

Organization and Financing of General Health Districts

Staff Research Report No. 41



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Preface

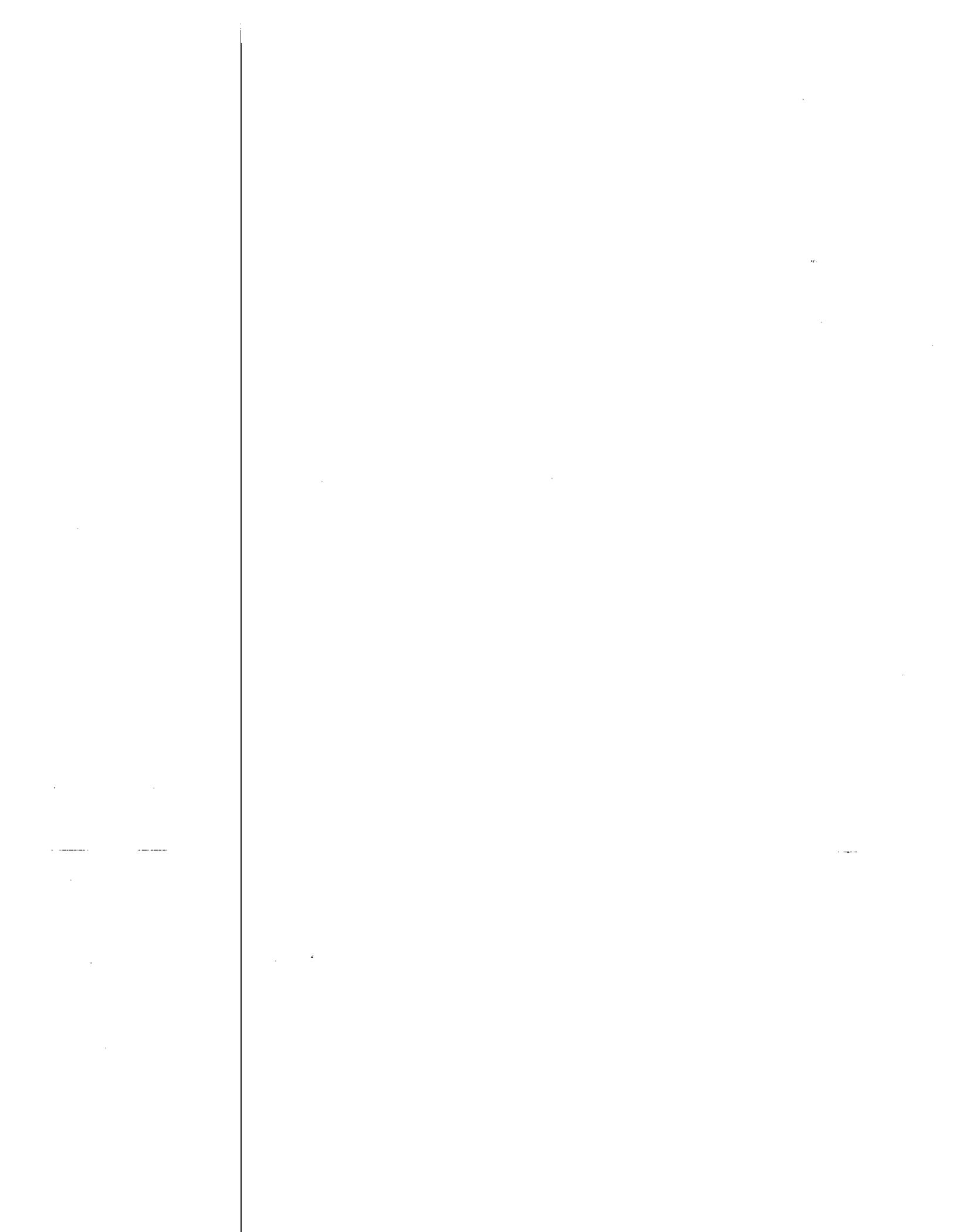
This publication is a report of the research staff of the Legislative Service Commission. The report consists solely of information and analyses relating to organization and financing general health districts, as prepared by the research staff. It does not purport to represent the findings or opinions of the Legislative Service Commission or of the Committee to Study General Health Districts.

Any recommendations which the study committee may adopt will be published in a separate report, as publication is authorized by the Legislative Service Commission.

The Legislative Service Commission authorized the present study and has authorized the publication of this report, but it has taken no position in regard to the material contained in the report.

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Introduction

Ohio citizens assume that their water is safe to drink, that their food and milk are pure, that sanitation facilities are satisfactory, and that local restaurants have been inspected periodically by competent public health officials. Most people also expect the local health department to take steps to curb the incidence and spread of contagious and infectious diseases, and to offer nursing services in the home, in clinics, and in schools. Ohio's people, furthermore, usually assume that they can enter any community in the state and be assured of reasonable health protection.

For most people, these are largely unconscious assumptions, since a local public health program is seldom directly visible. Failures of a public health program, however, may become dramatically evident in an outbreak of disease, absence of services needed in an emergency, and in the discovery that a child has for years been suffering from a dental, sight, hearing, or other defect long undetected because screening and case finding in the schools has been inadequate.

Providing adequate public health services entails a paradox. In one sense it is everybody's business because every individual citizen can suffer in a community with low public health standards; in another sense, public health is nobody's business because individuals are likely to think of public health as applying to their neighbors but not to themselves. Yet a good public health record in a health district tends to make the job of the public health administrator more difficult because the need for public health services is not apparent.

Some cities and counties in Ohio do not afford citizens with the public health services they have a right to expect.

Each city and county in Ohio by law must have a health department, but some of these districts fail to protect the health of the people within the district. Some districts employ part-time, and in some instances, poorly trained personnel. The result is the absence of the

essential public health services which the average person assumes are available to prevent the spread of disease, to locate and help the child with a defect, to provide clinics for maternal and infant care, to provide home nursing services for the aged, the convalescent, and the handicapped, and to educate the people as to the means of improving and maintaining their health.

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.

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.

Responsibility for the financing and administration of local public health services in Ohio has been traditionally located in local health districts. A state responsibility for the broader aspects of public health, however, has for many years been accepted by the General Assembly, the Ohio Public Health Council, and the Ohio Department of Health. The Hughes-Criswold Act of 1919, for example, was acclaimed nationally at that time as a major accomplishment in public health. This law: required 2,158 city, village, and township health units to combine into 88 general (county) health districts and 92 city health districts; required both general and city health districts to employ a health commissioner, public health nurse, and clerk; and provided that each district would receive up to \$2,000 annually to pay up to one-half of the salaries of these health officials.

Within the past decade the legislature has demonstrated its interest in improving local public health services. The General Assembly has authorized general (county) health districts to vote public health levies of up to .5 mill, subject to renewal every five years; amended the statute governing procedures for combining general and city health districts in order to facilitate such unions; considered but rejected a proposal that health districts be reduced in number to the 88 counties plus the eight cities over 100,000 in population; and requested that this study of the organization and financing of general health districts and of the selection of boards of health in these districts be undertaken.

The Ohio Department of Health, furthermore, has constantly promoted local public health programs through its direct services and special projects; supervisory and consultant activities; laboratory services; encouragement of voluntary combination of districts; in-service training programs and conferences for local health personnel, and distribution of federal grants-in-aid to local districts.

Purpose of this Report

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 changes 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?

This report undertakes to analyze the existing laws pertaining to the organization and financing of the 88 general health districts and to the selection of boards of health, to describe the problems arising therefrom, and to indicate the possible alternative solutions to these problems. It is not the purpose of this report to study the specific problems of individual health districts. Attention is given in this report to city health districts as well as to the general health districts, because district consolidation involves the union of city and general health

districts, because city districts provide useful comparisons with general health districts, and because some city health districts provide certain services in the surrounding general health district.

Some knowledge of local public health services is essential to understand the organizational and financial problems of general health districts. The following discussion indicates the nature of a local public health program, the varying factors affecting district health needs, and the duties of public health personnel.

FACTORS AFFECTING PUBLIC HEALTH NEEDS

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.

Some examples of the variety of factors influencing local public health problems are as follows:

Population Density. The estimated population density per square mile in Ohio in 1957 ranged from 26.8 in Morgan county to 3,564.7 in Cuyahoga county. Six counties had a population density of over 1,000 per square mile; five counties had less than 40 people per square mile. A high population density may result in crowded housing, unsatisfactory sanitation facilities, and rapid spread of communicable diseases. A low population density in a health district may make screening, case finding, health education, and other health services difficult to administer.

Age Distribution. The per cent of population under 15 years of age in Ohio in 1958 ranged from less than 24 per cent in Cuyahoga, Franklin, Guernsey and Hamilton counties to over 33 per cent in Holmes, Pike, and Vinton counties. Similarly, the per cent of population over 65 years of age in 1958 ranged from 6.6 per cent in Summit county to 14.7 per cent in Guernsey county. A health district with a relatively large percentage of school age children must emphasize its school health services, while a health district with many residents over 65 years of age must emphasize its chronic disease program.

Population Change. Population change in Ohio between 1950 and 1958 ranged from a 13.58 loss in Morgan county to a 85.23 per cent gain in Pike county. A rapidly growing health district is faced with a financial strain and planning difficulties in administering public health services. Severe losses in population, especially if the losses consist chiefly of the district's employable residents, may also produce financial problems.

Wealth. All indices of wealth demonstrate a great variety in the financial position of health districts. The effective buying income per household in 1957, for example, ranged from \$3,386 in Pike county to \$7,631 in Cuyahoga county. The average weekly earnings in employment subject to Ohio unemployment compensation laws in Ohio in 1958 ranged from \$54.90 in Brown county to \$121.30 in Monroe county. The 1958 per capita assessed valuation for real, public utility and tangible personal property ranged from \$1,100.32 in Scioto general health district to \$6,679.18 in Morgan general health district. The relatively poor health districts, which are unable to afford adequate public health services, are often the districts whose residents are in the most need of public health services because of unsatisfactory housing, lack of sanitation facilities, and inability to secure sufficient private medical attention.

Public health programs are not static but undergo a continuous process of change and development.

The concept of local health services has within a generation undergone considerable change. Advancing medical knowledge and public health practice have produced a sharp decrease in morbidity and mortality from infectious diseases, particularly in infancy, childhood and the early years of adult life. Typhoid and diphtheria in 1890, for example, accounted for 172 deaths per 100,000 people in the city of Cleveland; in 1956 there were no registered deaths from these diseases. Tuberculosis was annually killing nearly 150 persons per 100,000 people near the turn of the century; today the annual death rate from this disease has fallen to about 10 deaths per 100,000 people. In contrast, 128 deaths per 100,000 people were re-

corded in the year 1890 from heart disease and cancer; in 1956 the rate of death from cancer in Cleveland was 209 per 100,000 persons; from heart disease the rate was 430 per 100,000 persons. 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.

FUNCTIONS OF HEALTH DISTRICTS

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.

1. **Recording and analysis of health data.** A variety of data is necessary to define and locate local health problems and to assure sound planning for optimum health. This information includes the characteristics of the population, the incidence and prevalence of disease and impairment, and the disability and mortality resulting from them. Equally important is accurate information on the availability, utilization, and quantitative and qualitative adequacy of health personnel, facilities, and services. In order to obtain such information the local health department records births, deaths, and sicknesses. The state is divided into registration districts. Each health district is, by law, a primary registration district, but two or more districts may be combined into a single primary district. The reporting and recording of these vital statistics constitute no problem in Ohio since virtually all deaths and 97 per cent of all births are being reported.

The statutes also provide that communicable and occupational diseases should be reported by physicians to local health commissioners.

Most of the diseases are under-reported for the following reasons:

a. Many cases of such diseases as measles never come to the attention of a physician and consequently go unreported.

b. Many health departments have too few clerical workers.

c. Physicians often do not understand the importance of reporting, and do not like to take time to do it.

d. Venereal diseases often are unreported because of the feeling that they constitute a blot on the community's record and a stain on the individual's character.

Health districts may also obtain valuable information by maintaining registers of individuals known to have certain specific long-term diseases and impairments; collecting and interpreting morbidity data from such sources as clinics, hospitals, industry, and workmen's compensation programs; maintaining records of the number and qualifications of health personnel and the resources of available facilities and services provided through various voluntary and public programs; and periodic evaluation of community health needs and services.

2. Health education and information. An informed and educated public is one of the best guarantees of effective health service. No regulation can force a person to eat a balanced diet, or make a mother take her baby to a doctor, or make certain a child brushes his teeth. Such practices depend on two things: an understanding and conviction that make one accept the practice as essential, or a habit so firmly established that one performs naturally and without thought. Health education brings about the adoption of practices beneficial to health and the avoidance of those injurious to health. Law enforcement, itself, becomes more effective as an understanding of the need for it is recognized.

A local health department may perform its health education functions by: (a) stimulating the public to recognize and study existing health problems; (b) assisting official and voluntary organizations in the development of their health programs; (c) providing individual

instructions by public health nurses and other personnel, as in the case of families in which communicable disease has occurred or of mothers attending well-child conferences; (d) organizing lectures and classes for parents, food handlers, diabetics, and community groups; and (e) using mass information media such as newspapers, pamphlets, radio, and television.

3. Supervision and regulation. The local health department has supervisory and regulatory responsibilities covering various fields, such as the protection of food, water, and milk supplies; the control of nuisances; the sanitary disposal of wastes and control of pollution; the prevention of occupational diseases and accidents; the control of human and animal sources of infection; the regulation of housing; and the inspection of hospitals, nursing homes, and other health facilities. Health departments may use a variety of methods in carrying out these functions, such as issuance of regulations, laboratory control, public education, inspection and licensure, revocation of permits, and, as a last resort, court action.

The board of health, through its employees, is required by law to enforce the quarantine and sanitary regulations of the state department of health, to inspect houses or localities upon reasonable belief that contagious disease prevails and restrict persons to their homes, to inspect sanitary conditions of all schools at least semi-annually, to keep a record of the names, residences, and places of business of all persons engaged in the sale of milk and meat, to take specimens of dairy products to be used as evidence in prosecution where it is believed violations exist, and to enforce statutory building standards relating to sanitary construction. General health districts may regulate the location, construction, and repair of water closets, privies, cesspools, sinks, plumbing, drains, yards, pens, and stables; prosecute persons disregarding orders of the board of health; quarantine vessels, railroads, or other public or private vehicles; stop the sale of milk where dangerous disease occurs in the family of a dairyman or among his employees; adopt orders necessary to prevent and restrict disease and to suppress nuisances; inspect public institutions, jails, children's homes, maternity

boarding houses, infirmaries, and other charitable or correctional institutions; inspect places where food is manufactured, stored, handled, or sold; examine persons employed in food processing and handling; inspect trailer parks; and quarantine carriers of venereal disease.

4. Provision of quarantine and environmental measures. Health districts are required to abate and remove all nuisances, to disinfect houses where persons have had certain communicable diseases, and to provide food, fuel, medical attention and all other necessities of life to persons quarantined. The districts may destroy infected clothing, bedding, and buildings, and employ scavengers to remove garbage within a municipal corporation located in the district, provided authority to do so has been received from the municipal legislative body.

5. Administration of personal health services. Local health departments usually provide for or administer a variety of health services for the individual. These may include (a) immunization against infectious diseases; (b) application of fluorine to children's teeth; (c) advisory health maintenance service through prenatal clinics, parents' classes, and public health nursing visits to homes; (d) case finding surveys of the general population, such as chest X-ray surveys, cancer detection programs, and school health examinations; (e) provision of laboratory services and diagnostic and consultation clinics as aids to physicians; (f) provision of diagnosis and treatment services for specific diseases such as syphilis, tuberculosis, dental defects in children, and crippling impairments in children; (g) provision of bedside nursing care in the home; and (h) chronic disease control through screening and case finding, referral, provision of examination facilities, clinics, and information centers, and through nursing services.

6. Operation of health facilities. The local health department can fulfill its responsibilities effectively if it operates one or more well equipped centers providing adequate space for administrative offices, clinic facilities, and an auditorium or classrooms for public and professional education.

7. Coordination of activities and resources. The local health department has the general responsibility of providing effective leadership in meeting all types of community health needs. Its technical and administrative resources can provide accurate data for sound planning, for informing the public, and for improving and coordinating the community's public and private health facilities and services. A primary task of a local health department is to encourage full cooperation of the work of the various official and voluntary agencies so as to avoid unnecessary duplication in types of activity or in geographical coverage. A local health department may, for example, (a) develop combinations of voluntary and official nursing services; (b) act to coordinate the activities of the health department, voluntary agencies, hospitals, and the medical profession during emergencies such as epidemics or disasters due to flood and fire; (c) encourage boards of education, the medical and dental professions, service clubs, and other organizations to improve school health services; and (d) provide leadership in organizing community action to obtain additions and improvements in local health facilities, such as hospitals, chronic disease clinics, and rehabilitation centers.

In addition to the health functions assigned to local health districts, Ohio statutes also assign health functions to counties, municipalities, townships, and school districts.

Table 1, below, shows the distribution of some of these health functions among the various types of local government units. Many

specific public health services are assigned to two or more local government units.

Table 1
Distribution of Health Functions Among Local Government Units

Function	Health Districts	Counties	Municipalities	Townships	School Districts
Medical and dental supervision of school children.....	x		x		x
Free treatment of VD	x		x		
Inspect public institutions	x				
Vital statistics	x		x		
Erect hospitals for contagious diseases	x		x		
Provide prenatal clinics and infant welfare stations	x		x		
Free distribution of diphtheria antitoxin	x		x		
Consultants vaccinations	x		x		
Quarantine on transportation	x		x		
Charge fee for trailer park operations.....	x				
Inspect meat and milk foodstuff producers.....	x		x		
Regulate sale of ice	x				
Inspect and quarantine buildings.....	x		x	x	
Destroy contaminated property and buildings	x		x		
Abate and remove nuisances.....	x	x	x		
Employ scavengers to remove garbage	x				
Construct and operate general hospital		x	x	x	
Aid non-profit hospital corporations		x	x	x	
Provide TB hospital		x			
Form joint TB hospital district		x			
Bear costs of hospitalization of TB patients.....		x			
Provide facilities for care of mentally ill		x			
Detain mentally ill—court		x			
Support mental health clinics		x			
Pay expense of quarantining county public institutions.....		x			
Support free vaccination and immunization of school pupils		x	x	x	
Free diphtheria antitoxin for indigents.....		x			
Contribute to maintenance of physician in municipalities inaccessible to mainland		x	x		
Enforce water pollution statutes and regulations		x	x		
Regulate construction and maintenance of buildings		x	x		
Destroy bushes and weeds along county roads.....		x			
Drain stagnant water			x		
Regulate places of employment.....			x		
Street cleaning			x		
Prohibit public gatherings			x		
Maintain sanitary dumps				x	
Remove body laid in vault which has become offensive				x	
Enforce vaccination and immunization regulations					x
Provide health and physical education courses					x

SOURCE: Ohio Revised Code

FUNCTIONS OF HEALTH DISTRICT PERSONNEL

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.

