Health Care on the California Ballot: An Historical Review

Prepared for
California HealthCare Foundation

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About the Foundation

The **California HealthCare Foundation**, based in Oakland, is and independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care.

INTRODUCTION

For most of California's history, county governments have been responsible for providing health care services for the indigent. Funding for these services has fluctuated due to legislative and fiscal changes at the state and local level. As a result, a number of counties have proposed ballot measures in an attempt to raise additional revenues for health care infrastructure. This paper describes these ballot initiatives, contextualizes them within larger state-county financing structures, and explores the election outcomes.

California has also seen a number of health care measures introduced at the state level. This paper analyzes these measures and discusses trends in the use of ballot measures to restructure health care delivery or financing. This section of the report includes in-depth case studies of four recent health care-related initiatives and one referendum, including an analysis of the forces in the campaigns for and against these ballot measures that affected their success or failure.

THE HISTORY OF COUNTY HEALTH CARE FOR THE UNINSURED

As agents of the state, counties have long been responsible for the health of those who are unable to pay for services. Section 17000 of the California Welfare and Institutions Code, enacted in 1933, requires counties to be the health care provider of last resort for the indigent. Since the language of the section is very general, though, there is no statutory standard for the services provided. As a result, there is significant variation from county to county in both the priority that indigent care is given among county programs and the way in which service delivery is organized.[1]

The history of county management of health care services for the indigent has been significantly influenced by the ebb and flow of the larger state-local fiscal relationship. At times, the state and federal governments have augmented health services for the uninsured with additional programs or funding streams. At other points, however, budget pressures have caused state and federal government funding for county services to stagnate or decline.

The modern era of public health care programs in California began in 1966 with the implementation of Medi-Cal, the state's version of Medicaid. At that point, health care financing largely shifted to the state, while administration and delivery remained the responsibility of the counties. Counties paid a share-of-cost to the state for individuals covered by Medi-Cal, but were fully responsible for those who were completely uninsured. Counties could obtain additional funding for indigent care through a "county option," in which the county paid the state 100% of its medical care costs before Medi-Cal (1964 to 1965), and the state reimbursed any costs above the pre-Medi-Cal levels.[2]

In 1971, the state replaced the county option with a new method for determining the county share-of-cost for the Medi-Cal program, which was based on taxable assessed value within the county. This was intended to extend Medi-Cal coverage to uninsured individuals who were not eligible for reimbursement under the federal program.[3] Services for these recipients, who are referred to as Medically Indigent Persons (MIPs), were funded by the state and counties.

Voters approved Proposition 13 in 1978, which significantly reduced property tax revenue for local governments in California. A year later, the state partially replaced the lost local revenues by shifting property tax revenues from school districts to cities, counties, and special districts. (The lost school

revenue was made up by the state's General Fund.) In addition, the state created Assembly Bill 8 (AB 8), which provided funding for a variety of county health care programs, including services for indigents, public health services, and environmental health. The state also eliminated the county share-of-cost for Medi-Cal, but required counties to submit a plan and a budget to qualify for the AB 8 health services funds.

Facing a budget shortfall in 1982, the state created the Medically Indigent Adults (MIA) program to shift responsibility for adults in the MIP program back to the counties. In this program, counties only received about 70 percent of the funds previously spent on MIA recipients in the Medi-Cal program. The rationale for the lower level of funding was that counties would not have to meet Medi-Cal standards.[4] The larger counties in California administered their MIA programs directly, while thirty-four smaller counties contracted back with the state through the County Medical Services Program (CMSP) for the administration of their MIA programs. Over time, the state's support of the CMSP was capped and eventually discontinued.

As part of the effort to close the multi-billion dollar 1991 budget gap, the state shifted responsibility for about $2 billion worth of health, mental health and human services programs to the counties. This "realignment" created two new revenue streams, gave counties latitude as to how to spend those funds within broad categories, and relieved counties of burdensome reporting requirements. The goal was to give counties more flexibility over service delivery and create fiscal incentives for cost-effective approaches.[5] Unfortunately, the Legislative Analyst has concluded that a lack of data makes it difficult to evaluate the impact of this shift.[6] On balance, although counties have a dedicated revenue source for health services for the indigent (as well as other programs), demand continues to outstrip the available resources.[7]

Throughout each of these legislative changes, counties fought for more state funds for health services. Under a provision added to the state constitution in 1979 in the wake of Proposition 13, the state must reimburse local governments for the cost of new programs or higher levels of service imposed by the state, with certain exceptions. Following the 1982 creation of the MIA program, a number of counties pursued legal efforts to declare these services a reimbursable state mandate. Anticipating this challenge, the 1991 realignment legislation included a "poison pill" clause that would repeal certain provisions if the courts determined the MIA transfer to be a reimbursable mandate. As a result, most counties dropped their efforts to recover their costs from the state. However, San Diego persisted, and in 1997, the state Supreme Court held that the state is liable for certain costs resulting from the MIA transfer. The legislature subsequently eliminated the poison pill provision, leaving the realignment program intact, and a claim for reimbursement of counties' MIA costs is pending with the Commission on State Mandates.

In an environment of rising state revenues late in Governor Wilson's last term and the beginning of Governor Davis' first term, the state expanded Medi-Cal eligibility for a number of groups, including pregnant women, very low-income working families, and the aged, blind and disabled. These efforts resulted in additional medical coverage, particularly for children. However, these expansions did not cover most MIAs, and their care continues to be a county responsibility.[8]

THE COUNTY HEALTH CARE DELIVERY SYSTEM

The California Health and Safety Code gives counties and municipalities the responsibility for safeguarding local public health.[9] Over time, almost all cities have chosen to contract with county health departments for public health services. Only Berkeley, Long Beach and Pasadena retain their own health departments. In addition, 11 of the state's smallest counties contract with the state to provide at least some public health services, primarily in the area of environmental health and nursing services.

As discussed previously, in addition to providing basic public health services, counties are also the health care providers of last resort for the uninsured. Counties discharge this responsibility through a health care delivery system that includes public hospitals, private hospitals, medical centers and clinics.

During the 1960s, 49 counties operated hospital facilities in California.[10] As a result of the rising cost of health care services, the vagaries of state and federal funding streams, and competition from private hospitals (which do not have the same responsibilities for indigent care or medical education), the number of county hospitals has dropped to 20 facilities operating in 15 counties. In addition, three counties (Orange, Sacramento and San Diego) contract for health care services with University of California medical centers. According to a California Association of Public Hospitals analysis of 2004 Office of Statewide Health Planning and Development data, public hospitals accounted for 83 percent of total hospital-based outpatient visits for County Indigent Program patients.[11]

Public hospitals provide an array of services for the entire community, including emergency care and burn units, and most are teaching and research facilities that train nurses, pharmacists, and other health care professionals, including about half of the medical residents in the state.[12] County hospitals are often closely aligned with other hospitals and community-based clinics (both public and nonprofit) that provide outpatient services. There are over 600 not-for-profit community clinics and health centers in California.

Counties that do not have their own public hospitals contract with private hospitals, clinics, and private physicians to provide health care to indigents. As noted, 34 smaller counties contract back with the state through the County Medical Services Program (CMSP) for the administration of their medical services to indigents. Some also operate publicly-owned outpatient clinics to deliver these services.[13]

THE FUNDING ENVIRONMENT FOR COUNTY HEALTH SERVICES

Several major funding streams provide support for the county health care delivery system. One of the major sources of support is the state's Medi-Cal program, upon which county hospitals particularly rely. However, because a large number of adults are not Medi-Cal eligible, this program does not pay directly for care for medically indigent adults. Moreover, because California's Medi-Cal expenditures per beneficiary are at or near the lowest level in the country, county hospitals have been under significant pressure since at least the early 1990s.

In an effort to supplement Medi-Cal funding, the state established several programs, including the disproportionate share hospital (DSH) payment program and a program of intergovernmental transfers under Senate Bill 1255, to provide additional support for the county health services

delivery system. In 1989, California established a program of supplemental payments to hospitals under SB 1255, and then in 1991 California initiated supplemental payments to public and private hospitals that provide services to a disproportionate share of Medi-Cal recipients and the uninsured under the DSH program. Payments under both of these programs have declined since their inception, in part because the state has recaptured some funds, and in part because the federal government has limited the intergovernmental funds transfer mechanism on which both programs rely.[14]

Voters approved Proposition 99 in 1988, which increased cigarette taxes by 25 cents per pack. The resulting funds were allocated to health care for indigents, emergency room services, anti-smoking education and research, and other programs. The measure generated substantial revenues for health care services. Meanwhile, the measure's anti-smoking campaign component successfully reduced cigarette sales, meaning that revenues for Proposition 99 programs have declined from just under $600 million per year in 1989-90 to about $335 million currently. As a result, funding to support counties' health care services for indigents through the California Health Care for Indigents Program (CHIP) has declined from $336 million in 1989-90 to $45 million in 2006-07.

The 1991 "realignment" of health and social services between the state and counties gave counties a stable funding stream: a half-cent sales tax and vehicle license fee allocated to certain health programs. These revenues have grown steadily over the last 15 years. However, according to the Legislative Analyst, the formula for allocating realignment revenues to counties has resulted in slower growth for health and mental health programs than for social services programs.[15] This difference is due to a funding formula that gives entitlement programs first priority in order to pay for caseload growth, and all but one of the entitlement programs shifted under realignment are social services programs. The result is that the 42.3 percent share of total realignment revenues allocated to health programs in 1991-92 has dropped to an estimated 36.6 percent share in 2006-07.

In addition to state and federal funding, county general fund dollars are an important source of support for health care for the uninsured, helping to close the gap when dedicated funding sources are inadequate. However, only about a quarter of county revenues are available for discretionary purposes, while the balance goes to mandated programs and specifically designated services. County health programs must compete with many other county programs for the available funds.

In addition to administering health and welfare programs, counties also act as the municipal government for the unincorporated areas of the county, providing such services as garbage pickup, public safety and fire services. Counties also provide local services such as running the county jail and conducting elections. Mandated programs and public safety services are frequently the highest priorities for county policymakers when county budgets are being developed.

