# HEALTHY PEOPLE - HEALTHY COMMUNITIES

# AN AGENDA FOR PUBLIC HEALTH REFORM

***THE REPORT OF***
***THE OHIO PUBLIC HEALTH SERVICES STUDY COMMITTEE***

**October 13, 1993**

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Health Commissioner, in those instances, would be appointed by the mayor. City health departments failing to meet the established standards would be restructured and combined with a recognized public health jurisdiction.

The Committee's vision for the future requires that local public health jurisdictions have the critical mass necessary to assure that the core public health functions are available everywhere in this state. Critical mass is defined as those characteristics necessary to provide the core public health functions and practices. It may include, but is not limited to, financial resources, qualified personnel, local commitment, and population base.

It is anticipated that in most cases, the county boundaries would provide the critical mass necessary to carry out core public health functions, but it is recognized that multi-county jurisdictions may be desired or necessary. Such determinations should be made at the local level. While the administrative offices of a multi-county jurisdiction may be centralized, the Committee envisions one or more operating or program units within each county, all under the same governance and management.

**3.0 Governance**

**3.1 The governing body should be an appointed Board of Health. The appointing authority of the Board of Health should be required to assure that the Board is generally representative of the people and the population distribution within the jurisdiction.**

**3.2 The appointing authority for the Board of Health should be a District Public Health Council.**

**(a) The Council should consist of one County Commissioner, one trustee from each township, and the mayor or a designee from each village and the mayor or a designee from each city within the jurisdiction.**

**(b) The Council should be required to meet in March and September of each year.**

**(1) The purpose of the March meeting should be to elect its officers, elect a member(s) to the Board of Health, and to receive the Annual Report of the jurisdiction.**

**(2) The purpose of the September meeting should be to**

review and comment on the proposed budget and fee schedule of the jurisdiction for the ensuing fiscal year.

(c) A quorum, for any regular meeting of the Council, should consist of not less than a majority of the members.

(d) The Council should annually elect a chair, a vice-chair, and a secretary from among its members. The duties of the secretary may be delegated to the Health Commissioner.

(e) The Council should be permitted, by a two-thirds majority vote of the entire Council, to remove a member of the Board of Health for non-attendance or non-participation in the work of the Board or for acting in conflict of interest as a member of the Board.

3.3 The existing Boards of Health within a proposed restructured public health jurisdiction should be required to adopt Bylaws for the successor Board of Health. The Bylaws should become effective when approved by the Director of the Ohio Department of Health and ratified by the District Public Health Council. The Bylaws should define, within the following parameters, the size, term, and tenure for the new Board of Health.

(a) The Board of Health of a single county jurisdiction should have a minimum of seven and a maximum of fifteen members. At least one member shall be from a recognized health profession.

(b) The Board of Health of a multi-county jurisdiction should have an equal number of members from each county within the jurisdiction. The minimum size should be ten members. A maximum size should be determined during the process of developing the Bylaws for the Board of Health. At least one member shall be from a recognized health profession.

(c) The term of Board of Health members should range from a minimum of three years to a maximum of seven years. Terms should be staggered so that no more than one-third of the terms expire in any one year.

(d) Board of Health members should receive a stipend and

expense reimbursement. Any such stipend should not create membership in the Public Employees Retirement System.

3.4 Current Board of Health members should not be excluded from appointment to a successor governing body.

3.5 The Board of Health's primary responsibilities are to be the policy making and hearing body for the jurisdiction.

3.6 A major responsibility of the Board of Health is the selection, regular evaluation, and, when necessary, replacement of the Chief Executive Officer.

3.7 Governing body members should be required to participate in a formal orientation to their local public health jurisdiction prior to assuming membership on the governing body.

3.8 Board of Health members should be required to participate in a general orientation to public health provided by the Ohio Department of Health and/or the Ohio Association of Board of Health within one year of appointment to a Board of Health. Failure to participate in such an orientation should be grounds for removal from the Board.

3.9 Board of Health members should be required to attend at least five hours of continuing education during the second and each succeeding year of Board membership. Such continuing education should be at seminars/workshops approved by the Director of the Ohio Department of Health. The cost of this required continuing education should be paid by the Board of Health. Failure to attend the required continuing education should be grounds for removal from the Board.