Health Commissioner. The health commissioner serves as executive officer and secretary for the board of health. A typical health commissioner, during the course of a week's work, might be engaged in some of the following activities. With the aid of his staff of nurses, sanitarians, and clerks, he would help the board of health prepare its estimate of expenses for the following calendar year, which must be submitted to the county budget commission by the first Monday in April. The commissioner might contact the state health department for help in locating an additional public health nurse for his staff; review reports submitted by his nurses and sanitarians; assign nurses to home visits, clinics, and a health examination program in the local schools; direct his sanitarians to inspect the restaurants and dairy plants in the district and to examine the proposed sanitation facilities of a new housing development; meet jointly with the local tuberculosis and health society and the visiting nurses' association to plan improvements in the coordination of all public health nursing in the community; prepare his annual report to the one or more boards of health to which he is responsible; meet with the district advisory council to present the board of health's report to the council and suggest who might fill a vacancy on the board; and he might speak at a local civic club meeting and describe the modern public health program being conducted in the community, as well as some of the financial and personnel problems of the health department. Throughout the week he would, with the aid of his staff, ascertain that state and local health regulations were being followed in the district. One day of the week he might spend in conference with other health commissioners and state health officials meeting in Columbus or at the state health department regional office.

Public Health Nurses. The public health nurse is probably in contact with the public more than any other employee of the health district. A typical public health nurse during a week's work might perform some of the following functions. One day during the week she would assist at a clinic operated by the health department. Here she has the duties of preparing patients for examination, interpreting doctors' orders to the patients, giving prescribed treatments, performing diagnostic tests, collecting specimens for further tests, and referring patients to physicians or to voluntary and other government health service agencies.

On another day this nurse would visit one of the local schools. Here she would instruct teachers on vision screening, give hearing tests, present a health education film and talk to pupils, screen vision test referrals from teachers, and refer cases of defective vision and hearing to medical care.

The public health nurse would teach classes dealing with problems of overweight, diabetes, heart disease, and physical handicaps. She would participate in a well-child conference for mothers of pre-school children.

Some home visits by the nurse are but 10 or 15 minutes long; others may take several hours; some patients she has visited many times before; others she may see but once. In the home she demonstrates and teaches therapeutic nursing care to family members, interprets doctor's orders, instructs the family on health, assists families in carrying out the recommendations made by their physician and in making necessary adjustments to implement medical orders for rehabilitation, gives prenatal and postnatal instruction to mothers in homes, demonstrates baby care, advises on prevention of disease, immunizations, and nutrition, and gives special consultation on the care of premature infants.

Throughout the week the public health nurse exchanges information with doctors and other health workers for more effective care of individual patients, interprets the needs of particular families to other health workers, maintains records of her nursing services, and assists the health commissioner in evaluating data obtained in investigations. Once during the week she might appear at a meeting of a

local women's club to describe the public health services offered by the health department.

Sanitarians. The term sanitarian includes sanitary engineers, veterinarians, staff sanitarians, and sanitary inspectors.

A typical sanitarian might in one week have the following duties to perform. Several days of the week he might inspect schools, hotels, and rooming houses to determine adequacy of lighting, ventilation, cleanliness, heating, garbage and refuse facilities, recreational camp facilities, housing facilities for migrant agricultural labor, restaurants, taverns, and establishments with food and beverage vending machines for compliance with the state food service law and regulations of the Ohio Public Health Council. He would explain applicable portions of the sanitary laws and regulations to owners and operators of food service establishments and instruct them in the essentials of good sanitary practices. He might inspect both milk producers and milk plants to assure their compliance with state and local regulations governing the production, processing, and retailing of milk, semi-public and private

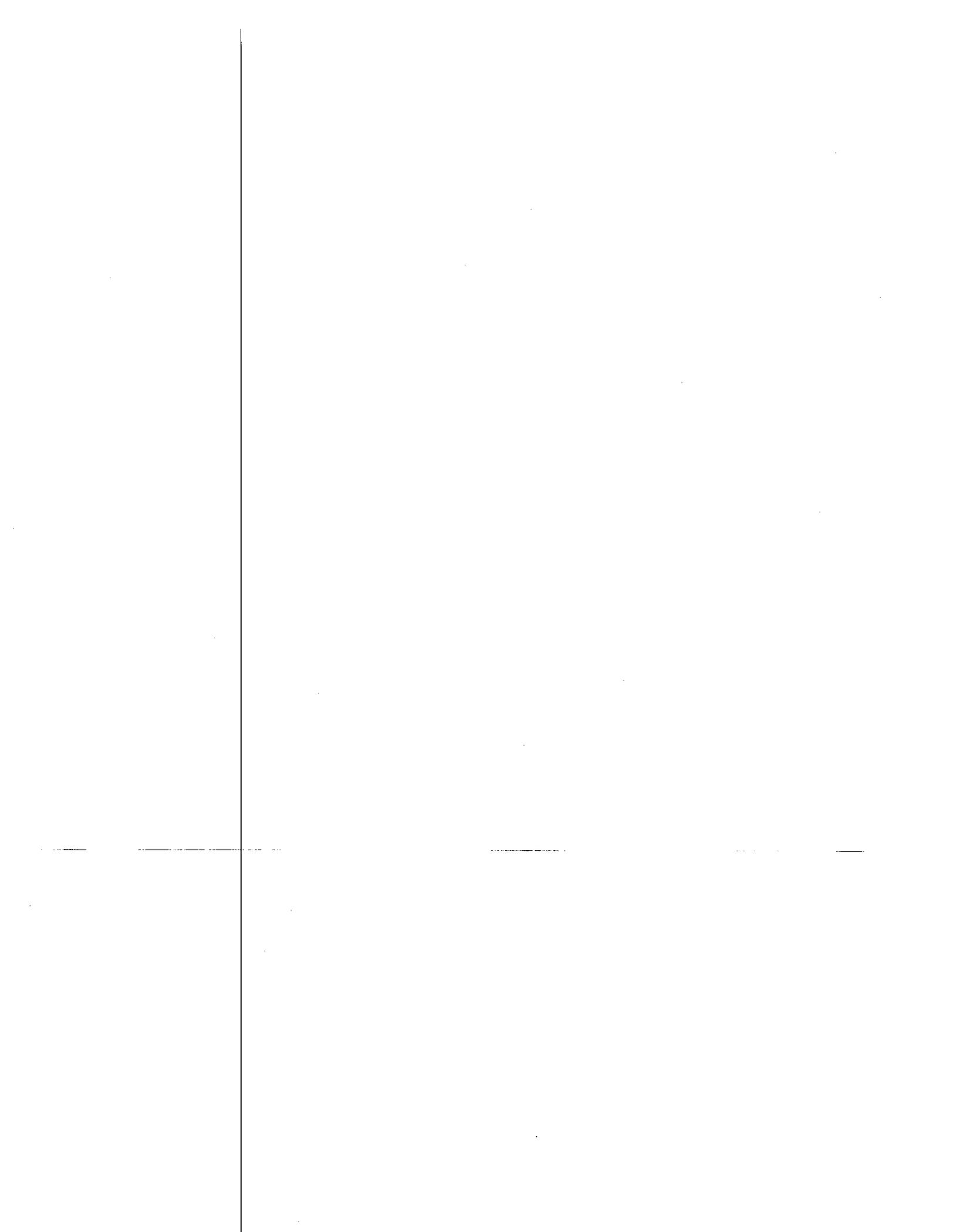
water supplies, swimming pools and swimming areas for safety and water quality, and semi-public and private sewage disposal systems. He would give technical advice to owners, operators, and contractors on plans, equipment, and operations relating to water supply and sewage disposal systems, milk sanitation, food service sanitation, and swimming pools, review and approve plans of proposed installations, investigate nuisance complaints and dog-bite reports, initiate insect and rodent control programs, investigate an outbreak of communicable disease in a neighborhood with faulty sanitation practices and facilities, confer with public officials regarding the technical problems of community sanitation, and would be called upon to explain the health department's sanitation program and community problems before local civic groups.

During his few hours in the health department office the sanitarian would keep records and make detailed reports relating to his activities, assist the health commissioner and other staff members in evaluating information obtained from investigations, and review plans of proposed sanitation installations submitted to him by local industries.

Part One

Organizational Problems

Part One of this report is divided into three sections devoted to (1) description of the present organization of health districts in Ohio, (2) problems arising from this organization, and (3) presentation of possible alternative solutions to these organizational problems.



I. Present Organization of Health Districts

Types of Health Districts

The two basic types of health districts are "city health districts" consisting of all municipalities over 5,000 in population and "general health districts" composed of the townships and villages in each county.

The statutes also provide that up to five contiguous general health districts may combine to form one unit, and that a city health district and a general health district may unite to form a "combined health district." One board of health replaces those of the uniting districts.

The Ohio Department of Health has also developed administrative classifications of health districts:

Qualified or Full-Time—a district which employs a full-time health commissioner, public health nurse, sanitarian, and clerk and is, therefore, entitled to receive a federal grant-in-aid.

Unqualified or Part-Time—a district which fails to employ full-time these four basic health personnel and is, therefore, ineligible to receive a federal grant-in-aid.

Contracting—a district, usually a city health district, which contracts for health services from another district, usually a general health district. Contracting districts retain their own boards of health.

Cooperating—a district which employs a health commissioner who is also employed by one or more other city or general health districts. Cooperating districts retain their own boards of health.

Organization of General Health Districts

The two agencies involved in the formation and operation of a general health district are known as the district advisory council and the board of health. The most important function of the advisory council is to appoint a board of health. The board of health, in turn, is charged with the operation of the general health district through its executive officer, the health commissioner.

1. General Health District Advisory Council.

The district advisory council consists of the chief executive of each village in the district, and the chairman of the board of township trustees of each township in a general health district. The council is required by statute to

meet annually on the first Monday in March. Special meetings may be called by the local health board or by the state director of health, but such meetings are infrequent. Council members are compensated at the rate of five dollars per meeting day, plus necessary expenses.

The statutory powers and duties of the district advisory council are:

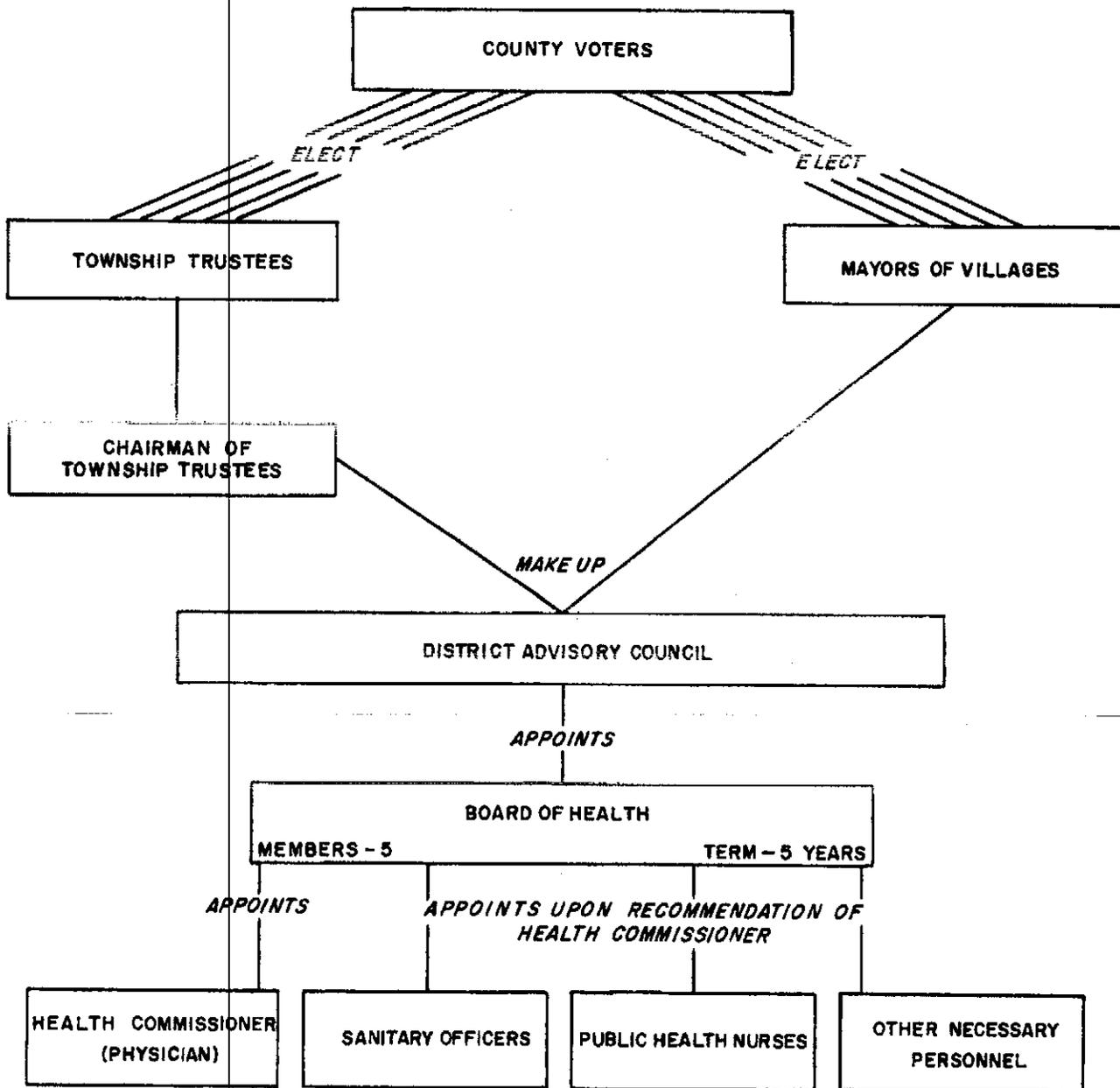
- a. To select a five-member board of health, with due regard to the equal representation of all parts of the district. Each village is entitled to one board position for every one-fifth of the total general health district population resident in that village. One board member must be a physician.
- b. To make policy recommendations to the board of health.
- c. To receive and consider annual or special reports from the board of health.
- d. To notify the health commissioner of the proceedings of any meeting.
- e. To unite with a city health district to form a new combined health district.

2. General Health District Board of Health.

The five members of the board of health are appointed for five-year overlapping terms. Board members are compensated for meetings at the rate of six dollars per day, eight cents per mile and necessary expenses for meetings, which are not to exceed 12 in any one year. The board must meet within 30 days after appointment and select a president and president pro tempore. Suitable quarters for the board must be furnished by the county commissioners.

The board of a general health district must appoint a health commissioner for a period not exceeding two years. This commissioner, unlike his counterpart in city health districts, must be a licensed physician. He acts as secretary and executive officer of the board and carries out all orders of the board. When the commissioner serves on a part-time basis, the time to be devoted to the duties of this office may be fixed by contract. Upon recommendation of the health commissioner, full or part-time public health nurses, physicians, clerks and other persons may be employed by the board. See Chart 1, page 16.

Chart I.
ORGANIZATION
of
THE GENERAL HEALTH DISTRICT IN OHIO



Organization of City Health Districts

Health services in city health districts are under the control of a five-member board of health appointed by the mayor, with city council approval, for five-year over-lapping terms. City charters, however, may provide for a department of health to operate directly under the city council without a board of health. A majority of the members of the city board of health constitute a quorum, and the mayor serves as president of the board. A president pro tempore is elected by the board from its own membership to preside in the absence of the mayor. The board must meet at least once in each calendar month, and special meetings may be called by the president or three members. Members serve without compensation. Suitable quarters for the board must be furnished by the city council.

Combined Health Districts

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 for a new advisory council and a new board of health.

The contract entered into by the uniting districts may provide that district administration be turned over to the city board of health, the city health department in a charter city which has no board of health, the board of health of the general health district, or a combined board of health. The district advisory council of the new general health district consists of the members of the original advisory council and the mayor of the city. The advisory council must elect a resident of the city district to fill the first vacancy that occurs on the board of health if the contract provides for administration of the combined district by the board of health of the original general health district. This procedure is at present followed in all but one of the combined districts.

House Bill No. 142, enacted in 1959, was designed to encourage voluntary combination of city and general health districts, although

no combinations under this provision have been undertaken. The act requires that a contract between a general health district and a city health district which provides administration of the combined district by a new combined board of health must set forth the number of members on the board, their terms of office, and the manner of appointment. The contract may also provide for representation of specific geographic areas. The status of the employees of city and general health districts is not to be affected by such combination.

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.

When two or more general health districts combine, a joint board of district advisory councils must locate the office of the new board of health at one of the county seats. The county auditor of this county serves as auditor of the combined district health fund; the county treasurer as custodian of the fund. The members of the county budget commissions of the uniting counties sit as a joint board to consider and act upon the budget.

No general health districts have combined their boards of health under this statute, because members of the district advisory councils, according to state health department officials, have been reluctant to permit an auditor and a treasurer in another county to control the health district fund. In some instances, however, two or more general health district boards of health have formed a "cooperating" district by employing the same health commissioner.

Patterns of Health District Organization in Ohio

Ohio's 88 counties and 150 cities totaled 238 health districts in 1960. Various types of district consolidations, however, have reduced the number of separate operating public health units to 129.

Over one-half of the 238 health districts are cooperating, contracting, or combined with other health districts. Most of these consolidated units are designated by the Ohio Depart-

ment of Health as "full-time" districts. Only one-third of the city and general health districts operating alone, however, are "full-time" districts. See Table 2, below. This suggests that

consolidated districts, in contrast to smaller independent units, tend to have the necessary incentive and financial resources to employ sufficient personnel on a full-time basis.

Table 2
Number and Percentage Distribution of Local Health Districts in Ohio, 1960

Type of Organization	Total		Multi-District		City		General	
	Number of districts	Per Cent						
Total	238	100	151	63	61	26	26	11
Full-time	169	71	138	58	22	9	9	4
Part-time	69	29	13	5	39	17	17	7

SOURCE: Ohio Department of Health, 1960 *Financial Report of Local Health Districts*.

Two-thirds of the general health districts are now consolidated 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.

Thirty-one general health districts are combined with city health districts through one board of health; 27 other general health districts have integrated their operations with

other districts to a lesser degree by employing one health commissioner to serve two or more districts; four general health districts have contractual arrangements with city health districts. Most of these consolidated general health districts are "full-time" districts; only one-third of the general health districts operating alone, in contrast, are employing a full-time health staff. Table 3, below, and Map 1, p. 19, show the distribution of types of general health districts.

MAP I. TYPES OF GENERAL HEALTH DISTRICTS, 1959.



-  Independent
-  Cooperating (common health commissioner)
-  Combined (one health board for city and county)
-  Combined and Cooperating
-  Contracting (cities contract with counties)
- P.T. - Part-time health commissioner
- F.T. - Full-time health commissioner

Table 3
Distribution of Types of General Health Districts, 1960

Type	Full-time	Part-time	Total
All types	65	23	88
Single county	9	17	26
Number of counties cooperating	24	3	27
Number of counties combined with cities	29	2	31
Number of counties contracting with cities	3	1	4

SOURCE: Ohio Department of Health, 1960 *Financial Report of Local Health Districts*.

Patterns of Health District Organization in the United States

Compared to the United States as a whole, Ohio has relatively few single county health units. Ohio has many city health districts operating independently of other districts, however, in contrast to other areas of the nation.

