PRESS ★

# A DEPARTMENT OF HEALTH

# FOR *California*

REPORT TO THE SECRETARY OF THE HUMAN RELATIONS AGENCY

Feb. 1, 1970

State of California

Human Relations Agency

# Memorandum

To : Honorable Ronald Reagan
Governor

Date : February 10, 1970

File No.:

Subject : A Department of Health for California

From : Office of the Secretary

Transmitted herewith is the report, "A Department of Health for California". The report was prepared by the Task Force on Organization of Health Programs, appointed by the Secretary of the Human Relations Agency. It represents the basis for my recommendation to you that a Department of Health be established in the Human Relations Agency.

I concur in all of the recommendations of the Task Force, except those pertaining to the Veterans Home and Hospital of the Department of Veterans Affairs and the meat, dairy and poultry inspection programs of the Department of Agriculture. I feel that these programs require further analysis and review, and I am not prepared to recommend their inclusion in a Department of Health at this time.

Establishment of a Department of Health, consolidating the health and related functions now performed in several departments, will permit us to do a more effective job of evaluating total health needs and developing and implementing programs to meet them. It is our intention to create the new department within the staffing that is currently authorized for the functions being consolidated. To the extent that reductions in staff are made possible as a result of the reorganization without curtailing essential services, they will be accomplished through attrition.

With the exceptions indicated, I recommend that you submit an organization plan for a Department of Health, embodying the recommendations of the report, to the 1970 session of the Legislature.

LUCIAN B. VANDEGRIFT
Secretary

Attachment

# A DEPARTMENT OF HEALTH

# for

# CALIFORNIA

Report to the Secretary of the Human Relations Agency

February 1, 1970

RONALD REAGAN
Governor of California

STATE OF CALIFORNIA
HUMAN RELATIONS AGENCY

LUCIAN B. VANDEGRIFT
Secretary

OFFICE OF THE SECRETARY
915 Capitol Mall
Sacramento 95814

DEPARTMENTS OF THE AGENCY
Corrections
Health Care Services
Human Resources Development
Industrial Relations
Mental Hygiene
Public Health
Rehabilitation
Social Welfare
Youth Authority

February 1, 1970

The Honorable Lucian B. Vandegrift
Secretary
Human Relations Agency
915 Capitol Mall
Sacramento, California 95814

Dear Mr. Vandegrift:

Pursuant to the Secretary's letter of July 24, 1969, the Task Force on Organization of Health Programs submits its report and recommendations for creation of a Department of Health. In accordance with the Agency charge, the Task Force has developed an organization plan that the Governor can submit to the Legislature at the 1970 Session.

The proposal represents a major change in the organization of the State's health programs. The Task Force recognizes that organizational change by itself is no panacea for the many complex problems related to health policies and programs. We believe, however, that a unified Department of Health will be in a much better position to deal with these problems than our present fragmented organization. In recent years we have seen tremendous expansion in health programs and services. This has placed a severe strain on the existing administrative machinery. This expansion also underscores the urgency of the State's acting now to develop an improved system of managing its health programs.

The Task Force did not attempt, within the limited time available, to carry out the detailed planning that will be necessary for implementation of the proposal. We have suggested a recommended structure for the new Department but recognize that the Director of Health, who hopefully will be selected as early as possible, must have an opportunity to bring his own ideas to bear on the organizational planning. If the Governor and the Legislature support the proposal, we recommend that the Department of Health be activated no later than July 1, 1971.

Throughout the study, the Task Force has been assisted by two advisory bodies. The Ad Hoc Advisory Committee was composed of persons associated with State Government. It included representatives of several legislative committees, the Commission on California State Government Organization and Economy, the Human Relations Agency, and the Department of Finance. The second advisory group assisting the Task Force was the Health Planning Council, consisting of a broadly representative group of persons from outside State Government. The Task Force expresses its appreciation to all of those who participated on these advisory bodies. The two groups provided an effective sounding board for testing various alternative approaches and made a valuable contribution to the project. It should be made clear, however, that the conclusions and recommendations in the report are those of the Task Force and that the Task Force assumes full responsibility for them.

The Task Force also acknowledges its appreciation for the willingness of many persons, both within and outside State Government, to discuss problems related to the present organization of the State's health programs. The Task Force met with numerous individuals and groups and, in the process, broadened its understanding of health programs and obtained many useful ideas. Our one regret is that time did not permit us to contact directly all of the many organizations and individuals that have a strong interest in health services.

In its charge to the Task Force, the Agency asked that we take a broad approach in our analysis, be innovative in our approach, give full consideration to the rapid changes that are occurring in the health field, and offer interested groups and individuals an opportunity to present their views. We have made an earnest attempt to carry out this directive.

Very truly yours,

Lee D. Bomberger

LEE D. BOMBERGER, Chairman
Task Force on Organization
of Health Programs

## TASK FORCE MEMBERS

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## SUMMARY OF PROPOSAL

The Task Force on Organization of Health Programs recommends that:

1. The State of California proceed with the establishment of a Department of Health.
2. The new Department include the following components:
   a. All of the functions of the Departments of Public Health, Mental Hygiene, and Health Care Services, except for the two Neuropsychiatric Institutes now in the Department of Mental Hygiene. These would be transferred to the University of California.
   b. Social Service functions of the Department of Social Welfare.
   c. Ten of the healing arts licensing boards in the Department of Professional and Vocational Standards.
   d. Alcoholism functions of the Department of Rehabilitation.
   e. Meat, dairy, and poultry inspection functions of the Department of Agriculture.
   f. State Veterans Home and Hospital in the Department of Veterans Affairs.

3. An Advisory Health Council be created to assume the functions of the existing State Board of Public Health, the Health Planning Council, and the Health Review and Program Council, except that the regulation and licensing responsibilities of the State Board of Public Health would be assigned to the Director of Health.

4. The Department of Health have the following organizational segments:

    Director's Office
    Advisory Boards and Commissions
    Comprehensive Health Planning
    Health Facilities
    Health Manpower
    Personal Health
    Environmental Health
    Comptroller
    Staff Services
    Hospitals
    Laboratory Services
    Program Management

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# INTRODUCTION

This report presents the results of a study by the Task Force on Organization of Health Programs. The study was part of a process initiated by the Human Relations Agency in November, 1968 to examine the feasibility of consolidating the State's health programs into a new organization. The present study is an extension of the preliminary work done by two earlier task forces established by the Agency to deal with certain aspects of the problem. The results of the earlier studies, plus the present study, are summarized below.

## First Task Force

The first Task Force was established in late 1968 to evaluate a proposal that the Departments of Public Health, Mental Hygiene, and Health Care Services be combined into one department. That Task Force was charged with determining whether the proposal had sufficient merit to warrant further study. In carrying out its charge, the Task Force identified a number of problems related to the existing organization of the State's health programs and recommended that a more detailed study be undertaken.[1] The problems were described as follows:

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Note: All footnote references are listed under Appendix A.

1. The State lacks a coordinated health program planning and resource allocation system capable of determining the needs of all the people, establishing goals, setting program priorities, and evaluating program effectiveness.
2. There is no integrated research program capable of assessing all the State's health research needs and allocating funds on a priority basis.
3. The present organization is unable to adjust to basic changes in medical knowledge, technology, or the health care delivery system.
4. Fragmentation and overlap exist in the administration of some of the State's health programs. This is most evident in the fields of mental retardation, alcoholism, and health facilities licensing.
5. There is a growing interrelationship between medical and social services that has not been adequately recognized within State Government.
6. In attempting to optimize Federal funding, the State has, in some cases, resorted to cumbersome organizational arrangements.
7. There has been a proliferation of boards and commissions related to health.

Second Task Force

The second Task Force was established in the spring of 1969 to conduct a more intensive analysis of four problems identified

in the earlier effort. These problems related to alcoholism, licensing, mental retardation, and research. The Task Force prepared five reports -- one for each of the problem areas and a summary report.[2]

The second Task Force considered three major alternatives for the State's organization of health services, as follows:

1. Create a number of independent departments to assume responsibility for specified programs or functions.
2. Retain the present departmental organization, but establish a coordinating mechanism in the office of the Human Relations Agency.
3. Consolidate all health-related departments into one unified Department of Health.

In its summary report, the Task Force recommended that the Administration consider adopting the third alternative. It recommended further that a new Department of Health include a program management system to assist the Director in managing selected health programs.

After reviewing the second Task Force's findings, the Governor requested the Human Relations Agency to prepare an organization plan for a unified Department of Health, which he could submit to the Legislature in 1970.

Third Task Force

The third, or present, Task Force was established by the Agency in July, 1969 to develop the basic plan for a Department of Health. The Agency Secretary instructed the Task Force to take a broad approach in its analysis, to examine health-related programs wherever they occur in State Government, to consider several organizational alternatives before recommending one for implementation, and to approach the task with the idea of constructing a new Department, not remodeling the old ones. (Appendix B)

In carrying out its charge, the Task Force reviewed the significant trends in health, attempted to gain an understanding of consumer attitudes toward health programs and services, inventoried the State's health functions, developed a program structure for health, defined the State's role in health, analyzed a number of functions for possible inclusion in a Department of Health, and developed an organization structure for the proposed Department.

The Secretary for Human Relations requested the Task Force to design the best organization possible, ignoring existing or potential obstacles to implementation. If adjustments in the proposal were required to obtain general acceptance, these would be made by the Agency once the study was completed.

The Agency imposed only two constraints on the Task Force:

1. The plan should be capable of implementation within available funds, and
2. The plan should not require a staff increase at the Agency level.