The proposed creation of the District Public Health Council is important in assuring broad representation of as well as accountability to the citizens of the public health jurisdiction. The Council's composition allows for participation by all units of local government. The elected officials designated as a part of the Board of Health appointment process must be accountable to their electorate for both their appointments to and removals from the Board of Health.

The District Public Health Council's participation in the budget process requires the Board of Health and the Health Commissioner to be accountable for the financial stability of the

jurisdiction. The receipt and review of the Annual Report requires accountability for documenting the process used for the community health assessment, the provision of core public health functions and practices, and in meeting established standards.

The Committee's recommendation that allows existing Boards of Health to adopt the Bylaws for their successor Boards is a unique aspect of this process and one that will allow for substantial participation and decision-making at the local level. This recommendation will assure that the unique characteristics and history of each district are taken into account during the transition phase.

Given the broad scope of authority and responsibility of the new Board of Health, each member must be committed to his/her responsibilities and should be knowledgeable about contemporary public health issues. Requirements for general orientation and continuing education will assist in meeting the goal of an informed Board. This training may be offered in a variety of forms, such as video discussions, teleconferencing, satellite seminars, traveling presentations, or centrally located conferences.

**4.0 Administration**

**4.1 The Health Commissioner should be designated as the Chief Executive Officer of the local public health jurisdiction. As Chief Executive Officer, he/she should be responsible for all administrative functions and should serve as Secretary to the Board of Health.**

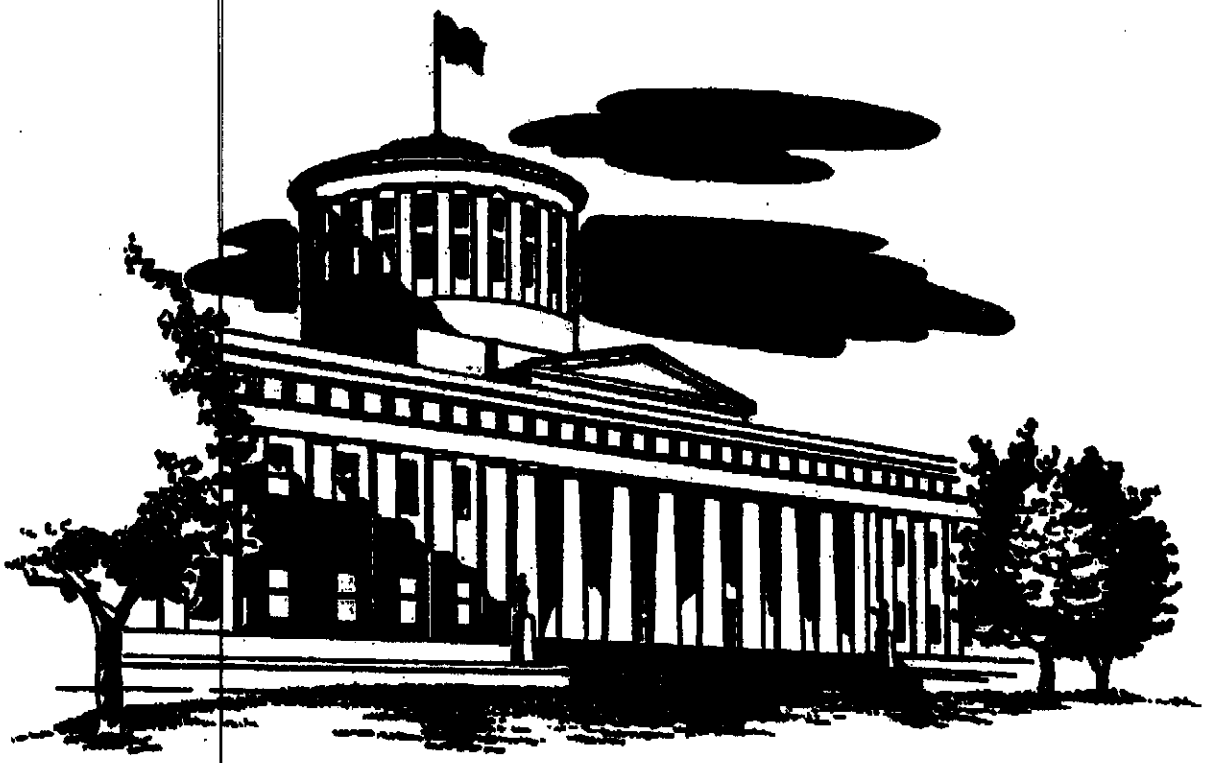
**4.2 The Board of Health and the Health Commissioner should be designated as co-appointing authorities for personnel actions. The Health Commissioner should exercise the appointing authority, with all employments subject to ratification by the Board. All disciplinary actions beyond a three day suspension should be appealable to the Board.**

