Bulletin 612

PUBLIC HEALTH

PREFACE

The Ohio Health Council published a booklet in 1962 and a revision in 1964 entitled, "Let's Speak Up For Public Health." Even though the supply is exhausted, numerous requests have been and are still being received for information contained in the booklet. In order to meet this need, the Ohio Health Council asked the following people to serve as a committee to develop this material:

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The members of the committee wish to thank all of the persons who reviewed this material and made many helpful suggestions.

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A Look at PUBLIC HEALTH

INTRODUCTION

Public health departments cannot achieve their objective of improved community health without the understanding and active support of the people. Citizens are needed to serve as knowledgable advocates of policies and legislation for improving the health of their communities.

The average citizen probably is not fully aware of the amount of time, effort and money expended by public health departments to safeguard and improve his health. In many instances, he takes for granted the existence and functions of the local health department. Many citizens are unaware of how their taxes are used to bring the public health services to their community.

Although public health in Ohio has a history of over one hundred years, this publication attempts to highlight only the last 50 or so of these (Appendix A).

The focus of this bulletin is directed toward lay leaders and the purposes are: 1) to trace the development of public health in Ohio, 2) to outline the major duties of local health departments as specified by Ohio law, and 3) to provide information relative to the organization and financing of local health departments.

It is hoped that the information contained in this bulletin will help citizens better understand and make informed decisions regarding public health in Ohio. More active citizens' involvement is a goal of this committee effort.

Statutory Duties of the Local Health Department

The overall objective of the local health department is to protect the health of the public and to prevent disease. To achieve this objective, the statutory duties

of the local health department include: inspecting, licensing, treating, regulating, screening, and reporting activities concerned with public and private health matters as well as maintaining vital statistics. Public health services are provided to business establishments, public institutions, and individuals within the community.

Duties specified by the Ohio Revised Code are contained in Chapters 3701, 3704, 3705, 3707, 3709, 3732, 3733, and 3781. Many of the duties contained in the Ohio Revised Code are permissive and are performed at the discretion of the local board of health. The general responsibilities of the local health department are summarized into the following seven categories:

1. **Inspection**—Health department sanitarians may enter and inspect any place where food is produced, manufactured, stored, handled, or sold. Inspections of public institutions such as schools, jails, children's homes, infirmaries, county homes, etc., are a responsibility of the health department. Providing for the inspection and abatement of nuisances dangerous to public health also is in this category.
2. **Licensing**—The department is responsible for issuing licenses to restaurants, vending machines, solid waste disposal sites or facilities, and trailer parks. In addition, licenses associated with the production, processing and transportation of milk are issued by those departments authorized to conduct a milk program.
3. **Immunization and Treatment**—The department may, through clinics or individual appointment, provide for immunization against communicable diseases and the treatment of individuals who have contracted venereal disease. Primary care clinics for treatment of other medical problems may also be established.
4. **Regulatory**—Health regulations may require the enforcement of statutory building standards relating to the location, sanitary construction and repair of plumbing and liquid waste disposal systems.
5. **Screening and Evaluation**—The local health department may provide screening program services for school and preschool children. Often included are vision, hearing and dental checks. Laboratory services for examining human, animal, water and food specimens are provided through the department.
6. **Reporting**—The county health department reports the existence of contagious and infectious diseases to the state department of health which provides for the prompt diagnosis and control of communicable diseases.
7. **Vital Statistics**—The local health department maintains a record of births, deaths and infectious diseases, as specified by law, which occur within the health district. Annual reports are made to local governmental agencies and the state department of health.

There are additional responsibilities of the local health department which are infrequently or rarely used. These are enumerated in chapters of the Ohio Revised Code.

In many communities, the public health department offers additional services beyond those which are specified by law. The kinds of services offered vary among the departments and are dependent upon the local needs and resources available.

Some of the major health services presently being offered include: school health programs, well-child clinics, home nursing health care, cancer detection, health education, and alcoholism programs. Several local health departments have sponsored, in cooperation with the Ohio Department of Health, multiphasic programs which screen for diabetes and heart disease and provide tests for blood pressure, tuberculosis, pregnancy, and urinalysis.

For a detailed summary of the public health services offered in your community, request a copy of the annual report of your local health department.

ORGANIZATIONAL PATTERNS

Present Organization of Health Districts

The two basic types of health districts are "city health districts" (See Figure 1), consisting of all municipalities over 5,000 in population which have been declared a city by the secretary of state, and "general health districts" (See Figure 2), composed of the townships and villages in each county.

