



BUILDING PUBLIC HEALTH
SYSTEMS TO IMPROVE

COMMUNITY
HEALTH IN
CALIFORNIA

An Action Agenda

*Developed by
The Partnership for the Public's Health
at the Public Health Institute*

EXECUTIVE SUMMARY

Community Health in California proposes a framework for thinking about the future of public health in California, and for the directions that efforts to strengthen and improve public health might take. Its focus on community health, the growing importance of chronic diseases, the broadly conceived prevention strategies they imply and the necessity of collaborative approaches among public health agencies, public and private organizations and communities distinguishes it from what has more generally characterized public health planning in California to date. Although *Community Health in California* suggests a different emphasis, it does so with the intent to complement those other efforts in the spirit of an enlarged vision for public health within which a multitude of agencies and organizations can participate in a thoughtful and cooperative division of labor.

Community Health in California begins with an overview of the tradition of public health, its great accomplishments over the past century and some of the new challenges that are posed in the 21st century. It is organized around three broad themes that define the territory for expanded public health improvement efforts. Within those three broad themes, ten action areas are identified, together with the agencies and organizations that will be essential to help carry them out.

The scale of change called for will require broad support and great perseverance.

First, it is argued that local public health infrastructure must be strengthened, beginning with local public health departments, but extending as well to the capacity of communities to engage in effective community health improvement activities and the ability to enlist key public and private organizations to participate in those efforts.

Second, if recent national trends to develop performance standards and to hold public health accountable are to be considered for adoption in California, this document suggests they must take into account the broader vision of public health it attempts to articulate.

Third, it is asserted that the potential for expanding the boundaries of public health practice at the local level will depend very much on greater support from the State health department and statewide public health organizations, which could require changes in governance, administrative priorities, state/local planning processes and relationships among key organizations.

Community Health in California emerges from a five-year grant-funded initiative to promote partnerships between local public health departments and communities to

improve community health in California. While the document is sometimes strong in the positions it advocates, it is humble in the recognition that the scale of change called for will require broad support and great perseverance. It concludes with a summary of the contributions the initiative will make to those larger efforts.

PREFACE

Community Health in California is intended to spark discussions about the priorities of public health policy, and of the specific actions that must be undertaken to improve the health of the people of California. It places a particular emphasis on community health, rather than specific diseases or populations, because community implies the physical and social environment in which people live, and the constellation of forces that affect their overall health and well-being. Seen from this perspective, community health poses significant challenges to the current organization and functioning of public health.

A central premise of *Community Health in California* is that strong local public health departments and organized communities, working with broader coalitions, can make important contributions to improving community health. However, it will require an

A central premise of Community Health in California is that strong local public health departments and organized communities, working with broader coalitions, can make important contributions to improving community health. However, it will require an expanded view of public health practice, and of the state and local policies that will be necessary to support it.

expanded view of public health practice, and of the state and local policies that will be necessary to support it. Current public health improvement efforts, including bio-terrorism preparedness, must be supported and built upon, but they will not be sufficient to achieve this larger vision of healthy communities.

WHY NOW?

This document appears at a time when California is experiencing its largest deficit in history, with resulting budget cuts that are likely to further erode support for state and local public health. It is also a time when bio-terrorism preparedness has commanded the attention of many public health officials throughout California and the nation, largely superseding other public health improvement efforts. In this environment, it is difficult to even suggest the possibility of an enlarged vision for public health.

There are, on the other hand, some recent developments that hold promise for reconsidering the overall purpose and present capabilities of public health in California. The State's Little Hoover Commission, for example, has issued a report, *To Protect & Prevent: Rebuilding California's Public Health System*, calling for a restructuring and increased commitment to public health (www.lhc.ca.gov). Although the Little Hoover Commission report focused only on the public safety responsibilities of public health, and its recommendations are a reflection of that restricted view, it nevertheless opened to public discussion the importance of public health and the kind of commitment it will require. More recently, the Institute of Medicine, part of the National Academy of Sciences, has issued a comprehensive report on *The Future of the Public's Health in the 21st Century* (www.iom.edu). The report argues for a broad view of health and the multi-sectoral collaborations that will be necessary to achieve it, which is consistent with themes raised in *Community Health in California*. These are encouraging signs that even in a period of retrenchment, it is still possible to think critically about the future directions of public health.

Although the current political and economic environment does not give cause for optimism in the short run, there is compelling reason to begin now to kindle the debates and build the constituencies for what must become substantially increased investments in public health over time. Too often, public health has been a casualty of the pressing priorities of the moment, with the unfortunate consequence that the benefits of long-term prevention efforts have been short-changed. If public health is always constrained by what is immediately practical, it will never grow to the scale that its mission requires.

HOW THIS DOCUMENT WAS PRODUCED

Community Health in California was produced by a policy work group made up of staff from the Public Health Institute and the Partnership for the Public's Health program office (see Appendix 1, About the Sponsoring Organizations). Much of the content was derived from focus groups, meetings and community health improvement plans developed by those participating in the Partnership for the Public's Health, a five-year initiative funded by The California Endowment and administered through the Public Health Institute, that supports collaborative planning for community health improvement among 14 public health departments and 39 community groups in California. The analysis and recommendations reflect the deliberations of the policy work group about the steps that can be taken to advance community health in California.

The purpose of this document was not to have the last word, but rather to encourage others to participate in discussions about the issues raised. Before appearing in its final form, an extensive review process was conducted to solicit comments from Partnership for the Public's Health grantees, state public health organizations, policy advocates and others interested in community health. Since people of good will and

deep commitment to public health can have differing views on what is most important, or which strategic paths hold the greatest potential, *Community Health in California* was received with a mixture of praise and criticism. The conversations were extremely valuable—including the most difficult ones—because they challenged our thinking, and forced us to clarify, and in some cases amend, our arguments. We know that the changes we made as a result will probably not satisfy everyone, but we are sincerely grateful for the time and thought people were willing to contribute, and we hope that the discussions will continue. (For a summary of reviewers' comments, see Appendix 2).

TABLE OF CONTENTS

Executive Summary	3
Preface	5
Public Health and the Health of Communities	11
• New Challenges for Public Health.....	11
• The Paradox of Public Health.....	13
• New Alliances for Community Health	15
• Why Community Health?	16
A Vision for the Future of Public Health in California	17
A Policy Agenda for Improving Community Health in California	19
Action Areas 1-10 describe HOW we see it, WHAT we recommend, WHO can do it and WHAT the Partnership for the Public’s Health can do.	
Local Public Health Systems must be strengthened in order to support broad prevention strategies to improve community health.	20
1) Local Public Health Departments	20
2) Community Capacity	22
3) Local Public Health Systems	23
4) State and Local Public Health Responsibilities.....	24
Local Public Health Systems must be held accountable to performance standards that support community health improvement	25
5) Public Health Performance Standards.....	25
6) Accountability for Performance Standards.....	26
State Public Health Leadership must be strong to achieve major community health improvement goals.	27
7) State Public Health Governance	28
8) State and Local Community Health Planning	29
9) Collaborative Planning Among Statewide Organizations.....	30
10) Government and Foundation Collaboration.....	31