The internal organization of Ohio health districts is similar to that of other states, although in a number of states the health officer is a member of the local board of health. Some of the characteristics of local health organization in Ohio, California, Illinois, Indiana, Kentucky, Michigan, New York, and Pennsylvania are compared in Table 4, below.

Table 4
Local Health District Organization in Selected States

	Ohio	Calif.	Ill.	Ind.	Ky.	Mich.	N. Y.	Pa.
Number of members on board of health	5	4	3-7	3-7	5-7	3-5	varies	5
Term—board members	5	5	3	4	2-4	5	2-6	5
Staggered terms	x	x	x	x	x	x	some	x
Separate boards for each governmental unit					x			
Professional representation on boards	x		x	x	x		x	x
General public representation on boards	x		x		x		x	
Geographic representation on boards	x	x	x	x	x	x	x	x
Legislative or administrative officials on boards	x		x	x	x	x	x	
Health officer member of board				x	x	x	x	x
Board members compensated	x			some	some	some	x	x
Health officer appointed by local board of health	x	x	x	x	x	x	x	x
Confirmation of appointment by state department			x	x		x		x
Term—health officer	2			4	4	1	4-6	1
Authorized to establish health districts:								
cities	x	x	x	x	x	x	x	x
counties	x	x	x	x	x	x	x	x
townships	x		x				x	x
Combined districts must be contiguous	x	x	x	x	x		x	x
Limitation on number of units in combined districts	5		4	4				

SOURCE: U. S. Public Health Service, *State Laws Governing Local Health Departments*, (Public Health Service Publication number 299), 1953.

II. Organizational Problems of General Health Districts

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 and keep, and to 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 expense.

As a general rule a small health district cannot afford adequate health services. A city health district with a population of 5,000, for example, in order to have minimum health services would have to spend over \$5.00 per capita. Expenses in such a district might be as follows:

1 Health commissioner	\$12,000
1 Public health nurse	5,000
1 Sanitarian	4,500

1 Clerk	3,000
Medical supplies	200
Office supplies	200
Board expenses	50
Retirement	1,600
Other	100

Total \$26,650

Per Capita—\$5.34

Close to one-half of the health districts in Ohio in 1959, even after some integration of districts, had a population under 35,000. Forty-six of these districts, including 16 general health districts, had fewer than 25,000 residents. A low population is the prevailing characteristic of city health districts operating alone; in 1959 approximately one-half of these independent city districts had less than 25,000 residents. See Table 5, below.

Table 5
Distribution of Health Districts by Population

Type of District	(Population in Thousands)						Total
	Under 25	25-35	35-50	50-100	100-500	Over 500	
Full-time							
General (alone)			2	5	2		9
City (alone)	3	3	6	4	5	2	23
Combined, Cooperating, and Contracting	1	1	6	16	12	1	37
Total	(4)	(4)	(14)	(25)	(19)	(3)	(69)
Part-time							
General (alone)	14	1	1	1			17
City (alone)	27	4	2	2			35
Combined, Cooperating, and Contracting	1		3	1			5
Total	(42)	(5)	(6)	(4)			(57)
TOTAL	46	9	20	29	19	3	126

SOURCE: Ohio Department of Health.

Most of the small health districts in Ohio, including 15 general health districts below 25,000 in population, employ a part-time health staff. In contrast, the large consolidated districts are "full-time" districts.

Forty-two of the 46 health districts in Ohio with a population under 25,000 employ a part-

time staff. Fifteen of these districts are general health districts, of which only one is combined with a city district. Twenty-seven of the 30 city health districts operating alone with a population below 25,000, furthermore, are "part-time" districts; 10 of these 27 cities had a population of less than 10,000 in 1959. In comparison with

the small health districts, most of the large health districts with over 50,000 in population employ a full-time staff; 47 of the 51 health districts over 50,000 in population are "full-time" districts. Significantly, over one-half of these "full-time" districts are consolidated districts. See Table 5, above.

The small staff employed by most of the small general health districts results in inadequate public health services.

The smaller general health districts do not provide as many health services as do the larger districts, according to reports submitted by local health departments to the Ohio Department

of Health for the year 1958. General health districts with a population between 35,000 and 50,000, for example, reported an average of 64.3 nursing visits per 1,000 population, compared to an average of 43.6 nursing visits per 1,000 population in districts under 25,000 in population. The contrast in health services between small and large districts is even more apparent in reports of sanitation inspections: the larger general health districts reported an average of 44.6 sanitation inspections per 1,000 population, compared to an average of 19.6 sanitation inspections per 1,000 population in the smaller districts. See Table 6, below.

Table 6
Number of Sanitation Inspections and Nursing Visits per 1,000 Population,
by Size of General Health Districts, 1958

Population (thousands)	Nursing Visits Per 1,000 Population			Sanitation Inspection 1,000 Pop.		
	Average	Range	Number of Districts	Average	Range	Number of Districts
10-25	43.6	9.0-127.1	18	19.6	.00-69.9	19
25-35	53.8	2.9-119.9	19	30.5	2.3-74.2	19
35-50	64.3	1-188.0	16	44.6	22.6-84.0	15
50-75	55.1	3.7-162.1	16	28.2	16.4-55.2	16
75-100	17.8	3.1-55.6	4	28.8	5.2-38.1	4
Over 100	48.9	3.3-108.3	12	35.1	15.6-55.8	12

SOURCE: Ohio Department of Health.

The smaller general health districts, particularly those with part-time health commissioners, tend to be understaffed. "Part-time" general health districts cooperating, combined, or contracting with city districts reported in 1959 an average ratio of over 20,000 persons per public health nurse, compared to an average ratio of less than 16,000 persons per public health nurse in "full-time" general health districts that are cooperating, combined, or contracting with city districts. The "part-time" general health districts that have consolidated with city districts also reported in 1959 an average ratio of about 33,000 persons per sanitarian, compared to an average ratio of about 23,000 persons per sanitarian in "full-time" general health districts that are consolidated with city

health districts. See Table 7, page 23. Some of the very small general health districts (around 10,000 population) have relatively low population ratios per nurse and sanitarian; such a district is required by law to employ, at least part-time, one public health nurse and one sanitarian, thus producing a population ratio which is far from ideal but quite favorable compared to some other districts. One nurse and one sanitarian in a very small district, however, may be ineffective as a result of a heavy burden of clerical duties; lack of supervision by a nursing supervisor and a sanitary engineer; direction of work by only a part-time health commissioner; and lack of funds to cover expenses and supplies for personnel.

Table 7

Ratios of Population per Public Health Nurse and per Sanitarian in General Health Districts, 1959

Type of District	Average Population Per Public Health Nurse **	Average Population Per Sanitarian *
Full-Time Alone	16,093	16,682
Full-Time Cooperating	13,812	21,730
Full-Time Contracting	16,253	24,956
Full-Time Combined	16,796	23,577
Part-Time Alone	19,032	24,637
Part-Time Cooperating	20,695	38,283
Part-Time Contracting	23,902	35,853
Part-Time Combined	19,825	28,424
Comparative Data:		
State Average	14,374	15,531
U.S. Average	9,844	17,040
California	10,500	15,782
New York	7,944	17,011

SOURCE: Ohio Department of Health and U. S. Public Health Service.

* Includes sanitary engineers, professionally trained sanitarians, sanitary inspectors, and veterinarians.

** Does not include public health nurses employed by boards of education and voluntary agencies.

Health districts in Ohio tend to be smaller in population than the health districts in other states.

Fifty-eight per cent of the general health districts operating alone in Ohio have a population below 35,000, while only 47 per cent of this type of unit reporting to the United States Public Health Service in 1958 were under 35,000 in population. An even greater contrast

between Ohio and the nation appears among city health districts operating alone: 64 per cent of the independent city health districts in Ohio had a population under 35,000, compared to 31 per cent of these districts nationally. Very few consolidated districts both in Ohio and throughout the nation have a population of less than 35,000. Some significant comparisons are shown in Table 8, below.

Table 8

Population of Health Districts in Ohio and in the United States

Type of District	Percentage of Health Districts With A Population Below 35,000	
	Ohio	United States
All types of districts	44%	36%
General (County) Alone	58	47
City Alone	64	31
Consolidated	7	19

SOURCE: Ohio Department of Health and U. S. Public Health Service.

Thirty-five or more villages will become new city health districts as a result of the 1960 census.

Many former Ohio villages now have a population above 5,000 and will soon be classified as cities. Every new city is required by law to become a city health district and to employ at least a health commissioner, public health nurse, and clerk. The state health department may find it difficult to persuade these new cities, whose residents are proud of their new status, that adequate health services can be provided at reasonable cost by remaining within the general health district by combining their board of health with the general health district board, or, at least, by reaching a co-operating or contracting arrangement with the general health district. Failure of these new city health districts to consolidate voluntarily with general health districts would result in still further splintering of public health programs, more shortages of personnel, loss of income for general health districts and further dilution of state and federal aid among an ever-growing number of inefficient districts.

"Ideal" Population Size of Local Health District

National public health authorities are currently recommending a minimum population of 100,000 for local health districts, although it is recognized that smaller units of 25,000 or 35,000 people may be more desirable in sparsely populated areas.

A community, whether of rural or urban character, may be so small in numbers, and with such slender resources, that it cannot afford the employment of even a skeleton staff of persons trained and experienced in public health. It is probable that the small population contained within certain Ohio regions makes it impractical to render health services on a local or even county-wide basis. Though small communities and scattered populations may have the same need for professional health services as large and concentrated aggregations, the former cannot individually afford the kind of local health officials employed by the larger population units.

The American Public Health Association has recently stated —

Generally, public health authorities agree that a population of 100,000 or more is desirable to support an adequate program of public health. Health units may be established to service smaller populations if exceptional health problems exist, or sparsity of population makes it impractical to have a service area for as many as 100,000. The trend is to have a single health department serve all of the political jurisdictions within a single county or in two or more counties, rather than to have an independent health department for each city or township. In this way, a single health department can deliver more economical and effective service for an entire metropolitan area.¹

Health officials have long been urging the creation of larger health districts. The late Haven Emerson, former head of the Columbia University School of Public Health, in a report endorsed by the American Public Health Association in 1945, recommended a population of 50,000 as the minimum for supporting adequate health services. Only 1,197 local health units in the United States would then cover the area now served by 3,070 districts. The Emerson report suggested that Ohio should have 53 local health districts including 21 one-county districts, 29 two-county districts, and three three-county districts. In 1945 the average population of the 53 proposed districts was about 130,000; the least populous had 40,500 inhabitants; the most populous 1,217,300; and 15 had over 100,000 residents. The Emerson report recommendations were based upon such factors as size of population; area in square miles; spendable income; number of hospital beds per 1,000 population; number of persons per practicing physician; political, social, and economic characteristics; and geographic, geologic, and transportation features of the terrain. See Appendix A for map of districts recommended by the Emerson report.

The United States Public Health Service recommended in 1950 that Ohio be divided into 47 local health districts, of which 17 would consist of single counties and 18 would consist of two counties each and the remaining units would contain three or more counties each. See Appendix B for map of districts recommended by the Public Health Service.

¹ American Public Health Association, *Guide To A Community Health Study*, (1960), p. 8.

Most state and local public health officials in Ohio have recommended a minimum health district of at least 25,000 population, although they prefer a larger size.

The director of the state department of health and most local health commissioners agree that 25,000 is the minimum acceptable and feasible population size for health districts, although they tend to prefer a larger population size. In 1960, prior to the release of the federal census figures, 30 city health districts and 28 general health districts had fewer than 25,000 residents. The state director of health has recommended that no new city health districts under 25,000 in population should be permitted, and that all existing city health districts under 25,000 in population should be required to consolidate with general health districts within a period of five or ten years. He has also recommended that general health districts below 25,000 in population should be encouraged by state subsidies and by a standard setting mechanism to consolidate voluntarily under existing statutes.

For a brief period in 1919 the state legislature prohibited cities under 25,000 in population to establish their own health departments.

Over 40 years ago public health officials and the state legislature recognized the desirability of larger health districts. With the 1919 enactment of the Hughes Act only cities having a population of 25,000 or more could constitute a city health district; all cities of less than 25,000 and the villages and townships of each county were consolidated into general health districts. Some public health officials and legislators, however, feared that this classification of city health districts would be declared unconstitutional by the courts. Accordingly, the legislature at a special session in 1919 enacted the Griswold Amendment to the Hughes Act with a provision that each city regardless of its population would constitute a city health district. The fear of an unfavorable court decision proved erroneous since the Supreme Court, in *Cuyahoga Heights vs. Zangerle* (1921), held that this classification of cities was reasonable and constitutional. Today, the problem of small city health districts would not be acute, had the Hughes Act been retained in its original form.

Consolidation

ARGUMENTS FOR

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

If the administrative structure of public health in Ohio were simplified by reducing the number of local health districts, the coordination and communication between health personnel would tend to improve. Public health problems then could be attacked on an area-wide basis in place of the present splintered efforts to protect public health. A weak health program in one jurisdiction can have serious adverse effects on neighboring areas, because germs and other health hazards cannot be confined within political boundaries.

If health districts were larger in size, broader local financial sources of support would be available. The financial burden of supporting the health program would then tend to be equalized. At present, many small city and general health districts benefit from the services provided by large neighboring health departments; suburban communities, for example, usually accept the milk inspections made by large city districts without contributing financial support for making these inspections.

The larger districts created by consolidation could offer better employment prospects to attract more experienced and better trained public health personnel than can the many existing small districts in Ohio. Better salaries, comprehensive personnel policies, and greater opportunity for advancement are some of the advantages of having larger health districts. Opportunities to employ professional personnel supervisors and persons trained in public health specialties occur only in the larger districts because the small districts cannot afford to employ professional staff supervisors, laboratory technicians, health educators, nutritionists, dentists, industrial hygienists, and sanitary engineers. If larger units were used, furthermore, some of the current severe shortages of professional public health employees might be lessened.

The present multiplicity of health districts leads to an increased number and variety of fees and to conflicting standards for installation of sanitary facilities, operation of dairies and meat-packing plants, food handler permits, and numerous other areas of public health regulation. Consolidation of districts might substantially eliminate confusion and duplication in collection of fees as well as in the enforcement of health regulations.

Consolidation can benefit the physician as well as the local public health program; physicians would need to report their cases to only one instead of several health departments and would be more inclined to make such reports. A large consolidated health district, furthermore, could furnish more consultation and laboratory services to physicians than can a small district.

After consolidation of local health districts the effectiveness of both federal and state aid would be enhanced because there would be fewer districts among which state funds would be divided. The effect of consolidation upon the distribution of federal grant-in-aid funds is uncertain; the total number of districts would, of course, be reduced, but consolidation would probably increase the number of districts which could through local efforts employ a full-time health staff and thereby qualify for federal aid.

Consolidation would probably produce economies by reducing the number of health commissioners, by reducing overhead expenses, by eliminating duplication of effort, by more effective use of personnel, supplies and equipment, and by the opportunity for better planning.

ARGUMENTS AGAINST

The disadvantages suggested by those opposed to health district consolidation include: fear that home rule may be endangered; the possibility that wealthy districts might pay disproportionately more to support health services than surrounding poorer areas; loss of status of some health commissioners; decrease in the quality of service from loss of local control of public health administration; loss of civil service status for city health district employees; and the difficulty in designing a representative combined board of health plan.

The people of Ohio have a strong attachment to the concept of home rule. Therefore, it has been argued, it may be desirable to retain responsibility for public health services close to local communities.

It has been argued that consolidation of health districts would either lower health service standards in relatively wealthy areas to that of less fortunate communities or, place the wealthier areas in the position of paying for health services in the poorer areas and for services they do not need. Residents of relatively wealthy suburban cities with few health problems might object to paying higher taxes in order to finance the greatly needed health services in both the poorer areas of the large cities and rural areas of the counties.

Some health commissioners would lose office upon consolidation of districts. City health commissioners who are not physicians, furthermore, would not be permitted to continue in office, under present law, after consolidation with general health districts.

Health officials, it has been argued, are likely to produce a better public health program if they are in close contact with local health problems, responsive to the needs of local residents, dependent upon local financial support. Public interest in local health problems also may be more easily stimulated if local health officials are within easy reach.

Consolidation of city and general health districts might jeopardize the civil service status now enjoyed by city health district employees, because general health districts are not under civil service. Section 3709.07 of the Revised Code, as revised in 1959, states that the status of employees of city health districts shall not be affected by combination of districts, although the legislative intent to extend civil service to employees of general health districts is uncertain.

A board of health which would fairly represent all the communities in large consolidated districts might be difficult to devise. A board of health which would be small enough to work effectively might deprive some small communities of representation on the board or cause large cities to be under-represented in proportion to their population.

EVALUATION OF ARGUMENTS

The advantages of consolidating health districts appear to outweigh the disadvantages. Some of the suggested disadvantages, furthermore, are subject to elimination by appropriate legislation while others are of questionable significance.

Obviously health commissioners of some districts would lose their titles as a result of consolidation. They could still serve, however, as deputy administrators without any necessary decrease in their financial compensation, and consolidation would provide opportunities for advancement. The status of health commissioners of city health districts, who are not physicians but who have the ability and experience to assume the duties of health officer for a consolidated district could be protected by appropriate legislation. Similarly, city health district employees' status could be preserved upon combination with a general health district by placing such employees under a state administered civil service program.

In answer to the charge that consolidation would endanger home rule, the proponents of consolidation have pointed out that what is at stake is not home rule but the assurance of adequate public health services in all communities. Consolidation of small health districts, furthermore, would strengthen and guarantee continued local responsibility for public health by providing effective and economical operation of local health services. The continued operation of small, inefficient districts, it has been argued, might eventually lead only to centralized administration of local health services by the state health department.

Although it is true that wealthier areas in some consolidated districts might help to support the health services in poorer neighboring areas, the economies in operation achieved through consolidation in most instances would permit improvement in services with minimal additional cost to the taxpayers of the wealthier areas. Health hazards, furthermore, cannot be confined to political subdivisions; an adequate public health program in a relatively poor area will protect neighboring areas from disease and sanitation problems.

When the goal of adequate public health services replaces the desire to satisfy local neighborhood pride, the difficulties that might arise in designing a board of health representative of all areas of a consolidated district assume diminished importance.

Constitutionality of Health District Consolidation

A series of court cases indicates that consolidation of health districts would be constitutional, because health districts are agents of the state and reasonable classification of cities to implement consolidation would probably not violate the principle of uniform application of legislation.

The question of the constitutionality of required consolidation of health districts has been raised by the opponents of consolidation on the grounds that home rule is guaranteed to municipalities by the constitution, and that any attempt to classify cities by population for determining which city health districts should combine with general health districts might violate the constitutional prohibition against special legislation. The courts have emphasized, however, that public health is a state responsibility, with health districts serving as agents of the state; therefore, consolidation would not deprive municipalities of any unalienable home rule powers.² The Ohio Supreme Court, in commenting upon the Hughes-Griswold Act of 1919, also stated that classification of cities for public health organization is reasonable and does not constitute special legislation.³

Disadvantages of Present Voluntary Methods of Consolidating Health Districts

Health districts under existing statutes can consolidate their operations to varying degrees to become combined, cooperating, or contracting districts, as explained on pages 15 to 17, above. The Ohio Department of Health, however, can only attempt to persuade health districts to undertake these consolidation efforts,

² *Board of Health v. State ex rel. O'Wesney*, 40 App 77, 178, NE 215; also *State, ex rel. V. Underwood* 137 Ohio St. 1.