The Task Force believes that the proposal set forth in the report provides a sound basis for an organization plan that the Governor can submit to the Legislature.

## AN OVERVIEW OF HEALTH

In any attempt to develop an improved organization of health programs, it is desirable at the outset to gain an overview of health. Major changes are occurring in technology, methods of providing services, and public attitudes toward the provision of health services.

For a number of years there has been a tendency to equate health with the provision of medical services. Medical services, in turn, have usually been considered to be of a diagnostic and treatment nature, provided directly by, or under the supervision of, a physician who operated as a solo practitioner on a fee-for-service basis. This view has prevailed despite the fact that ancillary and paramedical personnel now perform many health functions and that an increasing number of physicians are employed on a salary basis or financial arrangement other than fee-for-service.

Scientific and technological advances in medical care have occurred at a rapid rate in the past several decades. These advances have resulted in new and more complex procedures, the creation and training of more health specialists, and more costly and intricate equipment. With these advances, medical services have become more effective, and this, in turn, has created a greater demand for services.

These changes are creating new and difficult problems for both government and the private sector in trying to meet the public demand for health services. The Task Force has attempted to identify the most important of these problems, along with a number of solutions being proposed by health authorities to deal with them.

Some Major Problems

1. Health care costs over the past ten years have risen twice as fast as the Consumer Price Index.[3] There is, however, no conclusive evidence that this cost increase has resulted in a proportionately increased benefit to the general public -- the ultimate consumer of these services. Consequently, more attention is being paid to cost control and the reestablishment of a better balance between the supply of, and demand for, medical services.
2. There is growing dissatisfaction with the health care delivery system. The consumer often complains that he is being ignored and that medical services are inadequate or unavailable. Whereas the medical profession has traditionally emphasized quality of service, it must now devote increasing attention to the availability, adequacy, and appropriateness of medical services as well.

3. The concern with the diagnosis and treatment (curative medicine) of sickness and disease has tended to overshadow the prevention of disease. This does not overlook the fact that preventive health programs exist and, in many cases, are effective. However, the identification of preventive programs as "sickness control" programs is evolving and broadening into an ecological concept of man being a biological entity, existing as a psychological self in a complex physical and social environment that has a great effect on his health and well-being.

## A Smorgasbord of Solutions

The solutions that attempt to deal with these problems are many and varied. In an effort to gain a better perspective on health, the Task Force classified a number of these emerging concepts, program approaches, and innovations under the three basic problems described above.

1. Some solutions aimed at controlling the rising cost of medical services and alleviating the imbalance between supply and demand are:

   a. Prepaid medical insurance programs
   b. Peer review
   c. Utilization review
   d. Consumer cooperation in cost reduction

e. Hospital planning

f. Manpower planning

g. Fee schedules

h. Capitation

2. Some of the solutions being offered in an effort to deliver health services more effectively are:

   a. The "campus concept" of medical service, under which a number of operationally independent facilities located close to each other share some physical plant and services.

   b. Group practice and, related to this, the development of the professional corporation.

   c. The establishment of hospital centers providing a continuum of ambulatory as well as inpatient services.

   d. Various manpower innovations, including the assistant physician, Medex, and nurse pediatric practitioner.

   e. Neighborhood or community health centers.

   f. Financial and other incentives, encouraging the provision of services on an ambulatory rather than an inpatient basis.

3. Some solutions designed to make the citizen aware of, and take action to correct, those factors in the total environment that are detrimental to health are:

a. General health education programs to create an increased health awareness.

b. Immunization programs.

c. Safety and accident prevention programs.

d. Awareness and concern for those substances taken into or used on his body, including a variety of foods and drugs.

e. Environmental control programs, including air, water, solid waste, radiation, and noise.

## THE CONSUMER'S VIEW OF HEALTH SERVICES

One of the Task Force's concerns related to consumer attitudes toward health services. The difficulties in obtaining a cross section of public opinion in a field as broad as health are obvious. Within the time available for the study, the Task Force could not carry out an exhaustive analysis of consumer attitudes. However, by talking with a number of groups, including users of private as well as public health services, it was possible to gain some understanding of the way people feel about these services.

### Health As A Priority

It is apparent that health holds a high priority among the American people. This is evident not only from the fact that total expenditures for health services in the United States are approaching $60 billion per year; it is also indicated by the increasing public concern -- expressed through organizations and news media -- about the high cost of sickness, the intolerable burden of social disease, and the continuing deterioration of the environment. In a recent survey for Blue Cross, Harris and Associates found that 51% of the population as a whole gave good health a higher priority than possession of a job.[4]

What the Consumer is Saying

There is a growing awareness of the need for more consumer participation in planning health services. One of the requirements imposed by the Federal Government on comprehensive health planning activities carried out by the states is that advisory councils must include a majority of consumers in their membership. Similarly, consumer participation is an integral part of the planning and operation of the federally-funded OEO Neighborhood Health Centers.

The first question that usually arises in connection with consumer participation in the planning and delivery of health services is, "Does the consumer know what he wants?". Given an opportunity, consumers of personal health services are candid in their criticisms of "the system" and well aware of their needs. Various groups pointed out that available services are often not the needed ones, or they are inadequate. Among personal health needs, for example, out-of-hospital services (including home care) are insufficient; suitable out-of-home facilities that could provide continuity of care in the community are often not available; rehabilitative and restorative services are limited; personal health services, even if available, cannot be used because they are too costly or too far away; transportation to service agencies is not available or is too costly; no provision is made for child care if parents require services away from the home; language barriers add to the difficulty of providing care; and services

tend to be medically-oriented when the consumer often needs a broader kind of assistance.

Consumers also criticize the quality of services. Some of their more common complaints are long waits and poor facilities; an impersonal atmosphere; no house calls; and an inadequate explanation by the health professional of what is happening to and what is expected of the consumer.

An equally important consumer criticism is the fragmentation of health services. Even a cursory review of directories of health and welfare services available in medium-sized California counties reveals that a person seeking assistance is confronted by a confusing array of public and voluntary agencies. As a result, he finds himself being shuffled from one agency to the next during the course of what, for him, should be a continuum of care linking together preventive, diagnostic, treatment, and rehabilitative services. The result in all too many instances is that coordination is left to the consumer.

Coordinating services will not become easier for the consumer. This is indicated by the large increase in the number of programs providing services, facilities, and aid to communities, financed from Federal, State, and local government sources. The need for coordination has never been greater. In attempting to meet this need, public agencies have created a number of types of local centers which have contributed to

the overlapping and fragmentation. Meanwhile, the already slender resources of the multi-problem family are stretched to the breaking point, as the family tries to find its way through the maze.

Beyond the need for personal health services is a widespread public concern for the quality of the environment as an even more important determinant of man's physical and mental well-being. It has been stated that "An individually acceptable amount of water pollution added to a tolerable amount of air pollution added to a bearable amount of noise and congestion can produce a totally unacceptable health environment".[5] While this concern extends through all levels of society, the effects of a deteriorating environment fall most harshly on the underprivileged. For these people, lack of adequate environmental controls is real and close, taking the form of inadequate housing, dirty neighborhoods, lack of open space, overcrowding, and poor sanitary facilities.

Often, too, there is no single source of authoritative health information available in the community, and the consumer seldom has enough knowledge of the system to classify his needs in terms of the providers' labels. Lacking information about where help is available, the consumer does not know where to go for assistance on his problems and frequently does not even know that help is available. This is as true for general health services as it is for special problems, such as mental retardation, alcoholism, drug addiction, or family planning.

Organizational Implications

Any organization providing health services, to be effective, must be responsive to consumer needs. These needs are undergoing rapid and significant changes, and public programs must be flexible enough to meet these changing needs. The State, in administering health programs, must be prepared to listen to the complaints and suggestions of consumers, to weigh these against other competing demands, and to take appropriate action. Participation on advisory boards and commissions related to health programs which, for a long time, has been limited largely to providers of service, is now being opened to consumers. The Task Force regards this as a desirable change and feels that mechanisms should be built into any proposed health organization to ensure that the consumer's voice is heard by those responsible for planning and implementing health programs.

## TRENDS IN HEALTH CARE

Any new organization that is developed to administer the State's health programs must meet the needs not only of today, but also of the years ahead. It must be flexible enough to change as public needs change. It is essential, therefore, in developing the concept of a new organization, to identify the significant trends in health care. The Task Force regards the following as some of the more important trends and directions in this field.[6]

### Demand for Health Services

There is, and will continue to be, an increasing demand for personal health services. This demand results from several factors:

1. An over-all increase in population, from 76 million in 1900 to 195 million in 1965, with a projection of roughly 260 million by 1985,
2. An increasing ratio of older persons in the population,
3. Increased urbanization, with potentially easier access to health care,
4. A rising income level, and
5. A steady increase in education level.

## Scientific and Technological Advances

In the past twenty or thirty years there have been rapid advances in both the science and technology of medical care. These advances have resulted in new and more sophisticated equipment, facilities, and medical and paramedical manpower. The changes are transforming a highly individualized profession into a vast and intricately interdependent industry.

At least two major consequences have followed from these advances in medical science and technology. First, more medical manpower and facilities are involved, with the result that medical procedures cost more money. Second, the health services industry is able to offer better results, causing a greater demand for these services.

The expansion of scientific and technical knowledge in the health field brings with it the need for changes in the delivery system so that the advantages of these developments can be enjoyed by persons requiring the services. This has a tendency to obsolete facilities, equipment, and procedures. An example of this type of change is the treatment of the mentally ill in California, where the emphasis has shifted from treatment in large State hospitals to treatment in community facilities.