Priorities for the Partnership for the Public’s Health	33
1. Local Public Health Departments	33
2. Community-Level Data	34
3. Community Capacity	35
4. Regional Approaches to Public Health	35
5. Mobilizing for Action through Planning and Partnerships (MAPP)	36
6. Infrastructure, public health systems and state support	36
 Appendix 1: About the sponsoring organizations	 38
 Appendix 2: Summary of Reviewers’ Comments	 40
 Notes	 43

PUBLIC HEALTH AND THE HEALTH OF COMMUNITIES

The vision of *Healthy People 2010*, the national health promotion and disease prevention agenda developed under the auspices of the federal Department of Health and Human Services, is “healthy people in healthy communities.”¹ This vision is supported by over a century of important accomplishments in public health that

Looking forward into the 21st century...realizing the vision of healthy people in healthy communities will require not only building on...important (public health) traditions, but also incorporating new ways of thinking about public health.

have made communities healthier places to live. Since the beginning of the twentieth century, average life expectancy in the United States has increased by about thirty years, most of which—twenty-five of the thirty years—is attributable to public health measures, including improvements in the safety of food and water, the control of infectious diseases, reductions in vaccine-preventable illnesses, family planning, decreases in maternal and infant mortality, improvements in motor vehicle and workplace safety and reductions in smoking.² Looking forward into the 21st century, however, realizing the vision of healthy people in healthy communities will require not only building on those important traditions, but also incorporating new ways of thinking about public health.

NEW CHALLENGES FOR PUBLIC HEALTH

The profile of diseases that characterized the health of communities at the turn of the last century is very different from that which confronts us today. The three leading causes of death in 1900, for example, were pneumonia, tuberculosis and diarrhea/enteritis, all of which are infectious diseases. In fact, much of what occupied public health throughout its formative period in the 19th century involved the containment of outbreaks of infectious diseases through quarantine, environmental sanitation and later—with the discovery of germs and the emerging science-based disciplines—vaccines and antibiotics. High rates of maternal and infant mortality,

much of which was also associated with infectious diseases, gave rise to public health nursing and maternal/child health programs as an integral feature of public health.

By way of contrast, we know that the greatest overall threat to the health of communities today is chronic disease.³ The three leading causes of death are now heart disease, cancer and stroke, which account for nearly two-thirds of all deaths.⁴ As Los

The growing importance of chronic disease has come about in part because on average we live longer, which is largely attributable to public health measures, particularly in the control of infectious diseases.

Angeles County has documented, chronic diseases are the source of over 80% of the total burden of preventable disability and death.⁵

It is equally important, however, to look at the causes of disease. In a much-cited article published in the Journal of the American Medical Association, the *actual* causes of premature—i.e., preventable—death were identified as, in order: tobacco, poor diet and lack of exercise, alcohol, infectious agents, pollutants and toxins, firearms, illicit drug use, motor vehicles and sexual behavior.⁶

More generally, as we look at the health of our communities, we still see the use of tobacco, in spite of the decline by half in smoking rates over the past few decades as a result of an aggressive anti-tobacco campaign, and we continue to see the health consequences of past tobacco use. We see increasing rates of obesity, particularly among children, that serve as alarming precursors to the potential for chronic diseases in later years, and they are very much linked to how we eat and how physically active

we are in the course of our day-to-day lives. Youth in some communities come of age in social environments characterized by widespread unemployment, poverty, drugs and violence, contributing to youth homicide rates in the United States that far exceed those of other nations. We live in a chemical environment that did not exist even a couple of generations ago, and our soil, water, air and food pose potential health risks from contaminants that we do not yet fully understand. We have significant disparities among communities, with poorer health in low-income neighborhoods disproportionately made up of people of color.

This contemporary picture of what most affects the health of communities, however, does not correspond well with the strengths of public health. Local public health departments in California and in the nation still largely reflect developments that occurred over the last half of the 19th and early part of the 20th centuries, when environmental sanitation, control of infectious diseases and improving the health of moth-

ers and children formed the foundation on which public health was built. In a survey of local public health departments in California, for example, it was reported that nearly 90% of funding and staffing is dedicated to environmental health (narrowly defined), control of infectious diseases, maternal/child health, children's medical services and administration. Funding dedicated to the prevention of chronic disease, by way of contrast, represents less than 1% of the total budgets of local public health departments in California.⁷ Many public health departments in California have made important strides in their efforts to develop prevention strategies for chronic diseases, to expand the focus of maternal/child/adolescent health programs to become a base for early chronic disease prevention initiatives, to extend environmental health beyond its traditional functions and/or to prevent violence and accidental injuries.

These hopeful developments, however, do not yet reflect the scale or focus of what we understand about the causes of diseases that most affect communities today.

While it is essential that we take the threat of bio-terrorism seriously and prepare for its possible consequences, it is nonetheless at this point still a potential threat, and we are left with the irony that there is not a similar mobilization to prepare for the more substantial and present threats to their health and well-being that people experience every day.

THE PARADOX OF PUBLIC HEALTH

The limitations of public health are not the result of its failures but, ironically, the product of its triumphs. The growing importance of chronic disease has come about in part because on average we live longer, which is largely attributable to public health measures, particularly in the control of infectious diseases. We have made vast improvements in maternal and infant mortality over the last century enabling women to survive health risks once associated with childbirth and more children to grow into adulthood, although we continue to be plagued by disparities among populations and poor rates compared with many other countries in the world. We have made many aspects of our environment healthier, even as new environmental threats take the place of old ones. This success, however, has not

translated into a strong base of support for an enlarged role for public health, but rather the reality that it is a struggle just to carry out the traditional responsibilities.

One explanation for the apparent anomaly is that the successes of public health are a public relations liability. Prevention works best when nothing bad happens or, as one long-time public health practitioner has put it, few state capitol buildings have been the target of candlelight vigils of people who did not get diphtheria.⁸ As a result, public health has had a difficult time maintaining a constituency outside of its own professional organizations. In fact, much of the attention in the press, and much of the common understanding, equates public health with public hospitals and clinics, which are critical components of the health care system that serves the poor and uninsured, but which are not the same as the broad population-based, prevention-oriented approaches that characterize public health more generally.

Public health, as a consequence, has had limited success gaining political—especially budgetary—support, except when there is an outbreak, or fear of an outbreak, of disease.⁹ The current emphasis on bio-terrorism preparedness, which has subsumed much of the time and attention of local, state and federal public health officials, is a case in point. While it is essential that we take the threat of bio-terrorism seriously and prepare for its possible consequences, it is nonetheless at this point still a potential threat, and we are left with the irony that there is not a similar mobilization to prepare

for the more substantial and present threats to their health and well-being that people experience every day. It is one measure of the historical lack of political support that, for many working in public health today, bio-terrorism funding is the single most significant investment in basic public health infrastructure that they have seen in their professional careers.

