

Georgia Public Health Commission

*Report to the Governor, the Speaker,
and the Lieutenant Governor: O.C.G.A. 31-2-10*

December 1, 2010

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Executive Summary

The Public Health Commission fulfilled its statutory responsibilities to make a recommendation on the appropriate structure for public health management in Georgia, choosing from among four available options, by hearing expert testimony during five hearings, reviewing public comment received in person and online, and studying each of the options carefully through subsidiary working groups.

Since 2000, the population of Georgia has increased by 20%, healthcare spending (including state spending) has increased by approximately 100% and the public health budget has declined by 20%.¹ The effective practice of public health is a critical tool in our state's ability to improve and enhance the lives of Georgians, including our state's ability to produce and sustain a viable workforce.

The Commission reviewed data and testimony about the state of Georgians' health, including that the median life expectancy in Georgia is 73.9 years, well below the national average of 76.5 years. Thirty Georgia counties have a life expectancy lower than 73 years, which is lower than the life expectancy for those in Thailand, the Gaza Strip, El Salvador, and the Dominican Republic.² For the past four decades, Georgia has consistently ranked in the bottom third of state-by-state rankings of overall health,³ using mortality measures like premature death, infant mortality, cancer and cardiovascular mortality.⁴

Given this and other health results in our state, the unanimous recommendation of the Commission is that the Division of Public Health become an independent, cabinet-level state agency – the Georgia Department of Public Health, with a Commissioner directly reporting to the Governor and acting, by statute, as the state's chief health officer. The Commission believes that this is the single best option to improve the health of Georgia's citizens and to move Georgia from among the lowest-ranking states in the nation regarding health to among the best in the nation. The commission believes that an independent Department of Public Health can be created with existing human and financial resources, but in order to effect improvements in health outcomes, additional investments in public health will need to be made in the years to come. An independent Department of Public Health also fosters our state's ability to attract exceptional, cabinet-level leadership for Georgia's public health function.

Based on the testimony and recommendation of OHI staff leadership⁵, the Commission also unanimously recommends that the Office of Health Improvement (OHI), currently housed within the Department of Community Health, become part of the new Georgia Department of Public Health. The Office of Health Improvement is comprised of three

¹ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

² Community Health Status Indicators Report, 2010.

³ Public Health News Bureau, August 2010.

⁴ America's Health Rankings, 2009.

⁵ Testimony of James Peoples, Executive Director of the Office of Health Improvement, October 18, 2010.

units: the Office of Minority Health, the Commission on Men’s Health, and the Office of Women’s Health. The Commission recommends that all three units comprising OHI move to a new Georgia Department of Public Health.

The Commission further recommends that the Office of Emergency Preparedness, which is currently housed in the Georgia Department of Community Health, be fully integrated with public health and be moved to a new Georgia Department of Public Health, as recommended by Dr. Patrick O’Neal, Director of the Office of Emergency Preparedness.⁶ The Commission recommends that the Georgia Trauma Care Network Commission, currently an attached agency to the Georgia Department of Community Health, be moved to a new Department of Public Health, but continue as an attached agency to the new Department of Public Health.

The Commission believes that the right organizational structure for public health is one of the key pieces to having successful and improved public health outcomes in Georgia. The right structure, when combined with appropriate allocation of resources and the recruitment of exceptional leadership, will produce improved public health outcomes for Georgians. The Commission believes that the State Health Director should be a physician (as is currently required by statute) reporting directly to the Governor and possessing extensive public health knowledge, along with the ability to work effectively with elected and appointed officials and leading the public health system staff throughout the state.⁷

The Commission recommends that a Public Health Study Commission be appointed at least every three years to study the effectiveness of public health in Georgia, and that this Commission be charged with providing the Governor and the Georgia General Assembly with progress reports on the health of Georgians.

Background on Commission

The Public Health Commission was created July 1, 2010, pursuant to O.C.G.A. 31-2-20. Its purpose is to determine whether the interests of the state of Georgia are best served with the Division of Public Health being a part of the Department of Community Health, an attached agency, an independent agency, or as part of another organizational structure to be determined by the Commission.

The legislation, O.C.G.A. 31-2-20, gave the following charge to the Commission:
(a) Effective July 1, 2010, there is created a Public Health Commission to be composed of nine members as follows: two members shall be appointed by the Speaker of the House of Representatives, two members shall be appointed by the Lieutenant Governor, and five members shall be appointed by the Governor. The purpose of the commission shall be to examine whether the interests of this state are best served with the Division of Public Health being a part of the Department of Community Health, an attached agency pursuant to Code Section 50-4-3, an independent agency, or as part of another organizational structure to be determined by the commission. The commission shall have

⁶ Testimony of Patrick O’Neal, M.D., Director, Office of Emergency Preparedness, July 12, 2010.

⁷ Motion of the Commission, unanimously approved at its November 15, 2010, meeting.

the authority to contract with third parties subject to appropriations by the General Assembly. The commission shall make its recommendations to the Governor, the Speaker of the House of Representatives, and the Lieutenant Governor by December 1, 2010. The commission shall stand abolished on December 31, 2010.

(b) This Code section shall stand repealed on December 31, 2010.

Commission Members

Jimmy Burnsed, Richmond Hill, GA

Burnsed is the Chairman and Chief Executive Officer of Bryan Bank & Trust. He is the Chairman of both the Bryan County Board of Commissioners and the Bryan County Board of Health and is a member of the Richmond Hill Rotary Club and the Richmond Hill Lions Club. He also serves on the Coastal Regional Commission Council. Burnsed attended Armstrong State College. He and his wife, Becky, have four children, eight grandchildren, and seven great-grandchildren.