The statutes also provide that one or more city health districts and a general health district may unite to form a "combined health district" (See Figure 3) and that up to five contiguous general health districts may combine to form one unit. However, present law does not appear to allow a combination of general health districts to include any cities.

A union of two or more contiguous general health districts requires a majority vote of all district advisory councils involved. A board of health for the new district must be elected; each original general health district is entitled to at least one member. New legislation would be needed to permit a combination of two or more general health districts to include cities within the combination.

A union between a general health district and a city health district requires the majority vote of the district advisory council of the general health district and the approval of the legislative body of the combining city. The combining districts must make a contract which apportions expenses, prescribes administrative responsibilities and defines representation of the district on the board of health.

By entering into a contract, a health district, usually

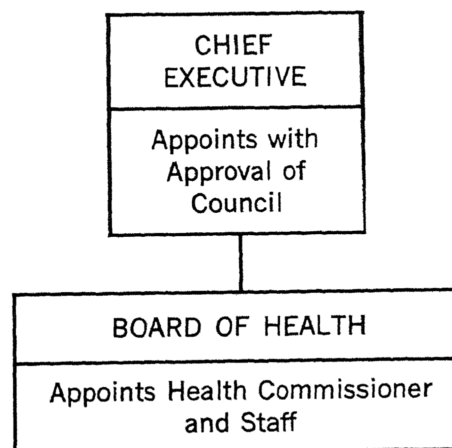

Figure 1: CITY HEALTH DISTRICT

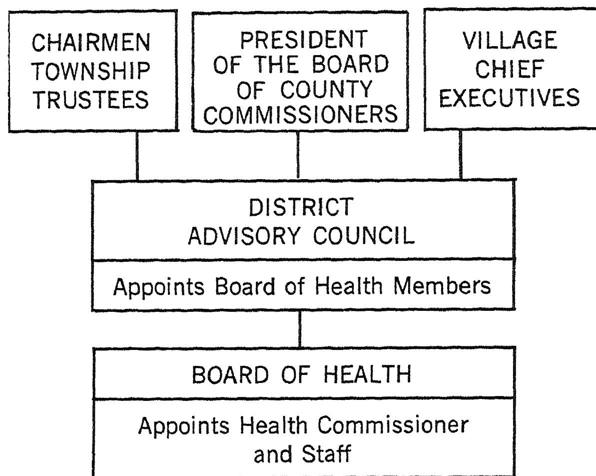

Figure 2: GENERAL HEALTH DISTRICT

a city, may secure services from another district, usually a general health district, without combining with it.

Health districts may also cooperate with each other by the joint employment of a health commissioner. Some cooperating districts also intermix other staff members and occupy the same office space; and, therefore, appear the same as combined districts. Cooperating districts each retain their own boards of health.

District Advisory Council

The townships and villages in each county form a general health district.[1] The chief executive of each of these villages, as well as the chairman of each township's board of trustees, are designated members of the "district advisory council."[2] They are required by law to meet annually (March) and their statutory powers and duties include:

1. Selection of a five-member board of health. The board must be representative of the district served. To insure representation, municipal corporations are entitled to one board position for every one-fifth of the total general health district population.
2. Making recommendations to the board of health of the health department.
3. Consideration of special reports from the board of health.
4. Authorizing the union of the general health district with another health district to form a new, combined health district, as well as authorizing other contractual agreements.

Board of Health

The **board of health** consists of five members who are appointed for five-year overlapping terms.[3] At least one member must be a physician. Board membership may be larger in a combined health district. The board meets monthly. The board of health appoints the health commissioner who, unlike his counterpart in city health districts,[4] must be a licensed physician, dentist, veterinarian, or holder of masters in public health.[5] The health commissioner, who is appointed for two years, acts as secretary and executive officer of the board and carries out all orders of the board. The commissioner also makes

1 R. C. 3709.01

2 R. C. 3709.03.

3 R. C. 3709.11.

4 City Health Districts also have five member boards with the same functions. They are appointed by the city chief executive with approval of city council.