Given the limited resources that counties have for discretionary spending, state budget cuts reduce counties' ability to provide health services for the uninsured. According to a 2005 survey of local health officials by the Public Policy Institute of California on the sources of fiscal pressure on local health program budgets, 79 percent of local health officials indicated that "changes in state funding were 'one of the most important factors' influencing their ability to balance their budget."[16] Most recently, in 2004-05 and 2005-06, the state shifted $1.3 billion in property tax revenues from local governments, including counties, to school districts, thereby reducing the state's cost of funding

schools, but significantly reducing local discretionary resources.[17] This shift further increased the fiscal pressure on counties to adequately fund health care services.

COUNTY TAXATION POWERS

LIMITATIONS ON POWERS OF COUNTY TAXATION

County government has always had limited fiscal powers. Unlike cities, county governments do not possess constitutionally granted "home rule" power to finance their services through countywide taxes unless the state explicitly grants authority to do so. Since the Depression in the 1930s, county government has acted as an "agent of the state," responsible for administering a wide variety of state programs with very little fiscal authority. Counties receive substantial financial support from the state for certain programs, whereas they have little state support for other services like criminal justice and transportation.

Lack of Countywide Taxing Authority

Other than the property tax, counties have always had limited *countywide* taxing power. In general, counties may not levy taxes within an incorporated city without a grant of authority from the state or the agreement of the affected city. Counties lack the authority to assess income taxes and excise taxes such as alcohol and tobacco, which generate significant income for the state. (Counties have statutory authorization to levy a utility user tax or transient occupancy tax, but they may only do so in unincorporated areas.)

Until 1978, county government had the authority to levy a countywide property tax rate. Each year, the county board of supervisors would set property tax rates (generally without a popular vote) based on economic conditions in the county and other local jurisdictions, including cities and school districts. Proposition 13 passed in 1978, capping the property tax rate at 1 percent statewide and allocating the proceeds of the property tax to the state.

Declining Own Source Tax Revenue

County "own source" revenue (revenue that is levied, collected and spent by the county) has declined from approximately 40 percent of total county revenue in the 1970s to about 13 percent today.[18] The remainder comes from the state or federal government. This fact, coupled with the lack of countywide taxing power, has narrowed the financing options of counties.

OPTIONS FOR COUNTYWIDE TAXATION

The most common tax sources for countywide services are the sales tax and the parcel tax.

Sales Tax

The state has authorized counties to levy a sales tax for general or specific purposes so long as the combined tax rate, including all other state and local levies, does not exceed 8.75 percent.

The sales tax is made up of the following components:

General state sales tax	5.00%
Local health, welfare and public safety	1.00%
Local transportation	.25%
Local government	1.00%[19]
Total Uniform state and local levy	7.25%

The local government rate is levied by each city within its boundaries and by each county in the unincorporated territory of the county.

Counties are authorized to levy additional sales tax rates with voter approval; the purpose of the levy dictates the vote requirement for the tax. Over the last 20 years, counties have sought voter approval for "add-on" sales taxes above the combined 7.25 percent rate. Twenty-seven counties levy add-on rates for a variety of services. Twenty-two counties levy the sales tax for transportation, three levy the tax for libraries, and two levy a tax for health-related programs.

Parcel Tax

The California Constitution (specifically Proposition 13) limits property taxation, other than the taxes subject to the one percent limit, to non-ad valorem methods of assessment, meaning that taxes may only be levied on a parcel basis without regard to the value of the property. School districts have used state authorization to add resources to local education programs, and cities have used the parcel tax to finance emergency medical services (discussed in depth later in this report).

VOTER APPROVAL REQUIREMENTS

Voter participation in local tax policy has been part of the process since 1978, when Proposition 13 required all local "special taxes" to be approved by a two-thirds vote of the electorate. Later, Propositions 62 and 218 revised the vote requirement on local taxes to specify that tax levies for general purposes require a majority vote, while tax proceeds used for a specific purpose (such as transportation) require a two-thirds vote.

Only San Francisco has levied a general purpose sales tax. All other successful countywide tax elections have been for a specific purpose, requiring a two-thirds vote. In 1996, Santa Clara County successfully placed a majority-vote general tax measure on the ballot with a "companion" advisory measure indicating that the will of the voters was to allocate funds from the tax to transportation. Some anti-tax advocates argue that the voter approval requirements of Proposition 218, which was approved by the voters on the same 1996 ballot, make such a companion measure strategy unconstitutional, though this question has not yet been tested in the courts.

CRITERIA FOR EVALUATING TAX OPTIONS

Policymakers use several criteria to evaluate the quality of tax measures, such as administration, the incidence of the tax, growth potential, and stability. Using these criteria, here is an evaluation of the two major sources used by counties to support health care service delivery, the sales tax and the parcel tax:

- **Administration.** Both sales taxes and parcel taxes are relatively easy and inexpensive to administer because they piggyback on existing collection processes. The sales tax is collected by the State Board of Equalization as part of its general collection of sales taxes, and local parcel taxes are collected by the county tax collector as part of the property tax collection process.

- **Incidence.** The incidence of a tax is the determination of who pays the tax and, in turn, whether the tax is fair or equitable. The sales tax is often thought to be regressive,

meaning that low-income taxpayers pay a higher proportion of their income than high-income taxpayers. However, the California sales tax is less regressive than it otherwise would be because certain necessities, such as housing, utilities and most food items, are not subject to the tax. Depending on how a parcel tax is structured, it would tend to be regressive since it is most often imposed as a flat dollar amount per parcel, regardless of the size or value of the parcel.[20] However, the regressive nature of the tax can be minimized by basing the tax on the number of rooms or the linear footage of lot frontage. In addition, some parcel taxes exempt certain kinds of property, such as property owed by the aged, disabled, or low-income individuals. It should be noted, though, that such exemptions make the tax somewhat more difficult to administer and may create the perception that the tax is not fairly imposed.

- **Growth Potential.** In evaluating a revenue source, growth potential is one of the most important factors. Ideally, revenue growth will keep up with growth in demands. Sales tax revenue growth is affected by underlying taxable sales growth and economic cycles. Statewide, growth in this source has been modest but steady. For example, from 1990 through 2004, statewide taxable sales grew by an average annual rate of 4.2 percent. However, during both of the recessions in this period, sales were flat for two to three years. In addition, because we are moving from a goods-based economy toward a service-based economy, the long-term potential for sales tax growth is less bright. Parcel tax revenue growth depends on the extent of development in a community, unless the tax rate itself is indexed in some manner to increase over time.

- **Stability.** Sales taxes are susceptible to economic fluctuations, but not as susceptible as, for instance, income taxes. Parcel taxes, on the other hand, tend to be very stable.

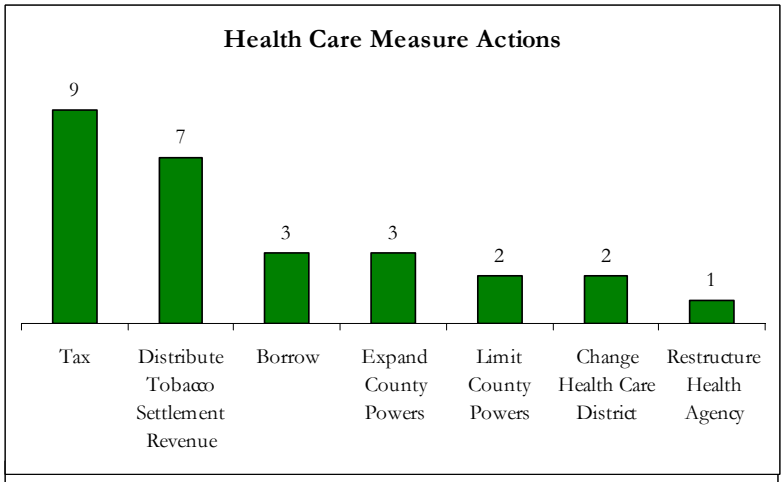
CALIFORNIA COUNTYWIDE HEALTH MEASURES

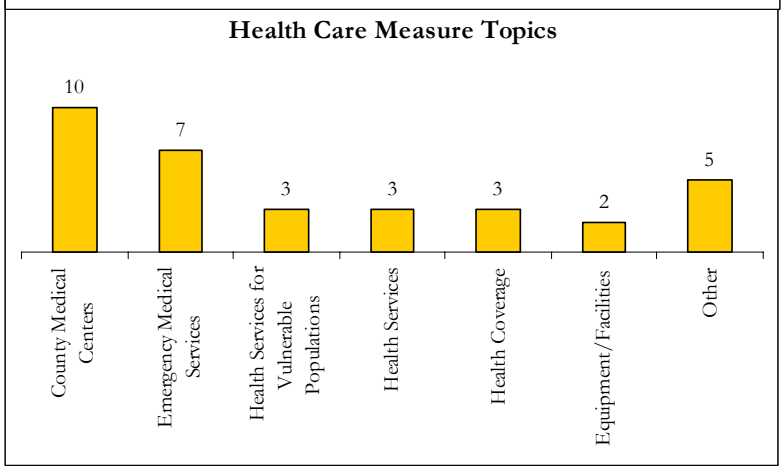
INTRODUCTION

Between January 1995 and June 2006, 692 countywide measures appeared on ballots across California.[21] Of these, 27 measures dealt with health care. The bulk of these measures were considered in counties with major metropolitan areas such as Los Angeles, Orange, Santa Clara, Alameda, San Francisco and Ventura, although a smattering of rural counties also saw ballot measures. Overall, health care measures had a passage rate of 55.56 percent, compared to a 54.6 percent overall approval rate for countywide measures.[22] Taxation and tobacco settlement revenue distribution were the most common issues decided by voters. Amending the county's ability to set health care policy and borrowing were also common ballot themes. Most of these measures were placed on the ballot to benefit county medical centers, although emergency medical services and health care services – often specifically for vulnerable populations – were also popular topics.

Counties with Health Measures

County	Total	Rank[23]
San Francisco	8	11
Alameda	3	7
San Luis Obispo	3	25
Inyo	2	52
Mariposa	2	53
Orange	2	2
Ventura	2	12
Butte	1	27
Los Angeles	1	1
Monterey	2	18
Santa Clara	1	5





This section of the report looks in detail at the nine tax-related health measures, then briefly discusses tobacco settlement revenue distribution and county policy powers. Reaching beneath the county level, the report also summarizes emergency medical service measures at the city and district level.