For public health to be prepared to address the range of factors that influence community health, however, it must stretch beyond its current organizational boundaries and the limited public health improvement strategies associated with bio-terrorism preparedness. More than that, the traditional science-based disciplines—medicine, nursing, microbiology, epidemiology—that have characterized public health for the past century or more, and which will continue to serve as its foundation, must be complemented with

It is one measure of the historical lack of political support that, for many working in public health today, bio-terrorism funding is the single most significant investment in basic public health infrastructure that they have seen in their professional careers.

a capacity to work in collaboration with others to confront the changing social and environmental sources of preventable illness and injury.¹⁰ That is especially true if public health is to be effective in efforts to eliminate disparities in health among different populations and communities.

NEW ALLIANCES FOR COMMUNITY HEALTH

The Institute of Medicine, which published an influential report on *The Future of Public Health*¹¹ that inspired over a decade of public health improvement activities, has recently issued a new report on *The Future of the Public's Health in the 21st Century*¹², which explores the implications of the current configuration of diseases and the prevention strategies they imply. The new Institute of Medicine report concludes that public health agencies must be strong, and they must assert a leadership role in protecting the public's health, but they cannot do it alone. The vision of healthy people in healthy communities requires more collaborative approaches to address the broad range of factors that most influence community health.

Similar themes were previously expressed in public health improvement approaches being advanced by the federal Centers for Disease Control and Prevention (CDC) in conjunction with several national public health professional organizations. The National Public Health Performance Standards Program (NPHP-SP) is based on the premise that the essential services of public health are provided through a "local public health system," which involves public health agencies, other public and private institutions and community residents and organizations.¹³ A companion tool, Mobilizing for Action through Planning and Partnerships (MAPP), is a collaborative strategic planning process for community health improvement that is also based on the NPHPSP concept of a local public health system¹⁴

"Healthy people in healthy communities" refers not only to common interests, but also to a common location—where people live. The notion of place is fundamental because it is where the constellation of forces that influence health come together and create the conditions in which people are—or are not—healthy, and where disparities in health are most dramatically revealed.

The approaches being advanced through these national public health organizations are well illustrated through four decades of efforts to reduce the harmful consequences of tobacco. They are also evident in incipient campaigns to reduce obesity through improved nutrition and physical activity. While public health agencies have provided critical research, leadership and advocacy, the participation of community activists, non-profit agencies, elected officials and supporters in key public and private organizations have been essential to the conduct of the campaigns. While they might not always see themselves as part of a “public health system,” a challenge to public health is to make these kinds of alliances more routinely the foundation of public health practice.

Place-based strategies seldom afford the luxury of focusing on just one disease, or one population, but require a sustained and comprehensive view of all the factors that affect the health of the entire community.

WHY COMMUNITY HEALTH?

Finally, it is important to pose the question, Why community health?, as a central theme of public health today. In fact, working with communities based on common interests has always been an integral part of public health, whether the interest was a population, such as maternal/child health, or a disease, such as HIV/AIDS.

As it is implied in the *Healthy People 2010* vision statement, however, “healthy people in healthy communities” refers not only to common interests, but also to a common location—where people live. The notion of place is fundamental because it is where the constellation of forces that influence health come together and create the conditions in which people are—or are not—healthy, and where disparities in health are most dramatically

revealed. Place-based strategies seldom afford the luxury of focusing on just one disease, or one population, but require a sustained and comprehensive view of all the factors that affect the health of the entire community. Community health viewed this way defies the categorical funding and programmatic organization of public health and pushes toward more flexible and comprehensive approaches, which will be required to ultimately achieve healthy communities.

A VISION FOR THE FUTURE OF PUBLIC HEALTH IN CALIFORNIA

To realize the *Healthy People 2010* vision of healthy people in healthy communities, the public health system in California in the 21st century will have to increasingly take on the characteristics of the expanded view of public health described in the previous section. That public health system would include the following:

- Public health policy and practice are based on the evidence of what most influences the health of communities;
- Government-based public health agencies at the national, state and local levels are strong and have funding and mandates consistent with the evidence about the health of the population;
- Local public health departments have organizational capacity, flexible and adequate financing, trained and experienced staff, data capabilities and leadership that support work with communities to achieve broad community health improvement objectives;
- Communities have sustained leadership, active resident involvement, effective organizations, broad coalitions, strategies to engage key institutions and appropriate funding to participate in community health improvement activities across issues and over time;
- Public and private agencies understand that it is consistent with their organizational missions and greater sense of purpose to act in partnership with public health departments and community residents to achieve improvements in community health and well-being;
- Public health policy and practice support broad prevention strategies carried out by public health departments, organized communities and public and private agencies, including those efforts that are required to eliminate disparities in health among communities;
- State and local public health departments and their partners are held accountable to high standards of performance based on a broad view of community health and have the capacity to meet those standards;

- State and local public health professionals are able to act based on the principles of good public health practice, can assert creative leadership and are not unduly restricted by political interests;
- Public health functions are reasonably distributed among state, regional and local responsibilities, and the uneven distribution of local public health resources throughout the state are compensated for by state and regional support;
- State/local public health planning is formalized, broadly participatory and supports local community health improvement objectives;
- Statewide public health organizations work collaboratively on a broad view of health and with an appropriate division of labor that reflects their respective organizational purposes; and,
- Constituencies for public health extend well beyond public health professional organizations because public health has become more important to, and better understood by, a wide range of people.

A POLICY AGENDA FOR IMPROVING COMMUNITY HEALTH IN CALIFORNIA

The sections on Public Health and the Health of Communities, and A Vision for the Future of Public Health in California, suggested some overall directions in which public health policy and practice must go in order to be more effective in creating healthy communities in the 21st century. This section outlines some of the key policy changes that can bring that vision closer to reality.

The content of the policy agenda is organized into three broad themes:

- Local public health systems must be strengthened in order to support broad prevention strategies to improve community health;
- Local public health systems must be held accountable to performance standards that support community health improvement, and,
- State public health leadership must be strong to achieve major improvements in community health.

Ten action areas are defined throughout the three broad themes. In each action area, suggestions are offered about what needs to be done, who needs to be involved and what role the Partnership for the Public's Health can play to help make it happen.

It is essential to emphasize that the changes recommended here are not intended to substitute for, but rather complement, other public health improvement efforts currently underway, including those associated with bio-terrorism preparedness. A foundation of strong government-based public health departments, the disciplines that characterize their workforce and the programs that have emerged from their historical responsibilities are a precondition for any hope that the mandates for public health can extend to comprehensive prevention strategies involving broad coalitions with organized communities and public and private agencies. This is an attempt to enlarge the framework in which we think about public health, and an entreaty to carry out our respective public health improvement activities with that larger vision in mind.

It is an ambitious undertaking. The scale of change envisioned goes far beyond what any single entity can accomplish, so it must have the active support and involvement of the California Department of Health Services, statewide public health organizations, schools of public health and other academic institutions, private foundations,

organized communities and others to make it possible. In addition, while some of the recommended actions can and should be undertaken immediately, others could take years and, in some cases, decades to accomplish. That is consistent with many of the greatest achievements in public health and should not be taken as a reason for discouragement, but rather as incentive for resolve.