## Growth of the Health Services Industry

There has been, and will continue to be, a substantial growth

in the health services industry. This is now the nation's third largest industry, exceeded only by agriculture and construction. Some three to four million people are engaged in some aspect of health services.

An interesting feature of this growth is the declining ratio of doctors to other health personnel. Whereas there was a one-to-one ratio at the turn of the century, it is now one-to-ten.

Specialization

Specialization has been increasing rapidly. In 1950, only about a third of the physicians in private practice regarded themselves as specialists. Today, the figure is closer to two-thirds.

There are a number of obvious advantages to specialization, but there are also several disadvantages. One of these is described in the following statement:

> "A major hurdle is the process of institutionalization of paramedical personnel. Every new skill in the health field tends to emulate the doctor. White coats are followed by certification, awards, association, officerships, and technical papers. More than fifty major paramedical specialties are working side by side or communicating across geographical gaps, on a downward spiral of efficiency, insulated from one another and preoccupied with the pursuit of skill, excellence, and professionalism. Even strenuous efforts of institutions cannot create enough horizontal pressure to achieve suitable coordination, so that service is relevant to the patient's total needs."[7]

Specialization, both among physicans and paramedical personnel, is adding to the complexity and difficulty of managing and utilizing health manpower. The physician is being called upon to function as a team leader, drawing upon all of the manpower resources available to him. Management skills are becoming increasingly important to the medical practitioner.

Combined Forms of Medical Practice

There is a distinct trend toward various kinds of combined medical practice. These vary from informal relationships of individual practitioners to formal incorporated groups.[8] Important legal decisions, such as the Kurzner decision, and the legal authority to establish professional corporations have influenced this trend. Salaried employment of physicians in government, hospitals, teaching, preventive medicine, and research accounted for 17% of all doctors in 1963. If one adds to these groups the unknown but growing number in partnerships, it appears that only about half the nation's doctors are still in solo practice.

Institutionalization

There is increasing institutionalization of medical care. Much of this centers around the modern hospital. These organizations range from the "medical center of excellence" visualized in the original DeBakey report[9] to a gradually evolving "campus concept". This institutionalization is

another outgrowth of the increasing complexity of medical care, including the use of highly specialized personnel and costly equipment.

Health Insurance

There has been a steady growth of mechanisms to cover expenditures for medical care, through private health insurance and expanded public medical care programs. Approximately 75% of the population now has some form of hospital expense coverage, the most prevalent form of health insurance. While there is a large portion of the population that is covered by health insurance, less than one-third of total personal health expenditures are now being met by such plans. With the passage of legislation in 1965 establishing the Medicare and Medicaid programs, additional millions of persons became eligible for insured medical care.

Comprehensive Health Planning

In the past, health planning has centered around a categorical approach. Programs have been developed to deal with such problems as tuberculosis, mental illness, alcoholism, heart disease, or cancer. Recently, this fragmented approach to planning has given way to comprehensive health planning. The Federal Government has encouraged the change by providing financial support for State, regional, and local comprehensive health planning activities.

Community-Based Programming

There has been growing acceptance of the need for more community-based health programs. At the State level, California's Short-Doyle Act was a pioneer in this regard, followed by the Federal Community Mental Health Center Program, the Mental Retardation-Facility Program, and the Neighborhood Health Centers established by the Office of Economic Opportunity.

## THE STATE'S RESPONSIBILITY FOR HEALTH

The State's basic legal authority in matters of health resides in its sovereign powers under the United States Constitution. While the State of California, under its own Constitution, has delegated certain powers to local units of government, it retains ultimate responsibility and authority for the public's health.

In its laws regarding health, the State has indicated a broad intent regarding "preservation of the public health and safety, including the health and safety of persons, ... the safety and protection of property; and matters incidental thereto".[10] In carrying out this intent, the State is responsible for organizing, financing, and staffing those health activities which the Legislature has authorized.

### The State's Role in Meeting the Health Needs of the Public

In recent years, the entire field of health has undergone major changes. This dynamic process is still underway. Most developments have revolved about concepts of public and private responsibility for health, health care delivery systems, the need for more effective controls over the environment, health facilities and manpower requirements, and the relative emphasis on health programs competing for funds. One consequence of these

changes is that public jurisdictions have been compelled to modify their roles significantly, and consequently, their health organizations and programs. In addition, there has been considerable discussion of the concept that health care should be considered a right. It is essential, therefore, that the State of California's role in meeting the health needs of the public be redefined, giving full consideration to the changes that have taken place in recent years and to future trends and developments.

The State's role in health is changing in the following directions:

1. The State is assuming greater responsibility for assuring the availability of health care.
2. The State is becoming a major purchaser of health services and reducing its role as a direct provider of services.
3. The State is accepting greater responsibility for the environment, especially in those areas detrimental to health.
4. The State is becoming increasingly concerned with meeting the growing needs for health manpower.
5. The State is accepting greater responsibility for comprehensive health planning.
6. The State is fostering community-based health programs.

7. The State is entering more frequently into fiscal and operating partnerships with the private sector in meeting health needs.

In addition, the State has significantly broadened its health authority by accepting responsibility for the implementation of various Federal programs. It does this through comprehensive health planning and policy determination; participation in regional planning; allocation of funds for specified services or facilities within the State (e.g., funds for local public health services and hospital construction); review and approval of health project proposals financed by Federal agencies (e.g., health projects under Model Cities and Housing and Urban Development programs); and certification of agencies and facilities for participation in federally-financed programs (e.g., Medicare and Medi-Cal).

The National Commission on Community Health Services (a private corporation sponsored by the American Public Health Association and the National Health Council) has provided a clear indication of the important role of the states in meeting health needs, as follows:

> "In discussing new organizational patterns for health services, the Commission arrived at the opinion that the state is the jurisdictional entity on which attention must be primarily focused. For, despite the continuing demand for independence among smaller, local communities, and despite a greatly increased participation by the federal government in matters pertaining to health and welfare, the state still holds the mandate stated in the Constitution of the United States as the governmental center of all power not

> specifically held by the federal government. In like measure, all counties, townships, and cities are political creatures of the state and their powers have been delegated to them by the state. Therefore, while there is a definite tendency to develop regional approaches (interstate and intrastate) to health services, by planning for them on the basis of geographical areas whose residents wish to secure common community objectives, it still seems feasible to consider the state as the filter, the arbiter, and in many instances, the level at which plans and programs are initiated. ..." [11]

## The State's Health Goals and Functions

For the State to exercise such leadership, a set of broad health goals must be enunciated. Functions essential to the State's achieving its health goals must be identified also. The Task Force recommends the following goals, along with some related functions, most of which would be the responsibility of a Department of Health:

GOAL To identify health needs and develop programs to meet them, giving consideration to relative priorities and effectiveness.

Functions

... Identify and evaluate health needs and problems

... Develop policies, plans, and programs

... Set program priorities and allocate resources

... Evaluate program effectiveness

... Encourage innovation

GOAL To promote an environment that will contribute to human health and well-being.

Functions

... Identify factors that cause deterioration of a healthful environment

... Set and enforce standards to control such factors

... Insure that consummable goods and other products available to the public are not detrimental to health

GOAL To assure the availability of comprehensive health services for all Californians, utilizing both public and private health resources.

Functions

... Develop plans to meet health manpower and facility requirements

... Provide assistance in the development of health facilities

... Train a portion of the health manpower

... Provide financial assistance to certain groups of people who are unable to bear the cost of medical care

... Provide certain types of direct medical services if private or local public treatment resources are unavailable or unsuitable

... Provide funds to cover some of the cost of local health program development

GOAL To assure that quality standards for health programs and services are established and maintained.

Functions

... Set standards for certain types of health manpower and facilities

... Ensure that standards are met

... Set and enforce performance standards for local subsidy programs

GOAL To assist in coordinating the activities of health agencies -- State and local, public and private -- along with medical schools, hospitals, and private practitioners, in providing health services.

Functions

... Ensure that the State's health programs are administered in an integrated way and that program fragmentation is avoided

... Provide consultation and technical assistance to public and private agencies in meeting health manpower and facility needs and in designing more effective systems for the delivery of health services

GOAL To promote the development of new knowledge on the causes and cures of illness and on the means of delivering health services to the public.

Functions

... Develop and maintain a health information system

... Conduct basic research

... Conduct research designed to deal with specific health problems

... Support the design and demonstration of more effective systems for the delivery of services

GOAL To help all the State's citizens understand the essentials of positive personal health and the effective use of available health services.

Functions

... Assist the public school system in presenting an effective health education program

... Extend the general public knowledge of nutrition

... Assist local public and private health agencies in broadening understanding of health and the use of available services

... Build an education component into all health programs

Need for a Unified Department of Health

One of the earlier task forces recommended consolidation of "all health-related departments into one unified Department of Health". Further consideration, including discussion at Cabinet level and the Agency charge to this Task Force, tended to reinforce this view. However, the charge was sufficiently

flexible that had this Task Force found some other alternative, including the status quo, to be clearly superior, it would have been free to recommend it.

It is the Task Force's independent conclusion that a unified Department is essential to the effective administration of the State's health programs. It is also clear that substantial consolidation of health programs will be necessary if the State is to fulfill its health goals. Accordingly, the Task Force recommends that the State of California proceed with the establishment of a Department of Health.