Lynne Feldman, M.D., Valdosta, GA

Feldman is the District Health Director for District 8-1. She is also the Medical Director for Partnership Health Center and serves as Chair of the Quality and Safety Committee for the South Georgia Medical Center Hospital Authority. She is board certified in both Pediatrics and Preventive Medicine. She is a member of the Lowndes/Valdosta Hospital Authority and is a member and past President of the Georgia Public Health Association. She is an active member of the Georgia Chapter of the American Academy of Pediatrics and is Chair of the Public Health Committee. She has received both the Jules S. Terry Memorial Award for Leadership in Public Health (2001) and the GlaxoSmithKline Child Health Recognition Award (2001). Feldman earned a bachelor's degree from Valdosta State University, a medical degree from the Medical College of Georgia, and a master's degree from Emory University. She has two children.

John T. "Ted" Holloway, M.D., Hoboken, GA

Holloway retired as District Health Director for the Georgia Department of Human Resources, Division of Public Health, and Southeast Health Unit. He serves on the Board of Directors of the Healthcare Georgia Foundation, Advisory Council for Public Health and is a member of the Medical Association of Georgia and the Georgia Public Health Association. Holloway earned a bachelor's degree from Wofford College and a medical degree from the Medical University of South Carolina. He and his wife, Linda, have one child and two grandchildren.

Diane Z. Weems, M.D., Savannah, GA

Weems is the Chief Medical Officer for the Chatham County Health Department and Coastal Health District. She also serves as the Medical Director for the

Chatham County Health Department Laboratory and is an adjunct faculty member of the Jiann-Ping Hsu College of Public Health at Georgia Southern University. Her professional associations include the American and the Georgia Public Health Associations, Georgia Medical Society, and the American Academy of Pediatrics. She is Chair of the Chatham County Safety Net Planning Council, Inc., and is on the Board of Directors for Step Up Savannah and the Savannah Country Day School. Weems earned a bachelor's degree and a medical degree from the University of Florida. She and her husband, David, have two children.

Phillip L. Williams, Ph.D., Watkinsville, GA

Williams is the founding Dean of the College of Public Health at the University of Georgia and he also holds the Georgia Power Professorship of Environmental Health Science in the College's Department of Environmental Health Science. He has authored over 100 publications including 2 textbooks on toxicology. Prior to his tenure at UGA, which began in 1993, Dr. Williams was the vice president of the Environmental Health Safety Division of A. T. Kearney from 1988 to 1993, a Senior Research Scientist with the Georgia Tech Research Institute from 1978 to 1988, and an Industrial Hygienist with the USDOL/OSHA from 1975 to 1978. Williams earned a bachelor's degree from Georgia State University and a doctoral degree from the Georgia Institute of Technology. He and his wife, Theda, have two children and two grandchildren.

Gregory J. Dent, Macon, GA

Dent is President and Chief Executive Officer of Community Health Works (CHW), a non-profit health care company. CHW began as a seven county collaborative whose vision of "better health for all residents through communities working together", supported by Mr. Dent's leadership, has enabled it to become a regional center for health innovation. Dent is a graduate of Georgia College and State University where he received a Bachelor of Business Administration with an emphasis in Accounting. Greg and his wife, Alecia, have one child and reside in Macon, Georgia.

Deborah Bailey, R.N., B.S., B.S.N., M.S.N., Gainesville, GA

Deborah Bailey is currently the Director of Governmental Affairs for the Northeast Georgia Medical Center, Inc. She has been responsible for coordinating, planning, and implementing the legislative agenda for the medical center at the state level for the past 14 years. Prior to her current position, she was the Vice-President for Nursing at Northeast Georgia Medical Center, where she was responsible for coordinating the nursing efforts of over 800 employees, as well as a 40 million dollar a year budget. Other job titles at her current facility include: Director of Nursing Finance and Information systems, Special Projects Coordinator, and Instructor of Educational Services. Before working at the medical center, Deborah was an Associate Professor of Nursing at Brenau University.

Jack M. Chapman, Jr., M.D., Gainesville, GA

Jack M. Chapman, Jr., M.D., practices ophthalmology in Gainesville, Georgia. He is a chemistry graduate of the University of Georgia. He holds the Doctor of Optometry degree from Southern College of Optometry in Memphis, Tennessee, and the M.D. degree from the Medical College of Georgia. Dr. Chapman exemplifies leadership and service on both state and local levels. He is an alumnus of Leadership Hall County. He is also a past President of the Hall County Medical Society and past President of the Medical Association of Georgia. He also serves on the Board of Directors of the Georgia Medical Care Foundation. In addition, he serves on the Board of Directors for the Georgia Chamber of Commerce and is on the Healthcare Policy Committee.

James G. "Jim" Peak, Bainbridge, GA

Jim Peak is the Chief Executive Officer of Memorial Hospital & Manor in Bainbridge, Georgia. He served as a Trustee and Chairman of the Board for the Georgia Hospital Association and as the immediate past Chair of GHA's Center for Rural Hospitals. Peak previously served as a long-time member of the Health Strategies Council for the State of Georgia. He currently serves as Chairman of the Georgia Alliance of Community Hospitals, a member of the Rotary Club and the Decatur County School Board Foundation. Peak earned a bachelor's degree from the University of Kentucky and a master's degree from Georgia Southern University. He and his wife, Bettie, have two sons.