**4.3 The existing Section 3709.11 of the Ohio Revised Code dealing with the qualifications of the Health Commissioner should be deleted. The qualifications of the Health Commissioner should be established by rules of the Ohio Public Health Council. The qualified individual should have a advanced degree in public health, preventive medicine, or community health.**

**4.4 After adopting a line item appropriation for each fund and establishing a reasonable spending authorization, the Board**

# Organization and Financing of General Health Districts

Staff Research Report No. 41



## Ohio Legislative Service Commission

December, 1960

## Part Three

# Selection of Boards of Health in General Health Districts

Part Three of this report examines some of the apparent disadvantages of the current selection system and concludes with a discussion of four possible alternatives, with special attention to county commissioner appointment of boards of health.

### Disadvantages of the Present Selection Procedure

*The appointment of the health board in general health units by the district advisory council does not assure competent and interested boards, because the appointing authority has no responsibility for, and often no interest in, the administration of a county-wide public health program.*

Some members of the district advisory council tend to be indifferent to the appointment of health board members because they have little direct interest or responsibility in maintaining a comprehensive county-wide health program. The council is required to meet only once each year on the first Monday in March. Special meetings are infrequent. Minutes of the meetings of 64 district advisory councils in 1960 indicated that attendance at these meetings ranged from 11 per cent to 95 per cent, with an average attendance of 64 per cent. Neither interest in public health problems nor the compensation of five dollars per meeting day plus expenses for each council member stimulates large attendance at these meetings.

Many district advisory council members believe that the scope of public health programs is confined to eliminating nuisances in their own communities. This narrow concept of a public health activity is reflected in the character of health board members and thwarts the development of a comprehensive county-wide program. The lack of interest in public health problems among some district advisory council members tends to produce four adverse results: health board members who are uninterested in improving public health services are appointed; board members who have gained little knowledge of public health problems during their board membership are automatically reappointed; board members who feel that their chief responsibility is not to maintain adequate public health services but to keep district health expenditures as low as possible are appointed; and the district advisory council tends to depend upon the health commissioner to name the members of his own board of health.

The large and widely dispersed district advisory council membership makes it difficult for this body to respond to the public's wishes in regard to public health policy and the selection of board members. The number of council members ranges from 15 to 43, with an average of 24 members. As might be expected, this large multi-member appointing body exercises an extremely diffused direction over public health policy. Individuals and groups within the district find it difficult to transmit their views on public health to the many council members. The large size of this appointing body, moreover, enhances the opportunity for the exercise of political and personal considerations in choice of board members.

Appointment of boards of health by the district advisory councils has been defended on the grounds that the traditional major source of income for general health units has been township and village property taxes. Some village mayors and township trustees, furthermore, believe that their appointing authority for the board of health should be retained and be accompanied with an additional power to review and to amend general health district budgets. To divest the district advisory councils of appointive power, however, would seem reasonable if the townships and villages were relieved of financial responsibility for public health services.

### Possible Alternative Selection Procedures

All methods of selecting health board members possess some weaknesses. No procedure can guarantee a board of health composed of interested and competent members. A good health board usually develops from the integrity and concern of the appointing authorities and from genuine community interest in an adequate health program. Since certain selection devices, however, may be more conducive to choice of competent board members than are other methods, four of the possible procedures are described below.

*Boards of health in general health districts could be appointed by the board of county commissioners.*

County commissioners might be inclined to appoint a satisfactory board of health, because the voters would hold the commissioners ultimately accountable for an adequate public health program. The prominent status which county commissioners enjoy within a county

provides the most effective answer to the critics of this plan who fear both inattention to citizen interests and political influence in public health personnel selection. County commissioner activities are better reported than are those of the 20 or more district advisory council members.