## COMPONENTS OF A DEPARTMENT OF HEALTH

The Task Force was charged with responsibility for developing an organization plan for a unified Department of Health. Having identified the State's health goals and functions, most of which would be the responsibility of a Department of Health, it was then necessary to analyze the many health and health-related programs in State Government to determine which of these should be transferred into a Department of Health.

Some guidance was provided by the work of the National Commission on Community Health Services, mentioned earlier in this report. The Commission conducted a four-year nationwide study of community health needs, resources, and practices, out of which it developed the following concept of a state health agency:

> "Every state should have a single, strong, well-financed, professionally staffed, official health agency with sufficient authority and funds to carry out its responsibilities. The state should assure every community of coverage by an official health agency and access to the complete range of community health services.
>
> "This state agency must be able to work effectively with federal agencies, to provide all the environmental and personal health services for which it is responsible, to stimulate and support the development of local health units that will provide official health agency services to local communities, to take leadership in broadening the scope and quality of health services available to its communities, and to respond positively to the health needs of the public.

> "This single agency, in which all the major health programs of the state government should be concentrated, would be able to coordinate the various environmental, preventive, curative, and rehabilitative components into a comprehensive health service system. It should be responsible for setting the health standards of other state programs even though they may be a secondary activity of another agency."[12]

As a first step in determining which functions should be transferred to a Department of Health, the Task Force inventoried the health-related programs in a number of State departments. While the primary interest was in the Departments of Mental Hygiene, Public Health, Health Care Services, Rehabilitation, and Social Welfare, the Task Force also looked at programs in several other departments. As an aid to understanding and classifying these programs, the Task Force developed a program structure for health, viewing State Government as a whole. (Appendix D) The Task Force also established criteria to assist in analyzing the desirability of including specific functions in a new Department of Health, as follows:

1. The function is concerned primarily with health preservation or restoration and is essential to accomplishment of a key objective of a Department of Health

or

2. The function is one which, because of close interrelationships with health, can be carried out most effectively if combined with other programs in a Department of Health.

If a function met one of the above criteria, the Task Force also examined it from the standpoint of how its transfer to a Department of Health from an existing department would affect the remaining programs in that department.

Applying these criteria to a number of functions led to the conclusions shown graphically on page 36. A discussion of the specific components follows:

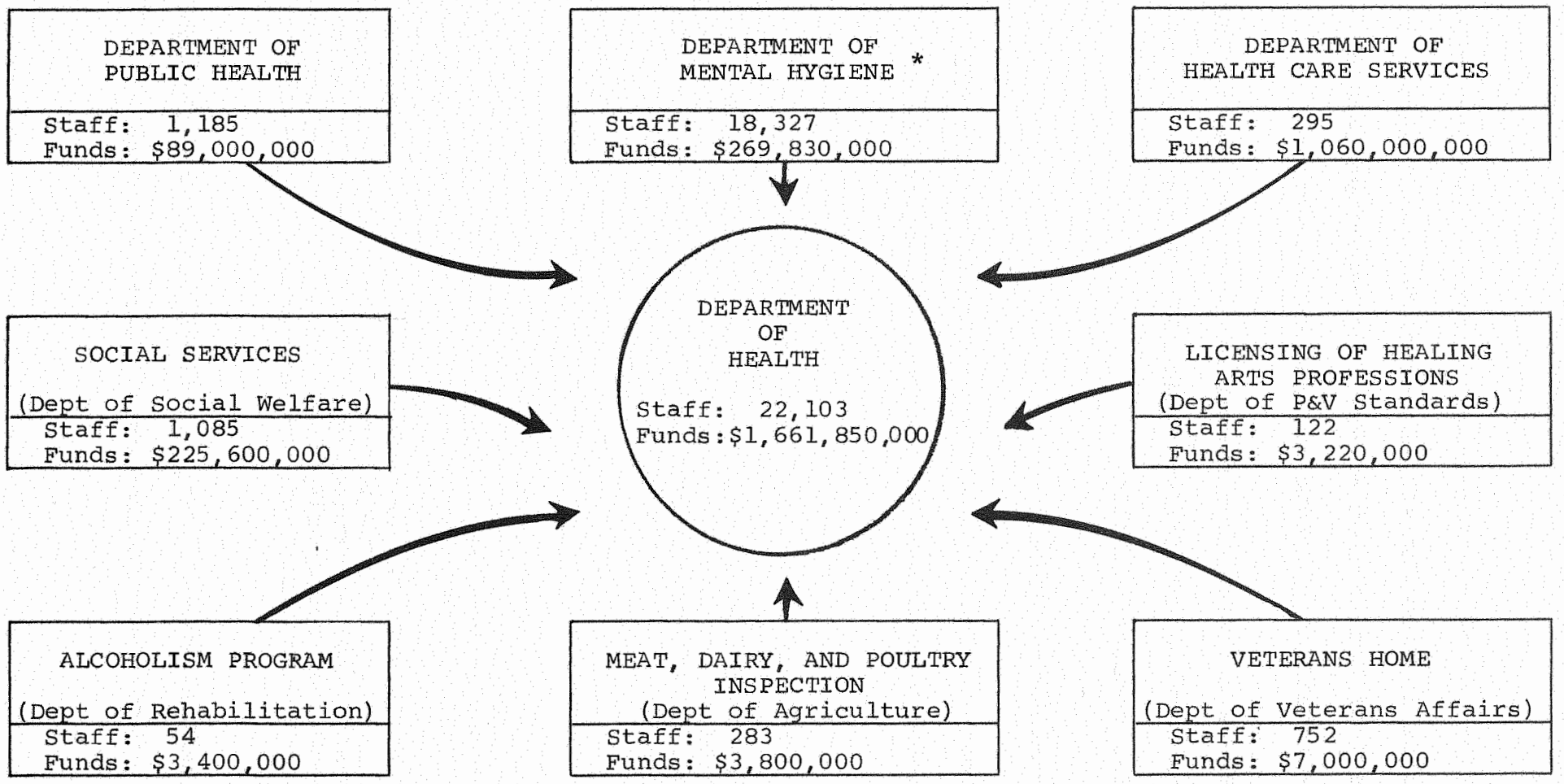
Department of Public Health

The Department of Public Health's program budget for the 1969-70 fiscal year describes its over-all objectives as follows:

> "The continuing mission of the State Department of Public Health is to promote the highest level of health attainable for every Californian in an environment which contributes positively to healthful individual and family living. This necessitates attention to all the complex factors that influence health and that cause disease, disability, and death. It also demands the technical competence and resources to forestall potential threats to health as well as to ameliorate adversity.
>
> "Within this mission, departmental responsibility includes identifying those biological, physical, and social conditions in working, living, and recreational environments that are detrimental to healthful living; planning and coordinating the provision of high quality comprehensive health services and facilities to all segments of the population for the prevention and control of disease and disability; and encouraging the full participation of the people in recognizing their health concerns and interests and in taking appropriate action in relation to these."[13]

The Department attempts to achieve these objectives through three basic programs: Environmental Health and Consumer

# COMPONENTS OF A DEPARTMENT OF HEALTH




NOTE: "Staff" represents funded positions, 1969-70 F.Y.
"Funds" represents total dollars (Federal, State, and local) controlled by the department, 1969-70 F.Y.

* Neuropsychiatric Institutes (Staff: 1,055; Funds: $13,170,000) to be transferred to University of California.

Protection Program, Preventive Medical Program, and Community Health Services and Resources Program. The Task Force concluded that all of the functions carried out under these programs are appropriate to a new Department of Health.

Department of Mental Hygiene

The Department of Mental Hygiene is responsible for providing mental health services, including diagnosis, care and treatment, and rehabilitation of mentally ill or mentally retarded persons for whom no other treatment resources are available or suitable. This responsibility is carried out through the operation of 14 State hospitals. The Department administers the Lanterman-Petris-Short Act, which provides funds for community programs for the mentally ill. The Department also conducts research into the causes, treatment, and prevention of mental illness and retardation; provides education for the general public on mental health; and conducts training for mental health specialties.

With one exception, the Task Force concluded that all of the functions of the Department of Mental Hygiene should be transferred to a Department of Health. The exception is the two Neuropsychiatric Institutes, one in San Francisco and the other in Los Angeles. The Institutes are located on the campuses of the University of California Medical Schools in those cities and are jointly staffed by the Department of Mental Hygiene and the University.

The programs for which the Neuropsychiatric Institutes are responsible are academic instruction and basic and clinical research. These are essentially university functions. Moreover, they appear to be incidental to the primary mission of the Department of Mental Hygiene, which is to provide diagnosis, care, treatment, and rehabilitation of the mentally ill and mentally retarded. This is not to ignore the continuing need of the State hospitals to conduct staff training in job-related knowledges and skills and to carry on research that is an integral part of its basic programs.

Since the Neuropsychiatric Institutes are performing a predominantly university function in a university setting and their transfer would have relatively little impact on the other Department of Mental Hygiene programs, the Task Force concluded that the Institutes should be transferred to the University of California for integration within its total educational system.

Department of Health Care Services

The Department of Health Care Services is responsible for administering the California Medical Assistance Program (Medi-Cal). The program was established by the California Legislature in 1965, following passage by Congress of Title XIX of the Social Security Act (Medicaid).

The objective of Medi-Cal is to provide for the purchase of basic health care and related remedial or preventive services

for recipients of public assistance and for medically needy persons. While the program is carried out under the over-all direction of the Department of Health Care Services, it also involves several other State and local government agencies. Each county, through its welfare department, certifies program eligibility for the applicants who meet established standards. The providers of services send their bills to the State's fiscal intermediaries (Blue Cross and Blue Shield) for payment. The fiscal intermediaries check the claims for program compliance and make payments to the providers of services.