Definition of Public Health

What is public health? The Institute of Medicine (IOM) of the National Academy of Sciences has defined public health as "...what we, as a society, do collectively to assure the conditions in which people can be healthy..."⁸

"Public health" is not the same as public medicine or public hospitals (such as Grady Memorial Hospital), nor public health financing (such as Medicaid, Medicare, and SCHIP⁹), but rather public health is more inclusive of all factors contributing to or detracting from health...including the healthcare system and health financing. This then includes, in addition to health services and financing, education, agriculture, transportation, and various economic solutions to poverty reduction since education and economic status are themselves social determinants of health.

In order to be effective, public health usually begins with a population perspective and emphasizes prevention first. This allows opportunities to improve health and reduce health disparities. Such a population perspective might be a geographic population (all in Georgia, all in DeKalb County) or a demographic one (all women, all elderly adults, all Hispanic children, etc).

⁸ The Future of Public Health, National Academy Press, 1988

⁹ State Children's Health Insurance Program, known as PeachCare in Georgia.

The Institute of Medicine further defines the core functions of public health as:

1. Assessment;
2. Policy development; and
3. Assurance.

Assessment involves surveillance of new or potential threats (e.g., H1N1 influenza, West Nile virus, salmonella in peanut butter) as well as tracking the status of other modifiable causes of illness or death throughout the state (e.g. cancer, cardiovascular disease, HIV infection, etc). This will also include modifiable risk factors such as adolescent and adult obesity trends; smoking, alcohol, and substance abuse trends; unintended pregnancy rates, etc.

It is only when a state possesses accurate information through assessment that the second function, policy development, can be addressed. When public health priorities are identified by accurate assessment, then policies to improve the health of Georgians can be proposed and established. These policies may involve legislation or regulation and are often are beyond the healthcare system (e.g., smoking or drug policies, safe traffic laws, food safety).

Finally, the third function of public health is assurance. It is not enough to recommend effective policies if they are not implemented due to lack of coordination in the state or with the private sector, or due to insufficient resources. This assurance function, of course, involves the important contributions of public health nurses and others as providers of essential prevention and care services throughout the state.¹⁰

Public Health: The Situation in Georgia

Georgia's public health system currently has 18 health districts, and a health department presence in each of Georgia's 159 counties, impacting each and every Georgian. The Georgia Division of Public Health is currently housed in the Georgia Department of Community Health, having moved from the Georgia Department of Human Resources (now the Georgia Department of Human Services) on July 1, 2009.

Georgia finishes near the bottom of state-by-state rankings of overall health, and has so for at least the past four decades.¹¹ In 2009, Georgia ranked 43rd among the states on overall health performance, dropping from 41st in 2008.¹²

Most of these disparities and the relatively poor rankings are not largely related to health insurance, though adequate health insurance is important. In addition, funding for public health in Georgia (and in many states) is highly vulnerable for the following reasons:

¹⁰ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

¹¹ Public Health News Bureau, August 2010.

¹² America's Health Rankings: United Health Foundation, American Public Health Association, and Partnership for Prevention.

- 1) During the recession (and even before) state budgets are very tight;
- 2) Healthcare costs (including Medicaid and SCHIP¹³) continue to escalate rapidly;
- 3) The core public health budget is relatively small and can be treated as discretionary compared to the other entitlement expenditures;
- 4) When prevention is successful, public health problems become invisible (e.g. food safety).

Since 2000, the population of Georgia has increased by 20%, healthcare spending (including state spending) has increased by approximately 100% and the public health budget has declined by 20%.¹⁴

Among the states, Georgia ranks as follows:¹⁵

- 31st for the percentage of adults who smoke.
- 37th for the percentage of adults who do not exercise regularly.
- 38th for the percentage of overweight high school students.
- 39th for the percentage of adults who are obese.
- 41st for the percentage of adults with diabetes.
- 40th for infant mortality.
- 41st for the teen birth rate.
- 43rd for pre-term births.
- 45th for low birthweight babies.
- 47th for the prevalence of infectious diseases like tuberculosis, hepatitis, and AIDS.

Equally disturbing is the finding that Georgia has the second highest rate of obese 10-17 year olds in the nation (Mississippi has the highest).¹⁶

The median life expectancy in Georgia is 73.9, well below the national average of 76.5. Thirty Georgia counties have a life expectancy lower than 73 years, which is lower than the life expectancy for those in Thailand, the Gaza Strip, El Salvador, and the Dominican Republic.¹⁷ These rankings are based on health determinants and health outcomes. Determinants refer to behaviors, community, and environmental factors, public and health priorities, and clinical care factors that influence health outcomes in a state. Georgia ranked 47th in determinants of health (2009).¹⁸

¹³ State Children's Health Insurance Program, in Georgia known as PeachCare.

¹⁴ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

¹⁵ 2008 Health Rankings: Georgia and Georgia's Children.

¹⁶ F as in Fat: How Obesity Threatens America's Health 2010: The Trust for America's Health

¹⁷ Community Health Status Indicators Report, 2010.

¹⁸ America's Health Rankings.

Outcomes traditionally have been measured using mortality measures like premature death, infant mortality, cancer and cardiovascular mortality. America's Health Rankings placed Georgia 43rd (among the states) in health outcomes in 2009.

Georgia's failure to invest in public health infrastructure is directly related to these outcomes, and to the overall cost that Georgia bears in terms of workforce development, productivity, chronic illness, and premature death.