The county commissioners could integrate public health functions throughout the county, if they were assigned financial responsibilities for health services and if health districts were reorganized into 88 county-wide units. The county health commissioners, furthermore, are already engaged in many public health activities, such as appointment of boards of trustees for county hospitals, and responsibility for tuberculosis, sanitation, and public welfare programs. They are also now designated by law as a special taxing authority for the general health district voted public health levy.

The following states rely upon county commissioners to appoint the board of health:

*California*—A "board of trustees" of five or more members for each health district is appointed for four year terms by the governing body of each county. Unincorporated areas of the district are represented by one member for each 100,000 people or fraction thereof, although each county is limited to three members. Cities of less than 2,500 population are included in determining the population of unincorporated territory.[8]

*Illinois*—Local boards of health consist of seven members appointed for three-year terms by the chairman of the county board of supervisors.[9]

*Indiana*—Seven-member county boards of health are appointed for four-year overlapping terms by the county commissioners. Cities above the "fifth class" must be represented in accordance to the population ratio of city and entire county. The boards must be bipartisan and must include three physicians, one dentist, and one school superintendent. In multi-county health districts the county commissioners of each county appoint four members each, of which two must be physicians and one a dentist. City-county joint health districts have seven-member bipartisan boards of health, including three physicians. Six members are appointed by mayors and one member by the county commissioners.[10]

*Michigan*—Where a single county has only one health department, a health committee of three county supervisors is selected by the chairman of the board of supervisors. In multi-county health districts, each county board of supervisors elects three supervisors to a district board of health.[11]

*New York*—Here the board of health of a county consists of seven members, one of whom is a member of the board of supervisors, selected by the board of supervisors. Three members must be physicians. Each city which becomes a part of the county health district is entitled to one additional representative member on the board of health. The county medical society may submit to the board of supervisors a list of physicians from which the board of supervisors may choose the medical members of the board. The additional city representative members of the board are appointed by the board of supervisors from a list of three persons submitted by the mayor of each city.[12]

*Pennsylvania* — Five-member boards of health are appointed by the county commissioners for four-year terms. Two members must be physicians. In a joint-county health district the joint-county health commission, which is composed of the combined boards of county commissioners, appoints a board of health which is equal in size to twice the number of counties involved plus one. The number of physicians on the board must equal the number of counties participating in this district.[13]

*The county commissioners could be added to the district advisory council to participate in the selection of health board members.*

The advantage of this plan, in addition to simplicity, is that the county commissioners

8. *California Health and Safety Code*, Chap. 6, Article 3.
9. Ohio Committee on Public Health, *Local Health Units in Ohio* (Preliminary Report, (1949), mimeographed), p. 26.
10. *Indiana Statutes*, sec. 35-605; 35-810; 35-815.
11. Ohio Committee On Public Health, (Preliminary Report, 1949), *op. cit.*, p. 26.
12. *New York Public Health Law*, (1958), sec. 343.
13. *Pennsylvania Statutes*, 16-12006; 16-12007.

would be able to contribute to the district advisory council their knowledge of county-wide problems of financing and administering public health services. The participation of the county commissioners on the council could stimulate their interest in public health. Some local health commissioners have suggested that if county commissioners were included in the district advisory council, they could be given statutory authority to make voluntary grants to health units from county funds.

This plan fails to overcome, however, most of the shortcomings of the present method of choosing health board members and might only further dilute responsibility for appointing boards of health.

*Local government officials, together with representatives of the medical professions and* ***the public, could constitute a board of health in general health districts.***

A board of health in each general health district could consist of one or all of the county commissioners, mayors of cities, some representatives of villages and townships, and representatives of the medical professions and the public. This type of board of health, if properly designed, might effectively coordinate health services now provided by several governmental and voluntary agencies. Several states now enjoy this type of county board of health:

*Kentucky*—County boards of health consist of three physicians appointed by the state board of health plus the county judge and one member appointed by the fiscal court of each county.[14]

*North Carolina*—The county board of health here is composed of three or more ex officio and four public members. The ex officio members are (1) the chairman of the board of county commissioners, (2) the mayor of the city or town which is the county seat, and (3) the mayors of all other cities with a population of over 15,000. The public members, selected for four-year staggered terms by the ex officio members, must include a licensed physician, a licensed pharmacist, and a licensed dentist.