The following observations and recommendations are offered in the spirit of inviting the dialogue and shared commitment that will be required.

Local Public Health Systems Must Be Strengthened In Order To Support Broad Prevention Strategies To Improve Community Health

Government-based public health departments are the foundation of local public health systems. Efforts to strengthen local public health departments in their current capacity must be supported. The global pandemic of HIV/AIDS, the re-emergence of drug-resistant infectious diseases such as tuberculosis and the fear that biologic agents will be intentionally introduced are testament to the importance of strengthening infectious disease control capabilities. The deeply troubling fact that the United States ranks 28th in the world in infant mortality, and that African-Americans continue to have infant mortality rates more than twice that of whites, demand greater support for maternal/child health programs. While these are compelling reasons for shoring up public health departments as they are presently constituted, they must be complemented with an insistence that public health departments are also better prepared to respond to the greater burden of chronic disease, and the social and environmental conditions to which they are linked.

Public health departments must also have strong partnerships with communities and with other public and private organizations to be effective in improving community health. To support this collaborative approach, the concept of public health infrastructure must extend from local public health departments to communities and other organizational partners, and public health improvement strategies must reflect this broader view.

ACTION AREA 1. The organizational structure, financing, workforce, data capabilities and leadership of local public health departments must support collaborations with communities and public and private agencies to engage in broad community health improvement activities.

What we see:

- The organization of local public health departments must be capable of carrying out broad prevention strategies targeting chronic diseases, their associated risk factors and the larger social and environmental determinants of health.
- The financing of public health must be more flexible to support creative approaches to community health improvement, and the statutory base of funding must support activities that reflect a broad view of health.
- The current public health workforce must receive training and incentives to work with communities and other public and private agencies to improve community health, new employees must be recruited into occupations (such as community health workers) that promote community-based approaches and work rules must be sufficiently flexible to support community work.
- Local public health departments and communities must be able to create community health profiles to guide community health improvement activities.
- The leadership of local public health departments must be encouraged and supported in their efforts to direct public health toward broad approaches to improving community health.

What we recommend:

- The California Department of Health Services, key statewide public health organizations and partners in the public health system should begin a comprehensive and systematic process to review the capacity of state and local public health infrastructure both to carry out their traditional functions and to support activities that reflect a broad view of community health, including:
 - the organization of public health at the state, regional and local levels;
 - the financing of public health;
 - the public health workforce;
 - the capacity to produce comprehensive health profiles at the county, sub-county region and community levels; and,
 - leadership development in local public health systems.

Who can do it:

- California Department of Health Services, statewide public health organizations, schools of public health, representatives of communities and allied organizations in public health systems.

What the Partnership for the Public's Health can do:

- Capture and disseminate models and strategies that public health departments in California have adopted to better prepare them to engage in broadly based community health improvement activities.
- Conduct analyses of existing funding streams, needed flexibility and adequate scope and sources of funding necessary to support community health improvement.
- Conduct analyses of workforce competency requirements, training programs (schools of public health, community colleges, etc.), work rule constraints and forums where workforce development is being considered in order to advance proposals for building a public health workforce that is better prepared to engage in broadly based community health improvement work.
- Capture needs and best practices for community-level data development, scan national examples both within and outside of public health, provide technical assistance and advocacy with state agencies to support the production community-level data.
- Convene gatherings of public health department staff and top officials to review the experience of the Partnership for the Public's Health to date and develop strategies to advance support for community-based public health.

ACTION AREA 2. Community capacity must be strengthened to support sustained community health improvement efforts.

What we see:

- Communities must have sustainable coalitions that can address a wide range of community health issues over time, strong and capable leaders who can effectively represent their communities and involve other residents in community health improvement activities, strategies for engaging key institutions to work as partners in community health improvement and the ability to define and mobilize community assets as a foundation for their collaborative work.

What we recommend:

- Representatives of community organizations, together with public and private funders, should convene a process to better define community capacity to engage in sustained community health improvement and to develop models

and strategies for community assets mapping, organizational development and funding.

Who can do it:

- Representatives of community organizations, community development agencies, public agencies and private foundations.

What the Partnership for the Public's Health can do:

- Conduct reviews of existing studies of community capacity.
- Conduct in-depth profiles of a sample of communities to further define capacity required to sustain community health improvement activities.
- Develop and disseminate principles for community capacity building.
- Convene funders to consider how they might better support communities to engage in comprehensive community health improvement activities.

ACTION AREA 3. Local public health systems must be developed and sustained to achieve significant improvements in community health.

What we see:

- Public and private agencies must understand how their own missions overlap with the goals of community health improvement and see public health departments and community residents as allies and partners in sustained collaborations that will be the foundation of broad community health improvement.

What we recommend:

- Based on examples drawn from bio-terrorism planning, tobacco control and nutrition advocacy, models of partnerships and local public health system functioning should be developed and promoted for community health improvement activities that reflect the most important influences on community health.
- Alliances among state-level organizations should be promoted to model collaborative approaches to broad population health improvement objectives and to encourage similar alliances within local public systems.

Who can do it:

- California Department of Health Services, statewide public health organizations, public and private agencies at the state and local levels

What the Partnership for the Public's Health can do:

- Develop profiles of the constellations of public and private agencies that have participated in various community health improvement efforts.
- Disseminate publications highlighting the contributions that various agencies can make to local public health systems.
- Participate in national forums dedicated to the development of public health systems, and bring those experiences to public health improvement efforts in California.

ACTION AREA 4. State and local public health responsibilities must be restructured, including development of regional public health functions.**What we see:**

- The uneven distribution of local public health resources, particularly between urban and rural areas, must be compensated for by regionalizing some functions that can better assure equal public health protections throughout the state.
- Regional collaborations among public health jurisdictions must be encouraged and supported to take advantage of pooled resources and regional strategies for community health improvement.

What we recommend:

- A systematic review of public health functions as they are currently carried out by state and local public health organizations should be conducted for reconsideration of the most appropriate level of responsibility, including the possibility of exploring regional models.
- Models of the distribution of responsibilities for public health functions among state, regional and local entities in other states should be gathered to help guide decisions about possible restructuring in California.

Who can do it:

- California Department of Health Services, statewide public health organizations and local public health departments participating in regional activities.

What the Partnership for the Public's Health can do:

- Participate in, and support, regional approaches to public health in California.
- Conduct a survey of ways in which other states have distributed responsibilities for improving community health among state, regional and local entities.
- Review and publish examples of how some regional initiatives in California have supported community health improvement efforts.

Local Public Health Systems Must Be Held Accountable To Performance Standards That Support Community Health Improvement

Accreditation of local public health departments is receiving national attention as one way to hold public health departments accountable and to help convince legislators and the general public that investments in public health will achieve their intended purpose. Accreditation based on what public health departments currently do, however, poses the danger of institutionalizing a narrow view of public health. Performance standards tied to the broad goals of community health improvement must become the basis for defining public health capacity and for holding local public health departments accountable in California, including the possibility of future accreditation. In addition, since community and other agency partners are integral to the functioning of local public health systems, models of public accountability that extend beyond formal governance must be explored.