³ *State ex rel. Cuyahoga Heights v. Zangerle*, 103 Ohio St. 566, 134 NE 686.

since present statutes are only permissive in nature. Statutory provision for voluntary consolidation of health districts has failed to eliminate small health districts.

Over one-half of all local health districts, as pointed out previously, are now cooperating, contracting, or combined with other health districts; over two-thirds of the general health districts have such arrangements. The Ohio Department of Health after the 1950 census, furthermore, was successful in persuading new cities to cooperate, contract, or combine with general health districts.

This apparently successful record of consolidation of Ohio health districts is blemished, however, by the 30 city health districts and 14 general health districts below 25,000 in population which continue to operate alone and by the inherent shortcomings of the present methods of uniting districts. Although 62 general health districts have entered into varying degrees of consolidation with other districts, in only 31 instances has this resulted in complete integration of public health administration under one combined board of health representing a city and a general health district. The temporary and limited degree of integration provided by cooperating and contracting arrangements entered into by the other 31 general health districts tend to be unsatisfactory.

Cooperating districts are not true integrated units, because the health commissioner may be the only public health employee who serves the entire area.

Only "paper" consolidation occurs when two or more boards of health employ a common health commissioner. The public may be given a false impression that all health services have been integrated. Under this type of consolidation proper coordination and policy-making may still be difficult because: the health commissioner remains responsible to a number of boards of health and, indirectly, to several district advisory councils and city councils; the health commissioner may concentrate his time and activities in one district while neglecting others; planning is difficult where the cooperating arrangement is not permanent and each board of health continues to make its own budget estimate, which is reviewed and

amended by separate authorities; uniformity in regulations, personnel policies, and salaries is not assured.

The cooperating districts, it has been argued, represent a sound first step which can be taken by districts wishing to proceed cautiously toward the total integration of health services available in a combined district. This plan has the following advantages: simplicity, authority and responsibility for public health and its financing is retained by each cooperating district, and cost of employing a health commissioner is reduced. The basic weaknesses of the cooperating arrangement, however, are revealed by these supposed advantages, because the plan does not go far enough in integrating health services.

Consolidation in contracting districts is not necessarily permanent where separate boards of health are retained, although it is a useful first step toward complete consolidation.

Efforts to achieve consolidation by the contract method fall short of attaining satisfactory integration of public health services in many ways: the annual renewal of the contract makes planning difficult; financial control is not centralized; and city health district residents have no direct voice in the public health program, because the city board of health surrenders its responsibilities to another authority. Contracting arrangements have been used by some small cities, furthermore, to supplement their income rather than to improve public health services; these cities contract for limited health services at a rate below their state subsidy.

The chief advantage of the contracting method of consolidation is that it provides an easy first step toward the goal of complete integration which characterizes a combined health district. The contracting device is useful for the village which has just attained the status of a city, but which is too small to support its own health department. The small city district can profit from the more adequate resources and health services available from a general health district; yet some local autonomy is retained by the district through its own board of health.

The combined health district provides the highest degree of permanent integration of public health services. Health districts, how-

ever, tend to reject this type of consolidation, because local units are reluctant to surrender authority for financing and policy-making.

The specific advantages of combined districts, compared to other types of consolidated districts, are: there is only one budget; the health commissioner is responsible to only one board of health; there is one uniform set of regulations, fees, and permits; health services and health personnel are completely integrated to achieve maximum efficiency; better health personnel may be attracted; centralized responsibility may encourage public interest in the health program; and planning is easier, because

the consolidation is permanent and income is more readily predicted.

Health districts for years have been reluctant to combine, despite the acknowledged opportunities for combined districts to offer better public health services. Efforts have been defeated to combine districts voluntarily under existing statutes because of fear of the purported disadvantages of consolidation, as described on page 26, above. As previously indicated, only 31 combinations of city and general health districts have been effected; no general health districts have combined with each other.

III. Alternative Solutions to the Organizational Problems of Health Districts

The possible alternative solutions to the organizational problems of Ohio health districts described in this section are: a minimum size requirement, establishment of the county as the local health unit, distribution of state subsidy to encourage consolidation, direct state administration of health services in selected rural areas, modification of present statutes, creation of a few large health districts, and direct state administration of local health services throughout the state.

A Minimum Size For Local Health Districts

All city health districts under 100,000 in population, or some lesser figure, could be required to combine with general health districts; in predominantly rural areas general health districts with under 50,000 in population, or some lesser figure, could be required to combine with each other.

This approach to consolidation of local health districts has the merits of being relatively simple, yet it assures a minimum district population which would conform to the suggestions of public health officials. The large cities, which can financially support adequate health services, would be free to concentrate on the problems peculiar to them. This plan appears to have the support of the state department of health and most local health commissioners.

This plan could be put into effect by amending the statutory definition of health district. A city health district could be defined as any city with a population over 100,000, or any city over 25,000 as prescribed in the original 1919 Hughes Act. All other municipalities together with townships would constitute general health districts. Statutes could also require the smaller general health districts to unite under a combined board of health appointed by a joint district advisory council.

The number of health districts in Ohio following the adoption of this proposal would, of course, be dependent upon the minimum population size established for health districts. If the minimum population size for city health units were set at 100,000 and for general health districts at 50,000, the number of health districts in Ohio would be reduced from the 238 reported in 1960 to 67, consisting of eight cities over 100,000 in population, 39 general health districts with a population above 50,000, and 20 districts created by combinations of the 49 general health districts with under 50,000 population. If, on the other hand, all districts below 25,000 in population were required to consolidate, the number of health districts would be held below 200, consisting of 120 cities over 25,000 in population, 60 general health districts with a population above 25,000,

and 12 districts created by combinations of the 28 general health districts with under 25,000 population.

A transition period might be provided to avoid the disruption of immediate change. City and general health districts with less than the prescribed minimum population could be permitted to continue to operate alone indefinitely, or for a period of five or ten years, provided they maintain certain standards in their health services.

Some relatively small city and general health districts which are now operating alone appear to be providing satisfactory public health services. It would seem reasonable that these units would not need to unite with other districts immediately or as long as they are willing and able to finance adequate health services. Such an arrangement would necessitate (a) the formulation of definite standards by the Ohio Department of Health for administering health services and (b) inspections by evaluation teams composed of state health officials and, possibly, local health commissioners.

Immediate action could be taken to prevent new cities from becoming independent health districts.

Emergency legislation could be framed to prevent the 35 or more cities created as a result of the 1960 census from becoming independent city health districts. All new cities could be required to remain part of general health districts pending consideration by the General Assembly of further reorganization of health units. Such an act would halt the continued increase in the number of health districts in Ohio, prevent the dilution of the present state subsidy program for health districts, assure the financial participation of these municipalities in general health districts, and assist the state department of health in promoting district consolidations.

Counties As the Local Health Unit

Larger health districts could be assured by designating counties as the basic health unit. This would be a simple and direct method of reorganizing health districts.

Ohio's 88 general health districts could be expanded to take in all city health districts. The outstanding advantage of this plan is its

apparent simplicity. The county, a traditional unit of local government, would be designated as the basic public health jurisdiction; no new organizational structure of special districts would thereby be superimposed upon the existing jurisdictions of local government. Responsibility for financing and administering health services over a relatively large area and population would be centralized under one board of health. This type of organization, furthermore, is followed in many other states.

This plan could be put into operation by adopting one of the following courses of action: require boards of health in general health districts to assume responsibility for financing and administering all county health services; provide for a new board of health in each county, appointed by either the county commissioners or jointly by the mayors in city health districts and the district advisory council; require all existing boards of health in each county to sit as one combined board; or require all districts within one county to combine under the provisions of existing statutes within a limited period. Villages which become cities would, of course, remain within the general health district.

The largest cities, such as the eight cities over 100,000 in population, could be permitted to operate as separate health districts. Small county health districts, such as the 28 districts below 25,000 in population could be required or encouraged to combine.

The principal weakness of the plan to designate counties as the only health districts is the lack of any rational attention to the population size, financial resources, and to economic, social, and geographic factors within the proposed 88 health districts. The disregard of sentiment for township, village, and city responsibility for public health, coupled with a possible lack of common interest between urban and rural areas within one county, might be difficult obstacles to overcome in order to consolidate all health districts into 88 county units. Some of the proposed county health districts, furthermore, would have a population well below the minimum usually recommended by public health officials. Only 18 of the 88 counties now have a population of more than 100,000, while 49 counties have a population

under 50,000, and 35 of these 49 counties have less than 35,000 residents.

If the largest cities were permitted to operate as independent health districts, and if small counties were required or encouraged to combine, the basic advantages of the county health district plan would be retained and some of the objections to it would be eliminated.

The county health district 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 were designated as the appointing authority for a county board of health.

Under this plan efficiency in public health administration would be enhanced by county financing of health services. Health services could be administered on the basis of need rather than ability to pay, if the tax burden for such services were shared equally by all county residents. If this county-unit health plan were adopted, it might also seem advisable to designate the board of county commissioners as the appointing authority for a county board of health. The county, as the agent of the state, would be given the responsibility for a public health program to protect and maintain the health of the people of Ohio.

State Subsidy To Encourage Consolidation of Health Districts

A substantial increase in the present state subsidy, to be distributed only to health districts above a minimum population, could serve as an incentive to encourage health districts to combine. As an alternative, all state subsidies could be denied to small districts which fail to combine.

Small health districts would tend to combine voluntarily under present laws, if they would thereby be eligible for state aid. Only a state subsidy for a combined district well above the \$1,900 distributed in 1960 would serve as an effective incentive to combine. In California, for example, no funds are given to any city of less than 50,000 population for the maintenance of an independent health department.⁴ In New York all health districts receive a state

⁴ California Health and Safety Code, Sec. 1141, 1154, 1155.

subsidy, but county districts receive larger amounts than do smaller units: county-wide units receive state aid equal to 75 per cent of the first \$100,000 expended and 50 per cent of all additional expenditures, while smaller units in contrast receive state aid equal to 50 per cent of local expenditures.⁵ As indicated previously, use of the state subsidy as an incentive to consolidation has the support of the state director of health and many local health commissioners.

The chief advantages of using the state subsidy as an incentive for consolidation are that health districts would not be required to combine and combination of districts would not result in an increased local financial burden for relatively wealthy areas in order to raise standards of health services in neighboring poorer areas.

Distributing an increased state subsidy to reward consolidation of health districts permits an element of choice for local districts. Small health districts could continue to operate alone if they so desired, as long as the residents of the district were able to support the cost of an adequate public health program. The state subsidy would be available for consolidated districts either to support adequate health services for relatively poor districts or to provide health services above minimum requirements in the districts with better local financial support.

Many residents of relatively wealthy health districts oppose consolidation with poorer units because they might have to pay higher taxes to improve health services in the neighboring district. The assurance of a substantial state subsidy for a combined district could diminish this fear of higher local taxes, thereby encouraging voluntary consolidation of health districts under existing laws. Further discussion of a state subsidy is set forth in Part Two, pages 63 to 64, below.

State Administration of Local Services in Sparsely Populated Areas

The relatively sparsely populated areas of the state could be permitted, under conditions set forth by law, to request the Ohio Department of Health to administer local public health services in these areas.

⁵ New York State Department of Health, 1959 Supplement to the Public Health Law, Sec. 608.

Some Ohio areas lack the financial resources to support even minimum public health services for a widely dispersed population. Extensive consolidation of health districts in these relatively poor areas might produce more administrative problems rather than improve health services. No financial reforms, short of substantial state subsidies, moreover, would solve the problems of these areas. A possible solution would be to permit these sparsely populated areas to apply for direct state administration of local public health services. Such a procedure is now followed in the mountainous areas of California:

... upon request of the board of supervisors of any county of less than 40,000 population and upon the appropriation for public health purposes by such a county of a sum of not less than fifty-five cents (\$0.55) per capita for the total county population, the State Department of Public Health may organize and operate a local public health service in such county.⁶

Under this California plan local health districts must continue to contribute to the financial support of health services. Forty-one Ohio counties have fewer than 40,000 residents.

Modification of Existing Statutes to Encourage Voluntary Combination

Existing statutes probably afford sufficient methods through which health districts may voluntarily unite, although the less desirable consolidated units, cooperating and contracting districts, might be prohibited or restricted in order to compel recourse to the more effective administrative unit, the combined district.

The General Assembly in 1959, as noted previously, amended an existing statute to facilitate the combination of general health districts and city health districts. This statute now permits these districts to arrive at a mutually satisfactory contract specifying the composition and manner of selection of the board of health of the new district. Before the enactment of this amendment cities would usually be seriously underrepresented on combined boards of health. Despite the advantages offered by this legislation, no combinations have yet been effected. Additional legislation can do little more to encourage voluntary combinations. A

⁶ California Health and Safety Code, Sec. 1157.

civil service system, however, administered for general health districts by the state department of personnel might create a more favorable attitude toward combination on the part of city health employees now under civil service. A statute that prohibited or curtailed the creation of contracting and cooperating districts might encourage further voluntary efforts to create combined districts. Such action, however, might be a step backward in the current trend toward voluntary consolidation, since health districts might be inclined to go their separate ways, rather than to combine their boards of health.

Although some voluntary consolidations of health districts under existing statutes can be expected in the future, only state intervention can bring substantial progress toward larger health districts.

Health districts will continue to combine, or at least to enter into cooperating and contractual arrangements. Some city units, however, are eager to establish their own health department, and can be expected to withdraw from their present cooperating or contractual relations with general health districts. Thirty-five or more villages, as a result of the 1960 census, will become city health districts which may or may not be persuaded by the state health department to consolidate voluntarily with general health districts. Fifty more villages may reach city status by 1970. As pointed out previously, 2,158 districts were reduced to 180 in 1919, but the creation of new city districts has increased the 1960 total to 238 units. Voluntary consolidation has reduced the number of separate operations to 131, but only 26 of these units are the completely integrated combined districts. In short, efforts to combine health districts voluntarily have failed to provide districts of sufficient size to support adequate health services at a reasonable cost in many Ohio communities.

Creation of a Few Large Health Districts

Existing local health districts could be reconstituted by law into fewer, relatively large districts.

A complete reorganization of health districts might be effected by statute, based upon such factors as density of population, existing politi-

cal boundaries, transportation, present medical facilities, and economic and geographic areas. This type of health district reorganization would conform closely to the standards recommended by the American Public Health Association and the United States Public Health Service. Local health districts could be reorganized along the lines suggested by these two groups, as reported on page 24, above, and as shown on the maps in Appendixes A and B.

Disregard of traditional public health responsibilities of existing local government units is the chief objection to this proposal.

The determination of the proper size and number of health districts with little regard for existing units of local government would be difficult. The resulting reorganization, it has been argued, might seriously weaken local public interest in the public health program. The probable administrative advantages of this plan might be overshadowed by a decrease in local concern for public health problems. Such a decrease of local responsibility for public health, however, is not a certain result of this proposal. In defense of this total reorganization plan, it has been declared that the possible efficiency of these relatively large health districts would strengthen, rather than weaken, local responsibility for public health services.

Direct State Administration of Local Health Services

Responsibility for the financing and administration of local public health services could be reserved to the state government, through the Ohio Department of Health. The necessary regional decentralization of the administration of health services would be determined by the state health department.

This proposal carries health district consolidation to the extreme; one state-wide health district, with necessary regional administrative divisions, would replace the existing local districts and local responsibilities. The major arguments against this plan are that: it runs counter to sentiment for home rule; it would

result in centralization of authority; certain local health problems might be neglected; and public interest in the local health program might decline as a result of the loss of local responsibility. Ten possible advantages of this type of consolidation include: the support of local health services by the financial resources available throughout the state; equalization of the financial burden; state-wide uniform regulations and standards; elimination of duplication of fees and inspections; attraction of better qualified public health personnel through higher salaries and greater opportunities for advancement; a career service for public health personnel without dependence upon the vagaries of local politics, local prejudice, and local whims; selection of the local health officer and the determination of the number and quality of personnel under him on the basis of needs of the area rather than its ability to pay; flexibility in state regional district boundaries; concentration of personnel at points of particular danger as in epidemics and disaster; and integration and effective use of highly specialized services now unavailable in some districts.

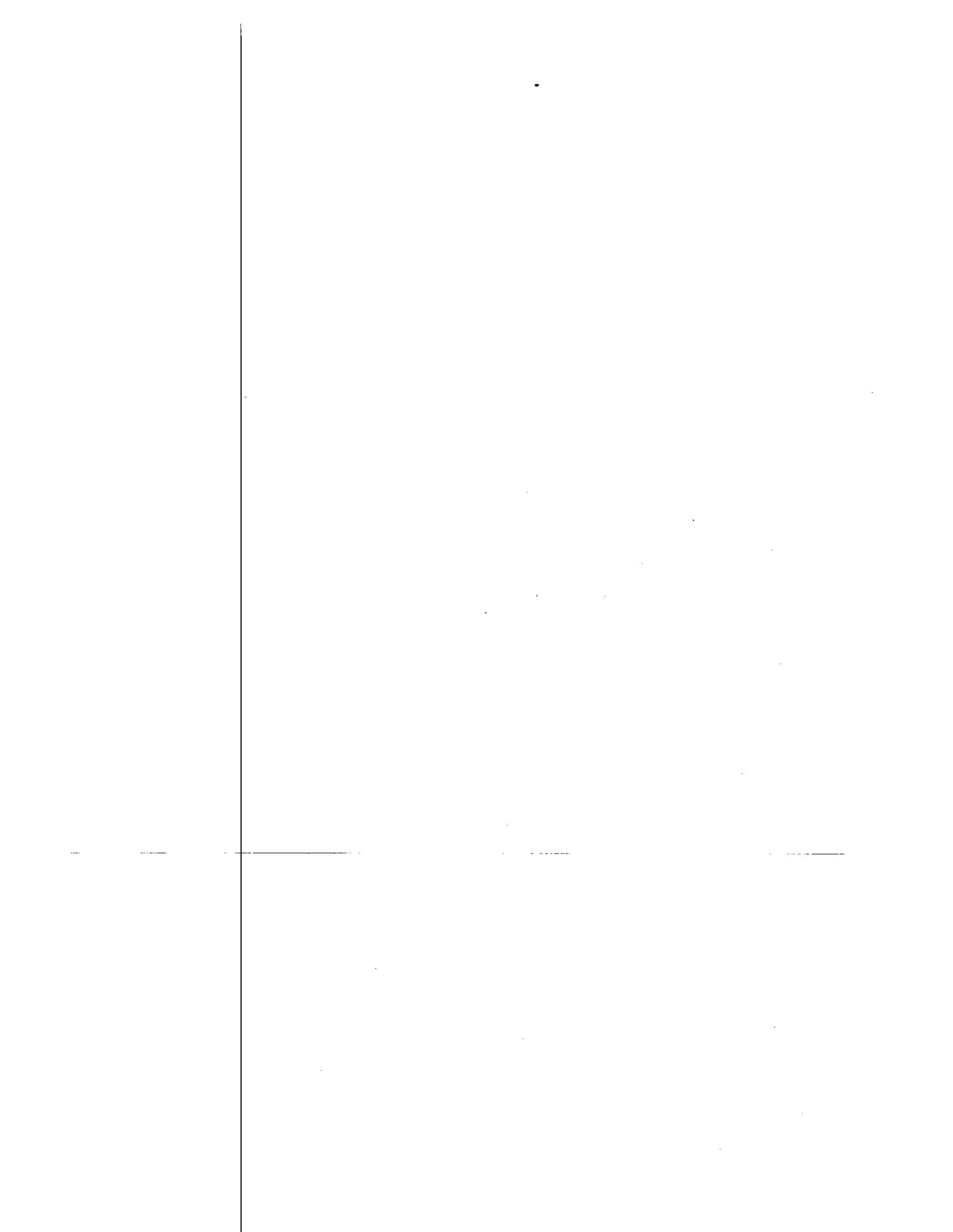
Some public health services now administered by local health districts could become the responsibility of the state health department without transfer of all functions. Certain health problems may be best met through state-wide action.