Whenever two or more counties are combined into a larger health district, the ex officio members of the board of health are selected by the state health director. At least one of the ex officio members must come from each participating county, and the ex officio members must include at least one chairman of a board of county commissioners, one mayor of a town which is a county seat, and one county superintendent of schools. Public members are selected as indicated in the preceding paragraph.[15]

*Tennessee*—The board of health is composed of two physicians, one dentist, the chairman of the county fiscal court (made up of representatives known as "magistrates" from each "civil district" and incorporated towns and cities in the county), and the local school superintendent. The physicians and the dentist are selected by the county fiscal court from nominations made by the local medical and dental societies[16]

*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. The membership, responsibilities, and duties of the board of health might be brought to the attention of the entire population. Health board members, furthermore, would be responsible directly to the health district's residents, who would then have more influence in public health policy.

The possibility of serious shortcomings in elected boards of health, however, tends to outweigh the supposed advantages. Able individuals who are willing to accept appointment to a board of health are often reluctant to spend their time, money, and energy in campaigning for membership. Other arguments which have been made against elected health boards are based on a lack of confidence in the voters. Board members, it is claimed, might be elected on the basis of their political affiliations rather than their competence and interest in public health. The voters might favor those persons

14. *Kentucky Revised Statutes*, sec. 212.010; 212.020.

15. Public Health and Related Laws of North Carolina, *General Statutes of North Carolina*, Article 3, sec. 130-13; 130-14.

16. Ohio Committee on Public Health (Preliminary Report, 1949), *op. cit.*, pp. 24, 26.

who were pledged to lower health expenditures rather than to higher health standards. Voters would be burdened with a longer ballot without the time and ability to evaluate the competency of board candidates. Residents of the relatively heavily populated areas, furthermore, might dominate the board of health, with a resulting neglect of rural health problems. Finally, some individuals fear political influence might be brought to bear on an elected board in the hiring of the health commissioner and other health personnel.

**Conclusions**

*Although no one procedure for choosing a board of health will guarantee selection of interested and competent board members, the advantages of appointment by the county commissioners appear to outweigh the advantages of the other alternatives. The county commissioners have a county-wide view of public health needs, are directly accountable to the voters, can integrate the public health program to other county health-related activities, and are accessible to individuals and groups interested in public health.*

The county commissioners by reason of their experience and interests are in a position to understand the desirability of county-wide financing, policy-making, and admnistration of public health services. This can not be said for the present district advisory councils, or councils which would include county commissioners, or a board of health composed of local government officers or possibly an elected board of health.

Under this plan the appointing body is locally elected. The voters therefore cannot be misled as to who is responsible for the public health program. The board of county commissioners, unlike the district advisory council, is a small group which meets frequently and can not easily avoid its duties.

The county commissioners now have responsibilities for other county-wide functions which are related to health, such as tuberculosis control and sanitation. Appointment of the board of health would provide a logical integration of health functions under the county commissioners. Coordination of county health activities is difficult under both the present selection procedure or under a proposed elected board of health. A board of health composed of local government officers might be able to facilitate such coordination, although its large size and diverse source of membership would be a handicap.

A difficult problem is now faced by groups and individuals who wish to express their views on health board selection and on public health policy, because they must consult with the 20 or more district advisory council members who usually meet only once a year. The county commissioners, as the appointing authority, on the other hand, would be easily accessible to the public because of their small number and day-by-day duties in county affairs.

*Appointment of the health board by the county commissioners would be particularly desirable if health districts were reorganized into 88 county units financed by county funds.*

Ohio's 88 counties, with possible exceptions for the largest cities, could become the basic health units, as suggested as one alternative solution to organizational problems in Part One, above. These county health districts could be financed by county funds, an alternative solution to financial problems described in Part Two, above. Adoption of both alternatives, or modifications thereof, to solve organizational and financial problems would make the county the responsible local government unit for public health and would imply that the county commissioners as the elected officials in charge of county affairs, should appoint the county health board.