be done in the state office. Public Health was and is the opposite. The action in Public Health occurs at the local level, which is where crucial decision-making on community and population health matters belong. Public Health authority needs to be as close to the ground as possible. This orientation was deemed to be incompatible with the way DCH was going to be structured.

3. Finally, there were a couple of practical considerations:

    a. On the positive side, there was no reason to believe that the DCH administration was going to have any trouble or difficulty working with the Public Health administration, and I am pleased to report that proved to be true. I had a very good working relationship with Dr. Toomey and all of Public Health.

    b. On the concern side, we were creating something very new with an already fairly lengthy piece of legislation, and we were trying to streamline the functions of DCH, not create a mega-agency. Keeping the number of DCH employees as small as possible was an important goal.

This structure worked well and it facilitated DCH getting its legs firmly set. As noted, it also worked because of the personalities involved and the shared goals around Public Health. One of those expressed goals was to maximize Medicaid funding for Public Health, so that also dictated a strong and collaborative working relationship. In time that changed, and when it changed, the dangers and weaknesses of having Public Health as a division in a large umbrella agency became all too apparent.

The dysfunction of the structure was noted and highlighted in two legislative studies, and in 2008 Governor Perdue created a task force to study the possible reorganization of health and human services in Georgia. He charged the group, with the assistance of his Office of Planning and Budget, to make a recommendation for change in the existing organization before the 2009 session of the General Assembly.

I am pleased to say that from GPHA's perspective, the task force was deliberative, the OPB staff did a very good job of researching and analyzing the issues, and the Governor made a bold and correct decision to have HB 228 introduced by his floor leaders. I hope that the Commission will hear from the OPB staff who prepared the final task force report. Their perspective would be valuable to you.

GPHA worked diligently with the Governor's representatives and the legislative leadership on the reorganization bill. We supported the Governor's initiative, and in cooperation with his staff, presented several amendments that were designed to strengthen the bill for Public Health. Nearly all of our suggestions were adopted, including the language creating this Commission, and we were pleased with the final version of the bill.

Having said that, there were two key provisions we asked for that were not adopted: first, we had asked for a separate Board of Health to be composed of individuals with Public Health or medical expertise; and second, we wanted language in the bill that would make it clear that the State Health Officer and the DCH Commissioner could not be the same person. Having been a DCH Commissioner, I can attest to the fact that it is more than a full time job. It is not possible to serve as both Commissioner and the State Health Officer for Public Health. The jobs are too big and too demanding.

Would GPHA have liked a separate Department of Health or Public Health? In a word, "Yes". The GPHA had gone on record before the task force asking for a separate agency dedicated to Public Health. - Did the GPHA think it <u>essential</u> to reorganization? In a word, "No". There was (and continues to be) universal agreement in the association that getting Public Health out of DHR was THE most important goal. There was consensus that Public Health had suffered enough and

had to be moved to be salvaged. To many of us, placing Public Health with the agency that managed Medicaid and the State Health Benefit Plan made sense:

1. It would maximize the ability of DCH to utilize Medicaid funds, both programmatic and administrative, to support Public Health, and that having access to federal funds was going to become even more critical in the event of health reform; and

2. It would create an opportunity for Public Health principles and practices to be adopted in the Medicaid and PeachCare programs as well as in the State Health Benefit Plan. As major payers, these programs were uniquely positioned to address some of Georgia's most profound health problems, including diabetes, hypertension and stroke, obesity and smoking.

Have these two key opportunities been realized? No, not yet. Could they? Yes, and frankly the realization shouldn't be wholly dependent on structure. They should happen irrespective of structure because they are the right thing to do financially, economically and health-wise. The principles of Public Health should be practiced across health programs, and not be confined to the walls of whatever structure Public Health is organizationally placed.

So how best to realize the opportunities? GPHA believes that before any discussion of structure or organizational placement occurs in earnest it is most important to embrace the three principles that have guided our position. These principles are straightforward: Public Health needs autonomy, access and authority.

Autonomy to get the best information and expertise available and having the freedom to act on them in times of emergency or impending crisis. Having to get permission to talk to scientific or programmatic experts is dysfunctional; having to get permission to talk to other Public Health staff is insanity, yet it has been a problem. When communication from the state epidemiologist has to be signed off by 17 individuals before it can be sent to the field, something is, as we say in South Georgia, bad wrong. Autonomy in Public Health is equally important at the local level. Public Health at its core is local, and it must have the ability to timely respond to local concerns and crises.

Access follows autonomy. Public Health needs to be positioned so that it can access scientists, federal officials, legislators and the Governor. It needs to be able to directly meet with and talk to legislators and other elected officials without restraint by those who do not understand the need for Public Health action or responsiveness. [I would note that Dr. Shelp, in his testimony this morning, highlighted the importance of identity and visibility, and Public Health has not had either.]

And Public Health needs statutory, regulatory and administrative authority to take action to prevent or respond to a Public Health crisis whether man-made or natural. Whether food-borne, viral, terrorist or hurricane driven, Public Health needs both the autonomy and the authority to act immediately. We do not have the ability to act in such a manner now. Legislation to correct this problem is needed in the next session.

Does this mean that Public Health must be a separate agency? No, not necessarily. As an attached agency, Public Health could still take advantage of the administrative efficiencies of being associated with or part of DCH, and the opportunities to direct Medicaid monies to Public Health would still exist. As an attached agency Public Health would not need to hire new administrative staff, nor duplicate the capabilities of DCH. Public Health would be well positioned to provide population health expertise to the Department on the Medicaid, PeachCare and SHBP programs, but as an attached agency, the problems of autonomy, access and authority could be addressed through a modicum of changes to the reorganization bill. Clarifying the role and autonomy of the State Health Officer and Public Health and creating an independent Public Health Board would be easy to do, and certainly less costly than creating an independent agency.

I would like to close my remarks with three brief but critical points.

1. One structure that does not need to be changed is the successful operation of the districts and local boards of health. They have proved their utility and value repeatedly and do not need revision. I hope your report will note this important observation.

2. Your charge is to figure out how best to serve the interests of the state. The structure that serves the state best is that which reinforces local Public

Health autonomy and action. Public Health does not need a large state office or more centralization.

3. Georgia now has eight (8) degree-granting Public Health training programs. We can help, and I hope that both DCH and Public Health will take advantage of the skills and expertise that reside in the programs. Both our faculty and students are committed to public service, and we would welcome the opportunity to assist the state in whatever way we can.

Thank you again for your service and deliberations. I wish you well, and am happy to answer any questions you may have.