It appears that some health services, such as inspection of milk producers and plants, might justifiably be performed by state officials. Such a program would eliminate duplication of inspections and fees, problems of reciprocity, lack of uniformity in standards and fees, and use of inspections as an economic weapon to protect producers and plants established in a community. Health clinics for migrant workers and inspections of migrant labor camps could possibly be handled by the state health department to avoid local financial and administrative obstacles to these programs. See the 1961 Ohio Legislative Service Commission Staff Report on "Migrant Farm Workers in Ohio."

Financial Problems

Part Two

Part Two of this report is divided into five sections devoted to (1) analysis of the financial requirements of general health districts, (2) description of health district sources of income, (3) problems of inadequate and unstable sources of income, (4) other financial problems, and (5) presentation of possible alternative solutions to these financial problems of general health districts.



I. Financial Requirements of General Health Districts

Essential Public Health Personnel

The public health functions of health districts are largely services, and by far the greatest part of general health district 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 largest item in many general health district budgets is the health commissioner's salary, which ranges from approximately \$12,000 to over \$20,000 per annum for full-time commissioners. Each health district, either full-time or part-time, also employs at least one public health nurse, one clerk, and one sanitarian. Contributions by health districts into the retirement fund for these personnel amount to several thousand dollars in most general health districts. Salaries accounted for seventy-four per cent of the total expenditures of general health districts in 1959.

There are serious shortages of all types of public health personnel in general health districts.

Public health is a specialty. The positions of health commissioner, public health nurse, and sanitarian usually cannot be filled satisfactorily by untrained laymen, or even by persons trained in other fields of medicine. Persons trained and experienced in public health tend to seek the positions in large cities in Ohio and in other states which offer relatively high salaries and opportunities for advancement.

HEALTH COMMISSIONERS

Although most of Ohio's 129 health commissioners are physicians, relatively few are trained or experienced in public health as a medical specialty. Only 15 health commissioners have the Master of Public Health degree; 31 commissioners are over 65 years old; 20 are employed on a part-time basis; 17 are employed by two or more boards of health.

The health commissioner is the key man in a health district. The American Public Health Association recommends that the local health officer have a medical degree, further education toward the Master of Public Health

degree, and some prior experience in public health. Only general health districts must by law employ physicians as health commissioners; only 19 Ohio city health commissioners are not physicians.

The director of health believes that required qualifications for health commissioners should be uniform in city and general health districts. He prefers physicians for this post, provided they are employed full-time and are trained and experienced in public health. In view of the general shortage of physicians, the director has recommended employment of non-medical administrators, as well as physicians, in both city and general health districts. Both non-medical administrators and physicians employed as health commissioners, however, should have a minimum of three to five years experience in public health, formal academic training in public health, preferably with a Master of Public Health degree, and a period of in-service training in the Ohio Department of Health.

PUBLIC HEALTH NURSES

Only one-half of the 1,348 public health nurses in Ohio are employed by health districts, and only one-half of these are employed by general health districts. Ohio needs 3,500 more public health nurses in order to have a recommended ratio of nurses per population. Many public health nurses, furthermore, lack adequate formal training.

Public health nurses are employed by voluntary agencies, by boards of education, and by other government agencies, as well as by health districts. It was reported in 1960, for example, that 31 voluntary agencies employed 199 public health nurses; 177 boards of education employed 342 public health nurses; 148 health districts and other government agencies employed 671 public health nurses (318 located in 79 general health districts); and five combined official and voluntary agencies employed 131 public health nurses. The total number of public health nurses employed early in 1960 was 1,343, compared to 1,253 in 1957 and 1,188 in 1955. The Division of Nursing of the Ohio Department of Health has estimated that Ohio

needs almost 3,500 more public health nurses in 1960 in order to have an adequate ratio of nurses per population. Only 22 general health districts employ a supervisor for the public health nursing staff.

Despite the relatively high level of Ohio medicine many public health nurses of various grades lack sufficient training. It was reported in January, 1960, that only 11 of 106 nurses serving in a supervisory capacity had a graduate degree or graduate work in public health nursing; 31 nurse supervisors had a baccalaureate degree in nursing with preparation in public health; 56 had no degree of any kind. One-half of the 22 staff directors had a graduate degree in public health. Insufficient training among public health staff nurses is also evident. Only six of the 1,200 staff nurses had a graduate degree in public health, although 17 others had some graduate work in other fields; 171 staff nurses had a baccalaureate degree with preparation in public health, although 59 others had a baccalaureate degree in another nursing specialty; 34 public health nurses had a baccalaureate in a field other than nursing. Over 900 public health nurses did not have a college degree in nursing or a related field, although about 350 of these nurses had completed some college work in public health.

SANITARIANS

Although over 600 sanitarians are employed by local health districts in Ohio, few have extensive formal training. Because sanitarians perform a key role in the execution of a public health program, their adequate training is essential to the successful operation of a local health district. Their work also has great influence on the public's judgment of the entire health department. Sanitarians include: (1) sanitary engineers, with a basic background and specialization in sanitary engineering, sanitary science, and public health; (2) veterinarians; (3) sanitarians, usually with at least two years of college work and specialization in biological and social science; and (4) sanitary inspectors, with little formal training other than short courses provided by the state health department. Local health districts in Ohio in 1960 employed only five sanitary engineers, 43 veterinarians, 335 sanitarians, and 238 sanitary in-

spectors. General health districts employed 220 of these 621 sanitation personnel.

PUBLIC HEALTH SPECIALISTS

Only a few health districts employ public health dentists, health educators, industrial hygienists, and other public health specialists.

The fields of the public health dentist activities are education, prevention, research, and introduction of remedial care. Some of the activities are: (1) advisory assistance to the public health nurse, the health educators, the nutritionist, and the family dentist; (2) screening programs in schools; (3) toothbrushing demonstrations; (4) application of sodium fluoride for prevention; (5) oral hygiene; (6) referral of deformities to other agencies; and (7) remedial care for children of indigent parents and dental treatment at county children's homes.

Only one general health district and five city districts in 1960 employed nine full-time health dentists; three general health districts and four city districts employed 34 part-time dentists. Boards of education employed seven full-time and nine part-time dentists. Four full-time dentists were employed by the state health department.

The state picture for Ohio health educators is no more favorable, as only six health districts employed in 1960 a total of eight such officials. Five voluntary agencies each employed one health educator.

The public functions of the industrial hygienist are investigation, prevention, and control of occupational health hazards. While Cleveland and Cincinnati each employ an industrial hygienist, private corporations employ about a dozen such officers. The Division of Industrial Hygiene of the Ohio Department of Health, which performs some local inspections, employs one physician, two nurses, three chemists, and five engineers. Each of the four state regional health districts is authorized to employ an industrial hygienist, but in 1960 only one of these positions was filled.

About 50 persons are employed in local health district laboratories, and over 60 in state laboratories.

**OHIO'S PUBLIC HEALTH
PERSONNEL POSITION**

Ohio falls far short of most of the personnel-population ratios recommended by the American Public Health Association and the National Public Health Council. Ohio has 129 full-time and part-time medical and non-medical health commissioners serving 238 districts. This does not meet the ratio of a full-time health officer for each district with additional physicians at the rate of one for each additional 50,000 population, as recommended by the American Public Health Association. The state has a ratio of 7,300 persons per public health nurse, including, however, 672 nurses employed by government and voluntary agencies other than health districts, compared to the recommended public health nurse ratio of one per 2,500 to 5,000 persons. Ohio also fails to reach the recommended ratio of one health educator per 50,000 population. Dentists, dental hygienists, veterinarians, and laboratory workers are not employed in all districts with a population above 100,000, as recommended by the association. Ohio, however, employs one sanitarian per 15,500 persons, and meets the recommended sanitarian ratio of one per 15,000 to 25,000 population.

Ohio, furthermore, lags behind some other states in the number of health personnel employed. Ohio's health districts in 1958 employed about one-half the number of health personnel employed in California, and only one-third the number employed in New York. In the same year Ohio employed only three sanitary engineers, while 22 states had a larger number, including New York with 73 and Pennsylvania with 54. Only California and New York, however, exceeded Ohio in the number of public health physicians, public health nurses, dentists, and sanitarians. Ohio's local health districts employed more veterinarians than any other state. In only three states were more clerks employed than in Ohio local health districts.

Minimum Cost of An Adequate Public Health Program

The cost of adequate health services, based on personnel requirements for minimum health services, would exceed \$2.00 per capita. State and local public health officials agree with the

current recommendations of the American Public Health Association that per capita appropriations should exceed \$2.50. Districts with small populations in rural areas tend to require higher appropriations.

Basic health services in a district with a population of 50,000, would cost \$2.16 per capita, or a total of \$108,550, if recommended minimum personnel were employed at current average salaries. Salaries and expenses of this hypothetical district would be—

1 Health Commissioner	\$ 15,000
1 Nurse Supervisor	7,500
10 Public Health Nurses	48,000
1 Sanitarian Supervisor	7,200
3 Sanitarians or Inspectors	12,000
1 Clerk-Administrator	4,200
2 Clerks	5,400
Medical Supplies	1,000
Office Supplies	500
Board Expenses	250
Employees' Expenses	1,000
Retirement	6,000
Other	500
TOTAL	\$108,550

This budget makes no provision for the employment of a public health dentist, a health educator, a nutritionist, or an industrial hygienist. The ten public health nurses would provide a nurse-population ratio of 1:5,000, which is the highest ratio recommended by the American Public Health Association. This health district could employ fewer nurses, if public health nurses were also employed within the district by boards of education and voluntary agencies.

The American Public Health Association recommended, in 1960, a local per capita public health expenditure of \$2.50 to \$3.50, exclusive of medical care expenditures.⁷ Although the Ohio Department of Health has suggested that \$2.78 per capita could adequately support present day public health programs in most districts of over 25,000 population, the actual

⁷ American Public Health Association, *Guide To a Community Health Study*, (1960), p. 12.

minimum figure would depend on such factors as population of district, population characteristics, nature of local health problems, and geographic considerations. Local health commissioners have reported that an expenditure of at least \$2.60 per capita in Ohio is needed to support an adequate public health program. If demands for public health services continue to increase and salaries and operating costs grow higher in the next five to ten years, this recommended expenditure would also increase.

Present Expenditures of General Health Districts

General health districts vary widely in the amount of per capita health expenditures, but most districts have relatively low expenditures. Sixty-nine of the 88 general health districts in

1960 had a per capita health appropriation below the state average of \$1.47. Thirty-five of these districts had a per capita appropriation below \$1.00.

The per capita appropriations of general health districts in 1960 ranged from 44 cents in Knox county to \$4.09 in Defiance county. The average per capita appropriation of general health districts (\$1.33) was below the state per capita average of \$1.47 and the \$1.54 average per capita appropriation of "full-time" city health districts operating alone. Appendix C lists the 1960 per capita appropriation of each general health district; Table 9, below, shows the expenditures of selected general health districts in 1958; and Map 2, page 42, shows the range of per capita expenditures of general health districts in 1959.

Table 9
Expenditures of Selected General Health Districts, 1958

Item	Amounts			
	Miami	Montgomery	Fairfield	Licking
Health Commissioner salary	\$ 7,500.00	\$ 11,725.92	\$ 4,000.00	\$ 3,830.00
Other salaries	20,027.65	87,958.57	15,003.50	18,625.73
Office supplies	935.79	799.14	233.47	857.84
Board members	186.90	215.80	175.20	162.80
Medical supplies	60.49	967.55	48.66	334.22
Employee's expenses	7,339.65	10,110.89	1,755.19	5,690.80
Retirement	1,773.69	5,849.10	1,335.21	1,578.58
Equipment	42.92	553.86	66.53	870.84
Other	1,855.53	12,788.71	200.33	732.18
Workmen's Compensation		257.71	542.19	487.05
Total	\$ 39,722.62	\$131,709.25	\$ 23,360.28	\$ 33,170.04
	Mahoning	Knox	Trumbull	Stark
Health Commissioner salary	\$ 8,000.00	\$ 1,200.00	\$ 8,090.00	\$ 11,850.00
Other salaries	48,167.50	4,500.00	52,355.00	93,496.72
Medical supplies	1,257.66	44.62	471.38	108.13
Office supplies	1,025.64	268.44	4,185.42	1,984.86
Board members	237.90	189.20	266.10	203.20
Employee's expenses	8,940.00	599.97	261.60	
Epidemic & Quarantine	654.65			
Other	2,316.93	207.37	1,416.17	1,771.92
Equipment	4,115.11			100.51
Retirement	3,660.17	358.16	4,149.88	7,488.79
Restaurant Licenses		1,272.01		
Workmen's Compensation		127.31		1,811.20
Total	\$ 78,375.61	\$ 8,767.08	\$ 71,155.55	\$118,815.33

	Belmont	Summit	Tuscarawas	Lake
Health Commissioner salary	\$ 6,524.46	\$ 13,300.08	\$ 12,000.00	\$ 13,000.00
Other salaries	22,452.00	200,693.59	49,807.20	42,240.75
Medical supplies	611.77	1,698.52	260.48	
Office supplies	1,611.58	3,544.90	702.04	5,537.27
Board members	203.40	152.00	204.15	
Restaurant Licenses	581.00			
Other	286.65	9,909.19	5,132.31	
Polio shots	1,574.11			
Employee's expenses	3,276.64		5,988.91	
Retirement	3,195.20	6,602.04	2,209.97	3,896.47
Equipment			515.14	3,880.32
Workmen's Compensation				502.05
Total	\$ 40,266.75	\$235,900.32	\$ 76,820.20	\$ 69,056.86

SOURCE: Ohio Public Expenditure Council, 1960.

EXPENDITURES COMPARED

In 1957, according to the U.S. Public Health Service, 32 states spent more per capita for public health than Ohio. Twenty-four of these 32 states had a per capita income below the per capita income in Ohio in 1957. Ohio, unlike most states, relies on local, rather than state, financing of local health services. In 1957 the

state government in Ohio spent less per capita for public health than did state governments in 18 other states. In the same year, however, local governments in Ohio spent more per capita for public health than did local units in 37 other states. (See Table 10, page 43, below.)

MAP 2. PER CAPITA HEALTH EXPENDITURES, GENERAL HEALTH DISTRICTS, 1959.



Source: Ohio Department of Health

Note: 1959 state average per capita expenditure (all districts) - \$1.38

Per capita expenditure recommended in 1960 by American Public Health Association - \$2.50 to \$3.50

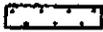
Less than \$.50	
\$.51 to \$1.00	
\$1.01 to \$1.38	
\$1.39 to \$2.49	
Above \$2.50	

Table 10
Health Expenditures of State and Local Governments, 1957

States Ranked By 1957 Per Capita Income	Total Per Capita Expenditure By State and Local Governments	Local Per Capita Expenditures, By Source of Funds				
		Local Total	From State Funds	From Local Funds	From Federal Funds	
Connecticut	\$2,821	\$ 3.97	\$ 1.60	\$.12	\$ 1.45	\$.03
Delaware	2,740	3.06	.56	.40	—	.16
New York	2,578	4.68	2.05	1.02	1.00	.03
California	2,523	4.35	1.90	.32	1.51	.07
District of Columbia	2,514	5.22	5.22	—	4.46	.76
New Jersey	2,504	2.75	1.88	.12	1.74	.02
Illinois	2,447	3.79	.99	.12	.83	.04
Nevada	2,423	3.66	.55	—	.37	.18
Massachusetts	2,335	5.87	.94	.05	.81	.08
Ohio	2,255	2.52	1.50	.12	1.30	.08
Maryland	2,156	3.75	2.04	.30	1.62	.12
Michigan	2,141	3.35	1.37	.07	1.19	.11
Washington	2,128	7.93	1.68	.09	1.55	.04
Pennsylvania	2,112	2.77	.99	.21	.73	.05
Wyoming	2,038	3.04	.88	—	.55	.33
United States Average	2,027	3.24	1.37	.28	1.00	.09
Indiana	2,010	1.77	.55	.14	.39	.02
Colorado	1,996	2.38	1.50	.03	1.39	.08
Rhode Island	1,990	3.74	—	—	—	—
Missouri	1,940	1.84	1.17	.08	1.01	.08
Wisconsin	1,920	2.60	1.26	.07	1.14	.05
Oregon	1,914	5.22	1.38	—	1.26	.12
Montana	1,896	2.67	1.52	—	1.16	.36
New Hampshire	1,862	6.12	—	—	—	—
Minnesota	1,850	3.87	.64	.05	.51	.08
Florida	1,836	4.11	1.30	.44	.80	.06
Nebraska	1,818	1.58	1.30	—	1.13	.17
Iowa	1,806	1.34	.27	—	.19	.08
Texas	1,791	1.70	1.15	.07	.95	.13
Kansas	1,787	2.30	.67	.08	.57	.02
Arizona	1,750	2.89	.96	.04	.72	.17
Utah	1,694	3.04	1.27	.33	.83	.11
New Mexico	1,686	4.01	1.81	.23	.50	.08
Vermont	1,665	4.38	—	—	—	—
Maine	1,663	2.99	—	—	—	—
Virginia	1,660	2.90	1.82	.58	1.10	.14
Idaho	1,630	3.28	1.06	.01	.60	.45
Oklahoma	1,619	1.92	.86	.17	.60	.09
Louisiana	1,566	2.75	1.16	.26	.76	.14
West Virginia	1,554	1.68	.67	.08	.54	.05
South Dakota	1,531	1.72	1.05	—	.97	.08
North Dakota	1,435	3.69	1.22	—	.99	.23
Georgia	1,431	3.00	1.54	.45	.98	.11
Tennessee	1,383	2.70	1.00	.27	.57	.16
Kentucky	1,372	2.16	.98	.38	.49	.11
Alabama	1,324	1.97	.89	.11	.61	.17
North Carolina	1,317	2.12	1.38	.28	1.02	.08
South Carolina	1,180	1.89	1.15	.50	.49	.16
Arkansas	1,151	1.83	.61	.18	.37	.06
Mississippi	958	2.88	1.08	.24	.57	.27

SOURCE: U. S. Public Health Service.