The projected Medi-Cal caseload for the 1969-70 fiscal year is 1.8 million, which includes 1.6 million in the categorical aid programs, 175,900 medically needy, and 7,000 mentally retarded patients. Medi-Cal expenditures for the fiscal year, as shown in the 1969-70 Governor's Budget, total $1,059,532,571. This is made up of: State General Fund, $386,768,790; County funds, $218,842,000; Federal funds, $453,921,781.

Obviously, the impact of a billion-dollar public expenditure program on the existing health care delivery system is substantial. This raises a fundamental policy issue: Should the State attempt to use this purchasing power to influence the character of the total health care delivery system? There is no question that the State, in spending this amount of money for medical care, <u>is</u> influencing the system, even if only to perpetuate the existing system. The issue revolves around the question of whether this influence should be random or purposeful.

There is ample evidence to support the view that the health care delivery system is inefficient, wasteful, and costly. For example, Secretary of Health, Education, and Welfare, Robert H. Finch, stated recently, "The Medicaid program, which already is costing twice as much as originally projected, was instituted with an appalling lack of planning." In calling upon the medical profession to join with government to provide the people with an adequate health care system, Secretary Finch added, "The crisis of which I speak is many-sided. It is a crisis of escalating costs, of inadequate facilities, of flaws in resource distribution, and at the very core it is a crisis of manpower."[14]

In 1967, the National Advisory Commission on Health Manpower reported that "Medical care in the United States is more a collection of bits and pieces (with overlapping, duplication, great gaps, high costs, and wasted effort) than an integrated system in which needs and efforts are closely related".[15]

Walter J. McNerney, President of the Blue Cross Association, stated recently:

> "... it is essential to face the fact that the system is fragmented, with gaps and overlaps in service, one that is too difficult for too many patients to use well when in need, or, at times, to afford. Bolder strokes than those taken to date are needed to give it greater effectiveness.
>
> "The challenge is one of selective involvement in providing discipline to the system without smothering its initiative and vitality. ..."[16]

Last year the Federal Government spent $1.6 billion on biomedical research. During that same year it spent less than $18 million for research on ways to improve the delivery of health services.[17]

Former Secretary of H.E.W., Wilbur J. Cohen, put the problem in this way:

> "American health care is not really a 'system' but is essentially a mosaic of public and private health programs -- one that has grown piecemeal to meet needs as they arose ...
>
> "This dynamic, pluralistic arrangement has definite advantages. It provides opportunities for innovation and competition for quality development, and incentives for organizational and quality improvements. And it has produced amazing medical miracles.
>
> "But out of it has evolved a number of serious problems that are likely to continue to face us in the decade ahead. Among the most serious, I would include the fact that the supply of certain services, such as those of physicians, dentists and nurses, is inadequate. There is often an excess in supply -- duplication -- of some services and facilities for high-income individuals, including some very expensive hospital services, and health facility planning is not now performed adequately. Also, children, the poor, the disadvantaged, the blacks, and other minority groups, often have inadequate access to medical care. There are often shortages in less costly alternatives to hospital care such as outpatient care, home health services, extended-care facilities and nursing homes. Some costly services, especially hospital services, are sometimes utilized unnecessarily. Many private health-insurance plans produce undesirable incentives to use the most expensive methods of care; there are substantial gaps in the coverage of health insurance. The cost of many drugs is too high. Many possible hospital management improvements have not been adopted. The growth of group practice has been retarded by legal bars and restrictive attitudes. Productivity in the provision of medical care has not been defined and measured. Insufficient attention is given to preventive care and health education. There are insufficient financial incentives to restrain mounting hospital costs while maintaining high-quality medical care.

> "Ignorance of quality comparisons or the failure to undertake them have resulted in the purchase of high-priced drugs or unnecessary services. There has been unsatisfactory organization of activities at all levels -- public and private -- in the health field. In summary, there are serious deficiencies in the organization, financing and delivery of health care in the United States.
>
> "These problems create obstacles to the provision of adequate health services for all Americans. Although the poor suffer most from the inadequacies of the system, American families of all income levels are experiencing the consequences of our piece-meal system."[18]

In discussing the role of a State health agency, the Advisory Committee on H.E.W. Relationships with State Health Agencies stated:

> "... A revolution in health delivery systems is called for; the situation demands innovation, wider use of allied health personnel, new channels of cooperative effort, and new partnerships. The state health department should be the focal point for these changes."[19]

The Task Force found these and similar arguments persuasive. While State Government must be concerned with the cost of Medi-Cal, there is an even larger concern, and that is the increasing cost of medical care for all Californians. The health services industry must be encouraged to find less expensive but equally effective forms of care. At present, insurance coverage is directed primarily at expenses incurred by patients while they are in a hospital, thus encouraging patients and their doctors to choose hospitalization when less costly outpatient facilities or services would be equally satisfactory from a medical standpoint. This emphasis on hospitalization in lieu of ambulatory care has been underscored

by Dr. Joseph P. English, Administrator of the Health Services and Mental Health Administration, Department of Health, Education, and Welfare, who said:

> " ... in recent years a great many conferences, commissions, and task forces have pointed out the need for relatively greater attention to ambulatory care vis-a-vis institutional inpatient services ... But when we look at the total health care enterprise, we must admit that we are not putting our money where our mouths are. As a result of the cumulative impact of our financing mechanisms and the present patterns of care, the system is swinging ever more strongly toward the institutional modalities of care."[20]

The Task Force concluded that the State of California has the opportunity -- and the responsibility -- to spend its Medi-Cal dollars in such a way that it exerts a constructive influence on the health care delivery system. Working in cooperation with the private sector, it can encourage the development of less expensive forms of medical care. It can stimulate and provide incentives for innovation. One of the State's major concerns in conducting comprehensive health planning should be the health care delivery system. If major improvements are to be realized in the system, it is essential that these planning decisions be reflected in program decisions related to Medi-Cal.

One other argument for including the functions of the Department of Health Care Services in a new Department of Health is that, in assessing total health needs and setting priorities, expenditures for the Medi-Cal program should be arrayed alongside expenditures for other programs competing for the health

dollar. There are those who contend, for example, that the State is spending too much on curative medicine and not enough on preventive health services. These kinds of decisions on resource allocation among competing programs can be made most effectively if Medi-Cal is viewed in the context of all the major health programs.

The main arguments presented to the Task Force against including the functions of the Department of Health Care Services in a Department of Health are (1) that Medi-Cal is a welfare program and not a health program, and (2) that there is more likelihood of the State's establishing effective cost controls on the program if it continues to be administered as a separate department. Advocates of this point of view contend not only that Medi-Cal is a welfare program, but that it is essential to maintain its identity as such. They point out that roughly 90% of the beneficiaries of Medi-Cal are recipients of some form of categorical assistance under the welfare program. They are also concerned that the costs of Medi-Cal would be submerged in a Department of Health and that there would be less likelihood under that organizational arrangement of establishing effective cost controls on the program.

The Task Force is well aware of the concern over the cost of Medi-Cal. However, the Task Force believes that in the long run the best chance of holding down the cost of this program is by improving the total health care delivery system through

the development of less costly alternative forms of care. This can be accomplished most easily if the responsibility for Medi-Cal is placed in a Department of Health, where it can be related more closely to basic health planning policies and decisions.

Social Services

The State Department of Social Welfare supervises the administration by the 58 counties of money payments to public assistance recipients and the provision of social services. The department reviews and licenses plans for the reception and care of the aged and children, both directly and through delegation to local agencies. It licenses public and private adoption agencies and provides reports to the courts on independent adoptions. It issues certificates of authorization for certain institutions to enter into "life care" contracts with aged persons. The department also provides directly certain social services, chiefly those related to adoptions, child protection, and patients released from State hospitals.

Under supervision of the Department of Social Welfare, the counties provide a broad range of social services to people -- most of whom are also recipients of cash or medical assistance. These social services have varying degrees of relatedness to health services. They range from the placement services for mentally or physically handicapped patients discharged from State hospitals to the supervision of county adoption programs;

from identification of medical treatment needs to promotion of adequate child nutrition; and from family planning counseling to the provision of a home health aide or homemaker.

It is becoming increasingly difficult to draw a clear line between health services and social services. This is evident when we examine some of the overlapping programs in this area. For example, alcoholism clinics, local mental health clinics, and diagnostic centers for the mentally retarded compete with the county welfare department's protective services for budget resources, qualified staff, and even clients. This fragmentation is evident also in the home health aide services for the temporarily ill, permanently disabled, or feeble aged. These services are licensed by the Department of Public Health, funded by the Department of Health Care Services, duplicated in large measure by the Department of Social Welfare's attendant care-homemaker program, and used by the same client group. To cite still another example, a health visitor from the county health department makes a post-partum call on almost every new mother to identify health problems; the county welfare department social service worker makes a routine call on each AFDC mother with a new baby to make sure that both mother and child are well and that the baby is not neglected.

Organizational separation of closely related services at the State level is carried over to the local level, with the result that the person seeking assistance is often shunted from one agency to another in a frustrating effort to coordinate for

himself those services that government has failed to coordinate. It is the Task Force's hope that the State, by placing its own house in better order, will stimulate local government to provide for better integration of its health and social service programs, with a consequent improvement in the quality of service to the public.