Examining the tax measures raises a number of questions related to the success or failure of the measure at the ballot. What problem did the proposed tax measure address? What were the chief forces at play from measure conception through the campaign to Election Day? Were there specific attributes that characterized the counties where voters approved the proposed tax? What are the implications for other counties considering similar measures?

THE COUNTY BALLOT AND HEALTH CARE FINANCING: EIGHT CASE STUDIES

COUNTY: ALAMEDA
MEASURE: C
YEAR: 1997
TOPIC: PARCEL TAX
OUTCOME: PASS, 81.38% YES

REGISTERED DEMOCRAT[24]	58.95%
REGISTERED REPUBLICAN	22%
PERCENT BELOW POVERTY LINE[25]	11.8% IN 1997
BOARD OF SUPERVISORS	4 DEMOCRATS, 1 REPUBLICAN
COUNTY HOSPITAL	YES
UNINSURED[26]	14% IN 1996-1997

In June 1997, Alameda County citizens agreed to a special tax of $21.14 on each household to pay for the county-run ambulance service and trauma centers at Highland Hospital, Children's Hospital, and Eden Medical Center.[27] The special tax replaced the 1982 voter-approved benefit assessment of $21.14, which was outlawed by Proposition 218, The Right to Vote on Taxes Act, in November 1996. Thus, passage of Measure C allowed the county to continue collecting approximately $11 million for these services, but did not increase the amount collected.[28] It did, however, authorize increasing the tax rate each year by no more than the amount of the increase in the Consumer Price Index for the San Francisco Bay Area for the immediately preceding year.

The Alameda County Sheriff & Fire Chief, Alameda County Taxpayer Association, Service Employees International Union (SEIU) Local 250, and the Board of Supervisors joined together on the ballot to argue that Alameda citizens had already voted to create the emergency medical system, one of the "premier programs in the United States."[29] Warning of closed trauma centers and lengthened response times for ambulances, proponents urged voters to make sure their families "get the quality of care and speed of response they deserve."[30] Recommended by the *San Francisco Chronicle* and lacking even a ballot argument against it, the measure easily passed the required two-thirds approval mark.

COUNTY: SAN LUIS OBISPO
MEASURE: M
YEAR: 1998
TOPIC: INCREASE SALES TAX BY ¼ CENT
OUTCOME: FAIL, 48.80% YES

REGISTERED DEMOCRAT	38.33%
REGISTERED REPUBLICAN	44.05%
PERCENT BELOW POVERTY LINE[31]	12.2% IN 1998
BOARD OF SUPERVISORS	3 REPUBLICANS, 2 DEMOCRATS
COUNTY HOSPITAL	YES
UNINSURED[32]	27% IN 1998-1999

The November vote on Measure M garnered less than 50 percent of the vote, well short of the two-thirds required to pass. The proceeds of the quarter-cent tax would have gone to upgrade or replace San Luis Obispo County General Hospital. Without structural improvements, the hospital would fail to meet new seismic safety standards applicable in 2008. The hospital's Financing Authority recommend the sales tax after determining that the county did not have the resources to finance the hospital's upgrade or replacement, and said, "the demand for inpatient services [had] been steadily declining for many years and [was] insufficient to generate the necessary revenue."[33]

Measure M failed despite the support of the Board of Supervisors, County Health Commission, County Medical Society, patient advocacy groups and others, and despite the absence of anti-tax arguments on the ballot. The Board of Supervisors argued that more money was needed in order to meet its legal mandate to provide health care services through the county-supported system of community based clinics. They also promised that if the tax was not approved, the county would move forward on the hospital closure and contract with private hospitals for inpatient hospital services.[34]

Talk of closure, however, was not new to county voters. In 1996, voters overwhelmingly approved a measure that required a vote of the people prior to any closure, sale or lease of the San Luis Obispo County Hospital by the Board of Supervisors. During this debate, the Board of Supervisors argued against the full service acute care hospital, saying that the county already contracted with local hospitals for indigent care for much less than it cost to take care of a patient at General Hospital. After the measure passed, the county counsel determined that the vote was non-binding and obtained a supporting Attorney General opinion.

After the election in 1998, the Board did in fact vote to close the hospital and contract out for hospital and emergency room services. However, after further debate in 1999, the Board decided to form a hospital authority to implement a three-year plan to reorganize the financially ailing hospital. Despite these continued efforts, the Board finally voted to close General Hospital in 2003.

COUNTY: MONTEREY
MEASURE: A
YEAR: 2000
TOPIC: PARCEL TAX
OUTCOME: PASS, 70.93% YES

REGISTERED DEMOCRAT	49.06%
REGISTERED REPUBLICAN	32.22%
PERCENT BELOW POVERTY LINE[35]	12.9% IN 2000
BOARD OF SUPERVISORS	3 DEMOCRATS, 2 REPUBLICANS

COUNTY HOSPITAL	YES
UNINSURED[36]	25.3% IN 2001

Because Proposition 218 – approved by the voters in 1996 – outlawed benefit assessments for non-property related services, Monterey County had to find a replacement funding mechanism for the county's Emergency Medical Services (EMS) program. Since the $12 benefit assessment approved by voters in 1988 could no longer be collected, the county would have to ask voters to approve a special tax in the same amount. But first, the county obtained judicial permission to continue the benefit assessment to fund contractual obligations through the end of 2000.[37] In December 1998, the county began to construct ballot language for a November 1999 special tax election. Unclear wording on supplemental assessments, new funding sources, and what exactly would be funded led the County Administrative Officer (CAO) to meet in September and October of 1999 with city managers, fire chiefs, elected officials, and health care providers to discuss their concerns.

In these discussions, issues arose about EMS spending, agency overhead, agency size and function compared to service efficiency, agency responsiveness, and interagency communication. In addition, the Fire Chief's Association vowed not to support the ballot measure unless it was postponed until March 2000 to allow the cities and fire protection districts time to prepare their own local special-tax measures for the same ballot. Agreeing to postpone the election to March 2000, the CAO also promised to reconvene the group to discuss and resolve the EMS issues that had been raised. In fact, EMS mismanagement seemed to be on everyone's mind. In 1999, a grand jury report was submitted to the Board of Supervisors to answer the question: is Emergency Medical Services providing the best and most efficient service for our citizens in the area of ambulance transport?[38] In addition, the Monterey County Fire Chief's Association published an Issue Paper on EMS in early 1999 promoting a revamped EMS management system.

With hope for future changes, a group representing cities, districts, health care professionals and the county developed new draft ballot language that gained the support of emergency response agencies. At the same time, a committee of citizens promoted the measure to voters. Proponents such as the Monterey Peninsula Taxpayers Association and the Monterey County Medical Society urged voters "to protect yourself and your loved ones" and highlighted the emergency services that would be supported just by continuing a tax they had already approved.[39] Opponents from anti-tax groups and the Libertarian Party called the tax a $2000 increase and argued that the county had enough money in its budget to provide for emergency services without the tax. In the end, the words of Measure A supporters proved more persuasive, as the two-thirds vote threshold was easily surpassed.

In April, as promised, a meeting to discuss EMS issues and determine how to best utilize the new funds was held. A Task Force was then formed to review the local EMS System and make recommendations in the form of a published report. The Task Force included representatives from city and district fire service, law enforcement, base-hospital emergency physicians, mobile intensive care nurses, field paramedics, ambulance companies, the County EMS Medical Director, the County EMS Administrator and the Interim Director of Health.

The county began system improvements after the release of the White Paper, disbanding the Emergency Medical Care Committee and establishing the recommended EMS Council in 2002. Thus, the county used a potential funding roadblock as a springboard to revamp and refine EMS

services in the county and can remain confident of a stable revenue stream ($1.48 million was collected in 2000-01, and $1.52 million in 2005-06) for years to come.

COUNTY: LOS ANGELES
MEASURE: B
YEAR: 2002
TOPIC: PARCEL TAX ON IMPROVEMENTS
OUTCOME: PASS, 73.2% YES

REGISTERED DEMOCRAT	52.32%
REGISTERED REPUBLICAN	27.59%
PERCENT BELOW POVERTY LINE[40]	17.3% IN 2002
BOARD OF SUPERVISORS	3 DEMOCRATS, 2 REPUBLICANS
COUNTY HOSPITAL	YES
UNINSURED[41]	26.6% IN 2001, 23.7% IN 2003

For the last 25 years, Los Angeles County has struggled to maintain its public health delivery system. Although changes in federal policy in the early 1990s relieved some of the strain on the county budget for public health services, health facility closures remained a concern. Over time, Los Angeles County Supervisor Zev Yaroslavsky had proposed a number of options for dealing with the chronic health budget deficits that faced the county. In 2002, he proposed Measure B to ease the county's fiscal burden and prevent the collapse of the emergency medical care system.

Measure B, which won overwhelmingly in Los Angeles County, instituted a tax on improved property, using the proceeds for emergency rooms, bioterrorism preparedness, and the county system of trauma centers, which includes both private and public facilities. Beginning with the 2003-04 fiscal year, the Board of Supervisors has levied an annual tax of three cents per square foot on structural improvements to property. The Board sets the tax rate annually and may adjust it by the change in the medical component of the Western Urban Consumer Price Index. To date the county has set the rate at the authorized maximum of three cents and has not adjusted the tax rate.