General health district expenditures are relatively small compared to expenditures for other government services in Ohio's counties. Expenditures by general health district boards of health accounted for 1.49 per cent of the total operation, maintenance, and interest expenditures of Ohio's counties according to the 1959 report of the state auditor. County health expenditures were exceeded by expenditures for administration, judicial functions, elections, buildings and lands, protection of persons and property, hospital care, charities and relief, highways and bridges, and insurance and pensions. General health districts, however, spent more money for public health, exclusive of hospitals, than the counties spent for agriculture, welfare and corrections, sanitation and drainage, public service enterprises, the county board of education, and interest payments.

Most of the general health districts have a per capita expenditure well below the \$2.50 expenditure recommended by the American Public Health Association. Only one general health district in 1960 appropriated more than \$2.50 per capita; five other districts appropriated

over \$2.00 per capita but less than \$2.50.

General health districts which employ a full-time staff and thereby qualify for federal grants-in-aid on the average have larger per capita appropriations than the "part-time" districts. General health districts which are contracting, cooperating, or combined with city health districts on the average have larger per capita appropriations than districts operating alone. The "full-time" consolidated health districts had the highest average per capita appropriations in 1960. Some comparisons are -

	Full-Time	Part-Time
Districts Operating Alone	\$.97 per capita	\$.92 per capita
Consolidated Districts	\$ 1.04 per capita	\$.95 per capita

The wealthier health districts do not always spend as much per capita for public health as do the poorer districts, although Table 11, below, shows that per capita health appropriations tend to be higher in districts with relatively high assessed valuations.

Table 11
Relation of Per Capita Health Appropriations to Per Capita Assessed Valuations in General Health Districts, 1960

Per Capita Assessed Valuation	Average Per Capita Health Appropriation	Range of Per Capita Health Appropriations	Number of Districts	Number of Districts Above State Ave., below \$2.00	No. of Districts Above \$2.00
\$1,000 — \$2,000	\$.94	\$.55 — \$1.85	18	2	0
2,000 — 3,000	1.23	.44 — 2.22	37	11	1
3,000 — 4,000	1.63	.73 — 4.09	25	0	9
Over \$4,000	1.39	.85 — 2.03	8	1	1
Total			88	14	11

SOURCE: 1960 budgets submitted by local health departments to Ohio Department of Health.

NOTE: State average per capita assessed valuation (all health districts)—\$2,731.32

State average per capita health appropriation (all districts)—\$1.47

Disparities between assessed valuation and health expenditures, however, are numerous. For example, Portage general health district, with a 1958 per capita assessed valuation of \$1,620.59, had a 1959 per capita health appropriation of \$1.10, while Stark general health district, with a 1958 per capita assessed valuation of \$3,339.71, had a 1959 per capita health appropriation of only \$.80. Disparities are even more apparent among city health districts. For example, Shaker Heights, with a 1958 assessed valuation of \$4,611.80, had a 1959 per capita appropriation of only \$.70, while Gallipolis, with a 1958 assessed valuation of only \$1,516.60, had a 1959 per capita appropriation of \$2.36.

The fact that some health districts with relatively high assessed valuations have relatively low per capita health appropriations may be explained, in part, by the lack of serious public health problems in the wealthier areas which have the advantages of good housing, good private health facilities, satisfactory sanitation facilities, and public and private schools which are able to finance their own school health services.

INCREASES IN OHIO PUBLIC HEALTH EXPENDITURES

Per capita money expenditures for public health in Ohio increased 60 per cent between 1949 and 1958; the effects of inflation however, limited this increase to 37 per cent in terms of purchasing power.

For over a decade public health expenditures have been increasing, even when the amount is corrected for inflation. Total local appropriations for public health were 5.7 per cent higher in 1960 than in 1959. Though most general health districts spent more for public health in 1960 than in 1959, in 9 districts expenditures declined by as much as 7.4 per cent to as little as .5 per cent.

Between 1949 and 1958 total per capita health appropriations at all levels of government in Ohio rose from about \$1.00 to \$1.60, which represents a 60 per cent increase, but the actual increase in per capita appropriations in terms of the 1947-1949 average dollar was only 33 per cent during this period.

The mounting need for more specialized public health services has also resulted in higher costs for supplies, equipment, and better trained public health specialists. New statutes enacted by the General Assembly and new regulations by the Ohio Public Health Council continually add to the work and expenditures of local health units. The legislature in 1959, for example, imposed upon local health districts the duty of inspecting vending machines. The Public Health Council in 1960 also added to the work load of local districts by requiring them to inspect and license camps for migrant agricultural laborers. Further discussion of this phase of health district activity may be found in the 1961 Ohio Legislative Service Commission Staff Report on "Migrant Farm Workers in Ohio."

Relation of Public Health Services to Expenditures

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 frequently mean more sanitarians and public health nurses and more sanitation inspections and nursing visits.

The extent to which the amount and quality of public health services vary with the size of expenditures is difficult to document because of the many variables in reporting health services. Many reports submitted to the Ohio Department of Health by local health districts lack accuracy and completeness. These reports show the number of nursing visits and sanitation inspections performed by each health district, but they do not indicate either the quality or the time consumed in each visit and inspection. One sanitarian, for example, may spend an hour inspecting a dairy farm, while another spends only 10 minutes, and yet does a better job. Much information also may be misleading such as the number of health personnel employed by a health district. The number of public health nurses employed by boards of education and voluntary agencies is not re-

ported by health districts, although this may be a significant part of the total community health program.

Personnel and service reports indicate that general health districts spending more than \$2.00 per capita in 1959 averaged a lower population per public health nurse ratio and

more nursing visits and sanitation inspections per 1,000 population annually than any other group of general health units. Other general health districts in 1959 spending \$1.75 to \$1.99 per capita, however, averaged the lowest population per sanitarian ratio.

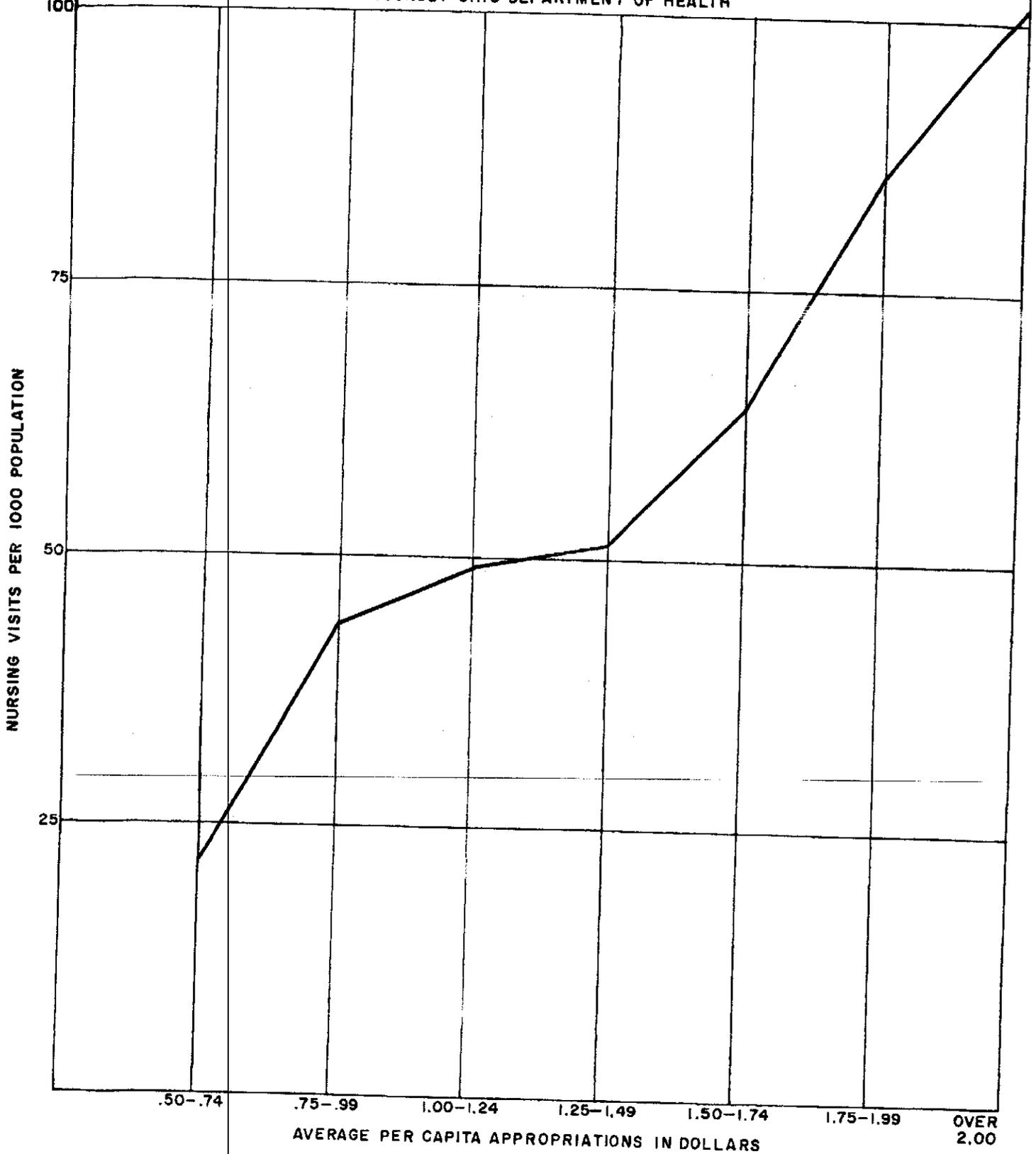
Some significant comparisons are as follows:

	General Health Districts Spending Over \$2.00 per capita in 1959	General Health Districts Spending Under 75c per capita in 1959
Average population per public health nurse, 1959	11,204	24,483
Average population per sanitarian, 1959	24,177	28,586
Annual average number of nursing visits per 1,000 population	101.9	22.4
Annual average number of sanitation inspections per 1,000 population	45.3	24.0

The relation of expenditures to nursing visits in general health districts is illustrated by Chart 2, page 47, below. This illustrates the direct relationship between per capita appro-

priations and number of nursing visits per 1,000 population; the number of visits increases with increases in average per capita appropriations.

Chart 2
NUMBER OF NURSING VISITS PER 1000 POPULATION ANNUALLY,
BY AVERAGE PER CAPITA APPROPRIATIONS
IN GENERAL HEALTH DISTRICTS
SOURCE: OHIO DEPARTMENT OF HEALTH



II. Sources of Income in General Health Districts

In General

General health districts receive their financial support from seven sources: deductions from property taxes distributed to townships and villages within the general health district; licenses, permits and inspection fees; contractual agreements with cities and boards of education; grants from unofficial agencies, such as the tuberculosis society; a state subsidy of approximately \$2,000 annually to each health district regardless of size and type; federal grants-in-aid to "qualified" districts; and voted public health levies up to .5 mill.

The accepted and traditional source of general health district income is the township and village property tax. The county auditors deduct moneys for health districts from property taxes levied within the 10 mill limitation before the semi-annual distribution to the townships and villages within the districts. This income, together with funds received from cooperating and contracting cities, represents 56.9 per cent

of the estimated revenue in 1960 for general health districts.

The second most important source of income for general health districts is the fees collected by health districts for permits, licenses, and inspections. This accounts for 16 per cent of the 1960 estimated income of general health districts.

A third source of income is the voted public health levy which accounts for 13.6 per cent of the estimated income of general health districts, although only 28 of the 88 general health units are operating with the levy. The four remaining sources (state subsidy, federal grants-in-aid, grants from unofficial agencies, and contracts with boards of education) are relatively minor sources of income for general health districts. Table 12, below, shows the sources of income in the various types of health districts. A percentage break-down of the sources of income of each general health district is listed in Appendix C.

Table 12
Expected Sources of Health District Income in 1960

Districts	Per Cent of Total Income						Total Income
	Townships, Villages, and Cities	State Subsidy	Federal Grant-in-Aid	Voted Health Levy	Fees	Other Agencies	
All General Health Districts	56.9%	5.1%	5.5%	13.6%	16.1%	2.8%	\$ 5,694,871.96
All City Health Districts	78.4	1.5	2.3	0	16.2	1.6	8,929,780.59
All Full-Time Health Districts	69.7	2.4	3.9	5.5	16.3	2.2	13,249,929.06
All Part-Time Health Districts	73.6	8.6	0	3.1	14.4	.3	1,374,723.49
All Health Districts	70.0	2.9	3.6	5.3	16.1	2.1	14,624,652.55

SOURCE: Ohio Department of Health (Reports of budgets submitted by local health departments.)

Wide variations occur in type and in per cent of the total income received from specific sources by health districts.

Property tax moneys from townships, villages, and combined city health districts, together with appropriations from the general funds of cooperating and contracting city health districts, totaled from 15.1 to 90.3 per cent of the total 1960 estimated income of general health units. The state subsidy, which was \$1,900 for each district, provided from 1.3 to 29.7 per cent of the income, while the federal grants-in-aid ranged from 0 to 24.9 per cent of the income. Milk fees provided up to 24.4 per cent and plumbing fees up to 63.1 per cent of the income. Other types of fees furnished up to 28 per cent of the income, while grants from unofficial agencies and contracts with boards of education provided up to 15.7 per cent of the 1960 total income. Table 12, above, shows the percentage distribution of sources of income in general health districts. See also Appendix C.

The general health districts with relatively

high 1960 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.

The better financed general health districts tend to depend upon the voted levy, as indicated by Table 13, below. Four of the seven general health districts with a 1960 per capita appropriation over \$2.00 operate with the voted public health levy. In contrast, only one of the 35 general health districts with a 1960 per capita appropriation below \$1.00 operates with the voted public health levy. General health districts with a 1960 per capita appropriation under \$1.00 receive over 65 per cent of their income from the property taxes distributed to villages and townships, while the districts with a per capita appropriation over \$2.00 receive only 55.4 per cent of their income from this source.

Table 13
Percentage Distribution of Sources of Expected Income
in General Health Districts in 1960

Average Appropriation Per Capita, 1959	Number Of Districts	Average Per Cent of Total Income							
		Townships, Villages, and Cities	State Subsidy	Federal Grant-in-Aid	Public Health Levy	Milk Fees	Plumbers Fees	**Other Fees	*Other Agencies
Under \$.50	2	66.4%	23.5%	0%	0%	0%	0%	10.1%	0%
.50 — .74	12	68.7	9.5	6.9	0	1.1	5.3	8.2	.3
.75 — .99	21	65.3	6.9	7.5	5.0	.4	3.8	10.4	.7
1.00 — 1.24	22	54.4	6.8	5.1	20.2	1.5	2.3	8.7	1.0
1.25 — 1.49	9	60.3	7.1	3.1	17.6	6.5	0	2.0	3.4
1.50 — 1.74	7	41.7	5.2	6.2	29.4	.3	9.8	7.3	.1
1.75 — 1.99	4	49.4	3.7	7.0	29.6	6.2	0	4.1	0
Over 2.00	7	55.4	5.4	2.9	21.2	2.3	2.4	6.3	4.1
All Reporting General Health Districts	84	58.2	5.3	5.5	12.0	1.3	6.8	7.9	3.0

SOURCE: Ohio Department of Health (Reports of budgets submitted by local health departments).

* Board of Education and unofficial agency contributions.

** The following types of fees have been reported: food service operation, septic tank, meat, trailer parks, vital statistics, food permits, grocery store fees, food handler permits, frozen dessert, scavenger, sanitation, wells, installers, F.H.A. permits, motels, water supply, land-fill haulers, plumber's examination, soft drink handlers, journeymen plumbers registration, master plumber sewer layers, water sample testing, water trucks, service stations, vending machines, septic tank cleaners, county sub-divisions, well-child clinics, cabins, food stores, blood fees, school nursing services, food and beverage permits, camps, privy permits, health cards, ice cream and vegetable wagons, rabies tags, and swimming pools.

Sources of Income Described

Townships and villages are required by law to support the general health district through deductions made from the property taxes which are distributed to them by the county auditor. Many townships, however, spend more for cemeteries or for fire protection than for public health.

On or before the first Monday in April the board of health of a general health district must submit to the county auditor an itemized estimate of amounts needed for current expenses for the following calendar year. The auditor in turn submits this estimate to the county budget commission which is composed of the county prosecutor, treasurer, and auditor. The county budget commission may reduce, but not increase, any item or the aggregate. The county auditor then deducts the expected state subsidy for the district from the total estimate of expenses. The remaining aggregate of estimated expenses is then apportioned by the auditor among the townships and villages within the general health district on the basis of assessed valuations. Apportion-

ment is made according to contract terms where a city has united with a general health district. The county auditor withholds one-half of the amount charged against each township and village at the semi-annual settlement of taxes. Amounts withheld are placed in the health district fund, with the county treasurer as custodian.

The total amount withheld in 1959 from from property taxes of 1,005 townships was \$1,266,765.15. Deductions from property taxes of individual townships ranged from a low of \$14.56 in both Marlboro and Kingston townships in Delaware county to a high of \$27,674.64 in Washington township in Lucas county. The average withholding from property taxes was \$1,260.46. These withholdings averaged only 3.7 per cent of the total township expenses for the year, although they ranged from 0.3 per cent to 40.6 per cent of the total expenditures of individual townships. By comparison, cemetery expenses in 114 of a sample of 239 townships exceeded deductions from property taxes for health purposes; fire protection expenses in 141 townships exceeded

Table 14
Estimated Income from Fees in 1960

Fees	General Health Districts		City Health Districts		All Districts	
	Amount	Per Cent	Amount	Per Cent	Amount	Per Cent
¹ Food Service	\$ 213,535.00	23.4%	310,707.28	21.5%	\$ 524,242.28	22.2%
² Sanitation Services	496,317.81	54.3	55,488.00	3.8	551,805.81	23.4
³ Milk	78,941.57	8.6	307,652.30	21.3	386,593.87	16.4
⁴ Meat	49,672.66	5.4	318,954.48	22.1	368,627.14	15.6
Trailer Parks	18,020.00	2.0	5,143.00	.4	23,163.00	1.0
⁵ Retail Food	9,265.00	1.0	65,039.60	4.5	74,304.60	3.2
Birth and Death Certificates	23,353.21	2.6	238,925.13	16.5	262,278.34	11.1
⁶ Other	24,750.25	2.7	142,579.00	9.9	167,329.25	7.1
Total	\$ 913,855.50	100.0	\$1,444,488.79	100.0	\$2,358,344.29	100.0

SOURCE: Ohio Department of Health.

¹ Restaurants and vending machines.

² Plumbing, septic tanks, wells, sanitary land fills, etc.

³ Producers and plants.

⁴ Abattoirs, retail and wholesale establishments, etc.

⁵ Groceries, bakeries, food processing, frozen dessert, etc.

⁶ Food handler permits, barber and beauty shops, bottling plants, rooming houses, motels, camps, immunization fees, etc.

property tax deductions for the health district fund. General government expenses and highway expenditures accounted for the largest part of most township budgets.

Most general health districts collect some kind of fees, although there is no specific statutory authority to do so.