In 2005, a comprehensive study of public health practice in Georgia was conducted by the Georgia Health Policy Center at Georgia State University.¹⁹ The study drew from more than 15 years of cumulative learnings from public health projects in Georgia and in other states. The 2005 study also included extensive interviews, focus groups, and evaluation of archival and documentary evidence. The study suggested that inherent systemic challenges such as siloed funding, the number of uninsured residents, and the fraying safety net were having a more powerful influence over public health activities than the desired drivers, which include community need and evidence-based practices.

This same study called for strengthened public health leadership and collaboration in order to:

- Protect the public's health;
- Lead the state in improving the health of all residents;
- Provide simple, clear messages; and
- Build – rather than be – the safety net.

A key conclusion of the 2005 study is that “structure influences behavior.”²⁰

The Georgia Health Policy Center's analysis of 15 previous years of public health practice revealed eight principles that should guide decisions about organizational structure:

1. When consumers interact with state-provided services, they are generally pleased with the services they received.
2. It is important to create policies that allow consumers to enter the system through any “door”²¹ and access all necessary services.
3. Employees need to be trained in multiple disciplines to facilitate this “no wrong door” model (see #2).
4. Technology should be integrated to increase efficiency and effectiveness, and improve decision making.
5. Funding should be linked to outcomes rather than programs.

¹⁹ Testimony of Karen Minyard, Ph.D., Director, Georgia Health Policy Center, Georgia State University, October 18, 2010

²⁰ Testimony of Karen Minyard, Ph.D., Director, Georgia Health Policy Center, Georgia State University, October 18, 2010

²¹ A “door” is an entry point for services and is not necessarily a literal interpretation, as services may be delivered in a physical location, a virtual location, or via telephone.

6. Collaboration should be required and seamless. Coordination and collaboration must be improved among agencies, divisions and departments.
7. Prevention services should be emphasized in all programs.
8. The success of public health initiatives hinges on long term planning – transformation should be the ultimate goal of change. When the majority of an organization is busy putting out fires, prevention tends to fall by the wayside.

Currently, the Georgia Division of Public Health (the “Division”) is located within the Georgia Department of Community Health, along with Medicaid, Healthcare Facility Regulation, and the State Health Benefit Plan.²²

The Division has a responsibility to work with and provide support to the local public health departments and to the public health districts so that public health services can be provided throughout the state. This requires a system of working together and managing infrastructure that is complex and requires a high level of leadership and managerial ability.

Structurally, the Division does not report directly to the Governor and is not a cabinet-level agency; however, by state statute, the state health director reports to the Office of the Governor and to the Commissioner.²³ The state health director is the primary statutory public health authority within the state of Georgia. Georgia statutes authorize the Division to declare a health emergency, collect health data, manage vital statistics, and conduct health planning.²⁴ The Georgia legislature has authority to approve the public health budget, adopt public health laws, and establish fees and taxes to generate revenue for public health services.

Methodology of the Commission

At its initial meeting on July 12, 2010, the Commission elected a Chair (Dr. Phillip Williams) and a Vice Chair (Dr. Diane Weems) and reviewed how the Commission would accomplish its charge.

The Commission met monthly from July to November to hear testimony from a wide variety of experts, hear and review public comments (in person and online,) and deliberate about the four options that it was charged with studying and making a recommendation about.

In early August, four working groups were appointed by the Commission Chair, one for each of the options to be studied by the Commission. The four options, and thus the four working groups, are:

²² Georgia Department of Community Health. Organizational Chart.
http://dch.georgia.gov/vgn/images/portal/cit_1210/52/53/52266428Visio-FY2010orgrev.pdf

²³ Official Code of Georgia, 31-2-18

²⁴ ASHTO Profile of State Public Health, Volume One, 2009

1. The Division of Public Health remains a part of the Department of Community Health, as it has been since July 1, 2009;
2. The Division of Public health becomes an attached agency pursuant to Code Section 50-4-3;
3. The Division of Public Health becomes an independent agency; or
4. The Division of Public Health becomes a part of another organizational structure (within state government).

The four working groups, each comprised of two members of the Commission, explored the benefits and concerns for each option, and made a recommendation to their Commission colleagues on moving forward with the particular option that they studied. In particular, they noted why each option might be a workable structure for public health in Georgia, and conversely, why each option might not be a workable structure for public health in Georgia.

The working groups each presented their results to the Commission during its October 18th meeting, with extensive discussion by Commission members. A summary of each of the working groups' recommendations is presented in the next section of the report.

1. The Division of Public Health remains a part of the Department of Community Health.

The positive attributes for this option, as described by the working group assigned this topic, include economies of scale (by being within a larger agency) and being housed inside the Department of Community Health with Medicaid and other healthcare financing programs that are integral to the success of public health in Georgia. The impact of across the board budget cuts are likely to be less, with the ability to transfer and share resources (human, technology, and financial) within a larger structure.

Remaining within the Department of Community Health is a significant improvement over the previous structure (within the Georgia Department of Human Resources, now the Georgia Department of Human Services.) The Division of Public Health has had more support within the Department of Community Health than it had within the Department of Human Resources, although it is still not where we need it to be.²⁵

The downside for this option is a lack of focus on public health due to competing priorities within the larger department, budget constraints due to that inherent internal competition, and “an inability to attract strong leadership due to lack of a direct, cabinet-level leadership position for the Division of Public Health.”²⁶ In addition, with the anticipated increase in the number of Georgians who will have Medicaid eligibility under the new Medicaid guidelines, the Department of Community Health (DCH) may be overwhelmed with managing that influx of people on the Medicaid rolls, requiring even more focus on that part of DCH's work.