Supervisor Yaroslavsky's measure was placed on the ballot by a 3-2 vote of the Board of Supervisors in July 2002 and marks the first time Los Angeles voters approved a direct increase in property taxes since Proposition 13 in 1978.[42] Observers predicted the measure would fail, citing poll numbers that gave it "no chance" just after Labor Day.[43] But a decision near the election to close 11 public health clinics and the Rancho Los Amigos National Rehabilitation Center, to trim beds at the county flagship hospital, County-USC Medical Center, and to delay the decision on two more hospital closures for a few months, signaled the dire financial straits the county health system faced.[44] But the numbers alone - a $332 million deficit expected to grow to $582 million in three years – did not sway residents in the polls, perhaps because the system had been bailed out of near bankruptcy twice before, in 1995 and 2000.[45]

In 2000, the county requested a renewal of bailout funds for the health system from the federal government. The system relied on good budget trends, including extra funding from the state and tobacco settlement revenues for the county. The renewal details, however, included a phase out of federal money and a written promise that the federal government would no longer bail out the county once that money was gone.[46] The precariousness of this lifeline funding was highlighted just months after the bailout, when a 50 percent cut to tobacco tax revenues from the state caused five private hospitals in Los Angeles County's trauma network of 10 private hospitals to threaten closure.[47] The *Los Angeles Times* sounded a meltdown warning at year end, writing:

> The county's 13-hospital trauma network was just pulled back from the brink of collapse. Its Department of Health Services, solvent only because of two massive federal bailouts since 1995, is looking at a $506-million deficit in five years. The private sector is suffering its own share of turmoil: Physician groups are merging and going under; community hospitals are fighting mightily to survive. Even a world-renowned medical center--UCLA's--this year found itself barely in the black. The volatility was underscored this week, as Anaheim-based KPC Medical Management, a physician management group in charge of 252,000 patients across Southern California announced that it was closing for financial reasons.[48]

By the 2002 elections, the threat of hospital closures was still pressing. This inspired Supervisor Don Knabe, one of the two original votes against putting Measure B on the ballot, to reverse his position and campaign for the measure.[49] Two weeks before the election, a coalition backed by the SEIU began running a television ad showing an injured child being refused medical service and being routed to an emergency room that was too far away.[50] Finally, and coincidentally, a 200-car pile up on the Long Beach Freeway sent dozens of people into the county's trauma units and emergency rooms, bringing the issue to the heart of every resident, insured or uninsured.[51]

With the passing of Measure B, residents finally approved a stable funding source for their county hospital system. This sent a message to legislators; days after the election, the state and federal government began searching for other means to decrease the county's financial burden.[52]

In another welcome move, the Board instructed the Auditor-Controller to establish a Measure B Oversight Committee that November with responsibility for watching over the millions raised. Every year, an annual report informs the Board of Supervisors of the amount of funds collected and expended, and the status of projects funded by the measure. For example, in Fiscal Year 2004-2005, a total of $177.5 million in expenditures were budgeted: $142.6 million to county hospitals, $26.1 million to non-county hospitals, $3.6 million for trauma access through air transport, $2.8 million for public health bioterrorism-related activities, $1.4 million to the Emergency Medical Services Agency, and $1 million to County Departments for administrative costs.[53]

COUNTY: MONTEREY
MEASURE: Q
YEAR: 2003
TOPIC: INCREASE SALES TAX BY ½ CENT
OUTCOME: FAIL, 61.7% YES

REGISTERED DEMOCRAT	47.37%

REGISTERED REPUBLICAN	33.8%
PERCENT BELOW POVERTY LINE[54]	13.6%
BOARD OF SUPERVISORS	3 DEMOCRATS, 2 REPUBLICANS
COUNTY HOSPITAL	YES
UNINSURED[55]	24.3% IN 2003

In an effort to stabilize funding for the county-run hospital, Natividad Medical Center, and stave off further reductions in services, the Monterey County Board of Supervisors placed Measure Q as the sole measure on a December 2003 mail-in ballot. The proposed half-cent sales tax would have raised $25 million annually for Natividad, which had been given millions of dollars in subsidies and cash advances by the county over the years. County officials discovered in 2002 that the hospital's debt to the county treasury had grown to $41 million.[56] It also struggled under construction debt from the new hospital facility that was built over budget in the 1990s. In 2003 alone, the hospital needed $74 million of its $117 million income to pay construction debt.[57] A blue-ribbon Action Committee instituted budget cuts, eliminating some programs in the process, to slow the losses. In October, the county imposed restrictions on the medically indigent adult program, restricting services to those patients who could prove legal California residence, which would save the hospital $2 to 3 million.[58] But these measures could not break the hospital even and the sales tax was seen as the only way to provide the hospital with a promising future.

Measure Q was supported by a large coalition of local groups and politicians including the neighboring hospitals Community Hospital of the Monterey Peninsula, Salinas Valley Memorial, and Mee Memorial. The measure was backed by the Monterey County Medical Society, League of Women Voters, and the Salinas United Business Association, a group of Latino business owners. The opposition included the Monterey County Farm Bureau, the Salinas Valley Chamber of Commerce, the Monterey County Hospital Association, and the Monterey County Taxpayers Association – representing major employers in the area whose workers often utilize county health services.

Supporters had raised nearly $440,000 by the last weeks of the campaign, with large contributions from the SEIU and the Community Hospital of the Monterey Peninsula.[59] In the beginning of November, commercials supporting the measure started airing on prime-time television. One showed an ambulance arriving at an emergency scene, reminded viewers that the number of local hospitals had declined in recent years, and claimed that Natividad would close unless the tax was approved, with the tagline, "Measure Q saves lives."[60] The week before the election, more pro-Measure Q ads ran, featuring Leon Panetta, former congressman and presidential chief of staff, and Dr. Steven Packer, the CEO of Community Hospital of the Monterey Peninsula.[61] These ads were on top of a sustained and systematic door-to-door campaign that stressed the vital role the hospital played in the county's health care safety net and the dire consequences if it closed.[62]

In contrast, the opposition group did not even raise enough money to meet the disclosure minimum. However, the group used signs, talk radio, and letter-writing campaigns to argue that the county should not be rewarded with new tax income after allowing Natividad to run into financial problems after decades of mismanagement.[63] In addition, the opposition criticized the vague ballot language and lack of a sunset clause, which meant the tax would be collected for at least

ten years and would require a vote by the Board of Supervisors to be suspended.[64] In addition, opponents argued that a quarter-cent sales tax would meet the hospital's current financial needs and keep the hospital from shutting down. This sent a confusing message to voters. As *The Monterey County Herald* pointed out in an early editorial:[65]

> It's billed as a desperation measure to "avoid the life-threatening shutdown of significant portions of Natividad," but the $25 million it would annually generate is almost twice as much money as the hospital needs to break even. Q backers say Natividad needs more money to upgrade equipment and expand. So which is it — rescue mission or upgrade? Persuading two-thirds of the voters to support a quarter-cent tax increase would be far easier than getting to yes on a half-cent increase.

The Board of Supervisors had an opportunity to modify the ballot language when they pushed back the original election date, but they did not do so. Thus, despite a series of investigative pieces by *The Monterey County Herald* that ultimately led to an endorsement, the measure failed. [66] Many expected the measure to fare poorly in the Monterey peninsula since Natividad is in Salinas, but it won 58 percent of voters there and 59 percent of voters in the Seaside-Marina area. The low turnout in East Salinas, however, kept the 75 percent approval rate there from making up the difference.[67]

COUNTY: ALAMEDA
MEASURE: A
YEAR: 2004
TOPIC: INCREASE SALES TAX BY ½ CENT
OUTCOME: PASS, 71.07% YES

REGISTERED DEMOCRAT	55.24%
REGISTERED REPUBLICAN	18.96%
PERCENT BELOW POVERTY LINE[68]	10.7% IN 2003
BOARD OF SUPERVISORS	4 DEMOCRATS, 1 REPUBLICAN
COUNTY HOSPITAL	YES
UNINSURED	17.9% IN 2003

Agreeing to raise their sales tax to the highest level in the state at 8.75 percent, voters in Alameda County passed Measure A in March of 2004. The measure levied a half-cent transactions and use tax in order to provide "additional funds for emergency medical, hospital inpatient, outpatient, public health, mental health and substance abuse services to indigent, low-income and uninsured adults, children, families, seniors and other residents of Alameda County."[69] The tax would be collected throughout the county but 75 percent of the funds would provide additional support for the Alameda County Medical Center, which was facing closures due to continued revenue losses and an unstaffed and unopened new critical care facility. In a compromise with suburban representatives, the remaining 25 percent of the funds generated would be allocated in a geographically dispersed way.[70] These monies could be expended for any of the following purposes:

- Critical medical services provided by community-based health care providers;
- Partially offset uncompensated costs for emergency care and related hospital admissions; and

- Essential public health, mental health and substance abuse services.

The proponents initially considered a parcel tax, but came to the conclusion that voters would not approve a parcel tax set high enough to raise the needed funds. The measure had widespread support from hospitals and business groups, including the Alameda County Taxpayers Association and the Alameda Contra Costa Medical Association. There was no organized opposition and the measure received the endorsements of *The San Francisco Chronicle* and *The Oakland Tribune*.[71]

Still, Measure A faced a few obstacles. First and foremost, Oakland, San Leandro, Hayward, and Newark facilities in the northwestern area of the county were going to receive the bulk of the funding even though the entire county would be taxed. In addition, the measure lost support of a key union when SEIU Local 250, which represented 800 health care workers at the medical center, did not campaign for Measure A due to concerns that the initiative did not require a specific level of funding for the medical center.[72] The SEIU wanted a maintenance-of-effort requirement for the medical center included in the measure. In addition, *The Oakland Tribune* editorial board criticized the Board of Supervisors for approving a $3.2 million consulting contract for the Medical Center while asking voters to tax themselves in order to "bail out" a system that was $71.6 million in deficit with virtually no prospect for new revenue.[73]

In the end, the measure relied on heavy support in the Oakland metropolitan area. In the suburbs in the east end of the county, the measure did not garner the two-thirds vote necessary to win. In the precincts that included Pleasanton, Livermore and most of Sunol, only 56.7 percent of voters gave the nod to the tax. In Fremont and Hayward, the measure just lost with 66.6 percent of the vote.[74] In Oakland, Albany, and Berkeley, however, 83.3 percent of the voters supported the measure.[75] These results supported pre-election predictions that passage would rely on overwhelming support in the Oakland metropolitan area, "where problems with the county's deteriorating public health care system have been most strongly felt."[76] Individuals involved in the campaign believe that the time spent developing a consensus over the allocation of the revenues from the tax was critical to the measure's success.