5 R. C. 3709.11.

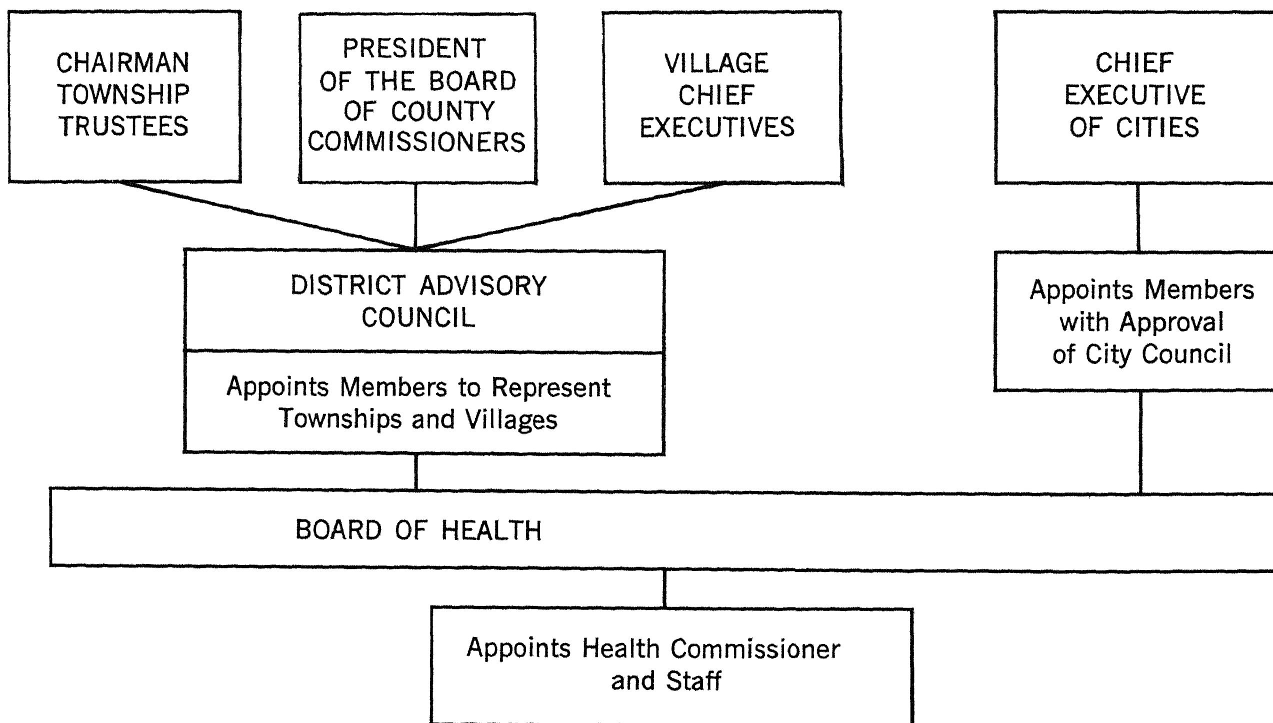

Figure 3: COMBINED GENERAL HEALTH DISTRICT

recommendations to the board on the employment of all health department personnel.

Ohio's 88 counties and 232 cities totaled 320 health districts in 1975. Various types of district consolidations reduced the number to 162 and if the cooperating departments, with a co-mingled staffing pattern are included, there are 153 separate operating public health units.

About three-fourths of the general health districts are now consolidated or have cooperating staffing with city health districts or other general health districts, but in most instances, only a limited degree of consolidation is afforded through cooperating and contractual arrangements.

Size of Health Districts in Ohio

A health district, the same as a school district, has to be of sufficient size in order to afford to attract, keep and effectively use the professionally trained personnel essential for an adequate public health program. Many health districts in Ohio are too small to employ a full-time staff and to provide minimum public health services, except at great per capita expense.

Thirty-nine general health departments serve populations of less than 50,000 and 14 of these serve less than 25,000. City health departments tend to be even smaller. Nearly half (36) serve populations under 25,000 and 14 of these serve less than 10,000.

In past years, population was used by national public health authorities as a primary criterion to determine desirable size of a health unit. While this remains a useful measure, the most recent policy statement, December 6, 1974, by the American Public Health Association allows a much wider latitude in setting the size of health units and places the responsibility for this squarely in the laps of local community officials.

"Each of the three levels of government in the United States—federal, state and local—has a role to play in the provision of comprehensive health services. Without demeaning the part to be played by the federal and state governments, the role of the local government is crucial in the actual development and provision of services. This is the place 'where the action is.' Unless services are available and are utilized, no health program can succeed. If we as a country are going to attain our health goals, it is imperative that local governments recognize and exercise their responsibilities in the health service field. Of particular importance is the role of local government in coordinating inputs from the federal and state levels with those from the private sector to produce truly comprehensive health services."