²⁵ Testimony of Georgia Representative Mickey Channell (R-116,) Vice Chair, Appropriations Committee, October 18, 2010

²⁶ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, October 18, 2010

In addition, a public health leader “at the Commissioner level has a greater opportunity to shape policy and has more access to the Office of Planning and Budget, and the House and Senate Budget offices.”²⁷ The Commission recognizes that organizational structure alone will not be the solution, but when combined with greater leadership accountability, transparency and visibility, and more access to Georgia’s statewide leadership, the change in organizational structure will contribute to improved public health outcomes for Georgians.²⁸

2. The Division of Public Health becomes an attached agency pursuant to Code Section 50-4-3.

An attached agency is one that is traditionally a *smaller agency* that is ‘attached’ to a *larger agency/department* for reasons of economy of scale and efficiency. (“Smaller” is usually defined as smaller in budget size than the agency that it is attached to.) Attached agencies maintain their own rule-making and policy-making functions, while tapping the larger agency to which they are attached for administrative functions, as needed.

The working group on this option made the following observations to the Commission about the positive aspects of the attached agency option:

- Potentially, a closer relationship with the state’s Medicaid agency, which is the Department of Community Health, could assist in maximizing federal funding for the public health functions for the state.²⁹
- An attached agency is more independent than a Division; public health is currently a Division.
- An attached agency may have more direct access to the Governor and the members of the Georgia General Assembly.
- An attached agency would have a separate Board of Public Health - with Board members who were interested in, and knowledgeable about, public health matters.
- An attached agency may be more responsive to the county Boards of Health than a Division can be when that Division is a part of another, larger agency.
- Higher visibility with the public could be achieved if public health, as an attached agency, had its own public relations and communications functions.
- Expansion of public health activities may be easier to advocate for within an attached agency structure.

²⁷ Testimony of W. Douglas Skelton, M.D., Coastal Georgia District Health Director and former Commissioner, Georgia Department of Human Resources, August 9, 2010.

²⁸ Testimony of Donna Sheldon (R-105,) Chair, 2006 House Study Committee on Public Health, September 13, 2010

²⁹ Testimony of Russ Toal, M.P.H., former Commissioner, Department of Community Health; Immediate Past President of the Georgia Public Health Association; Clinical Associate Professor at the Jiann Ping Hsu College of Public Health of Georgia Southern University; Chair, McIntosh County Board of Health, August 9, 2010

In order to perform at maximum efficiency, public health needs to be able to make decisions based on accurate scientific information without having to have these approved by multiple levels of staff with limited formal public health experience or knowledge. Having public health remain as an attached agency would not (necessarily) solve this dilemma.

The current placement of public health functions (within the Department of Community Health) does not allow for the full integration of state and local resources. An attached agency structure may move one step closer to bringing all public health resources to bear on the population-based health issues facing Georgians.

Conversely, the working group reviewed the reasons that an attached agency option might not be the best one for public health in Georgia:

- Public health is already a much larger and more complex agency, as a Division, than are the other attached agencies affiliated with the Department of Community Health. There is some question, due to its size and structure³⁰, as to whether the Division of Public Health would actually fit the legal definition of an attached agency in Georgia.
- As an attached agency, the Division of Public Health would still be dependent on the Department of Community Health for administrative support. With competing priorities in the Department of Community Health, the Division may still not receive timely attention or assistance.
- If the Division of Public Health becomes an attached agency, the Commissioner of the Department of Community Health would still be perceived as the leader for public health in the state, even though the head of the Division of Public Health is the designated state health officer (by state statute). The head of the Division of Public Health would still report to the Commissioner.
- Public health, as an attached agency, would not have the ability to influence administrative functions or create additional efficiencies.

Although this structure does have some of the independence that Georgia's public health function needs to adequately serve the state's citizens, there are significant barriers to maximum efficiency even in an attached agency structure. Georgia's citizens deserve a public health organization that can move rapidly to address health issues and outbreaks as effectively and efficiently as possible, and this working group's conclusion is that an independent public health agency is the best solution for Georgians.

This working group based its conclusions on a variety of data sources, including testimony received by the commission, principally that of Clyde Reese, Commission of

³⁰In Georgia, public health practice is delivered through a combination of state and county services, with some practitioners employed by the state and some by the individual county boards of health. This requires a high level of coordination, communication and transparency in order for public health to function as it should and protect the health of Georgians.

the Department of Community Health,³¹ Dr. Doug Skelton, former Commissioner of the Department of Human Resources and Coastal Health Director,³² and Dr. Frank Shelp, Commissioner of the Department of Behavioral Health & Developmental Disabilities³³. The working group also analyzed Georgia Code 50-4-3, which provides for the establishment of attached agencies, in reaching its conclusion.³⁴

3. The Division of Public Health becomes an independent agency.

The working group on becoming an independent agency put forth the following as the reasons that an independent agency option would make sense for Georgia. The independent agency option:

- Provides public health with the authority needed to assure a rapid response/ reaction in crisis situations (e.g. pandemic influenza, natural disasters, mass casualty).
- Provides for the ability to advocate more effectively for public health priorities.
- Provides public health with greater autonomy and the ability to set its own priorities, and create and communicate a common vision. Provides enhanced ability to assure the leadership needed by recruiting talent, including a Commissioner and leadership team, from a higher strata pool; candidates for these leadership positions will feel they have more responsibility when reporting directly to the Governor and interacting with the General Assembly on a regular basis.
- Provides greater visibility for public health within the state's bureaucracy and contributes to a greater respect and understanding of the mission of public health. With that greater visibility also comes a greater focus on transparency - and accountability for outcomes. "An independent Department of Public Health would also enhance the exchange of information between public health officials at the state level and the specialists in the field, it would allow public health officials to respond to public health concerns and emergencies in the most timely and appropriate way, and it would help raise awareness among key stakeholders – including the media and other influential advocacy organizations."³⁵
- Enhances the ability to justify the salaries required to recruit the talent needed at all levels to get the job done and assure an adequate public health workforce for the 21st century.
- Provides public health with greater access to and influence with decision makers, including legislators and the Governor. "A free standing Department of Public Health would have greater access to the individuals who establish public policy in

³¹ Testimony of Clyde W. Reese, Commissioner, Georgia Department of Community Health, July 12, 2010, and August 9, 2010

³² Testimony of W. Douglas Skelton, M.D., Coastal Georgia District Health Director and former Commissioner, Georgia Department of Human Resources, August 9, 2010.

³³ Testimony of Frank Shelp, M.D., M.P.H., Commissioner, Georgia Department of Behavioral Health & Developmental Disabilities, August 9, 2010

³⁴ Official Code of Georgia, 50-4-3.

³⁵ Public comment submitted to the Commission by Dan DeLoach, M.D., President, Medical Association of Georgia, on November 4, 2010.

the state, including the governor, legislators, and other key officials. That means our state leaders would gain a better appreciation for the important role that public health plays in Georgia – as well as the need to adequately fund the state’s public health efforts.”³⁶

- Provides the ability to focus on the mission of Public Health - distinct from the issues of health care financing/Medicaid that are currently significant focus areas for the Department of Community Health.
- Provides the ability for Public Health to have its own Board and the ability to create its own scientific advisory panels.

Testimony from several individuals noted Georgia’s poor health ranking. Dr. James W. Curran, Dean of Rollins School of Public Health, specifically noted that Georgia ranks very low (“somewhere in the ‘40’s, with 1 being the best”³⁷) among all States in terms of health conditions and that Georgia has large health disparities by geographic areas... and by race/ethnicity.

Dr. Curran discussed the factors contributing to the vulnerability of public health funding, including the fact that “when prevention is successful, public health problems become invisible (e.g. food safety”³⁸). Since 2000, the population of Georgia has increased by 20%, Georgia’s healthcare spending has increased by approximately 100%, and Georgia’s public health budget has declined by 20%.³⁹

The structure for Georgia’s public health operation should be designed to improve health outcomes for all Georgians. Dr. Curran specifically noted that the best structure would accomplish the core functions of public health of assessment, policy development, and assurance (as defined by the Institute of Medicine⁴⁰).

The enabling conditions to achieve this, as presented in testimony by Russ Toal, are authority, autonomy, and access⁴¹. Other testimony, including that of Dr. Doug Skelton⁴², noted the importance of leadership, workforce and resources in implementing

³⁶ Public comment submitted to the Commission by Dan DeLoach, M.D., President, Medical Association of Georgia, on November 4, 2010.

³⁷ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

³⁸ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

³⁹ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

⁴⁰ The Institute of Medicine of the National Academies. The IOM is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.

⁴¹ Testimony of Russ Toal, M.P.H., former Commissioner, Department of Community Health; Immediate Past President of the Georgia Public Health Association; Clinical Associate Professor at the Jiann Ping Hsu College of Public Health of Georgia Southern University; Chair, McIntosh County Board of Health, August 9, 2010

⁴² Testimony of W. Douglas Skelton, M.D., Coastal Georgia District Health Director and former Commissioner, Georgia Department of Human Resources, August 9, 2010.

effective public health programs. As outlined, the movement of public health to an independent agency allows the new agency to benefit from those conditions.

The House Study Committee on Public Health (2006) concluded, “It is the intent of this report and any resulting legislation, policy, executive action, rules or regulations so promulgated that the capabilities of Georgia’s public health system be increased and improved in order to ensure the health and safety of all Georgians from threats both routine and extraordinary.”⁴³ The House Study Committee further recommended that the Division of Public Health - and all other departments concerning health or mental health - - should be removed from the Department of Human Resources and combined with the existing Department of Community Health, to create a new state agency referred to as the Department of Health.⁴⁴

Subsequent to the work of the House Study Committee referenced above, the Georgia Department of Behavioral Health and Developmental Disabilities has been established as an independent agency. It is comprised of 7 regional hospitals, 6 regional offices and 25 community service boards. Frank Shelp, M.D., M.P.H., the Commissioner of this year-old department, testified to the importance of the autonomy and authority realized as an independent agency as contributing factors to the ability to strengthen the leadership, attract talent, provide the ability to be flexible and respond quickly to situations as they arise, to establish departmental priorities and alter resources as needed to support those priorities.⁴⁵

Testimony offered before the Commission, including that of Dr. James W. Curran,⁴⁶ noted that the voice of public health “needs to be independent of health financing, as well as other departments of state government, since many areas (of public health) affect the overall health of the population and solutions are not restricted to any one area.”

Senator Renee Untermann⁴⁷ identified several longstanding problems with Georgia’s public health system in terms of leadership and consistency, and discussed the need for a general and cohesive public health mission for the state that can be articulated to the General Assembly. The Senator also noted that moving the Division of Public Health to the Department of Community Health had been a compromise in 2009, recognizing that an independent agency for public health would be a future consideration.