Proponents argued that an overburdened Alameda County Medical Center would "cause uninsured patients to spill into public and private emergency rooms and make long waits there worse,"[77] and held out 25 percent of funding for local facilities to manage uninsured patients. Still, suburban voters were left "wondering what the additional tax would bring them."[78] To partly answer this question, Measure A provided for an oversight committee. The language in the measure and the following ordinance did not allow the committee to provide funding recommendations to the supervisors, but only to review expenditures made by receiving agencies. "The committee's function is to determine if the agencies have spent the money consistent with the broad guidelines set forth in Measure A, as well as actually spent it on the items that were in their proposal," Health Services Agency Director Kears told the *Berkeley Daily Planet*. "Their purpose is to make sure the money is well-audited and that organizations don't keep the money and spend it for something else."[79]

Appointment issues delayed the oversight process by about two years. After a year and a half of collection, the chair of the League of Women Voters, Nancy Bickel, wrote to Alameda County Supervisor President Keith Carson to express the organization's concern. In response, Director Kears explained that the delays were due to the nominating organizations, and promised that the

nomination process for the committee would begin in November 2005. Eventually, the Board of Supervisors appointed 18 members to the board: 5 representing each supervisory district; 2 each for the League of Women Voters, the SEIU, and the City Managers Association; and 1 each for the Alameda Taxpayers' Association, the Alameda County Mental Health Advisory Board, the East Bay Hospital Council staff, the Alameda Contra Costa Medical Association, the City of Berkeley, and the Alameda Health Consortium.[80]

Although the oversight committee first met in December of 2005, the 2004-05 report was not completed at the time this paper was written.[81] According to other records, however, tax revenues have been running above budgeted expectations. Collections started in September 2004, and the county received $95.8 million in fiscal year 2004-05, with $71.6 million going to the medical center and $24 million going to the remaining health care agencies.[82] By May 2006, the 2005-2006 revenues equaled $74.2 million, with $55.6 million going to the medical center and $18.7 million to the health care agencies.[83]

COUNTY: MARIPOSA
MEASURE: C & G
YEAR: 2004
TOPIC: EXTEND ½ CENT SALES TAX
OUTCOME: FAILED IN MARCH, 62.34% YES
PASSED IN NOVEMBER, 69.67% YES

REGISTERED DEMOCRAT	32.82%
REGISTERED REPUBLICAN	47.97%
PERCENT BELOW POVERTY LINE[84]	11.4% IN 2003
BOARD OF SUPERVISORS	4 REPUBLICANS, 1 DEMOCRAT
COUNTY HOSPITAL	NO[85]
UNINSURED[86]	23.3% IN 2003

In 2004, the John C. Fremont Healthcare District asked its countywide constituents to extend a half-cent sales tax imposed in 2000 to keep the county hospital in operation. The 2000 ballot measure had been advanced in response to the threat of insolvency on the part of the hospital. In the face of that threat, hospital managers developed a recovery plan that contemplated keeping the tax increase in place for four years in order to avoid the hospital's closure. As expiration of the tax approached, hospital managers reached the conclusion that the tax needed to be renewed and proposed a 15-year extension on the March 2004 ballot.[87] That effort failed because, in the view of the proponents, they were not clear enough with voters about the need to continue the tax. The hospital itself is a Critical Access Hospital and, thus, a part of a federal program to provide rural hospital services. Yet, it had been identified as economically fragile by the California Healthcare Association just that year.[88]

As proponents attempted to secure the voters' approval again in November 2004, they faced no organized opposition, but realized that they needed to be direct with voters about the consequences of failure. Hospital managers and others reached out to the community and informed them of the consequences of failure to approve extension of the tax. Voters may also have been favorably swayed by the realization that a significant portion of the tax increase would be paid by visitors from outside the county, given that Mariposa County is the gateway to Yosemite National Park.

In the 2005-06 fiscal year, the health care district received a total of $971,566 in receipts from the tax.[89]

COUNTY: SANTA CLARA
MEASURE: A
YEAR: 2006
TOPIC: INCREASE SALES TAX BY ½ CENT
OUTCOME: FAIL, 42.87% YES

REGISTERED DEMOCRAT	44.9%
REGISTERED REPUBLICAN	27.23%
PERCENT BELOW POVERTY LINE[90]	8.8% IN 2003
BOARD OF SUPERVISORS	4 DEMOCRATS, 1 REPUBLICAN
COUNTY HOSPITAL	YES
UNINSURED	14.4% IN 2003

The Santa Clara Board of Supervisors placed this general tax on the ballot, promising to spend the revenues from the half cent sales tax on:

- The county hospital and clinics;
- Trauma and emergency services;
- Affordable homes for families and seniors;
- Health insurance for uninsured children;
- Prevention programs for at-risk youth, families and seniors;
- Transportation improvements approved in city and countywide transportation plans; and
- Services for abused and neglected children.

This approach mirrored a 1996 strategy in the county, when a measure to approve a general-purpose tax increase, accompanied by an advisory measure regarding the intended purpose of the tax, instead of a special sales tax increase, was approved with a simple instead of a two-thirds majority vote.[91] However, in this case the supervisors made representations as to what the tax would be used for but did not place a companion advisory measure on the ballot. The general tax revenues would then be spent on these special areas even though the Board of Supervisors could legally use them for any county business.

The measure was supported by a long list of local officials and health, housing, business, transportation, social service, labor, public safety, environmental, and civic organizations, which were referenced heavily in ads and arguments for the measure. It was also endorsed by *The San Francisco Chronicle*, *The San Jose Mercury News*, *The Silicon Valley Metro*, and *The Milpitas Post*. The fundamental argument for the measure was to provide local funds for local priorities, untouchable by the state.

Opponents argued that a "general" tax was a way to fund the extension of BART from Fremont to San Jose, which had already been promised by 1996 and 2000 tax measures.[92] They also argued that

the Santa Clara's Valley Transportation Authority (VTA) was inefficient and that money from these taxes would mostly be spent on transportation projects. Citizens for Sensible Transportation Solutions and the Silicon Valley Taxpayers' Association warned voters that proponents were over-promising services from the tax, and asking citizens to pay the highest tax rate in the state for a "backroom deal for the VTA."[93]

After the measure's defeat, *The Milpitas Post* argued that the half-cent sales tax was an overreach. Pointing to pre-election surveys, the editorial board claimed that voters might have approved a quarter-cent sales tax for county health and hospital needs.[94] *The San Jose Mercury News*, in turn, recommended that the Board of Supervisors learn a valuable lesson: "new appeals will need to be more clearly defined and offer greater accountability."[95]

ADDITIONAL INSIGHTS FROM THE LOCAL BALLOT

Aside from tax initiatives, local ballot measures allowed voters to decide on other health-related topics, including health care funding, hospital management, insurance coverage expansion, and emergency medical services.

Allocating Tobacco Settlement Revenue

In 1998, a multi-state agreement to settle tobacco lawsuits provided a monetary windfall to state, county, and city budgets. According to the agreement, 40 percent of the settlement money would go to counties according to their population. In 2000, Orange County Medical Association placed a measure on the ballot to mandate that the county share of money actually go toward tobacco prevention and other health-related programs, instead of general county services. More specifically, Measure H set aside 80 percent of the $30-million-plus annual payment for health-related programs, with the remaining 20 percent going to the Sheriff's Department for public safety matters.[96] The move came after 18 months of dialogue with the Board of Supervisors to "increase inpatient/outpatient health care spending above last place of the 10 largest urban counties in California."[97] The county filed a lawsuit to keep the measure off the ballot. When that failed, the county introduced a competing ballot initiative, Measure G, which would set aside 60 percent of the revenues to fund health care services, tobacco use prevention, and public safety programs and services, with the other 40 percent used to reduce the County's bankruptcy-related debt. In the end, voters rejected the county plan and approved the original measure. After the outcome was upheld against legal challenges, health care advocates in various counties took tobacco settlement money allocation measures to the voters, always against the wishes of the Board of Supervisors.

In San Luis Obispo, Butte, and Inyo counties, battles waged in 2002 over how to spend the tobacco settlement money. In both San Luis Obispo and Butte counties, the measures set aside specific percentages for emergency room services, community clinics, charity care, tobacco prevention, and public safety programs. The voters agreed to the spending in San Luis Obispo, but the Butte County measure failed on Election Day after the Board of Supervisors preemptively passed an ordinance creating a Tobacco Monies Advisory Commission to monitor and coordinate the use of funds for tobacco prevention. In Inyo, a measure to redirect the money to the county's hospital districts beat out a measure to create a countywide health grant program.

In Ventura County, interestingly enough, a private medical facility spent $2.3 million in 2000 in support of its measure to have tobacco settlement money *banned* from use at the county hospital

system and sent directly to certain private hospitals. The measure failed, but the county did pass an ordinance committing the settlement money to community health care programs such as campaigns to reduce tobacco use, prevent chronic and communicable diseases, and provide elder care, mental health, and dental services as an oversight panel saw fit.[98]

Amending County Policy Powers

In 1996, two counties faced ballot measures to remove their ability to close county hospitals without a vote of the people. Faced with growing competition from private hospitals and the loss of patients and Medi-Cal dollars, county hospital systems continued to face pressures to modify services or close.[99] In Alameda County, county supervisors argued that voters were not capable of making day-to-day decisions in health care management, and the measure failed. In San Luis Obispo, the same arguments were used, but voters passed the measure – only to have it overturned by legal rulings.

The Local Initiative Process

The statewide initiative process is generally referred to as the "direct" initiative. If the signature requirements are met, an initiative will appear on the ballot at the next statewide election. The local initiative process is known as the "indirect" initiative. Initiative petitions are presented to the board of supervisors in the case of counties or the city council in the case of cities. The proposed measure can be adopted by the board of supervisors or city council, as the case may be, thus avoiding a countywide or citywide vote on the measure. If, however, the respective governing body does not adopt the measure, it is placed on the ballot pursuant to the following requirements.

In the case of countywide initiatives, the petition must have 10 percent of the number of votes cast within the county for all of the candidates for governor at the last gubernatorial election. In the case of general law cities, initiative petitions must contain signatures of 10 percent of the registered voters in the city. Charter cities may establish their own signature requirements or may use the statutory provisions that apply to general law cities.

Three other measures to expand county health care policy powers were passed in San Francisco. Two of the measures were in essence advisory. In 1998, the county asked if it should look into plans to expand city employee health care coverage to the uninsured. Then, in 2004, Measure G allowed the Health Services Board to establish plans for city residents. The three-fourths vote requirement in both the Health Services Board and Board of Supervisors along with the ballot summary that stressed that the measure does not require the city to pay for any of these plans, made the vote more advisory than mandatory. The final powers modification was a 2000 measure that increased health benefits for retired city employees by placing a cap on monthly health care premiums and paying one-half the costs for a dependent.

Funding Emergency Medical Services

County responsibilities for ambulance and emergency services often trickle down to cities and other local government entities. For example, Community Service Districts (CSDs) and County Service Areas (CSAs) are two types of special districts – voter-created local government entities – that can provide multiple services by raising money through user fees, property tax revenues, or bonds (for capital improvements).[100] Although often lumped together with public safety issues like fire protection, emergency medical services measures offer specific insight into health care funding.