One of the social service functions for which the Department of Social Welfare is responsible is licensing of institutions for children and aged persons. The Departments of Public Health and Mental Hygiene also have licensing functions with respect to certain types of out-of-home care facilities. The administration of these licensing functions by the State has been subject to considerable criticism in the past. All indications are that the licensing of out-of-home care facilities will be an expanding function as the State continues to move toward more community-based programs. It is essential, therefore, that the existing problems in relation to facility licensing be solved as soon as possible.

The second health Task Force identified the following problems resulting from this fragmentation of responsibility for facility licensing:

1. Multiple interpretation and application of licensing laws, rules, and regulations by licensing departments.
2. Inconsistencies in enforcement through inspection by several departments.

3. Enforcement and regulation by more than one department for some facilities.
4. Duplication of consultative services within licensing departments.
5. Lack of accountability for consistency in setting and revising standards.
6. Lack of a comprehensive licensing program which emphasizes the common program elements of medical, health, and social care instead of the distinctive elements.[21]

It is the present Task Force's opinion that consolidating the facility licensing functions of the Departments of Mental Hygiene, Public Health, and Social Welfare in a Department of Health will enable the State to overcome the problems indicated above.

The Federal Department of Health, Education, and Welfare has recommended organizational separation of social services from cash payments in welfare programs. The State Department of Social Welfare has already organized along these lines and has directed county welfare departments to effect a similar organizational separation by July 1, 1970. The Task Force agrees with this separation and feels that the State should take the additional step of effecting a closer integration of health services and social services.

The value of social services to health programs has been recognized for a long time. For example, each of the State hospitals

has a staff of social workers. The staff of the Community Services Division of the Department of Social Welfare, which assists in providing out-of-home placement for persons released from the State hospitals, was in the Department of Mental Hygiene until a few years ago. (The staff was transferred to the Department of Social Welfare primarily to optimize Federal funding.) In addition, both the Department of Public Health and the Department of Health Care Services have small social service staffs.

Social services are also recognized as an essential part of various community health programs. In the local mental health program, the diagnostic centers for the mentally retarded, and the OEO Neighborhood Health Centers, social workers serve as a valuable part of the total therapeutic team.

It was the Task Force's conclusion that:

1. Most of the social service functions of the Department of Social Welfare are related in one way or another to protective living,
2. The primary reason for providing protective social services is to insure the health and well-being of people requiring this kind of assistance,
3. It is becoming increasingly difficult to draw a workable dividing line between health services and social services, and
4. The public will be served best by integrating these services as fully as possible.

Licensing of Health Professionals

Within the Department of Professional and Vocational Standards, there are ten licensing boards related to the healing arts. They are responsible for issuing licenses to more than 310,000 persons. Their purpose is to protect the public by insuring that persons practicing the healing arts possess the necessary skill and proficiency. Some of the boards have the additional responsibility of establishing and enforcing standards for accreditation or approval of more than 500 schools in their respective fields. The healing arts boards include:

Board of Chiropractic Examiners
Board of Dental Examiners
Board of Medical Examiners
Board of Nursing Education and Nurse Registration
Board of Optometry
Board of Osteopathic Examiners
Board of Pharmacy
Board of Examiners in Veterinarian Medicine
Board of Vocational Nurse and Psychiatric Technician Examiners
Social Worker and Marriage Counselor Qualifications Board

The boards have broad statutory powers to set standards, conduct examinations, investigate complaints, and take disciplinary action against erring licensees. The number of members on a board varies from five to twelve. The staff assigned to each

board varies from one to thirty-one. Board members are appointed for three or four-year terms by the Governor and are selected from the professions licensed, except for one non-licensed public member on six of the boards.

The Department of Public Health also licenses or certifies a number of types of health personnel. These include clinical laboratory technologists and trainees, bioanalysts, home health aides, public health microbiologists, public health nurses, public health sanitarians, radiologic technicians, and school audiometrists.

Providing sufficient health manpower is becoming an increasingly serious problem. The problem has been aggravated by the fact that Medicare and Medicaid have made health care services available to many persons who did not have access to them before. The State has an obligation to assess the need for health manpower and take steps to meet the need. This includes such things as working with public and private training institutions to provide the necessary curricula, stimulation of new approaches to meeting manpower needs, and encouraging those responsible for licensing the health professions to tailor their credentialing requirements so that they are truly relevant to the tasks to be performed.

This is consistent with steps being taken by the United States Department of Health, Education, and Welfare to support innovative programs aimed at shortening physician training

curriculums, increasing the number of family physicians, and training physicians in the efficient and effective use of auxiliaries. In line with its announced intention of integrating returning medical corpsmen into the health care team, the Department of Health, Education, and Welfare plans to work for revisions of State licensing practices and educational standard setting to permit greater mobility within health occupations and greater access to such occupations by those who can substitute experience for education.[22]

The healing arts boards in the Department of Professional and Vocational Standards are limited in their capacity to provide this kind of leadership in meeting the total need for health manpower. The autonomy of the individual boards, along with the small size of their staffs, inhibit them from viewing the problem in terms other than that of a relatively narrow occupational specialty. The present organization, in some cases, has also led to a series of exclusive and rigid requirements for licensing in particular fields. Upgrading from one field to another may require repetition of the education required for the lower level.

The Task Force sees several advantages in placing the licensing of healing arts professions in a Department of Health. It will facilitate the coordination of the licensing function with health manpower planning. It will provide a better climate for innovation in meeting the rapidly expanding demand for health manpower. It will be better able to eliminate the

artificial barriers that exist among professional classifications. It will provide a better framework within which to evaluate the need for new professional boards when new specialties emerge with a request for licensure. And a Department of Health will be in a position to encourage the educational institutions to develop new and improved courses of instruction.

Alcoholism Program

The State's alcoholism program started with the establishment of an Alcoholic Rehabilitation Commission in 1954. The program was transferred to the Department of Public Health in 1957. In 1967, legislation was passed directing the Department of Public Health to contract for services with the Department of Rehabilitation, followed by legislation in 1969 which designated the Department of Rehabilitation as the State department responsible for the alcoholism program. The primary reason for transferring the function to the Department of Rehabilitation was to take advantage of the more favorable Federal funding. However, recent Federal legislation (Section 204, PL 90-577) appears to have removed the necessity for locating the program in the Department of Rehabilitation in order to assure maximum Federal participation.

Under the provisions of the McAteer Alcoholism Act, the Department of Rehabilitation operates one clinic directly and contracts with cities and counties to operate ten others.

A similar program exists within the Department of Mental Hygiene, which administers the Lanterman-Petris-Short program. This program provides treatment and care through local clinics, purchased services, and State hospitals. The Task Force is unable to identify any concerted effort to coordinate the activities of the two programs.

Transfer of the alcoholism clinic program from the Department of Rehabilitation to a Department of Health will reduce the fragmentation in this program area and will facilitate a systematic approach to the prevention of alcoholism and to the identification, treatment, and rehabilitation of alcoholics.

Meat, Dairy, and Poultry Inspection

All meat, poultry, and dairy products sold in California are subject to inspection. The principal agency responsible for these programs is the State Department of Agriculture.

Inspections made of milk, milk products, and products resembling milk products start at the dairy ranch, or other production facility, and continue through processing to the consumer. The objectives of the inspection program are to insure that the products are nutritionally adequate, that they are not hazardous to health, and that they are unadulterated and properly labeled. The inspection includes physical facilities, equipment, operational procedures at producer and processor levels, and serving of both milk products and products resembling milk products at restaurants. The conduct of these

inspections is divided approximately equally among three groups: State Department of Agriculture field staff, local milk inspection districts, and county health departments.

The objective of the State Department of Agriculture's meat inspection program is to insure that only wholesome, clean, and truthfully labeled meat products are sold to the consumer. Inspections are conducted in slaughtering and processing establishments. Meat food labels are approved. The department maintains quality standards through chemical laboratory analysis for biological residues, pesticides, permitted and non-permitted additives, contaminants, adulterants, and preservatives.

The poultry inspection program attempts to assure the sale of wholesome, unadulterated, and correctly labeled poultry products. The Department of Agriculture carries out this responsibility by enforcing sanitary building and processing procedure requirements in plants licensed to process poultry and rabbit meat for human consumption.

The Department of Public Health conducts several related functions. Its food protection program attempts to eliminate or reduce chemical, bacterial, or physical adulteration; misbranding; false advertising; and substandard food products. Its cannery control program attempts to eliminate the risk of botulism.

The primary purpose of the meat, dairy, and poultry inspection functions of the Department of Agriculture is to protect the consumer public from human and animal diseases capable of being transmitted through these food products. The Task Force regards this as basically a health purpose and believes that the functions should be made the responsibility of a Department of Health.

State Veterans Home and Hospital

The Department of Veterans Affairs is currently responsible for administering the State Veterans Home and Hospital. The facility is supported by both Federal and State funds. It provides not only hospital care, but also nursing home and domiciliary care. The average age of the residents is 72 years.

Since 1957, use of the domiciliary wards has declined so that less than half of the 1,558 beds are now utilized. The hospital and nursing home wards, on the other hand, are utilized at over 90% of capacity. Further evidence of the medical orientation of the facility is the fact that approximately 56% of all civilian employees are medical, ancillary, or paramedical personnel.

The Task Force concluded that the Veterans Home and Hospital program is primarily medical and that the facility should be made the responsibility of a Department of Health. Bringing the facility into the same organization with other health

programs will make possible the sharing of technical and management knowledge, better utilization of staff, improved professional contacts, and better care for the resident veterans.