Consolidation

The advantages that consolidation of health districts might afford would include: more efficient administration, broader financial resources, improved personnel management, less duplication of fees and inspection, improved physician reporting, more effective use of financial aid, and more economical operation.

The disadvantages suggested by those opposed to health district consolidation include: fear that home rule may be endangered by loss of local control of public health administration, the possibility that wealthy districts might pay disproportionately more to support health services than surrounding poorer areas, and loss of status of some health commissioners.

Counties as Local Health Units

Although present laws would have to be changed, a relatively simple and direct method of reorganizing health districts into larger units would be the designation of the county as the basic health unit.

This plan would be particularly suitable if financing of health services were made a county, rather than a municipal and township, responsibility and if the county commissioners could participate in the appointment of county board of health members. It is likely that if such a law were passed, the legislation would permit some of the largest cities to retain their separate health departments. Small county health districts could be encouraged to combine. However, the difficulties in arranging financing across county lines and the need for new legislation to include city health districts hinder combinations of this type.

FINANCIAL REQUIREMENTS OF GENERAL HEALTH DISTRICTS

Essential Public Health Personnel

The functions of health districts are largely services to people and by far the greatest part of their expenditures are for salaries of local health personnel. Knowledge of personnel needs is necessary to the understanding of the financial requirements of health districts.

The shortage of all types of public health personnel in general health districts is due primarily to the lack of adequate funding.

Sources of Income in General Health Districts

These are the primary sources of income for local health departments:

a. Property taxes (appropriated from townships and villages).
b. Levies.
c. Fees for licenses, permits, inspection and home health services.
d. Contract agreements with cities and boards of education.
e. Federal and state grants for special services.
f. Grants from other agencies such as the Cancer Society or Lung Association.
g. State subsidy.

Wide variations occur in type and in percent of the total income received from the above sources by health districts.

The general health districts with relatively high per capita health appropriations derive more of their income on the average from the voted public health levy and from fees than do the relatively low per capita units. Relatively high health expenditures seem dependent upon additional sources to supplement the income from the property taxes withheld from townships and villages.

Most general health districts collect some kind of fees, although many programs have no specific statutory authority for the fees.

City health districts and boards of education may enter into contract with general health districts to purchase health services for a specified amount of money.

Voluntary agencies may make contributions to general health districts or may combine their services.

Present Expenditures

General health districts vary widely in the amount of per capita health expenditures, but most districts have relatively low expenditures. Seventy-nine of the 88 general health districts in 1974 had a per capita health expenditure below the state average of $3.96. Seven of these districts had a per capita expenditure below $1.50.

Residents of general health districts with relatively high per capita public health appropriations usually are afforded better public health services than are the residents of health units with low per capita appropriations. Higher per capita expenditures for public health mean more and varied public health personnel providing not only the traditional and required services but also additional vitally needed services.

Special Levy for General Health District[6]

If the estimated expenses of money necessary to meet the expenses of a general health district are insufficient within the 10 mill limitation, the Board of Health shall certify this insufficiency to the Board of County Commissioners who are empowered as the special taxing authority.

The Board of County Commissioners shall declare by two-thirds vote that there is an insufficiency of funds, and shall submit to the Board of Elections, 90 days prior to the election, a tax levy to be voted upon by the people. This levy cannot exceed one mill for a time period of up to 10 years.

Organizing to Pass a Public Health Levy

If a Board of Health decides to place the Public Health Levy on the ballot, it is most important that the citizens be informed and made aware of the health services of the department.

It is important to involve the people in group action by organizing a citizen's committee. The State Election Law stipulates that all publicity be identified by name, address and organization. There must be an accounting of all expenditures which are filed with local Boards of Elections.

The committee should have representatives from all townships or key communities and agencies. This group should analyze the attitudes and the needs of the community, and develop plans to effectively reach all citizens. Certain committees would be utilized as:

1. Speaker's Bureau
2. Finance
3. Publicity
4. Membership
5. Area Leaders, etc.

Voters are becoming highly resistant to proposed new tax levies. It is only when the voter is made aware of the extent of health services which will be lost or gained by the rejection or approval of the levy that the decision is made in the affirmative.

Financial Problems

Local expenditures in some general health districts are insufficient to support adequate health services.

[6] R. C. 3709.29.

A number of general health districts have not solved their financial problems due to a low tax base. Other districts with a higher tax base have failed to develop sufficient funds to support a minimum public health program.