According to data from the California Elections Data Archive (CEDA),[102] 14 counties in California were represented by 8 Community Service Districts, 5 County Service Areas, and 22 cities in sponsoring 57 ballot measures to support emergency medical services.

Of these 57 ballot measures, 44 dealt with continuing or increasing tax revenues. The majority of the tax initiatives were property tax-related, with a 59.1 percent passage rate. At least 9 of these approved measures were to transition EMS funding from property assessments to special taxes (as required by the passage of Proposition 218 in 1996) and did not raise additional tax revenue.[103] When replacement taxes are removed from the equation, the passage rate for tax measures declines to 51.4 percent.[104]

Counties with EMS Measures

County	# on Ballot	Pop. Rank[101]
Alameda	12	7
San Diego	11	3
Marin	8	24
Monterey	7	18
Los Angeles	5	1
Mendocino	3	37
Contra Costa	2	9
Lassen	2	46
Plumas	2	50
Humboldt	1	33
Nevada	1	36
Riverside	1	6
Siskiyou	1	44
Sonoma	1	16

Four sales tax measures were on the ballot in 2004. Alameda County and the City of Richmond passed increases while the City of Ukiah failed twice (but just barely) to muster the two-thirds required. The City of Richmond measure funded general city services including EMS, while the Ukiah measure focused on safety services. The Alameda County measure is discussed in depth above. A utility tax was passed in the City of Richmond in 2002, but emergency services were just one enumerated city service for a tax that would provide revenue for general city services.

DISCUSSION AND CONCLUSION

Examining the nine county-wide measures, several trends emerge. First, measures succeeded predominantly in counties where registered Democrats outnumbered Republicans. In addition, these counties tended to have either uninsured rates or poverty levels equal to or higher than state averages, with the exception of Alameda County in 1997. However, digging beneath county-wide percentages to examine these rates for subpopulations according to race, geography, or income may provide more illuminating trends.

COMPARISON OF ATTRIBUTES ACROSS TAX MEASURE COUNTIES

County	Year	Status	Registered Majority	Supervisor Majority	Relation to State Poverty Rate[105]	Relation to State Uninsured Rates[106]
Alameda	**1997**	**Pass**	**Democrat**	**Democrat**	**-4.20%**	**-9.4%**
San Luis Obispo	1998	Fail	Republican	Republican	-2.70%	+2.6%
Monterey	**2000**	**Pass**	**Democrat**	**Democrat**	**-0.20%**	**+3.4%**
Los Angeles	**2002**	**Pass**	**Democrat**	**Democrat**	**-4%**	**+4.7%, +2.6%**
Monterey	2003	Fail	Democrat	Democrat	-0.10%	+3.2%
Alameda	**2004**	**Pass**	**Democrat**	**Democrat**	**+3%**	**-3.2%**
Mariposa	2004	Fail	Republican	Republican	-2.30%	+2.2%
Mariposa	**2004**	**Pass**	**Republican**	**Republican**	**-2.30%**	**+2.2%**

Santa Clara	2006	Fail	Democrat	Democrat	-4.90%	-6.7%

STATEWIDE HEALTH-RELATED BALLOT MEASURES

INTRODUCTION

California voters have had a long history of participating in the public policy process. Since 1912, the first election following the adoption of the citizen initiative process, the voters have considered 1,134 measures. Of these, 321, or about 28 percent, were brought to the ballot through the initiative process (including the eight measures on the November 2006 ballot).[107] 38 of the measures considered, or about 12 percent, dealt with some aspect of the health delivery system.

During a flurry of health-related activity in the first decade of the initiative process, voters decided on measures that focused on medical practice, including chiropractic and dentistry. The topic of health care then saw little action until the mid 1980s, when five measures qualified for the ballot in the 1986 and 1988 election cycles.

The largest number of health-related measures appeared on the ballot during the sixteen years from 1990 to 2006. During this period, there were 213 measures (both initiative and legislative) considered by the voters. Of these, 24 were related to health and 18 were placed on the ballot through the initiative process.

The period from 1990 to 2006 represents 10 regular election cycles and two special elections held during this time. Of those 10 election cycles, each one had at least one measure related to health. The issues considered by the voters during this period were many and varied, but can be categorized by three distinct time periods, corresponding to the nature of the policy debate then occurring:

HOW DO MEASURES GET TO THE BALLOT?

Legislative process

Legislative Constitutional Amendments: Proposed amendments to the California Constitution can be submitted by the legislature to voters by a two-thirds vote of both houses. The governor's signature is not required and passage is attained by a majority of yes votes.

Legislative Bond Measures: Legislation calling for the issuance of general obligation bonds requires a two-thirds vote of the legislature, the signature of the governor, and a majority vote of the votes cast in a statewide election.

Legislative Initiative Amendment: The legislature may propose amendments to statutes adopted through the initiative process. The proposal requires a majority vote of the legislature and the signature of the governor. In order to take effect, the voters must approve the amendment by a majority vote.

Initiative Process

Initiative Constitutional Amendments and Statutory Laws: The constitution allows registered voters to propose and enact statutes and amendments to the constitution. To qualify for the ballot, a statute requires the signature of at least 5 percent of the votes cast for all candidates for governor at the last election. A constitutional amendment requires 8 percent of the gubernatorial vote.

Referendum: The referendum process allows citizens to approve or reject most statutes adopted by the legislature. Citizens wishing to block implementation of a statute adopted by the legislature must gather signatures of more than 5 percent of the votes cast by all candidates for governor in the last gubernatorial election within 90 days of the enactment of the legislation.

Ballot Measures Related to Health Since 1990

Year	Title	Subject	Type	Status
1990	113	Chiropractic	6	Passed
	124	Local hospital district	6	Failed
	128	Environment/public health bonds	6	Failed
	129	Drug treatment/enforcement bonds	6	Failed
	134	Alcohol surtax fund	2	Failed
	135	Pesticide regulation	6	Failed
1992	161	Terminal illness, assistance in dying	6	Failed
	166	Basic health coverage	1	Failed
1994	186	Health services, taxes	1	Failed
	188	Regulation of tobacco products	6	Failed
1996	214	Health care business regulation	3	Failed
	215	Medical use of marijuana	5	Passed
	216	Health case regulation/ consumer protection	3	Failed
1998	10	Early childhood development/health	2	Passed
2000	28	Repeal tobacco surtax	6	Failed
	36	Drug treatment diversion program	4	Passed
2002	44	Chiropractors	6	Passed
2004	61	Children's Hospital Projects	6	Passed
	63	Mental health funding	2	Passed
	67	EMS telephone tax	2	Failed
	71	Stem cell research bonds	2	Passed
	72	Referendum - Health care legislation	1	Failed
2005	73	Parent notice teen pregnancy	6	Failed
	78	Prescription drugs	5	Failed
	79	Prescription drugs	5	Failed
2006	85	Parent notice teen pregnancy	6	Failed
	86	Cigarette Tax	1	Failed

Ballot Measures Type	#	Passage Rate
1: Financing insurance coverage	4	0%
2: Expanding health services	5	60%
3: Regulating health care organizations	2	0%
4: Health and criminal justice	1	100%
5: Regulating treatment provision	3	33%
6: Other	12	25%

1990–94

The three election cycles during the early 1990s saw an active debate over the financing of health services. All of these measures were placed on the ballot through the initiative process. Proposition 134 in 1990 included a tax on alcohol to help support emergency medical services. Propositions 166 and 186 were considered by voters during the 1992 and 1994 election cycles, and were the first attempts at seeking voter approval for a more comprehensive health care insurance system for California. All three of the measures considered by voters during this period failed by wide margins.

1996

Regulation of health care organizations was a major issue for health consumer groups in the mid-1990s. Propositions 214 and 216 were placed on the ballot by consumer groups concerned about oversight and control of HMOs. Both measures failed.

2004-06

The 2004 election cycle saw five measures on health care programs, all related in some degree to financing. Proposition 61 allowed the state to sell $750 million in general obligation bonds for the construction, expansion, remodeling, renovation, furnishing, equipping, financing, or refinancing of children's hospitals. Proposition 63 levied an income tax surcharge on high income Californians for mental health treatment, Proposition 67 levied a telephone tax for emergency medical services, Proposition 71 used general obligation bonds to finance stem cell research, and Proposition 72 included

an employer mandate for health insurance. Three measures passed (Propositions 61, 63, and 71) and two measures failed (Propositions 67 and 72). The 2005 special election included three health-related measures, one relating to parental notification of teen pregnancy termination and two related to prescription drugs. All three measures failed. Two health-related measures in 2006 also failed: Proposition 85, which again proposed parental notification for teen pregnancy termination, and Proposition 86, which was a cigarette tax to fund expanded health insurance to cover all California children, as well as a host of treatment, prevention, and research services.

THE INITIATIVE AND HEALTH CARE FINANCING: FIVE CASE STUDIES

The following section contains five case studies of statewide ballot measures that related to health care financing. The five measures appeared on the ballot between 1990 and 2006. Four were initiative measures and one was a referendum on a statute passed by the legislature and signed by Governor Davis. These case studies illuminate the difficulty of dealing with health care financing through the initiative or referendum process, given the perennial underlying conflicts between employers, employees, taxpayers and interest groups.

PROPOSITION 134
ALCOHOL SURTAX
NOVEMBER 1990
FAILED, 31.01% YES

Proposition 134 was a surtax on alcoholic beverages. Beginning on January 1, 1991, the proposition would have increased the state tax on beer from 4 cents to 57 cents per gallon, on most wines from 1 cent to $1.29 per gallon, and on liquor from $2 to $8.40 per gallon. This roughly translated to an additional 30 cents on a six-pack of beer, 25 cents on a bottle (750 milliliters) of most wines, and $1.27 on a bottle (750 milliliters) of liquor.

Funds from the surtax (estimated at $760 million for FY 1991-92) would be used for a variety of health-related programs. These were allocated as follows: alcohol and drug abuse prevention, treatment and recovery programs (24%); emergency medical care (25%); community mental health programs (15%); child abuse and domestic violence prevention training and victim services (15%); and alcohol and drug-related law enforcement costs and other programs (21%). The proposition contained a "maintenance-of-effort" provision that provided a minimum funding guarantee for a variety of health, mental health, criminal justice, and other programs at their 1989-90 levels, plus adjustments for population and cost increases.