Programs Reviewed but Not Included in a Department of Health

In addition to the functions described above, the Task Force examined a number of other health-related programs to determine the feasibility of including them in a Department of Health. For various reasons, the Task Force decided not to recommend their inclusion at this time. Several of these programs merit special comment, as follows:

1. Pesticide residue and agricultural chemical programs.

The State Department of Agriculture carries out several functions relating to agricultural chemicals and pesticides. It requires agricultural chemicals to be properly labeled and provides for inspection and enforcement of quality requirements. It licenses agricultural pest control operators, regulates the use of pesticides, the sale of pesticides, and the issuance of licenses to qualified pest control operators and pilots operating aircraft used in pest control. It establishes standards for pesticide residues and conducts inspections to see that the standards are not violated.

While these functions have a health relationship, the Department of Agriculture is also concerned about the effectiveness of pesticides in eliminating plant pests.

The Task Force concluded that the Department of Agriculture should retain its present responsibilities in this field. It concluded further that a Department of Health should conduct and support research activities in the field of pesticide residue, make recommendations regarding standards for residue, and maintain an overall surveillance on the use of agricultural chemicals as they affect the health of the people of California.

2. Air Resources Board

The extent to which air pollution is a health problem is an issue subject to considerable debate. This adds immensely to the difficulty of defining the responsibility of a Department of Health in controlling air pollution. Does it involve only questions of whether air pollution clearly contributes to morbidity or disease, or does it extend to eye irritation which may affect comfort but is not a serious illness? Does it extend to increased stress, which may be the primary "health" effect of limitation of visibility? A good case could be developed that almost any aspect of air pollution has some health connection and should be within the sphere of a Department of Health. On the

other hand, there are other interests besides health that are concerned with air pollution. For example, concern with hydrocarbons in California's air stems primarily from its adverse affect on vegetation and agricultural crops rather than on human health.

The Task Force concluded that no action should be taken to transfer the functions of the Air Resources Board to a Department of Health. In addition to the fact that there are other interests besides health that are concerned with air pollution, the Task Force noted that the Air Resources Board is a relatively new organization that has not yet had an adequate opportunity to prove its effectiveness.

The Task Force believes, however, that a Department of Health has a valid concern with the problem of air pollution and its impact on human health. The proposed Department should conduct research to determine more precisely what that impact is; it should continue to recommend minimum standards for air quality; and it should exercise surveillance as to the current status of air quality and its effect on human health.

3. Water Quality Control.

The State Water Resources Control Board and the nine Regional Water Quality Control Boards are charged with providing coordinated, statewide control of water

quality and water rights so that the water resources of the State are beneficially utilized to the maximum extent, and to prevent water pollution by unreasonable waste disposal practices.

The State Water Resources Board, established in 1967, is the successor to the State Water Quality Control Board. The Regional Water Quality Control Boards (and the previous State Water Quality Control Board) date back to 1949, when the responsibility for water pollution control was shifted to them from the Department of Public Health. These boards have been part of the Resources Agency since its establishment in 1961.

Following the establishment of a stronger organization in 1967, the State Water Resources Control Board, at the request of the Assembly Committee on Water, created an independent panel to study the water quality program. The results were enacted in 1969 as the Porter-Cologne Water Quality Control Act. This act materially strengthened the authority of both the State and regional boards. It also declared the intent of the Legislature for a stronger water quality control program and strengthened the existing law and enforcement procedures.

A number of other departments in State Government, such as Public Health, Fish and Game, Agriculture, and Water Resources, are also concerned about maintaining water

quality. The Department of Public Health, for example, maintains surveillance and exercises preventive and control measures relative to providing safe, wholesome, and potable water supplies; to treatment and reuse of sewage without hazards of disease or adverse effects upon water supplies; to assuring that shellfish are grown and processed in water such that the product will be free of disease organisms, hazardous chemicals, and toxins; and to achieving sanitation and safety for bathers at public swimming pools, beaches, and other recreation areas. The staff works closely with staff of the State Water Resources Control Board and the regional boards.

The Task Force concluded that no action should be taken to transfer any of the water quality functions of the State Water Resources Control Board or the nine Regional Water Quality Control Boards to a Department of Health. One reason for this is that health is just one of a number of interests concerned with water quality.

Another reason why no change is being considered at this time is the recent reorganization in 1967, followed by the significantly strengthened program adopted in 1969. Prior to 1967, the State and Regional Boards admittedly represented a weak administrative structure, with limited power and authority to deal with the problems of water pollution and water quality. The new organization, with

stronger laws and enforcement procedures, reflects public demand for more effective water quality control. The Task Force concluded that these developments should be allowed time to demonstrate their effectiveness before any further changes are considered.

The Task Force believes, however, that the present powers and responsibilities of the Department of Public Health relating to water quality are appropriate for a Department of Health. The new Department should carry out research on the impact of water quality on human health. It should exercise general surveillance over the status of water quality. It should have summary abatement powers when water contamination represents a threat to human health. It should formulate and recommend minimum standards of water quality necessary for human health. And it should be a strong spokesman for health concerns relating to water quality.

4. Division of Industrial Safety.

The Task Force examined the functions of the Division of Industrial Safety of the Department of Industrial Relations for possible inclusion in a Department of Health. The Division's program is aimed at preventing industrial injuries and deaths to California workers. The Department of Public Health has two related functions, namely, occupational health and radiological

health, as part of its Environmental Health and Consumer Protection Program. The Division of Industrial Safety has a staff of about 300, most of whom are safety engineers. The Department of Public Health, in its occupational and radiological health functions, employs a staff of 55, most of whom are physicians, chemists, statisticians, nurses, and other health-related specialists.

While there is some similarity in these functions, the Task Force concluded that:

a. The responsibilities of the two departments' programs in this area are delineated,
b. The programs appear to be coordinated, so that there is a minimum of duplication,
c. The roles of the two departments are established and understood by their respective "publics", and
d. There would be little advantage in transferring the entire Division of Industrial Safety to a Department of Health.

The programs of both departments are clearly directed toward the safety and health of employees in work situations. There may well be a need for a more extensive program of safety for the general public, not limited to industrial working conditions. If such a program were established, the skills of both groups would be

extremely useful in this broader approach to safety and accident prevention. At that point, consideration might be given to consolidation of the two functions in a Department of Health.

If there is no immediate action taken along the lines suggested in the previous paragraph, it would, however, be in order to analyze further the responsibilities and staffing of the two organizations in the radiological and occupational health areas. The Task Force felt that a more intensive review than was possible during this study would suggest consideration of nominal transfers of specific activities and related personnel to clarify the responsibilities and consolidate health-related activities. Since this is not a major organizational or program change, it could be accomplished administratively within the Human Relations Agency.

## RECOMMENDED ORGANIZATION

Having reached certain conclusions with regard to the components of a Department of Health, the Task Force then developed an organization structure for the new Department. The Task Force, before deciding on a recommended organization, examined several alternatives, including proposals developed by groups outside State Government. (Appendix E)

The recommended organization structure is not intended as a detailed blueprint. Rather, it is a concept of what the Task Force considered to be a logical grouping of functions in a Department of Health. Once the Director of Health is appointed, he and the staff assisting him with the implementation planning should have the flexibility to modify the structure as necessary.

### Criteria for Recommended Organization

In evaluating various organizational alternatives, the Task Force was guided by a number of criteria which should be met by a new Department of Health. The Task Force felt that the new Department should be capable of ...

... conducting comprehensive health planning, giving consideration to the needs of all Californians.

... establishing goals and setting program priorities.

... making a rational allocation of health resources among programs competing for these resources.

... consolidating or coordinating programs that are now fragmented.

... fixing responsibility and accountability for program results.

... evaluating program effectiveness in accomplishing stated goals.

... exerting a major impact on environmental issues that affect people's health.

... fostering better service to the public through the integration of health services and social services.

... influencing constructively the nature of the health care delivery system.

... moving toward a continuum of care, embracing both preventive and curative services.

... making effective use of advisory boards and commissions.

... demonstrating a concern for people's health, in the broadest sense, and moving away from the archaic dichotomy between the physically ill and the mentally ill.

... maintaining sufficient flexibility to modify programs and organization structure in response to changing public needs.

... placing more responsibility for health-related services at the local level, with a gradual reduction in the State's role as a provider of direct services.

... making optimum use of Federal funding without resorting to cumbersome organizational arrangements in order to meet Federal requirements.

It is the Task Force's view that the recommended organization is capable of meeting these criteria.

Director of Health

Selection of a director for the Department of Health is a matter of utmost importance. He will be responsible for administering the largest department in State Government, excluding the University and State Colleges, with approximately 22,000 employees. He will be responsible for the annual expenditure of $1.7 billion in Federal, State, and local funds. He must organize and manage a broad range of programs with numerous public and private groups with an interest in health services.

To carry out these responsibilities, the Director should be a person with proven managerial skills. In molding the Department of Health into an effective organization, it will be most important to have a director who is able to deal with a broad range of programs, to select capable subordinates, to organize resources effectively, and to apply sound judgment to difficult issues.

Some of these desirable qualities were described well in a recent publication:

> "Ideally, an administrator should be an individual with proper training, experience, and temperament to work with and through people. He must understand problems of precedent, organization, personnel administration, and decision making and be able to function with such judicial evaluation that his judgment will be equitable and acceptable, even though the results are in disagreement with the desires of many pressure groups. In addition, the administrator must be able to appreciate the finite quality of money and the selection of activation priorities within dollar limits in terms of potential results. He must balance long-range planning with decisive implementation of programs to meet immediate needs. The success of any operational program depends upon such energetic implementation. It is so easy to delay until there are more facts, more committee meetings, and more planning and philosophizing."[23]

## Boards and Commissions

There are a great many boards, commissions, councils, and committees related to the State's health programs. The Task Force found it impossible, within the time available for the study, to review the activities of each of these bodies. It was the Task Force's conclusion that, once the Department of Health is activated, there should be a comprehensive review of all the advisory bodies related to health programs. Most of them are undoubtedly serving a useful purpose, but it is possible that there are some for which the need no long exists or whose functions could be consolidated with other boards and commissions.