ACTION AREA 5. Standards for improvements in community health must become a basis on which public health performance is measured.

What we see:

- Subvention funding formulas and advocacy for increased financing of public health as it is currently constituted in California must be supplemented with

capacity assessments linked to public health performance standards based on the ability of public health systems to improve community health.

What we recommend:

- State and local public health capacity assessments, the National Public Health Performance Standards Program (NPHPSP) and Mobilizing for Action through Planning and Partnerships (MAPP) should be implemented throughout California.

Who can do it:

- California Department of Health Services, statewide public health organizations and representatives of community organizations and allied public and private agencies.

What the Partnership for the Public's Health can do:

- Advocate for and support the implementation of National Public Health Performance Standards.
- Support the local implementation of Mobilizing for Action through Planning and Partnerships (MAPP) and advocate for statewide adoption.

ACTION AREA 6. Performance standards in public health must be reinforced by mechanisms of accountability.

What we see:

- Performance standards for broad community health improvement linked to public health capacity assessments must become the basis for any future consideration of accreditation of local public health departments and for determining the most appropriate mechanisms for carrying out public health functions in California.
- Models of accountability must be developed for local public health systems, since partner organizations are subject to their own governing authorities.

What we recommend:

- Any process and timeline for possible statewide accreditation of local public health departments should be predicated on the ability to carry out capacity

assessments and public health performance standards for broad community health improvement.

- Public health statutes, which provide the legal basis for public health responsibilities, should be re-examined to determine their current appropriateness for ensuring a commitment to a broad view of community health.
- Mechanisms for public accountability that go beyond formal governance should be explored to hold local public health systems accountable.

Who can do it:

- California Department of Health Services and statewide public health organizations.

What the Partnership for the Public's Health can do:

- Review models of accountability for local public health systems, including the use of community health report cards.
- Consult with public health attorneys on the potential statutory basis for ensuring a commitment to a broad view of community health.

State Public Health Leadership Must Be Strong To Achieve Major Community Health Improvement Goals

The constitutional basis for public health in the United States rests primarily with the states. Most states, including California, choose to exercise that responsibility by funding and supporting local public health departments. Attempts to broaden the focus of public health at the local level, or to adopt performance standards for local public health systems, will depend very much on support from the State. Many of the policies that govern the organization, financing, staffing and other capacities of local public health departments to carry out a broad mission to improve community health originate at the State. The ability of local priorities to inform State policies depends very much on structures for collaborative planning between the State and local public health agencies.

Public health at the State level in California is organizationally contained within a Department of Health Services, where the priorities of the health care system and recurring Medi-Cal deficits often take precedence. The Department of Health

Services is itself part of a larger Health and Human Services Agency, whose secretary occupies the cabinet-level position representing public health. Public health is politically accountable to a governor, which subdues the voices of committed public health leaders in State government, especially when the interests of the public's health might be at odds with the governor's political priorities. In spite of those shortcomings, California has achieved some significant accomplishments in selected program areas, such as having set the national standard for states in tobacco control. Nevertheless, other states have paved the way in more broadly based efforts to transform public health. Washington, for example, has modeled state/local planning through its Public Health Improvement Plans. Illinois has been certifying local public health departments for over ten years. Minnesota has established the elimination of health disparities as a state goal through collaborative planning. By way of contrast, California has no public health improvement plan, limited state/local planning, no process for statewide public health capacity assessment or performance standards, no accreditation of local public health departments and little state public health leadership on key public health issues such as health disparities.

The prospects for collective leadership at the state level are hampered by often-tense relationships among key statewide public health organizations whose different and sometimes conflicting interests make it difficult to develop a common vision for public health in California. Those organizations—the California Conference of Local Health Officers (CCLHO)/Health Officers Association of California (HOAC), County Health Executives Association of California (CHEAC), Southern California Public Health Association (SCPHA), California Public Health Association-North (CPHA-N), Public Health Institute and others—are too often divided along administrator/physician, health care provider/population health, urban/rural or north/south lines, and the lack of a clearly articulated and commonly shared sense of a higher purpose fosters suspicions that the actions of one group are contrary to the interests of another. A failed statewide public health improvement planning process during the late 1990s did not help sustain optimism that a shared vision was possible.

ACTION AREA 7. Alternative models of state public health governance must be explored that can minimize political accountability of public health policy and practice in California, and to give public health greater organizational prominence.

What we see:

- A representative oversight body, such as a state board of health, must be considered for reintroduction in California to provide greater public transparency

for policy priorities and a better balance between professional and political accountability.

- Consideration must also be given to making public health a cabinet-level position so it does not remain submerged in the priorities of the larger health and welfare agency.

What we recommend:

- A comprehensive review of governance structures from other states should be undertaken to propose models of effective public health governance for California.
- Any governance structure that is to be recommended should be constituted in a way that supports a broad view of public health and a commitment to community health improvement.

Who can do it:

- The Little Hoover Commission, the California Department of Health Services, state public health organizations, elected and appointed officials.

What the Partnership for the Public's Health can do:

- Contribute to a review of governance models from other states to supplement the Little Hoover Commission recommendations, and promote the importance of State governance and administrative changes for community health improvement in California.

ACTION AREA 8. State/local planning relationships must be strengthened and broadened to reflect the range of participants in community health improvement efforts.

What we see:

- State/local planning bodies must be formed to make community health improvement a greater priority.
- A California Public Health Improvement Planning process, involving broad state and local representation, must be re-instituted with new leadership and a new resolve from both the Department of Health Services and statewide public health organizations.

- A California Office of Community Health or similar organizational unit—with appropriate funding, staffing and influence—must be created in the Department of Health Services to assure a commitment to collaborative planning for community health.

What we recommend:

- Models of state/local planning, successful public health improvement processes and Offices of Community Health from other states should be reviewed for potential adoption in California.

Who can do it:

- California Department of Health Services, statewide public health organizations.

What the Partnership for the Public’s Health can do:

- Contribute to the review of state/local planning, public health improvement processes and Offices of Community Health, and advocate for stronger commitment to planning and support for community health improvement at the State.
- Explore models of state/local planning through Turning Point, a national public health initiative in which the Partnership for the Public’s Health has established “linked state” status on behalf of California.

ACTION AREA 9. Statewide public health organizations must engage in better collaborative planning for common goals based on a broad view of community health.

What we see:

- Key statewide public health organizations must act less out of individual organizational interests and overcome tense histories of failed public health improvement efforts to embrace collaborative planning based on a broad view of health.
- The two state affiliates of the American Public Health Association—the Southern California Public Health Association and the California Public Health Association, North—must consider unifying to increase the effectiveness of their advocacy on behalf of public health in California.

What we recommend:

- There should be a statewide conference convened to review the implications of the new Institute of Medicine report on *The Future of the Public's Health in the 21st Century*, and it should have among its explicit purposes a commitment to collaborative planning, a common view of the mission of public health and a thoughtful division of labor to strengthen public health in California.
- Governing boards of the two state public health associations, building on the legacy of such recent collaborations as the California Center for Public Health Advocacy, should initiate a process to consider the formal unification of their organizations.