Passage of a health levy is not always the solution to financial problems. After the levy has been passed, township trustees and village majors, in some instances, attempt to persuade the county budget commission to reduce the amount of their property taxes allocated to the health district. As a result, funds available to the health district from within the 10 mill limitation may be less than before the passage of the public health levy.

Proposals for Local Sources of Support

General health districts could be encouraged to make more extensive use of the voted public health levy.

With some programs, more extensive use of collection of fees could be encouraged to cover the cost of issuing permits and of making inspections to enforce public health regulations. With others, legislative action would be needed to obtain additional funds.

Some groups suggest that the county commissioners be given the responsibility for the financial support of the health district. This support of the general health district would be particularly appropriate in counties in which the general health district and all city health districts are now or could be combined under one county-wide board of health. Participation by the commissioners in the appointment of board of health members has also been considered.

Small health districts could combine to effect operating economies and to make more effective use of federal and state aid (see Consolidation on page 5).

The boards of health of general health districts might be elected as are boards of education. The advantage of electing a board of health would be the stimulation of public interest in the local public health program through periodic election campaigns.

A CITIZEN'S ROLE IN PUBLIC HEALTH

This publication was developed to point out the duties, organizational pattern and financial support of the public health program in Ohio. It can serve as a base to help acquaint you with the services and programs available to the public through the local health department.

In addition to the basic services, a local health department can foster innovations and respond to the needs of the community if the people support the program. A number of health departments have responded to the needs of people by adding new programs when local financial support was available. This is why the services and programs offered by a local health department will vary from county to county.

What you can do to support public health in your county and state:

1. Encourage your organization to study the public health department in your county.
2. Identify and work with the local health organizations. It takes group action and support to initiate new programs in local health departments.
3. Get acquainted with the health commissioner, the board of health and staff members. This will give

you an opportunity to become familiar with the total health program.
4. Work with the staff members to develop materials to be used to inform the general public on the services available. Staff members could be encouraged to attend meetings and other events in the county to talk about the program.
5. Develop a directory of health services available to the people and distribute through the various health organizations.
6. Every citizen in Ohio has a stake in public health. Health services and programs available to the people in the county are the result of public support.
7. The key to any service or program that depends upon local finances is to involve the community leaders in defining the need and developing and initiating the program. In this manner, a health program can be designed to meet the needs of the people and community.

APPENDIX A

Background

Prior to 1919—every city, vallage and township in Ohio was a separate health department or public health unit. There were 2,158 individual units.

1919—With the enactment of the Hughes Act, a major stride toward effective administration of public health was started. Under this Act, the state was divided into health districts as follows:

1. Each city having a population of 25,000 or more constituted a municipal health district.
2. All cities having less than 25,000 and the villages and unincorporated areas of each county constituted a general health district.

Later in 1919—the Griswold Act amended the Hughes Act to provide that each community in Ohio with a population of 5,000 or more constituted a city health district, and the villages together with the unincorporated area of each county constituted a general health district, regardless of population size.

1931—Legislation was enacted to enable or permit the voluntary combination of city and general health districts by means of contract.

1951—The Wheeler Act was passed, which provided for a voted public health levy for general health districts of up to .5 mill for one year. Later the law was changed to allow a levy to continue for five years. This support is now known as the Public Health Levy Section 3709.29 of the Ohio Revised Code.[7]

1959—The McGovery-Oyster Act, passed by the Legislature, permits contracting health districts which desire to form a combined general health district to specify in the contract the number of members, terms of office and manner of appointment of the new boards of health. This Act was an amendment of R.C. 3709.07, which allowed combined health districts the option of more than five members on the board of health.

1971—The General Assembly changed section 3709.29 to permit an operating levy for a county health department to:

1. Be as much as one mill instead of a half mill.
2. Be effective as long as ten years instead of five.

[7] R. C. refers to the Ohio Revised Code.

The Public Health Levy, to help finance local health departments, has been successfully used to date in at least 40 counties in Ohio "Appendix B."

It has never been easy to encourage voters to pass a new health levy; however, in recent years passage has become increasingly difficult. Once a levy has passed in a county, health levies are usually renewed with less difficulty.

1975—Under Amended Substitute House Bill 155, the General Assembly delegated the responsibility for determining the eligibility and amount of the subsidy for local health departments to the Public Health Council for the biennium July 1, 1975 through June 30, 1977. The Public Health Council determines the amount to be allotted to each health district within the limitation of the funds appropriated by the General Assembly. With the passage of Senate Bill 200 in 1976, this present system will continue beyond 1977.