General health districts in 1960 expect to receive income from over 40 different kinds of fees, although most districts collect only two or three. Most common are fees for licensing milk and meat processing plants, plumbing and septic tank installations, and retail food and meat outlets. See Table 14, above.

Some general health districts collect reasonable fees to cover the cost of enforcing some of their regulations, although fee collection is not specifically authorized by law. Court decisions in some counties have prohibited or restricted the collection of such fees.

Small city health districts and boards of education often enter into contracts with some general health districts, which sell health services for a contracted amount of money.

Four general health districts have contractual arrangements with one or more cities. Cuyahoga general health district, for example, provides health services to 30 contracting cities. The law requires that these contracts must be approved by the district advisory council of the general health district and by the city council. By law the Ohio Department of Health, furthermore, is required to determine if the general health district providing the services is organized and equipped to provide adequate health services. Contractual arrangements are particularly suitable for villages which become cities and must withdraw from the general health district, since these city districts are too small to finance and to justify a separate health department.

Some boards of education pay general health units for the health services rendered to them by the local health department. The present statutes specify that boards of education may set up their own health program, but, in the absence of such a program, the local health district is required to perform health services for the schools. Boards of education are not required by law to pay for these services, al-

though in some instances they do in accordance with local tradition, the persuasiveness of the local health commissioner and the board of health, and the financial situation of the school district.

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

Grants of money to general health districts made by voluntary agencies, such as the Tuberculosis and Health Society, are usually not for specific services. Assignment of personnel occasionally takes the place of money; a public health nurse, for example, may work under the direction of the general health district but receives her salary from a voluntary agency. In many districts manifold services are supplied by these voluntary agencies. By directly providing nursing services, by establishing clinics, by their public health education functions, and by grants to health districts to meet an unforeseen emergency, private agencies have played an important role in local public health.

Each city and general health district, regardless of its size, kind of organization, health problems, financial need, and quality of services, is authorized by law to receive a state subsidy of up to \$2,000 annually.

The Ohio Department of Health, in accordance with the Hughes-Griswold Act of 1919, must make a subsidy payment every six months to each local health district which employs a health commissioner, public health nurse, and clerk, and which is certified by the state health department as having complied with state statutes and departmental regulations. No local health district has ever been denied its subsidy. The amount paid may not exceed \$2,000 annually or one-half of the salary of the health commissioner, nurse, and clerk. Appropriations to the Ohio Department of Health rarely permit distribution of the full subsidy to each district. The continual creation of new city health districts, which become eligible for the subsidy, furthermore, tends to dilute the funds available for distribution. Any city which contracts, cooperates, or combines with a general health district retains its eligibility for the subsidy. Appropriations in 1960 permitted each one of the 238 health districts in Ohio to receive up to \$1,900.

General and city health districts which employ a full-time health commissioner, public health nurse, sanitarian and clerk are eligible to receive federal grants-in-aid distributed by a formula determined by the Ohio Department of Health.

These "full-time" or "qualified" health districts receive federal funds in quarterly installments on a fiscal year basis from the Ohio Department of Health. The formula for distributing these funds is weighted to favor general health districts over city health districts. General health districts, including those which are cooperating, contracting, and combined with city health districts, received almost 70 per cent of the \$350,000 in federal funds distributed in the 1960 fiscal year. See Table 15, below.

Federal grant-in-aid distribution formula:

a. Population is determined from official department estimates.

b. The index of financial need is obtained by dividing the state average per capita tax duplicate by the per capita tax duplicate for each participating local health district. The population of the local health district is then multiplied by this index, giving an adjusted resource-population figure for each health unit.

c. The adjusted population figure is then weighted by a factor of 2 (multiplied by 2) in the case of all general health districts operating alone or in combination, and for all city health districts operating in combination with a general health district.

d. The adjusted weighted populations are then converted to percentages of the total, and the grant-in-aid funds available are distributed according to these percentages.

Total federal aid for public health given to Ohio in 1959 amounted to \$1,819,005. This aid was received under several federal aid programs:

Cancer	\$111,050
General Health	643,880
Heart	114,620
Maternal and Child Health (A)	391,878
Maternal and Child Health (B)	261,768
Water Pollution	110,706

This federal aid has been used to finance about 50 per cent of the salaries of personnel in the four *state* regional health offices; to pay for drugs and other supplies which are distributed free to local health districts; to finance special projects in cooperation with local health districts; and to aid general health services in local districts through the distribution formula.

Some general health districts receive income from a voted public health levy of up to .5 of a mill for a period of up to five years.

Since 1953 general health districts have been authorized by law to supplement their income with a voted public health levy of up to .5 of a mill for a period of up to five years. The board of health may certify to the county commissioners that the income from property taxes

Table 15
Distribution of Federal Grant-in-Aid Funds to Local Health Districts, Fiscal 1960

Type of District	Per Cent of Total Grant	Range of Per Cent	Total Amount	Range of Amount
Cities Alone	30.3613	0.1223 to 6.3189	\$106,200	\$ 400 to 22,100
General Health Districts Alone	10.6031	0.7179 to 1.6901	37,100	2,500 to 5,900
Cooperating, Contracting, and Combined Units	59.0356	0.0665 to 2.0929	206,700	1,400 to 24,100
Total	100.		\$350,000	

SOURCE: Ohio Department of Health.

levied within the 10 mill limitation is insufficient to meet the estimated expenses for the next calendar year, as approved by the county budget commission. The county commissioners, as a special taxing authority for the health district, are authorized by law to declare that the amount of tax moneys raised within the 10 mill constitutional limitation will be insufficient to support health units and that a voted levy in excess of such limitation is necessary to provide sufficient funds for the health district. A simple majority of the voters can approve the levy, when placed on the ballot at a general election, although a 60 per cent majority was required in the years 1953 through 1958.

Public health levies have met with varying success at the polls. In the period since 1954 the public health levy has been approved 51 times in 28 general health districts; 20 of these approvals were renewals of existing health levies, and six approvals followed previous failures. The public health levy has been defeated 39 times in 21 counties, although 26 of these defeats were concentrated in eight counties; only two of these defeats were for levy renewals. More public health levies were approved in 1959 than in any year since 1954. Eighty-three per cent of the public health levies were approved by the voters in 1959, while county tuberculosis and welfare levies

Table 16
Success and Failure of Voted Public Health Levy, by Characteristics
of General Health Districts, 1953-1959

Characteristic	Number of General Health Districts				
	Levy Passed	Levy Passed After Initial Defeat	Levy Renewal Defeated	Levy Defeated	Total No. of Levies Submitted
Type of District					
Full-Time Alone	3	1		3	7
Full-Time Cooperating	12	1	1	4	18
Full-Time Combined	13	2	1	3	19
Part-Time Alone		2		4	6
Part-Time Cooperating	1				1
Part-Time Contracting					0
Part-Time Combined					0
Population (thousands)					
10 - 25	6		1	3	10
25 - 35	4	4		2	10
35 - 50	11		1	5	17
50 - 75	6	1		3	10
75 - 100		1		1	2
Over 100	2				2
* Per Capita Assessed Valuation (1958)					
\$1,000 - \$1,500	1				1
1,500 - 2,000	4	1		7	12
2,000 - 2,500	12	1	1	3	17
2,500 - 3,000	7	2	1	3	13
3,000 - 3,500	4	2			6
Over 3,500	1			1	2
Totals	29	6	2	14	51

SOURCE: Ohio Department of Health.

* State per capita assessed valuation (1958): \$2,652.57.

had less success. The apparent success of the public health levy in 1959 may be explained in part by the change in the statute in 1959 to require a simple majority approval, rather than 60 per cent. Four of the 10 public health levies approved in 1959 would have been defeated if a 60 percent majority requirement had still been in effect.

Public health levies have been most frequently approved by voters where the general health districts have a full-time health commissioner, public health nurse, sanitarian, and clerk, and thereby qualify for federal aid; a

population between 35,000 and 50,000; and a per capita assessed valuation slightly below the state average. (See Table 16, above)

The 28 general health districts operating with a public health levy have estimated that the total 1960 income from the levy would be \$784,867.00, which is 13.6 per cent of the total anticipated income of all 88 general health districts. In these 28 general health districts the public health levy provided from 16.7 per cent to 76.3 per cent of their 1960 expected income.

III. Problems of Inadequate and Unstable Sources of Income

In General

Although it is easy to contend that general health districts in Ohio do not spend enough per capita for public health services, it is difficult to evaluate the financing and administration of public health services to test this contention. Comparatively, most general health districts have a per capita health expenditure which is simultaneously lower than the state average of all health districts, the per capita expenditure in many other states, and the per capita expenditure currently recommended by the American Public Health Association. Yet statistical information and comments made by state and local public health officials about general health districts in Ohio are of greater importance in defining financial problems than are such comparisons. Evidence indicates, as pointed out on pages 45 to 46, above, that general health districts with relatively low per capita health expenditures usually have less health personnel and perform fewer services than do the better financed districts.

The basic financial problem is how much income is available for a health district, rather than how much is spent, because the low per capita expenditures of many general health districts tend to be related directly to income.

Inadequate Resources in General Health Districts

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

Forty-eight of the 77 general health districts with a per capita appropriation below \$2.00 in 1960 had a per capita assessed valuation below the 1959 state average per capita assessed valuation. A \$2.00 per capita appropriation appears to be the absolute minimum to support adequate public health services. See pages 39 and 40, above. Only 29 of the 77 general health districts spending less than \$2.00 per capita in 1960 had an assessed valuation above the \$2,731.32 state average. In 1959 eighteen districts had a per capita assessed valuation between \$1,000 and \$2,000, and 36 districts were between \$2,000 and \$3,000 in per capita assessed valuations. See Table 17, page 55, below.

Township and village property taxes provide an unsatisfactory income for many general health districts.

Districts with relatively low assessed valuations tend to have inadequate income because property taxes are traditionally the major source of general health district income. Expenses for a public health program estimated annually by the board of health and the health commissioner must be approved by the county budget commission, which may reduce any item in the estimate. Thus the board of health has to compete for tax funds with the elected mayors and township trustees who, as members of the district advisory council, appoint health board members. Rightly or wrongly, the elected officials on the county budget commission in some instances may be influenced more

by the mayors and township trustees than by the board of health which has been appointed by these mayors and trustees.

General health district income received from township and village property taxes does not necessarily increase at the same rate as population growth and resulting increased needs for public health services. At the same time, population increases and new community problems tend to strengthen the demands of villages and townships to retain more of the property tax.

A number of general health districts with low property valuations cannot solve their financial problems by recourse to the voted public health levy. Other districts with above

average property valuations have failed to develop sufficient income to support a minimum public health program.

Some relatively poor general health districts have failed to reach a per capita appropriation of \$2.00 in spite of their efforts to develop additional sources of local revenue. Eighteen of these districts with a 1959 per capita assessed valuation below \$3,000 are already operating with a public health levy, yet they are still unable to support a per capita expenditure of \$2.00. See Table 17. Although fees have been an attractive source of income in some general health districts, eight of these units with a per capita assessed valuation below \$3,000 are now

Table 17
General Health Districts with Per Capita Appropriation
Below \$2.00 in 1960

Range of Per Capita Assessed Valuation (1959)	Number of Districts	Number Now Operating With Levy	Number With Above "Average" Fees*	Voted .5 Levy Would Support Over \$2.00 Per Cap. Approp.	Increase in Fees to "Average" Would Support Per Cap. Approp.	Levy Plus Fees Would Support Over \$2.00 Per Cap.	Levy, or Fees, or Combination Would NOT Support Over \$2.00 Per Cap. Approp.	Average Tax Rates In Mills (1959) in Districts Without Public Health Levy	With Levy
\$1,000-2,000	18	4	4	3	0	0	15	27.19	29.23
2,000-3,000	36	14	4	18	2	2	14	26.88	28.63
3,000-4,000	16	3	1	13	0	0	3	25.94	24.66
4,000-5,000	4	0	2	4	0	0	0	27.96	
Over 5,000	3	0	0	3	0	0	0	15.37	
TOTALS	77	21	11	41	2	2	32		

SOURCE: Ohio Department of Health, 1960 Financial Report of Local Health Departments; and Department of Taxation.

* "Average" refers to the average per capita income from fees in the eleven general health districts with a per capita appropriation above \$2.00 in 1960; this average is 26 cents.

Note: State average per capita assessed valuation in 1959—\$2,731.32; 29 of the above 77 general health districts had an above average per capita assessed valuation.

State average per capita appropriation for health in 1960—\$1.47; 15 of the above 77 general health districts had an above average per capita appropriation.

State average tax rate in mills in 1959—30.64 M.; 8 of the above 77 general health districts were in counties with an above average tax rate; 4 of these 8 districts do not have the public health levy.

collecting fees which exceed the average per capita income from fees obtained by the 11 general health districts that appropriated more than \$2.00 per capita in 1960.

Twenty-nine general health districts with a per capita assessed valuation below \$3,000 do not have the voted public health levy or above average fees. These units, furthermore, could not support a per capita appropriation of \$2.00 even if they had additional income from a .5 mill voted levy, or an average income from fees, or both.

Twenty-nine other general health districts with a 1960 per capita appropriation below \$2.00, however, had an above average 1959 per capita assessed valuation, as indicated in Table 17, page 55, above. Only eight of these 77 districts furthermore were located in counties with a tax rate above the 1959 state average of 30.64 mills. The three districts in counties with the highest per capita assessed valuations had the lowest average tax rates.

Twenty of the 23 health districts with a 1959 per capita assessed valuation above \$3,000 would be able to support a per capita appropriation above \$2.00, if their total income were to be increased by a voted public health levy. Forty-one of the general health districts, as shown in Table 17, would be able to increase their per capita appropriations to over \$2.00, if they adopted the voted public health levy; one-half of these districts have an above average assessed valuation.

WEAKNESS OF PUBLIC HEALTH LEVY AS SOURCE OF INCOME

Passage of voted public health levy does not always mean increased income for the public health program.

After the public health levy has been passed, the township trustees and village mayors in some instances attempt to relieve a serious financial crisis by persuading the county budget commission to reduce the amount of their property taxes deducted for the health district. As a result, total funds available to the health district are actually less than before the passage of the public health levy and health services may be drastically reduced. Since the voters have approved the levy because they want a better public health program, they are

inclined to reject any pleas for levy renewal when they discover that the additional voted taxes have been used to give townships and villages financial relief rather than to improve public health services.

The public health levy, as pointed out previously, on page 53, above, has been approved 51 times in 28 counties and has been defeated 39 times in 21 counties, although in 1959 10 out of 12 health levies were passed. Until 1959 these levies were required to have the approval of 60 per cent of the voters, rather than a simple majority. The levy can be submitted to the voters only with the cooperation of the county budget commission and the approval of the county commissioners. The campaign for passage of the levy usually takes much of the time, and money, of the health commissioner and other professional health personnel. The necessity of renewing the levy every five years is an additional burden for the staff. Defeat of a tax levy has occurred only in counties where the existing tax rate was below the state average; and in all except three of these counties the per capita assessed valuation also was below the state average.

WEAKNESS OF STATE SUBSIDY AS SOURCE OF INCOME

The present state subsidy fails to raise public health standards; equalize the financial burdens of health districts; help districts with serious financial, health, and population problems; stimulate local efforts to initiate and maintain better health services.

Some 40 years ago the \$2,000 annual authorized state subsidy to each health district went a long way toward paying one-half of the salaries of the health commissioner, public health nurse, and clerk in each district. In recent years the state subsidy has not paid even the retirement system contributions for employees in many health districts. Appropriations over the years to the state health department frequently have been insufficient to permit payment of the full \$2,000 subsidy. The appropriations are diluted by the continual creation of new city health districts; Ohio in 1960 had 150 city health districts, compared in 1919 to 92 units.

The small and equal state subsidy distributed to each district does not help districts meet their special financial problems caused

by low assessed valuation of property, large or rapidly expanding population, and annual sanitation and disease situations.

The state subsidy, furthermore, fails to stimulate citizens, boards of health, and local health officials into improving public health services, because the same amount is distributed to each district without regard to local effort. Districts are not required to match the state subsidy with local funds, to provide adequate health services, or to employ highly qualified personnel in sufficient numbers.

Absence of Board of Education Support of Health Services

Little or no financial support for school health services is given to general health districts by boards of education.

Boards of education are permitted to establish their own school health program. In the absence of such a program, however, the local health district is required by law to provide health services in the schools. Relatively few boards of education pay the health districts for these services, because the law does not require them to pay. If a school district decides to operate its own school health services, lack of adequate supervision of the program by a physician trained in public health tends to result in inefficient use of public health nurses employed by the board of education. On the other hand, if the school district relies upon the local health department to provide school health services without paying for these services, the school health program is usually limited by insufficient funds and health personnel within the health district.

Instability of Income in General Health Districts

The general health districts must rely on types of income that tend to be particularly unstable. Causes of unstable income are the power of the county budget commission to reduce the estimate prepared by the board of health; the possibility that a public health levy may not be passed or renewed; the possibility that contracts with cities and boards of educa-

tion may be altered or not renewed; and unpredictable changes in federal and state aid.

Not only do the general health districts have no taxing powers of their own, but continually they are subject to circumstances beyond their control. The board of health, appointed by and responsible to the district advisory council composed of township trustees and village mayors, cannot easily persuade the county budget commission to improve the district's income. The general health district's traditional source of income, support from the property taxes distributed to the townships and villages within the district, may be reduced by the county budget commission. If the district turns to the public health levy for a substantial portion of its income, it faces the danger that the entire levy will not be renewed. The failure to renew a levy can be a serious blow to a district which receives over one-half of its income from the levy, as illustrated in Hocking county in 1958, where a defeated levy resulted in a budget decrease of almost \$11,000, or 38 per cent. If the district has a contract to provide health services to a city in return for a stated amount of money, there is a possibility that the contract may not be renewed. City health districts occasionally withdraw from their contractual arrangements with general health districts because they desire to operate an independent health department. Similarly, a board of education might give up its contract with the board of health because it plans to employ public health nurses to operate its own school health program without the aid or supervision of the local health department. The federal aid which the district may receive also varies from year to year, the amount being influenced by changes in federal appropriations to the state, eligibility standards determined by the state health department, changes in the number of districts eligible for federal aid, and changes in district population and assessed valuation. As noted previously, districts do not receive the authorized \$2,000 annual state subsidy in full because of insufficient appropriations and an increasing number of districts eligible for state aid.

IV. Other Financial Problems of General Health Districts

The Problem of Fees in General Health Districts

Fees collected are not specifically authorized by statute, are not uniform in character or amount, and in some districts are used to replace taxes as the chief source of income.

Although districts usually assume the power to collect reasonable fees to cover the cost of regulating certain industries and occupations, court decisions in some counties have been conflicting in regard to collection of fees by general health districts.

Fees which are collected by general health districts lack uniformity in kind and amount. Only 53 general health districts, for example, expect to collect milk fees in 1960. In many of these districts milk fees will provide less than one per cent of the total income for 1960, although one district expects to receive as much as \$17,800, or almost one-fourth of its income, from milk fees in 1960. General health districts also collect more than 40 other types of fees.

A basic question which arises from the use of fees is whether inspections performed by health officials in order to protect the public health should be paid for by individuals and businesses or by the general public through taxes. In some health districts the fees of a few industries are supporting a substantial portion of the total public health program.