⁴³ Georgia House of Representatives Study Committee on Public Health, Final Report of the House Research Office, 2006

⁴⁴ Testimony of Donna Sheldon (R-105,) Chair, 2006 House Study Committee on Public Health, September 13, 2010

⁴⁵ Testimony of Frank Shelp, M.D., M.P.H., Commissioner, Georgia Department of Behavioral Health & Developmental Disabilities, August 9, 2010

⁴⁶ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

⁴⁷ Testimony of Senator Renee Untermann (R-45,) Vice Chair, Senate Health & Human Services Committee, September 13, 2010

Representative Mickey Channell⁴⁸ testified that “if the state can improve health outcomes through an independent public health agency, we can save (the state) money”. In his testimony, he noted that the Department of Community Health does a good job at its core mission – to “pay for healthcare that someone else provides,” but that this has little in common with public health delivery. Representative Channell went on to point out the likelihood that public health will be lost in the enormity of the Department of Community Health, similar to its previous condition within the Department of Human Resources, and that the state’s experience with consolidating agencies as a way to save money has not been successful (with the Department of Human Resources as a key example.)

A recurring theme in testimony, including that of the Department of Community Health’s Commissioner, Clyde Reese⁴⁹, was the importance of public health and emergency preparedness being combined to assure an appropriate response that minimizes death, injury, disability and infection during and after a disaster.

This working group presented additional information to the Commission on the potential challenges with creating an independent public health agency.

- A move to an independent agency may require significant changes in high level work flows and, to some extent, “deconstructing” in some areas that have been transitioned. Such a move may also require an audit of the Division as it becomes a Department.
- With the federal health care reform law now in place, and a growing Medicaid population in the state, the importance of partnership between the Department of Community Health and a Department of Public Health would be critically important. Testimony by Russ Toal suggested that keeping the Division of Public Health as a part of the Department of Community Health - or alternatively as an attached agency - would create a stronger link than if it were a separate agency.⁵⁰

4. The Division of Public Health becomes a part of another organizational structure (within state government).

The working group that was charged with exploring this option determined that a positive aspect of this option is the potential for cost efficiencies by combining resources for administrative functions. Also, if similar mission and goals exist between the merged agencies, strong outcomes may be achieved.

⁴⁸ Testimony of Georgia Representative Mickey Channell (R-116,) Vice Chair, Appropriations Committee, October 18, 2010

⁴⁹ Testimony of Clyde W. Reese, Commissioner, Georgia Department of Community Health, August 9, 2010

⁵⁰ Testimony of Russ Toal, M.P.H., former Commissioner, Department of Community Health; Immediate Past President of the Georgia Public Health Association; Clinical Associate Professor at the Jiann Ping Hsu College of Public Health of Georgia Southern University; Chair, McIntosh County Board of Health, August 9, 2010

This working group looked at the entire structure of state government, and concluded that the only other departments in state government that would offer a possibility for combining all or portions of the current functions of the Division of Public Health are the Department of Human Services, the Department of Behavioral Health and Developmental Disabilities, the Department of Natural Resources (Environmental Protection Division,) and the Department of Agriculture.

The Department of Human Services, as concluded by the working group, is not an appropriate umbrella organization for the Division of Public Health for two reasons – we have already done that, unsuccessfully. Secondly, the Department of Human Services, as it is currently configured, now has a much narrower focus and is not appropriate for public health at this time.

The Department of Behavioral Health and Developmental Disabilities also does not appear to be an appropriate place to house public health functions for the state. This department's services are *client-based* and clinical in nature. The functions of public health are *population-based*, and by nature, include all Georgians. In addition, Georgia's history of mental health, substance abuse and developmental disabilities being under the auspices and direction of the County Boards of Health led to the passage of Georgia House Bill 100, which separated public health and mental health.⁵¹

Frank Shelp, M.D., M.P.H., noted that, in his opinion, public health would not be well served by being a part of the Department of Behavioral Health and Developmental Disabilities.⁵²

The only connection to public health within the Department of Natural Resources is one to environmental health programs, which we learned are clearly separate functions and, again do not seem to serve the needs of the state when it comes to the overall, population-based focus contained in public health functions.⁵³

The Department of Agriculture has, similar to the Department of Natural Resources' Environmental Health Division, some responsibility for food safety, which could be partnered with public health in some instances, but the overall focus of all of these areas is clearly very different and distinct.⁵⁴

Both the Department of Human Services and the Department of Behavioral Health and Developmental Disabilities have experienced major legal and organizational issues in the past few years, including the threat of actions by the federal government. Attempting to

⁵¹ Georgia House of Representatives, HB 100, passed by the House and enacted in July 1994.

⁵² Testimony of Frank Shelp, M.D., M.P.H., Commissioner, Georgia Department of Behavioral Health, August 9, 2010

⁵³ Analysis by Dwain Butler, President-Georgia Environmental Health Association and Scott Uhlich, Environmental Health State Director, October 2010

⁵⁴ Analysis by Dwain Butler, President-Georgia Environmental Health Association and Scott Uhlich, Environmental Health State Director, October 2010

integrate public health into either of these departments could be an added distraction for these departments.

In addition, both the Department of Agriculture and the Department of Natural Resources have regional structures, with a focus on industrial or institutional entities (as opposed to public health's focus on population groups in order to impact the overall health of Georgians). Our current public health system is a county-based system of services that works closely with county governments through programs such as septic tank and restaurant inspections. So, these competing structures (regional vs. local) may pose problems with integration that cannot easily be overcome.

The Department of Community Health is the most closely related Department (within state government) to the mission of the state's public health function.