Proponents referred to the proposition as the "Nickel-A-Drink" alcohol tax initiative. They argued that the proposal "targets the heavy drinkers – the drunk drivers and alcohol abusers who cause most of the deaths and injuries attributable to alcohol," and referred to the cost to most taxpayers as "pocket change."[108] They also pointed out that California liquor sellers and consumers faced the lowest alcohol taxes in the nation. Surgeon General C. Everett Koop advocated for the measure, asking, "Who could quarrel with a nickel-a-drink user fee... to help save lives?"[109]

Opposition to the measure came primarily from the liquor industry. A wide coalition of liquor interests argued that the proposition was a bad financial deal for all of California. Since the measure

guaranteed spending levels, opponents argued that the proposition "penalizes all Californians – not just drinkers – by spending far more in taxes than it raises."[110]

The opposing coalition also counter-attacked the proposition by placing two other measures on the ballot, Propositions 126 and 136.[111] The coalition then approached the California Teachers Association to support Proposition 126, which would only increase alcohol taxes by about a penny a drink and direct revenue to the general fund instead of specific health programs.[112] The CTA had just passed Proposition 98, which guaranteed education a significant share of state general fund resources, and therefore agreed to back Proposition 126, which would directly benefit the association.[113]

Proposition 136 required any tax initiative that earmarks its revenue to pass by a two-thirds vote. It was designed to complicate an election-day victory for Proposition 134, should it pass. In fact, when Proposition 134 was first introduced, electoral victory seemed likely. In August 1990, a California Field Poll found that 78.7 percent of voters were in favor of raising money through alcohol taxes, and 51.7 percent of voters believed that these taxes should go to treatment programs (versus 42.5 percent who thought the money should go to the general fund).[114] That same month, 68.4 percent reported support for Proposition 134 after it was explained to them. In contrast, a minority of voters, just 44.4 percent, supported the liquor industry's Proposition 126.[115] By early October, support for Proposition 134 had fallen to 59.5 percent while intended yes votes for Proposition 126 had risen to 53.5 percent.[116] Right before the election, support for Proposition 134 plunged to 53.2 percent and support for Proposition 126 fell to 43.8 percent.[117] On election night, both measures were defeated, but Proposition 126 garnered about 9 percent more support than Proposition 134.

By November, the liquor industry had spent $28 million to defeat Proposition 134 and pass their own ballot initiatives, dwarfing the $1 million raised by the supporters of Proposition 134.[118] At the time, this was the largest amount a single industry had spent on initiative campaigns since the insurance industry worked to defeat Proposition 103 in 1988.[119] On election day, Proposition 134 only garnered 31% of the vote.

PROPOSITION 166
EMPLOYER-PROVIDED HEALTH INSURANCE
NOVEMBER 1992
FAILED, 30.8% YES

Proposition 166 sought to place additional responsibility for health insurance on employers. The measure required all employers to provide health insurance to full-time employees and their families. The program also contained an employee mandate for participation unless the employee already had health insurance.

The measure required employers to pay at least 75 percent of the cost of insurance, with employees paying the remainder, and capped employee participation at 2 percent of wages. This approach required a change in federal law in order to implement it.

The program carried with it a basic benefit package that included hospital care, outpatient care and a variety of commonly used medical services. The measure also contained requirements for insurance

companies to make coverage available. The program was to be administered by a newly-established Health Care Coverage Commission.

In order to blunt criticism that the new employer mandate would be too costly for small business, the measure expanded an existing small business health care tax credit. All employers with 25 or fewer employees would be eligible for the tax credit. The Legislative Analyst estimated a cost to the state general fund of at least $100 million.

The debate over the obligation for providing health care coverage has centered on who pays and how the costs would be distributed. In this case, 75 percent of the costs were to be borne by employers, with the remaining 25 percent borne by employees. The plan was put forth by the California Medical Association (CMA), a group of physicians who sought to reform health care through legislation, but no strong source of support for the proposition ever emerged. Both liberal and conservative groups attacked the measure, and in the end it failed in all counties (its strongest support was in Imperial County, with only 43 percent in favor).

A report on interest group motivations in the campaign for Proposition 166 by Thomas Oliver and Emery Dowell found that the CMA had insufficient allies and financial support to wage a successful campaign. Opponents to the measure included consumer groups, labor unions, the AARP, the California Nurses Association, the California Restaurant Association, the National Federation of Independent Business, the California Manufacturer's Association, and insurance providers. Thus, while the CMA attempted to paint the opposition as coming primarily from "heartless insurance companies," liberal and conservative forces actually joined together to defeat the measure.[120] Liberals argued that the mandate was not sufficient to solve the problems of access and rising expenditures, while employers argued that the program would hurt the economy.[121] A ballot argument opposing Proposition 166 claimed that the measure hurt the economy and workers, while blocking real health care reform, reducing coverage, locking in benefit levels, and not ensuring actual coverage – an argument that covered the ideological spectrum.[122]

The measure's opponents spent $6.8 million while proponents spent just $2 million.[123] Six million of the opposition purse came from the Consumer Health Insurance Coalition (CHIC), a group of insurance companies and trade associations.[124] The rest came from the Health Coalition '92, which was made up of small employers.[125] The opponents launched a high profile media campaign, including three weeks of 30-second movie-theater ads aimed at the youth vote, which had been found to favor the goals of the initiative.[126] They also saturated the television airwaves just before the election, targeting areas of economic distress in the state and making job loss the dominant theme.[127] In a September California Field Poll, 68.6 percent of voters stated that they were extremely concerned about health care, but an even larger share, 79.4 percent, felt the same about the state's economy.[128]

On the proponents' front, the CMA was in a weak fundraising position and had lukewarm support, so it used its limited resources for a statewide mailing, radio spots, and newspaper advertising.[129] Proposition 166 showed 44.9 percent approval in an early October California Field Poll, but only 36.4 percent of voters supported the measure by the end of the media campaigns in late October.[130] An election-night survey of voters indicated that they had heard the opposition's message:[131]

- 50% believed the measure would put many small employers out of business;

- 14% said it would cause a loss of jobs or cut in wages;
- 17% said it was inadequate and that more sweeping changes were needed;
- 10% were concerned that it would not control health care costs; and
- 6% thought it would not cover all uninsured Californians

PROPOSITION 186
SINGLE PAYER PROPOSAL
NOVEMBER 1994
FAILED, 26.6% YES

At the November 1994 election, health advocates returned with a new proposal. Rather than requiring employers to provide health insurance, Proposition 186 sought to establish a "single payer" health care system in which the State of California would administer and finance health coverage, thereby replacing most private health insurance and current public health care programs. The measure sought to consolidate funding from all of the then-existing governmental programs and levy a tax to meet the remaining obligation to provide health insurance for uninsured Californians. Similar to the elected Insurance Commissioner approved by the voters in 1988 (Proposition 103), a newly installed Health Commissioner would be responsible for managing the new health insurance system. Like Proposition 166, it required a change in federal law in order to work.

In order to finance the new program, revenues would come from a payroll tax, an income tax surcharge, and an increase in the cigarette tax. The revenue from these sources plus existing sources was estimated by the Legislative Analyst at between $40 and $50 billion annually.

The initiative itself was carefully crafted. According to one review, by Farey and Ligappa:

> The initiative legislation was carefully designed to be implementable if passed, with valid mechanisms for financing, governance and administration, and to be as free as possible of features that could leave it open to challenges of constitutionality….Dozens of professionals in health care, health policy, and legislation, in both the US and Canada, were contacted for input and advice along the way.[132]

Unlike in 1992, when the CMA was unable to gather support for Proposition 166, a strong coalition emerged to usher Proposition 186 through the initiative process. Although the CMA itself did not publicly support the single payer plan, some of its members moved privately in the measure's favor.[133] The first movers on the issue were the California's Physician Alliance and the state chapter of Physicians for a National Health Program, who drafted the measure before bringing it to the California Congress of Seniors and Neighbor to Neighbor, both capable grassroots organizers and historical advocates of the single payer system.[134] Health Access, the liberal health coalition that turned against Proposition 166, threw its support behind Proposition 186, as did the California chapter of the AARP, the League of Women Voters, Consumers Union, the American Nursing Association and a slew of state and national labor unions, including the California Teachers Association and the SEIU.[135]

The opposition included well-financed health insurance companies, the California Association of HMOs, the California Association of Hospitals and Health Systems, the National Federation of Independent Businesses, the Organization of Nurse Executives, the California Taxpayers Association, and the California Chamber of Commerce. Governor Pete Wilson and his Democratic gubernatorial challenger, Kathleen Brown, also came out against the measure.[136]

Proponents knew that they would be outspent in a media war and set out to mobilize grassroots support through a hands-on, low-cost approach. They prioritized fundraising, media, and visibility. Outreach was done via a house party program, a speakers' bureau, and endorsement solicitation.[137] Almost 1,500 house parties were held to educate, mobilize and fundraise, garnering over $1 million.[138] In the end, supporters raised $3.2 million.[139] However, they only spent $898,555 on paid advertising, running two television ads and two radio spots that reached fewer of the state's voters, later, and less often than the opponents' ads.[140]

In their paid advertising campaign, supporters vilified the insurance industry, asking Californians to rebel against the "coverage-denying, profit-maximizing" ways of the insurers. The Kaiser Foundation later declared this tactic ineffective, citing a post-election survey that found that only 15% of California voters supporting the initiative on Election Day identified the desire to eliminate the role of private insurance companies as their main reason for supporting the initiative.[141] In their ballot arguments, proponents emphasized that the program guaranteed a choice of doctors, helped California's economy by reducing costs to businesses and taxpayers, saved the state money for educational purposes, and represented the consumer interests of the people.[142]

These arguments and tactics failed, however, to overcome the opposition, which appealed to voters' dislike of "big taxes" and "big government." This message also tapped into voter concerns over the economy, potential job losses, and perceptions of diminished provider choice and quality of care.[143] Opponents raised over $9 million by Election Day and purchased over $4 million in advertising across the state.[144] The campaign used third-party sources to lend credibility to its message and secured prominent endorsements.[145] Ultimately, all major newspaper editorial boards in California came out against the measure.[146]

PROPOSITION 72
REFERENDUM ON SENATE BILL 2
NOVEMBER 2004
FAILED, 49.2% YES

A referendum of a statute passed and signed by the governor in 2003, Proposition 72 was placed on the ballot after business groups underwrote a signature gathering process to force SB 2 to a popular vote before going into effect. SB 2 required all businesses over a certain size to provide health insurance for their employees by enacting a "pay or play" system. Under the new rules, California employers with more than 50 employees would provide 80 percent of insurance premiums or pay a fee to the state to provide health insurance for their employees and, in some cases, their dependents. Employees would generally be required to make a contribution of up to 20 percent of the amount of the fee charged by the state to their employer. Contributions paid by employees would be collected by their employer and transferred to the state. Low-income employees would have contributions capped at 5 percent of their wages. The program requirements would be phased in over a 3-year period depending on the number of employees.