The Task Force confined its attention to those statutory boards and commissions with broad general powers, objectives, and concerns. This revolved primarily around the State Board of Public Health, the Health Review and Program Council, and the Health Planning Council.

The State Board of Public Health is unique among the health-related boards and commissions in that it has quasi-judicial powers. It is a regulatory body in the health field, with power to formulate policies affecting health; adopt, promulgate, and repeal rules and regulations consistent with law for the protection of health; issue licenses and permits; conduct hearings; and subpoena witnesses and documents.

The present Administration has been attempting to reduce the number of boards and commissions in State Government and to make those that continue in existence advisory rather than administrative. In keeping with this general approach, the Task Force recommends that the Director of the new Department of Health assume from the State Board of Public Health its regulation and licensing responsibilities. The Director, in carrying out these responsibilities, would follow the provisions of the Administrative Procedures Act.

The Health Review and Program Council is in the Department of Health Care Services. The Council's statutory responsibilities are to plan for the development of a comprehensive program of medical care for all medically indigent persons by 1977;

to promote the most efficient use of available health facilities; to compare the medical care given under Medi-Cal with accepted standards of care; and to review the need for systematic grading of health insurance prepayment plans. It appeared to the Task Force that there were some major areas of overlap between the responsibilities of the Health Review and Program Council and the Health Planning Council.

The Health Planning Council was established by the Legislature in 1967. The Council has the legal responsibility to advise the Department of Public Health in the conduct of its comprehensive health planning activities and in the setting of priorities. It also makes recommendations to the Director of Public Health on the expenditure of planning money and health grant funds. The Office of Comprehensive Health Planning in the Department of Public Health provides the necessary staff work for the Council. The Task Force endorses the concept of comprehensive health planning and feels that this function will be an extremely important part of the total responsibility of a Department of Health.

During the first two years of its existence, the Health Planning Council has concentrated on organizing State and regional planning services and on reviewing applications for health grant funds. The Task Force believes that, in the future, comprehensive health planning should devote increased attention to the health care delivery system. It should assist in the formulation of public policy on health, clarify the roles

of government and the private sector in meeting health needs, explore a whole range of social problems with health implications, direct attention to basic health issues, and provide leadership in formulating proposals for legislation.

The Task Force recommends that the State Board of Public Health, the Health Review and Program Council, and the Health Planning Council be replaced by a new Advisory Health Council. The Advisory Health Council would assume the existing powers and duties of these bodies, with the exception of the State Board of Public Health's authority to hold hearings on, adopt, or hear appeals on regulations regarding public health and to issue licenses and permits. This authority with respect to regulations and licenses would be assigned to the Director of Health. In addition, the Advisory Health Council would be authorized to advise and make recommendations to the Director on any matter within the purview of the Department.

The membership of the Advisory Health Council, with regard to number of members, their qualifications, and appointments, would be similar to that of the existing Health Planning Council. However, the total membership would be reduced from 21 to 19 as a result of abolishing the positions of Director of Mental Hygiene and Director of Public Health, both of whom are members of the present Council. It is recommended that the members appointed by the Governor be selected, to the extent practical, from existing members of the three boards being abolished.

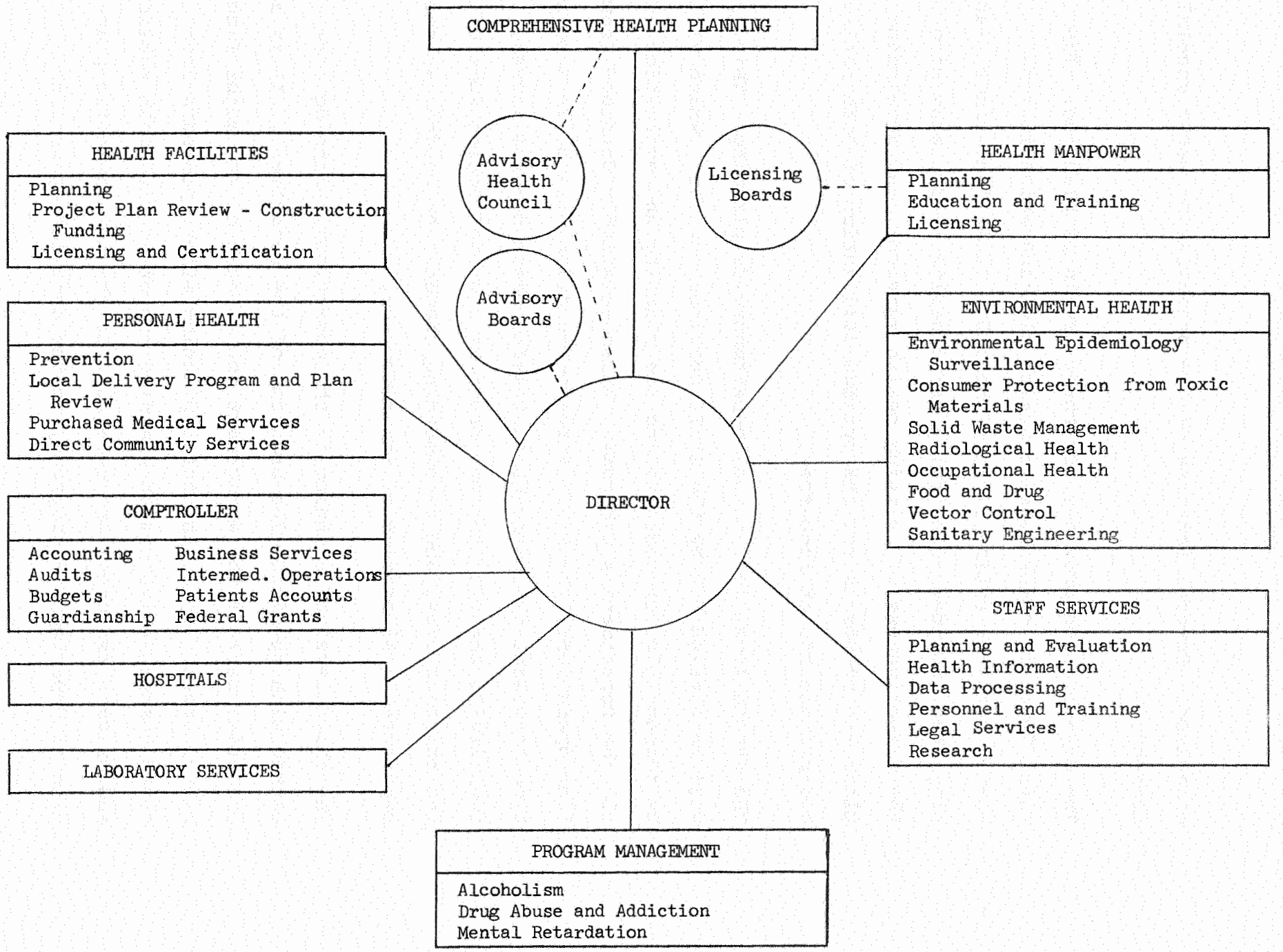
At some future time it may be desirable to expand the membership of the Council, convert it to a part-time, paid body, or make other basic changes in it. However, the Task Force concluded that such decisions should be deferred until the proposed Council has functioned for a time.

The Advisory Health Council will play a key role in assisting the Department of Health to develop basic health goals, formulate plans and policies to accomplish these goals, and establish program priorities. It will provide a forum at which all groups with an interest in health will have an opportunity to make their views known and to influence policy decisions. The Task Force expects the Advisory Health Council, serving in an advisory capacity to the Director of Health, to have a major impact on health plans, policies, and programs for the State of California. It will play an important part in giving meaning to the term "comprehensive health planning", which Congress, in enacting Public Law 89-749, defined as "... a process that will enable rational decision making about the use of private and public resources to meet health needs. Its concern encompasses physical, mental, and environmental health; the facilities, service and manpower required to meet all health needs; and the development and coordination of public, voluntary and private resources to meet these needs."

Some Comments on the Recommended Organization

A chart showing the recommended organization appears on page 73. It offers a concept of how a Department of Health might be

PROPOSED DEPARTMENT OF HEALTH



organized. Several features of the organization merit special comment.

The organization provides for three levels of planning. The first level is comprehensive health planning which is concerned with the entire field of health. It is long-range planning that includes identifying broad health needs, examining the effectiveness of existing health services, and developing plans and proposals for the optimum utilization of both public and private health resources.

The second level is internal departmentwide planning. This will be carried out by the Staff Services function, which will be responsible for coordinating the planning and evaluation of all the Department's programs. Being relatively detached from line operations, the Staff Services function will be in a position to assist the Director in raising basic program issues, identifying the need for new programs and challenging some of the existing ones, and recommending changes, as needed, in the Department's allocation of its resources.

The third level of planning is the operational planning concerned with specific line programs of the Department. It is an essential part of the management job in each of the major functional areas. Thus, the total planning effort proceeds from broad comprehensive health planning concerned with both public and private resources and services, to the more specific planning of departmental programs, to the detailed operational