Who can do it:

- California Conference of Local Health Officers, Health Officers Association of California, County Health Executives Association of California, Southern California Public Health Association, California Public Health Association-North, Public Health Institute, schools of public health. Foundations to provide financial support for the conference and joint planning.

What the Partnership for the Public's Health can do:

- Participate in and, when needed, host collaborative planning among statewide organizations, assist in the development of a statewide conference on *The Future of the Public's Health in the 21st Century* and provide information and advocacy on behalf of an expanded view of public health capacity based on a broad view of community health.

ACTION AREA 10. State and local government agencies and private foundations must engage in collaborative planning to improve coordination of priorities for funding and other support.

What we see:

- Funding and other support from public agencies and private foundations must reflect the priorities of community health improvement activities rather than the separate priorities of the funding organizations.

What we recommend:

- Based on a common commitment to community health improvement, public agencies and private foundations should engage in joint planning to align their individual priorities with support for community health improvement initiatives.

Who can do it:

- California Department of Health Services, private foundations.

What the Partnership for the Public's Health can do:

- Develop models of community health improvement capacity building that reflect integration of public and private funding.

PRIORITIES FOR THE PARTNERSHIP FOR THE PUBLIC'S HEALTH

The policy agenda outlined in the previous section is a long list of actions to be taken, including some that are very ambitious and will take years to accomplish. Furthermore, each of the recommended action areas calls upon other organizations to take responsibility, including in many cases a leadership role. Whether or not they are able and willing to assume those responsibilities will most likely be the result of diplomacy, advocacy, capacity and the organization's own priorities.

While the Partnership for the Public's Health has made specific commitments about what we will contribute over time, a more immediate practical question is, which of the proposed action areas, through some combination of importance and opportunity, deserve our greatest attention in the near future? Since it is also likely that the next phase of the Partnership for the Public's Health will involve work with initiatives to prevent diabetes and obesity, another factor in the practical decisions about priorities will be how some elements of the policy agenda can be more clearly illuminated through that more specific focus.

The short list below cites six concrete actions within the framework of the policy agenda that seem to hold the most promise for the Partnership for the Public's Health to make priorities at this point. Each includes a brief summary of the importance, opportunity and specific actions that will be undertaken. They will all benefit from the legacy and future of the Partnership for the Public's Health, and the capacity of the Public Health Institute to promote significant public health policy change in California.

1. Capture and disseminate models and strategies that public health departments in California have adopted to better prepare them to engage in broadly based community health improvement activities. (Action Area 1).

Local public health departments participating in the Partnership for the Public's Health and elsewhere have developed innovative approaches to working with communities on broad community health improvement goals. These approaches illuminate many of the public health infrastructure issues outlined in Action Area 1, including organizational changes, creative financing, workforce development, data and leadership. These innovations, however, have been carried out largely in isolation from each other, and without support from the State health department or statewide public health organizations. Nonetheless, they hold the potential for demonstrating

the movement of public health in the direction outlined in this policy agenda, and a base from which to better organize that movement on a statewide basis.

Staff from the Partnership for the Public's Health and The California Endowment have interviewed public health directors and/or health officers from 20 local public health departments throughout California to document models of community-based public health practice and strategies for the transformation of local public health departments to be more supportive of broad community health improvement efforts. The Partnership for the Public's Health and The California Endowment will summarize the findings from those interviews and make them available to the participating public health officials and other interested parties. Follow-up forums will be hosted to determine collectively how these lessons from practical experience can inform more purposeful, coordinated efforts to transform local public health departments.

The Partnership for the Public's Health has sponsored a similar process involving senior and middle managers from grantee public health departments. That process will further inform the results from the public health director interviews, and it will merge with the planned follow-up activities.

2. Research best practices and support the development of community-level health profiles throughout California (Action Area 1).

An analysis of population health reports produced by local public health departments in California in the early stages of the Partnership for the Public's Health indicated that many had made significant progress in broadening their indicators of health and making their reports more readable through such techniques as mapping and use of common language, but few had made any progress in consistently presenting health profiles at a sub-county level. Because evidence-based public health practice relies on good information to guide priorities and actions, community-based approaches to public health require good community health data.

Since the time of the initial review, some local public health departments have made important progress in producing community health profiles. In addition, developments outside of public health—most notably, the National Neighborhood Indicators Project administered through the Urban Institute—have advanced the capacity to produce meaningful community-level data. The Center for Health Statistics at the California Department of Health Services, in conjunction with the California Conference of Local Health Data Managers, has made a priority of providing sub-county data. These developments suggest an environment that is increasingly ripe to advance the development of community-level data throughout California.

The Partnership for the Public's Health, working with interested local public health departments, the Center for Health Statistics and others, will provide peer support and technical assistance for the creation of community health profiles. The

Partnership for the Public's Health will retain a consultant, experienced working with local data, who will cull best practices from around the nation and provide practical support for the production of community-level data that can guide community health improvement activities. Dissemination of notable accomplishments through publications will further support those developments. They will also be used to support advocacy with State agencies to promote the development of community level data.

3. Document the essential features of community capacity necessary for sustaining collaborative community health improvement activities and conduct follow-up activities to support the development of an advocacy base for community capacity building (Action Area 2).

If community residents and organizations are to be essential partners in community health improvement efforts, the capacity necessary to support that participation must become a priority. The Partnership for the Public's Health offers a rare opportunity to explore what that capacity is when applied to broad community health improvement activities. A series of interviews and focus groups is being conducted with Partnership for the Public's Health community grantees to better define the essential features of that community capacity. In addition, an extensive literature review is underway to take advantage of related work that has already been done elsewhere in the nation.

Follow-up forums will be held to review the findings and help build an organized constituency that can act on those findings. The forums will also include trainings and peer learning in policy advocacy.

4. Support regional approaches to public health in California (Action Area 4).

Although very few public health functions have been formally regionalized in California, there are good examples of regional collaborations for specific purposes that hold the promise of more generalized regional approaches. A regional initiative to reduce health inequities in the San Francisco Bay Area, the Central California Public Health Partnership in the Central Valley and a statewide asthma initiative with regional coalitions as centerpieces of support and coordination are just a few examples that merit consideration for how public health in California might benefit from regional approaches. In addition, regional approaches afford an opportunity to demonstrate how public health infrastructure and practice can be transformed through collaborative efforts, as well as serving as sources of leverage to gain greater state support for those efforts.

The Partnership for the Public's Health will financially and/or logistically, through foundation funding, support the regional collaborations in the Bay Area and Central Valley, and serve as a bridge between the two to better enable them to learn from each other. The Partnership for the Public's Health will also document the experiences of the two regional collaborations, and integrate the lessons from the four regional centers participating in The California Endowment's Community Action to Fight Asthma (CAFA) initiative, to better define the unique contributions and strategic issues emerging from regional approaches.

5. Support the implementation of Mobilizing for Action through Planning and Partnerships (MAPP) among interested local jurisdictions in California (Action Area 5).