The proposition lost by 180,436 votes, which is a small margin considering that 990,247 of the ballots cast in the election did not contain a vote on the measure one way or the other. Still, the measure carried in 12 counties[147] despite the opposition of *The Los Angeles Times*, *The San Francisco Chronicle*, and *The Sacramento Bee*, whose editorial boards argued that the measure did nothing to actually stem the rising cost of health care and instead placed the burden on, and created disincentives for, business.[148]

Pre-election indicators had seemed promising for Proposition 72. Just as in 1992, the California Medical Association was the sponsor of the legislation, but this time was able to garner key liberal allies. Universal health care advocacy group Health Access joined the coalition, as did the California Labor Federation, the Foundation for Taxpayer and Consumer Rights, and the California Partnership. Save Your Healthcare, a coalition of doctors, nurses, consumers, teachers, and unions, created a Yes on Proposition 72 web site.[149] And finally, proponents were barely outspent by the opposition, $15 million to $16 million.[150]

Opponents were led by the California Chamber of Commerce, which formed Californians Against Government Run Healthcare to spearhead the referendum movement. This coalition included the California Restaurant Association, California Taxpayers Association, California Retailers Association and the California Business Properties Association.[151] The California Restaurant Association was the single largest contributor to the opposition, giving $2.5 million in October.[152] Wal-Mart gave $500,000 to defeat the measure after proponents launched an ad citing a University of California at Berkeley Labor Center study concluding that state taxpayers pay $32 million a year to subsidize health care for Wal-Mart employees.[153]

Opponents to the measure threatened large job losses and business relocations if the measure passed. They also criticized the plan as government-managed health care. Proponents countered with ads that underlined how the uninsured were costing taxpayers money and driving up employee health care costs. They also argued that the proposition leveled the playing field for businesses.[154]

Pre-election polls revealed that the measure's supporters included Democrats, nonpartisan voters, minority voters, lower income individuals, and people with concerns about being without health insurance.[155] In May, the measure garnered 50 percent support, but support eroded with each successive poll. In the last few weeks of October, the opposition pulled ahead, with opponents outnumbering supporters.[156]

Those who favored the measure were split in their reasons for doing so, with 39 percent saying that "it's a step in the right direction, will expand insurance coverage" and 36 percent agreeing that "employers should share in the costs, do their part, contribute to the health care of their workers."[157] As the election approached, supporters were more likely to say they were voting yes because the measure directly affected their own coverage, and less likely to say it was because it was a step in the right direction.[158]

At the election, 43 percent of those who voted against the proposition said they opposed it because "it would increase the cost of doing business in California, make business less competitive, [or] would be bad for business."[159] The next most frequently cited reason for opposition, at 24 percent, was "providing workers health insurance should remain voluntary, a benefit, should not be

mandated by government." In contradiction to this poll result, a Public Policy Institute of California poll found "a strong preference for a system of universal, government-administered health care (60%) as opposed to the current system in which most people get their health insurance from private employers (35%)."[160] In the end, though, Proposition 72 did not pass.

PROPOSITION 86
CIGARETTE TAX
NOVEMBER 2006
FAILED, 48.3% YES

Proposition 86 sought to impose a cigarette tax that would create funds to extend health care insurance to all children in California, shore up emergency services, address a statewide nursing shortage, and provide funds for prevention and research efforts. The extensive bill was actually a combination of two separate ballot initiatives. A group of children's health advocates, including Children Now, PICO California, and the Children's Partnership, had recently worked on a measure to provide universal health coverage for children that had been vetoed by the Governor. A group of health care associations that included the American Cancer Society, the California Hospital Association, the American Heart Association, and the American Lung Association of California was already at work on a tobacco tax increase to fund emergency care, nursing education, chronic disease treatment and research, and tobacco cessation. These two groups joined forces, along with other children's and health care advocates, and the Coalition for a Healthy California directed volunteer power to overwhelmingly qualify the measure for the ballot.[161]

At first, the initiative fared well in the polls, showing 63 percent support for the measure in August.[162] Tobacco companies then began to campaign against the measure, and support dropped to 53 percent in October, then to a dead heat in November, with opposition at 45 percent.[163] At the same time, undecided votes increased following television and mailing pieces backed by RJ Reynolds and Phillip Morris, who tapped their collective $58 million war chest to defeat the proposition.[164]

For the proponents' campaign, hospital groups contributed about $10 million of the $13 million spent.[165] In fact, opposition groups attacked Proposition 86 as a windfall for special interests: the hospitals themselves. Language in the bill provided that hospitals would receive funds according to the number of people that went through their emergency rooms, not the number of uninsured they treated. If a hospital's funding exceeded its emergency care losses, it could use the money for new equipment and upgrades. Since hospital emergency services were slotted to get the largest share of the new tobacco tax (74.5 percent of the 52.75 percent set aside for health treatment programs[166]), projected revenues for hospitals in 2007-08 were $300 million above losses, according to a nonpartisan report by the California Budget Project.[167]

Opponents also argued that only 10 percent of the revenue from the cigarette tax was apportioned to smoking cessation and prevention programs, and that smokers – a predominantly poorer demographic – would unfairly pay for the health care needs of all of California. They also attempted to connect the issue to law enforcement and education policies, arguing that high cigarette taxes induce black market and criminal activity while the tax's revenues would be exempt from state laws that mandate education funding levels.[168]

Proponents, on the other hand, argued that tobacco companies were out to stop a tax that would reduce smoking by 312 million packs a year while funding much needed health programs.[169] *The Oakland Tribune* believed that the lives saved from smoking deterrence alone was worth a "yes" vote while *The Los Angeles Times* offered its endorsement based on both health arguments.[170] The editorial board dismissed concerns that the tax would paradoxically depend on cigarette sales that it aimed to decrease, and that there was a collective duty to pay for health programs. *The San Francisco Chronicle*, however, could not overlook the collective duty to pay, reminding voters that "taxing small groups of people in order to pay for benefits for all of us is an unethical strategy."[171]

In the end, after a high profile and deep-pocketed campaign from both sides of the issue, the measure failed.

DISCUSSION AND CONCLUSION

The policy debate over health care finance has centered largely on a single question: how should the burden of financing health care coverage be shared by employers, employees and the taxpayers? Although the issue has been on the legislature's agenda for each legislative biennium for as long as anyone can remember, the fight over this question has also been waged through the initiative process.

Four consecutive election cycles – 1990 through 1996 – saw measures attempting to establish a method for financing some aspect of health care coverage, or setting up a regulatory system focused on health maintenance organizations. Three measures proposed a revenue structure to improve the delivery of health services. All failed.

Of the 24 measures considered by the voters since 1990, it is striking that only 7 passed – about 29 percent – and many failed overwhelmingly. With the exception of Proposition 63, which levied an income tax surcharge on high income Californians for mental health treatment, all of the measures that would have used some form of taxation or an employer-based obligation to finance their provisions were rejected by about 70 percent of the vote. The closest any measure got was the referendum on SB 2, which created an employer mandate.

In contrast to statewide measures, local ballot measures have been more successful in the last decade. Generally the question put to local voters has not been complex as many of the statewide measures, which sought to significantly overhaul the structure or financing of health care at the state level. Incremental increases in taxes, particularly when paired with specific health care needs at the county level, have proven more palatable to voters than the more sweeping reforms proposed at the state level.

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[18] This figure differs from the percent of total county revenues that are discretionary referenced earlier because, while the property tax is a discretionary revenue source, pursuant to Proposition 13 it is actually levied by the state and, thus, is not an own source revenue.
[19] In 2004, the local government rate was reduced by ¼ cent to ¾ cent and a new ¼ cent state rate was imposed to pay for retirement of the state's Economic Recovery Bonds (ERBs). The local government rate will revert to 1 percent when the ERBs are retired. The revenue loss due to the reduction in the local rate is being replaced with property tax revenue.
[20] In the case of Los Angeles County and Measure B adopted in 2002, a three cent per square foot tax was levied on improved property. This tax is not levied on parcels, rather it is levied on the square footage of buildings and structures.
[21] Four counties had records prior to 1995 available: San Francisco since 1992, San Diego since 1991, Tulare since 1994, and Alameda since 1992. Five counties could not provide complete records: Sutter prior to 2003, Mariposa prior to 2001, Butte prior to 2000, Mendocino prior to November 1999, and San Mateo prior to September 1998. Six could not provide any records by the issue of this report: Colusa, Inyo, Kings, Plumas, San Benito, and Trinity. For unavailable periods, the California Elections Data Archive (CEDA) from California State University, Sacramento was utilized.
[22] There are 18 unknown outcomes, if they all passed, the passage rate increases to 57.23%. The true rate is probably between 54.62% and 57.23%.
[23] By population.
[24] Democrat and Republican registration percentages were only available from Alameda County for September 1997.
[25] Poverty levels for counties are from the US Census Bureau, Small Area Income & Poverty Estimates: Model-based Estimates for States, Counties & School Districts. "The estimates are not direct counts from enumerations or administrative records, nor direct estimates from sample surveys. Data from those sources are not adequate to provide intercensal estimates for all counties. Instead, we model the relation between income or poverty and tax and program data for the states and a subset of counties using estimates of income or poverty from the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). We then use the modeled relations to obtain estimates for all states and counties." htt p://www.census.gov/hhes/www/saipe/nontechdoc/intro.html

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[41] 2001 and 2003 uninsured rates are from the 2001 and 2003 California Health Interview Surveys. The rates cover all non-elderly persons who did not have insurance for any part or all of the year. http://www.chis.ucla.edu/default.asp
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