1976—Additional provisions of S.B. 200, which have been signed into law, seat the President of the Board of County Commissioners as a member of the District Advisory Council and make it possible for the Board of County Commissioners to give financial assistance for any health program conducted by a city or general health district.

OHIO COMMITTEE ON PUBLIC HEALTH STUDY

1950—The Ohio Committee on Public Health made a study of local public health services in Ohio. (This committee was formed as an outgrowth of the interest developed by the then Ohio Rural Health Council.)

The study showed:

1. There were too many separate health jurisdictions.
2. Most health districts did not have sufficient funds to employ an adequate staff.
3. The method of appointment of boards of health needed improvement in order to secure competent, alert and interested members.
4. The alternative methods of organization and financing, quality of personnel and local services needed, and methods of appointment of board of health members.

1951—The above study resulted in the introduction of House Bill 95 which would have formed 88 county health districts, plus a city health district in each of the eight cities over 100,000 population. The bill died in the health committee of the House.

1960—After a study by the Ohio Legislative Service Commission, the report, **Organization and Financing of General Health Districts,** was published. A condensation giving some of the major points covered in the report follows:

1. Some cities and counties in Ohio do not afford citizens with the public health services they have a right to expect.
2. The causes of inadequate public health services in some communities are threefold: (1) many small city and county health districts are unable to finance, employ and effectively use needed qualified personnel; (2) the financial resources of many

health districts are inadequate, unstable, diverse in character and suffer from additional shortcomings in collection procedures; and (3) local boards of health in some districts appear to lack interest in developing a satisfactory public health program, or competence to do so, if interested.

3. Adequate public health services in all communities can be developed through a combination of local efforts and legislation designed to help local health districts to help themselves.
4. This report presents an analysis of the desirability and feasibility of improving the organization and financing of general health districts. Three basic issues are presented: To what extent, if any, does the General Assembly wish to provide for the reorganization of health districts? To what extent, if any, would change be desirable in the statutes governing local and state financing of public health services? To what extent, if any, can the present method of selecting boards of health in general health districts be improved?
5. Public health needs vary from one district to another as a result of such factors as population density, age characteristics of the population, economic level of the community, climate, housing and extent of industrialization.
6. Public health programs are not static but undergo a continuous process of change and development. Marked changes in the age distribution of the population and in the spectrum of our health problems have forced the theory and practice of public health to include not only prevention of illness but also curtailment and cure of disease, associated complications and disability.
7. Public health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts. The optimal responsibilities of the local health department, according to the American Public Health Association, are (1) the recording and analysis of health data, (2) health education and information, (3) supervision and regulation, (4) provision of quarantine and environmental health measures, (5) administration of personal health services, (6) operation of health facilities and (7) coordination of activities and resources.
8. The basic professional personnel of local health districts are the health commissioner, the public health nurse and the sanitarian. Large districts may also employ dentists, industrial hygienists, nutritionists, health educators and laboratory personnel.

The foregoing comments from the Legislative Service Commission Report reflected the situation as of 1960. Public health authorities still indicate this situation has not changed greatly.

APPENDIX B

OHIO COUNTIES AND PUBLIC HEALTH LEVIES

Northwest District	Year Passed	Number of Renewals
Auglaize	1954	4
Delaware	1954	3
Erie	1953	7
Fulton	1954	3
Huron	1953	5
Morrow	1953	4
Paulding	1964	2
Putnam	1963	2
Richland	1955	3
Sandusky	1953	4
Seneca	1953	4
Union	1953	4
Wood	1960	0
Wyandot	1959	1
Northeast District		
Ashland	1953	4
Geauga	1956	4
Harrison	1955	4
Lorain	1953	4
Medina	1953	4
Portage	1955	4
Tuscarawas	1958	5
Wayne	1956	2
Southwest District		
Clark	1957	3
Clinton	1963	2
Fayette	1954	4
Greene	1954	4
Highland	1962	2
Miami	1968	1
Preble	1970	1
Shelby	1954	4
Warren	1975	0
Southeast District		
Athens	1972	0
Guernsey	1960	2
Hocking	1953	4
Jackson	1953	4
Muskingum	1953	4
Noble	1968	1
Perry	1960	3
Pike	1953	4
Ross	1963	2
Vinton	1954	4

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