The Partnership for the Public's Health has provided financial and/or logistical support for a cohort of nine local public health departments in California (Alameda, Contra Costa, Kings, Los Angeles, Mendocino, Pasadena, San Luis Obispo, Shasta and Stanislaus) that are at various stages of implementing MAPP. A training hosted by the Partnership for the Public's Health and conducted by CDC and NACCHO was held in the Fall, 2003. Regular telephone conferences and small grants awarded to some of the public health departments are part of the developing support structure for the MAPP work.

The Partnership for the Public's Health will continue to provide this support, and will work with the California Department of Health Services and statewide public health organizations to translate this experience of nine public health departments into a platform for potential statewide implementation of MAPP. The Partnership for the Public's Health will also continue to serve as the liaison with CDC and NACCHO to provide additional support for MAPP in California, and to establish linkages to similar efforts in other states.

6. Use the experiences of diabetes and obesity prevention, and asthma prevention, initiatives to explore major themes outlined in the policy agenda, including the implications for public health infrastructure, the functioning of public health systems and development of strategies for state support (Action Areas 1, 2, 3, 4 and 8).

The future of the Partnership for the Public's Health is likely to become more specifically focused on initiatives to prevent diabetes and obesity as part of an overall campaign to eliminate health disparities. In addition, the Partnership for the Public's Health has been closely aligned with asthma initiatives in California, including the mod-

el Regional Asthma Management and Prevention (RAMP) initiative in the San Francisco Bay Area. These initiatives will afford an opportunity to take a more concrete approach to several of the major themes highlighted in Community Health in California. The Partnership for the Public's Health will, for example, systematically explore and document the local public health department organizational, financial, workforce, data and leadership implications of broad, community-based approaches to diabetes and obesity prevention, and asthma prevention, as well as the community capacity required to carry out this collaborative work effectively. The Partnership for the Public's Health will also chronicle the models and strategies for working with other public and private organizations in coalitions attempting to improve nutrition and physical activity, and to reduce environmental asthma triggers, in California communities.

This evidence base for an evolving public health practice will be used to support local and statewide advocacy efforts on behalf of building strong public health systems capable of engaging in broad prevention efforts. The diabetes and obesity prevention, and asthma prevention, initiatives will also provide an excellent opportunity to both support and document the value of regional approaches.

While the Partnership for the Public's Health will attempt to secure additional funding from a variety of sources to carry out other actions outlined in Community Health in California, the diabetes and obesity prevention, and asthma prevention, initiatives will illustrate the importance of many of its recommendations.

APPENDIX 1

About The Sponsoring Organizations

THE CALIFORNIA ENDOWMENT

The California Endowment, the state's largest health foundation, was established in 1996 to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. The California Endowment has regional offices in Los Angeles, San Francisco, Fresno and San Diego with program staff working throughout the state. The California Endowment makes grants to organizations and institutions that directly benefit the health and well-being of the people of California.

The California Endowment initiated the Partnership for the Public's Health and selected the Public Health Institute (PHI) as its partner. The California Endowment provides funding for all aspects of the program. The California Endowment's vision is to work in partnership with organizations to invest in strategies that help people live health lives, and ensure that quality health care is available for all. This partnership with PHI will accelerate the work of strengthening and modernizing systems to protect and improve the public's health through a comprehensive, integrated approach.

The California Endowment
21650 Oxnard Street
Woodland Hills, CA 91367
(818) 703-3311; (800) 449-4149 (California only)
www.calendow.org

THE PUBLIC HEALTH INSTITUTE

The Public Health Institute is an independent, nonprofit organization dedicated to promoting health, well-being and quality of life for people throughout California, across the nation and around the world. At the forefront of current issues, PHI is an incubator for innovative community-oriented solutions to emerging public health issues and a vital connector for traditional and non-traditional public health partnerships.

Founded in 1964, PHI is one of the largest public health nonprofit organizations in the United States. The Institute nurtures new programs and initiatives, often in partnership with foundations and other funders. PHI has an annual budget of more than \$65 million and a staff of more than 550, including more than 100 researchers, community specialists and project directors conducting approximately 300 projects funded by state and federal government and private foundations.

The Public Health Institute
2001 Addison Street, Second Floor
Berkeley, CA 94704
(510) 644-8200
www.phi.org

PARTNERSHIP FOR THE PUBLIC'S HEALTH

The Partnership for the Public's Health, funded by The California Endowment and administered through the Public Health Institute, is a five-year initiative that funds 14 local public health departments and 39 community groups throughout California to engage in joint planning and community health improvement activities. The public health jurisdictions cover a range from rural to urban, north to south and coast to central valley. The Partnership for the Public's Health office includes grantee support (grants management and technical assistance), evaluation, communications and policy components. This policy agenda is published in final form as the grant-funded partnerships approach their final year.

Partnership for the Public's Health
505 14th Street, Suite 810
Oakland, CA 94612
(510)-451-8600
www.partnershipph.org

POLICY WORK GROUP

The policy work group that produced the initial draft of Community Health in California is made up of staff from the Public Health Institute and the Partnership for the Public's Health. The primary author is Bob Prentice, Senior Associate for Public Health Policy and Practice at the Partnership for the Public's Health, with major contributions from Joe Hafey, President and CEO of the Public Health Institute. Other members of the work group include Carmen Nevarez, Vice President for External Relations and Medical Director, and Carol Woltring, Director of the Center for Health Leadership, from the Public Health Institute; and, Maria Casey, Executive Director, Julie Williamson, Associate Director, Adele Amodeo, Senior Policy Associate and Rhonda Sarnoff, Evaluation Coordinator from the Partnership for the Public's Health. Bill Beery, Vice President of the Group Health Community Foundation and Associate Director of the Center for Community Health and Evaluation (CCHE), and Pam Schwartz, Oakland Manager for CCHE, participate in their capacity as evaluators of the initiative.

APPENDIX 2

Summary Of Reviewers' Comments

The review period lasted approximately six months. It included written comments, telephone conversations, e-mail exchanges and face-to-face meetings. We tried to incorporate as many of the comments as we could, although some contradicted each other, and some were not consistent with the basic message we wanted to convey. However, there were five general themes that emerged from the review period that deserve special note, not only because they were repeated by several reviewers, but because they went to the heart of some of the deficiencies of the draft document.

1. The policy agenda is too overwhelming. It is almost paralyzing to contemplate the scope of what is being called for, especially when budgets are being cut and people and organizations are struggling to survive. It is difficult to see any practical path that leads to the vision outlined in the document.

This reaction was heard from some reviewers in each of the major groups. Our response is that we are trying to lay out a framework for the future of public health, not a work plan for the next year or two. While there are many practical steps that can be taken now—some of which we cite as immediate priorities for the Partnership for the Public's Health in the last section—much of what is proposed will take years, if not decades. The value of a framework is to help mark the progress of actions undertaken now, and to establish a direction for future activities.

We also think the likely participation of the Partnership for the Public's Health in diabetes and obesity prevention initiatives will provide an opportunity to give a more practical focus to many of the more global recommendations made in the policy agenda. The practical implications of comprehensive prevention strategies focused on diabetes and obesity can illuminate many of the larger issues raised, while simultaneously suggesting concrete steps that can be taken to address them.