If public health remains a division of another state agency, it would be best placed in a department with a health focus. The Department of Community Health is clearly the department that is more closely aligned with the mission of public health if this becomes the desirable option.

The Commission's Recommendation

"The Georgia Health Policy Center participated in a recent national meeting with similar organizations, spanning the space between governmental public health and private public health interests, and it was noted that governmental organization of public health often impedes public health practice. This group agreed that for public health agencies to lead in the protection and promotion of overall health, the "gold standard" was for public health to be an independent department reporting directly to the Governor. I would like for Georgia to have the "gold standard" especially given the health needs in Georgia." (Karen Minyard, Ph.D., Director, Georgia Health Policy Center, Georgia State University.)

"What is the best structure in Georgia to accomplish the important assessment, policy development, and assurance functions of public health? First, it is important for public health to have an informed and strong independent voice to advise the Governor and legislature on how best to improve public health in Georgia. This voice needs to be independent of health financing as well as other Departments of Government since many areas affect health and solutions are not restricted to any one area. It is crucial that public health and public health preparedness be aligned closely or combined since the capacity for responding to new public health or terrorist threats require close synergy and habitual collaboration. For these reasons, it would seem that public health would be best served by a direct reporting relationship to the Governor and legislature. This could also best serve to attract and retain the most qualified professionals needed in Georgia to make us the healthiest State in America." (James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University.)

The Medical Association of Georgia “believes that an independent Department of Public Health offers the most effective organizational option because it will be focused exclusively on public health issues.” (Dan DeLoach, M.D., President, Medical Association of Georgia.)

The Public Health Commission fulfilled its statutory responsibilities to make a recommendation on the appropriate structure for public health management in Georgia, choosing from among four available options, by hearing expert testimony during five hearings, reviewing public comment received in person and online, and studying each of the options carefully through subsidiary working groups.

Since 2000, the population of Georgia has increased by 20%, healthcare spending (including state spending) has increased by approximately 100% and the public health budget has declined by 20%.⁵⁵ The effective practice of public health is a critical tool in our state’s ability to improve and enhance the lives of Georgians, including our state’s ability to produce and sustain a viable workforce.

The Commission reviewed data and testimony about the state of Georgians’ health, including that the median life expectancy in Georgia is 73.9 years, well below the national average of 76.5 years. Thirty Georgia counties have a life expectancy lower than 73 years, which is lower than the life expectancy for those in Thailand, the Gaza Strip, El Salvador, and the Dominican Republic.⁵⁶

Given this and other health results in our state, the unanimous recommendation of the Commission is that the Division of Public Health become an independent, cabinet-level state agency – the Georgia Department of Public Health, with a Commissioner directly reporting to the Governor and acting, by statute, as the state’s chief health officer. The Commission believes that this is the single best option to improve the health of Georgia’s citizens and to move Georgia from among the lowest-ranking states in the nation regarding health to among the best in the nation. The commission believes that an independent Department of Public Health can be created with existing human and financial resources, but in order to effect improvements in health outcomes, additional investments in public health will need to be made in the years to come. An independent Department of Public Health also fosters our state’s ability to attract exceptional, cabinet-level leadership for Georgia’s public health function.

Based on the testimony and recommendation of OHI staff leadership⁵⁷, the Commission also unanimously recommends that the Office of Health Improvement (OHI), currently housed within the Department of Community Health, become part of the new Georgia Department of Public Health. The Office of Health Improvement is comprised of three units: the Office of Minority Health, the Commission on Men’s Health, and the Office of

⁵⁵ Testimony of James W. Curran, M.D., M.P.H., Dean, Rollins School of Public Health, Emory University, October 18, 2010

⁵⁶ Community Health Status Indicators Report, 2010.

⁵⁷ Testimony of James Peoples, Executive Director of the Office of Health Improvement, October 18, 2010.

Women's Health. The Commission recommends that all three units comprising OHI move to a new Georgia Department of Public Health.

The Commission further recommends that the Office of Emergency Preparedness, which is currently housed in the Georgia Department of Community Health, be fully integrated with public health and be moved to a new Georgia Department of Public Health, as recommended by Dr. Patrick O'Neal, Director of the Office of Emergency Preparedness.⁵⁸ The Commission recommends that the Georgia Trauma Care Network Commission, currently an attached agency to the Georgia Department of Community Health, be moved to a new Department of Public Health, but continue as an attached agency to the new Department of Public Health.

The Commission believes that the right organizational structure for public health is one of the key pieces to having successful and improved public health outcomes in Georgia. The right structure, when combined with appropriate allocation of resources and the recruitment of exceptional leadership, will produce improved public health outcomes for Georgians. The Commission believes that the State Health Director should be a physician (as is currently required by statute) reporting directly to the Governor and possessing extensive public health knowledge, along with the ability to work effectively with elected and appointed officials and leading the public health system staff throughout the state.⁵⁹

The Commission recommends that a Public Health Study Commission be appointed at least every three years to study the effectiveness of public health in Georgia, and that this Commission be charged with providing the Governor and the Georgia General Assembly with progress reports on the health of Georgians.

All testimony, previous reports of study commissions, and public comments received by this Commission from July through November 2010 are available on the website of the Georgia Public Health Commission:

http://www.georgia.gov/00/channel_title/0,2094,31446711_161166468,00.html.

⁵⁸ Testimony of Patrick O'Neal, M.D., Director, Office of Emergency Preparedness, July 12, 2010.

⁵⁹ Motion of the Commission, unanimously approved at its November 15, 2010, meeting.