2. The argument that chronic diseases account for the largest proportion of preventable disability and death, and that they require a different way of thinking about and practicing public health, comes across as dismissing the importance of infectious disease control and the other vital programs that have been the traditional responsibility of public health departments. It conveys an “us vs. them” tone, which is inconsistent with the invitation to work together.

This criticism, which was made by a several public health professionals, was particularly disturbing, since we have great respect for the tradition of public health and the people who practice it, often in the face of extraordinarily difficult circumstances. In hindsight, the policy work group struggled over how to get a message heard when it is at odds with the priorities of key state public health agencies and organizations. The polemical tone was partly in anticipation of a critical reception from some of those organizations—a speculation that was largely borne out in the review process, which elicited a response that ranged from cool to hostile from a few key public health professional organizations. Our rhetorical zeal for evidence-based public health, and the challenge of pushing the boundaries of public health so that they better correspond to the demands of improving the health and well-being of communities, apparently came across to some as a lack of respect for what they do. That is an impression that we absolutely do not want to convey. We see the tasks we have outlined as requiring a division of labor within a common vision, not a contest over who best represents public health. To the extent that we have not remedied that implicit message in this final document, we have fallen short of our intent.

3. The document talks about the importance of working with communities, but its focus is almost exclusively on official public health agencies and their professional organizations while it makes only passing reference to building community capacity.

This comment was repeated by several of the community reviewers, some of whom suggested that it reflects a “top-down” perspective that is at odds with the collaborative approach being put forward. It is a compelling criticism. This limitation is in part a reflection of one of the document’s themes—until community capacity is understood to be part of an enlarged concept of public health infrastructure, it will continue to be a minor element in public health policy discussions. It will take lessons from public health practice, an expanded constituency and persistent advocacy to bring community capacity to the center of public health improvement processes. To support those efforts, the Partnership for the Public’s Health is undertaking an extensive review of current literature on community capacity for health improvement, and it is surveying its community grantees to learn from their insights. Although the results of that work are not yet available to inform this document, we will not only publish the findings of the review and survey, but we will host strategy sessions to help community residents and organizations develop an action agenda to improve community capacity for health improvement in California.

4. The document talks a great deal about state policies and administrative practices, but it makes little mention of local policies or administrative constraints.

The intent of Community Health in California is to complement community health improvement initiatives at the local level with a policy agenda that can create a more supportive environment for those activities at the state level. We certainly agree that local policies and practices are fundamentally important—in fact, we have conducted interviews and analyses in order to characterize the environments in which local public health departments operate, and we are chronicling the capacity issues in communities, including local policy advocacy. The overriding concern of Community Health in California, however, is not to let the burden of demonstrating how to effectively improve the health of communities rest exclusively at the local level, but to have state agencies and organizations take a lead in supporting and promoting those policies and practices throughout California.

5. The way the document is written—its length, its language and its focus on parochial concerns like “public health infrastructure”—will prevent it from reaching an audience beyond a small circle of public health professionals. If we want this policy agenda to help build a broader constituency for public health, or to influence legislators on funding priorities, it will have to be substantially shortened, written in a more accessible language and focused on issues that more people can understand and care about.

This theme was echoed in comments from several policy advocates, who must regularly consider the practical aspects of influencing legislators, when legislation is the goal, or of reaching potential constituents in order to build a movement. It is a criticism well-taken. While we continue to believe that the focus on issues that might not have wide political appeal is necessary because they have important consequences nonetheless, we agree that there must be a simpler, easier-to-understand version that more people can read and take seriously. A shorter, more accessible version will be published as a companion piece to this longer, denser document.

NOTES

¹U.S. Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health*, 2nd edition, U.S. Government Printing Office, Washington, D.C., November, 2000

²See, e.g., Centers for Disease Control and Prevention, *About a Century of Success*, and the series of associated articles published in the April through December, 1999 issues of *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Atlanta, GA

³The actual configuration of preventable illness and death within specific communities may vary, with infectious diseases or injuries playing a relatively larger role. However, the greater overall burden of chronic disease on communities is well established in public health data.

⁴*Healthy People 2010*, 10 Leading Causes of Death, op cit

⁵*The Burden of Disease in Los Angeles County*, Los Angeles County Department of Health Services and the UCLA Center for Health Policy Research, January, 2000. "Burden of disease," a concept adapted from the World Health Organization, is a measure that combines years of potential life lost (premature mortality) and years lived with a disabling condition.

⁶McGinnis, JM, Foegen, WH, "Actual Causes of Premature Death," *JAMA*, 1993;270:2207-2212

⁷California Department of Health Services, *A Description of Services Provided by Local Public Health Jurisdictions for 1996-97*, August, 2001. Although the survey report included caveats about, for example, the various ways in which public health is defined among local jurisdictions, and about the activities included within each program area, the overall portrayal of how public health functions at the local level is generally accurate.

⁸Bernard Turnock, *Public Health: What It Is and How It Works*, Aspen Publishers, Gaithersburg, MD, 1997 (p. 20)

⁹Much of the early history of public health and the formation of local boards of health in the United States were a response to outbreaks of infectious diseases, such as yellow fever and cholera. Laurie Garrett provides an excellent account of the growing middle class as a political base of support for public health and the sanitarian movement in the latter part of the 19th Century in *Betrayal of Trust: The Collapse of Global Public Health*, op cit pp. 284-292

¹⁰For an experience-based argument about the shift from relying primarily on the expertise of science-based public health disciplines to the necessity of collaborative approaches to community health, see Wendel Brunner, Ph.D., M.D., "A Model for Local Success," *Community-Based Public Health Policy & Practice*, Partnership for the Public's Health, Oakland, CA, Issue #1

¹¹Institute of Medicine, *The Future of Public Health*, U.S. Government Printing Office, Washington, D.C., 1988

¹²Institute of Medicine, *The Future of the Public's Health in the 21st Century*, The National Academies Press, Washington, D.C., 2003.

¹³The National Public Health Performance Standards Program (NPHPSP) has been under development since 1998. NPHPS measures public health practice at the local and state levels based on the Ten Essential Public Health Services. It is a collaborative project of the Centers for Disease Control and Prevention (CDC), the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the American Public Health Association (APHA), the National Association of Local Boards of Health (NALBOH), the National Network of Public Health Institutes (NNPHI) and the Public Health Foundation (PHF). A copy of the NPHPSP is available on the NACCHO website,

www.naccho.org, or it can be acquired from the Public Health Program Office of the Centers for Disease Control, Atlanta, GA.

¹⁴Mobilizing for Action through Planning and Partnerships (MAPP) was funded by CDC and developed by NACCHO. It has nine national pilot sites, including Mendocino, CA. The field guide is available through the NACCHO website, www.naccho.org.

Inside back cover



Partnership
for the Public's Health

The text "Partnership" is in a bold, sans-serif font, with the tagline "for the Public's Health" in a smaller, italicized font below it. To the right of the text is a small, stylized graphic of two hands clasped together, representing partnership.