The imposition of fees by many health districts creates an additional problem by subjecting some businesses, particularly milk producers, to several fees. Fees have also been used in some health districts as an economic weapon to exclude competition and to assist businesses located within the community.

Financial Problems Arising From Budget-Making Procedures

Handicaps in the budget-making procedures in general health districts include: the requirement of early preparation of the budget; inability to transfer funds from one item in the budget to another; and lack of provision for an emergency fund within the budget.

The board of health of a general health district must by law submit an estimate of its expenses for the next calendar year to the county budget commission by the first Monday in April. At this date it is difficult for the board to anticipate its expenses for the next year because legislative action may result in increases in required contributions to retirement and insurance funds and in new and expensive mandatory health services. The board also is unable to accurately estimate in April its income beginning the following January from federal grants-in-aid, contracts with city health districts and boards of education, voluntary agency grants, the voted public health levy, and the state subsidy.

The early date for submitting the budget would not be serious, if the budget were flexible. The county budget commission, however, may not at any time increase any item in the budget, or the aggregate. Under the present statutes, funds may not be transferred from one item to another within the budget, even with the approval of the county auditor or the county budget commission. The general health district, furthermore, unlike city health districts which can make appeals to city council, cannot provide for unanticipated expenses since emergency funds within the budget are prohibited by law.

V. Alternative Solutions to the Financial Problems of General Health Districts

Although general health districts' financial problems cannot be met and solved solely by legislative action, such units need legislative help in developing their own resources. Some districts are unable to support minimum health services, although they are making or could make strenuous efforts to improve their local financial situation, as indicated on pages 54 to 56, above. The legislative issues involve questions of whether and to what extent general health districts should be helped to develop local sources of income, and whether and to what extent direct state financial aid or intervention should reduce the financial problems of these districts.

Some of the general health districts' financial problems can be eased through local efforts by the residents, boards of health, health commissioners, and other local government officials in these districts. The public health levy, for example, could be submitted to the voters in more counties. More districts could voluntarily combine under existing statutes in order to improve health services with little or no additional expense. Some districts also might make more use of fees as a source of income.

A number of legislative actions can be taken to help general health districts to help themselves financially: the voted public health levy might be made a more reliable source of income; the collection of fees might be specifically authorized; boards of education might be required to pay for school health services rendered by health districts; appropriations from the county general fund to the health district might be authorized; a specific millage rate might be guaranteed for general health districts; and some of the obstacles in the budget-making procedures might be eliminated.

If it is decided that some direct state action is also needed and desirable to supplement local financial efforts to solve financial problems, there are at least three possible alternatives that could be adopted separately or together: the state subsidy program might be expanded and the distribution formula revised; health districts might be required to combine in an at-

tempt to effect economies of operation; and the internal structure of general health districts might be reorganized to provide county, rather than township and village, financing.

These alternatives are discussed below. The adoption of one proposal would not exclude consideration of others; a combination of several approaches to financial problems might be the most effective and practical solution.

Action to Develop Local Sources of Income

General health districts could be encouraged to make more extensive use of the voted public health levy. The statute authorizing the voted levy might be revised to permit the voters to approve a levy effective for an indefinite length of time or for 10 to 15 years, in place of the present necessity of renewing the levy every five years. The county budget commission could also be restricted by statute in its reduction of the total amount or per cent of property taxes withheld from townships and villages after the levy has been approved.

The public health levy since 1953 has been submitted to the voters 90 times in 41 general health districts, although it has been approved in only 28 counties. The importance of obtaining passage and renewal of the levy to secure income is apparent: four of the six general health districts with a per capita health appropriation in 1960 above \$2.00 have approved the levy, while only 24 of the 82 districts below \$2.00 have approved the levy. The total estimated additional revenue, based on 1959 assessed valuations in general health districts, would be \$3,389,489, if all general health districts had a .5 mill public health levy. This is close to one million dollars more than was needed in 1960 to support per capita appropriations above \$2.00 in the 82 districts as a group; in 41 of these 82 districts a .5 mill levy would have been sufficient to support a per capita 1960 appropriation of \$2.00 or more.

The health officials in general health districts might be more inclined to work for the passage of the voted public health levy, if the income

from the levy could be relied upon indefinitely, or for a period of more than five years since rejection of a levy renewal after a five-year period can be a damaging blow to established health services. Planning of public health programs is difficult in general health districts which now receive from 16 to 76 per cent of their income from a levy which must be renewed at frequent intervals. The authority of school districts to vote levies for an indefinite period raises the question whether education is more deserving of fiscal stability than other local services.

The voted public health levy might be adopted by more general health units if both the voters and the health officials in the district could be assured that the levy would result in better health services, rather than a reduction of the amount of township and village support. The voters, however, are not likely to approve or renew a levy which serves only to provide financial relief for townships and villages through decreased property tax deductions. The wisdom of seeking to settle township and village financial problems by appeals to the voters for tax increases for better public health services is questioned where revenue may never be forthcoming because of reduction in property tax deductions.

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. These units might be granted specific authority to collect reasonable and uniform kinds and amounts of fees from certain industries and occupations.

ARGUMENTS FOR PROPOSAL

Relatively few districts now use fees as a substantial source of income. Twenty-seven of the 69 general health districts with a 1960 per capita appropriation below the state average, for example, have no income from milk fees, while only eight of the 19 districts above the state average are without such fees. See Appendix C.

Fees can provide general health districts with substantial income, especially if expressly authorized by statutes. If all general health districts received as much in plumbing fees as does Clermont county (\$43,200), the total in-

come from this source would be close to four million dollars, as opposed to the approximately \$350,000 total in plumbing fees actually anticipated in 1960 by general health districts. Clermont general health district is, however, an extraordinary case, since plumbing fees provide over 63 per cent of the support for the public health program. Columbiana county, where the public health levy has been rejected four times, has turned to fees other than milk and plumbing for 28 per cent of its income. If all 88 general health districts on the average collected a similar amount, this would produce \$1,091,200 as opposed to approximately one-half million dollars anticipated in 1960. The 77 general health districts which appropriated less than \$2.00 per capita in 1960 would, as a group, have had an additional income of \$323,842 if they had had a per capita income from fees equal to the average per capita income from fees collected by the 11 general health districts with an above \$2.00 per capita appropriation. Such an increase in fees, however, would have supported a \$2.00 per capita appropriation in 1960 in only two of these 77 districts.

It has been argued by local health commissioners that general health districts should be assured this source of income, because city health districts are now able to legally collect fees through ordinance of city council.

The proponents of the fee system have pointed out that businesses, such as dairy producers, whose products are more readily acceptable in interstate and intrastate commerce as a result of inspections by public health officials, might justifiably be expected to bear the cost of these inspections. Many business and industrial activities, furthermore, create special health problems, and therefore require regulation to protect both the general public and the participants in the activity. The cost of this special regulation and inspection is a consequence of that industry just as much as the cost of the labor and materials that go into its product. If this cost of regulation is borne by the health district, the public is subsidizing part of the cost of the product. This subsidy is known as a "subsidy in kind," and a case can be made for covering these costs by an inspection fee or permit imposed on operators and owners of a private activity. The special fee or

license eliminates, or partially eliminates, the subsidy by becoming a cost to private parties involved in the activity.

The difference between the cost of health inspections in Ohio and the amount of fees collected is unknown but apparently substantial. Not only could existing fees be raised, but they could also be extended to other activities which currently require inspection but upon which no fees are now imposed.

ARGUMENTS AGAINST PROPOSAL

Some local health commissioners believe that taxes, rather than fees, should be used to support public health services. It has also been asserted that inspection fees may be used by one community as an economic weapon to protect its own businesses from outside competition, especially if the amounts and kinds of fees are determined locally. Some dairy producers, furthermore, oppose the fee system, at least in its present form, because they are frequently subject to inspections, varying standards, and fees imposed by several health districts.

County, city, and exempted village boards of education might be required by statute either to contract with and reimburse health districts for school health services, or to provide their own services, subject to supervision by the local health department.

ARGUMENTS FOR PROPOSAL

Boards of education would pay for the health services rendered to them by local health districts. Boards of education could afford to pay health districts for services, it is argued, because state school foundation money may now be used to employ public health nurses, although money is not granted specifically for this purpose to school districts. At present, some local health districts are unable or unwilling to undertake in the schools a comprehensive program of screening and preventive medicine because they receive no financial assistance from boards of education.

Under this proposal, school health services would be effectively supervised. Inefficient use of professionally trained public health nurses employed by boards of education with the nominal supervision of a contract physician tends to arise under the present independently school-operated health services.

ARGUMENTS AGAINST PROPOSAL

Payment by a board of education for health services, it is claimed, might prevent it from fulfilling its responsibilities for an adequate educational program. Boards of education, furthermore, might provide inadequate school health programs of their own, if the only alternative were to enter into costly contracts with local health districts.

The county commissioners might either be required, or be permitted voluntarily, to make appropriations from the county general fund to the health district fund. County 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. (See pages 30 to 31, above.)

ARGUMENTS FOR PROPOSAL

It is urged that financial support of health services no longer be determined exclusively by direct competition with townships, villages, and school districts. Boards of health under this plan would be less dependent upon the county budget commission and the district advisory council.

Many county commissioners, furthermore, now have an interest in and awareness of county-wide public health problems. Precedent has already been set to secure health funds from this source, since tuberculosis care is already lodged with the county commissioners; some county commissioners are now assisting general health districts by employing tuberculosis control nurses and nuisance inspectors who are placed under the supervision of the health district; and county commissioners by law constitute a special taxing authority for the public health levy.

ARGUMENTS AGAINST PROPOSAL

Local government units presently benefiting from the county general fund would probably have strong objections to using any part of this fund for public health. Residents in city health districts also might object to using county funds to aid general health districts providing services outside the cities, unless city health districts would also receive a proportionate share of the county general fund.

Some public health officials fear that under this proposal the county commissioners might tend to combine the public health program with the medical aspects of the welfare program, thus neglecting public health programs.

The proposal has been made that a specific millage rate within the present constitutional limit of 10 mills be assigned by statute to general health districts which could be designated as taxing districts similar to school districts. As an alternative to this proposal, a constitutional amendment might be proposed to authorize health districts to receive funds from a permanent mandatory levy above the present 10 mill constitutional limitation. The advantages of this type of income, however, might be outweighed by the interference with traditional sources of income for other local government units.

ARGUMENTS FOR PROPOSAL

A stable and predictable income would permit better planning, and some general health districts might receive an increase in their income. Boards of health would cease to be at the mercy of the county budget commission and the district advisory council, because health services support would no longer be fixed exclusively by direct competition for funds with other units of local government.

ARGUMENTS AGAINST PROPOSAL

Any attempt to guarantee by statute a specific millage to the general health districts would probably meet with strenuous opposition from the other local governments that presently share the income produced under the 10 mill limitation. All tax rates now used in every county fall within the constitutional 10 mill limitation. The lowest average tax rate in 1959 was Gallia county with 14.02 mills and the highest was Geauga county with 41.15 mills; the state-wide average tax rate was 30.64 mills; 62 counties had an average tax rate in 1959 of 25.00 mills or more. A guarantee of a millage rate for general health districts would deprive other units of some of their income, which might force them to seek additional voted levies. County tax rates inside the 10 mill limitation in 1959 ranged from 1.50 mills to 5.00 mills, while school tax rates inside the 10 mill limitation in local school districts ranged from 1.50 mills to 7.10 mills.

No doubt a general increase in the 10 mill constitutional limitation would meet very strong opposition, since it might lead to increased costs from all departments. Boards of health, it is also feared, might become financially irresponsible if they had an independent source of income.

Revision of budget-making procedures of general health units would permit a later date for budget preparation, fund transfer from one item of the budget to another, and an emergency fund for unanticipated expenses. Placing general health districts under the provisions of the Uniform Tax Levy Law would reduce some budget-making problems.

Boards of health could be permitted to submit their estimate of receipts and expenditures for the following year to the county auditor, who in turn submits it to the county budget commission, at some date later than the first Monday in April, as now required by law. The Uniform Tax Levy Law, enacted in 1927, is not applicable to health districts, but could be amended to include health districts. Section 5705.28 of the Revised Code provides that each "district authority entitled to participate in any appropriation or revenue of a subdivision shall file with the taxing authority . . . before the first day in June in each year, an estimate of contemplated revenue and expenditures for the ensuing fiscal year, in such form as is prescribed . . . by the bureau of supervision and inspection of public offices." The taxing authority must prepare a tax budget on forms prescribed by the Bureau of Supervision and Inspection of Public Offices; the budget must be submitted by July 20 to the county auditor. Submission of the health district budget estimate in June, for example, would assure better financial planning than in early April; yet the townships and villages in the district would still have sufficient time to prepare their own budget estimates, with regard to their contributions to the general health district.

Budget-making procedures also could be revised to enable general health districts to meet unanticipated public health problems and expenses. The boards of health of these districts might be permitted by law to transfer funds from one item of the budget to another, subject to the approval of the county budget com-

mission. If, for example, a qualified person could not be found to fill a vacancy on the nursing staff, the money which had been budgeted for this salary could then be used to employ an additional sanitarian, provided such an employee were needed. Permission to include a relatively small emergency fund within the budget to provide for unanticipated expenses would give boards of health still more flexibility in financial affairs. It has been argued, however, that emergency funds tend to be used to meet situations which are not really critical. To a limited extent, the law now makes provision for emergencies. To meet an epidemic or threatened epidemic when the health district fund, in the judgment of the board of health, is insufficient to defray the expenses of preventing the spread of disease, the board may estimate the required amount and apportion it among the townships and villages on the basis of assessed valuation. After the certification of estimate and apportionment by the board of health to the county auditor, he in turn draws an order on each township and village for the amount due. This procedure of meeting emergencies has not been used for many years because it may be used only in the rare circumstance of an entire community being subjected to a devastating epidemic.

Action to Provide Direct State Assistance

Revision of the present state subsidy to health districts could provide substantially larger amounts; help equalize public health standards and financial burdens throughout the state; stimulate local efforts to improve the financing and administration of public health services; and encourage districts to combine.

State aid to health districts could be distributed by a formula based on the population size; financial need; and special public health problems and necessary services resulting from district characteristics, such as population age distribution, an unusually high incidence rate of certain diseases, a special sanitation situation, or unique industrial health hazards. This distribution formula would tend to raise public health services throughout the state to uniform standards and might tend to equalize the financial burden of supporting these services.

A state subsidy distribution formula could

also require a certain minimum local effort in financing and in providing public health services. State aid could be distributed on a matching basis representing a certain percentage of local appropriations, perhaps 25 per cent; in 1960 the state subsidy represented only 5.1 per cent of the total income of all general health districts. Another approach would be to require each district to make a certain minimum or local total or per capita appropriation in order to qualify for state aid. The state director of health believes that a desirable state subsidy would initially amount to three million dollars. This amount would provide state aid equal to approximately 25 per cent of the 12 million dollars currently spent by all city and general health districts. If these districts, through local efforts, were to raise their per capita appropriation to \$2.50, they would, at the local level, be appropriating 19 to 20 million dollars and the state would, at the maximum, be spending five to six million. Other types of state aid formulas might be more or, possibly, less expensive. The total state subsidy in 1960 was \$430,516.56 or 2.9 per cent of the total income of all 238 health districts.

The state subsidy also could be distributed as an incentive for small health districts to combine. City and general health districts below 25,000, for example, might be denied the state subsidy; or as an alternative, all districts which met certain minimum standards might receive a subsidy, but only districts over a certain population size would receive additional amounts. Distribution of state aid to encourage consolidation of health districts was described in Part One, page 31, above.

ARGUMENTS FOR STATE SUBSIDY

The state subsidy formulas described above, it is claimed, might equalize the burden of financing local health services. At present the ability to finance health services varies considerably from one district to another. A state subsidy distributed by a formula requiring matching of local appropriations also might encourage the voters to approve public health levies and might stimulate the county budget commission to approve larger local health appropriations. Uniformly higher standards of public health services might result, especially if the subsidy were distributed only to districts meet-

ing certain standards determined by the state health department.

Health districts would be encouraged to combine, if the state subsidy were made available only to districts above a certain minimum population. Giving publicity to the fact that combined units would have an opportunity to receive these state funds also might tend to greatly reduce wealthier health districts' fears that combination with poorer districts would result in higher taxes in order to maintain the present health service level. The state also would be justified in denying state subsidies to health districts with uneconomical operations resulting from their small size.

Statutes in 39 states authorize allocation of state funds to local health districts. Seventeen of these states have provisions for distribution of state aid by a formula; 12 by a percentage of the total cost of local health services; seven by a percentage of local salaries. In 1958 the state government in Ohio spent less per capita for public health than did state governments in 18 other states. See Appendix D for a description of state subsidies in other states.

ARGUMENTS AGAINST STATE SUBSIDY

The state, it is argued, cannot afford larger appropriations for public health only to replace local public health financing with no corresponding improvement of health services. The taxpayers of the state collectively, moreover, would receive no tax relief by a shift of financial responsibility for health services from local to state government.

Some opponents of a revised state subsidy believe that an increased state aid program might result in an undesirable centralization of control of public health. Local citizen interest in the public health program also might decrease, because local financial responsibility for raising revenue would decrease.

Administration of a state subsidy distribution program might be difficult as well as expensive. Health district needs vary so widely that a formula cannot be devised for the allocation of state funds which would be commensurate with individual district needs. Income can more easily be proportioned to requirements if it is raised by local health districts which are in need. If state aid were to be given

only to those districts meeting certain standards in the operation of their local public health program, the cost of this evaluation to the Ohio Department of Health might amount to \$100,000 to \$200,000 annually, according to estimates of department officials. But a comprehensive evaluation program can be an effective means of improving public health services, even if not included as part of a state aid plan.

Small health districts could be required to combine to effect operating economies and to make more effective use of federal and state aid.

The methods and advantages of combining health districts into larger units have been discussed in detail in Part One, above.

The county, rather than townships and villages, could be designated by law as the responsible taxing authority for health districts.

County financing of health districts would be appropriate if Ohio's health districts were reorganized into 88 county units, as described in Part One, pages 30 to 31, above. The county commissioners, in place of the district advisory council composed of village mayors and township trustees, could be given the authority to appoint the county board of health, because townships and villages would no longer contribute their funds to the health district. See Part Three, page 70, below.

Under this proposal the board of health would submit its annual estimate of expenditures to the county commissioners, pursuant to the Uniform Tax Levy Law. The county commissioners, in turn, would include health district expenditures as an item in the county budget which they submit to the county budget commission. The board of health expenditures would be met by allocations from the county general fund. For this purpose, the county budget commission might approve an increase in the county tax levy and a decrease in township and village levies, because the townships and villages would no longer be responsible for health district support. The county commissioners also could place a public health levy on the ballot whenever the county levy within the 10 mill limitation, together with other sources of health district income, would fail to meet board of health expenditures.

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

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

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

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 administration 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 respon-

sibilities 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.

Appendixes

Appendix A



HEALTH DISTRICTS IN OHIO RECOMMENDED BY THE "EMERSON REPORT", AMERICAN PUBLIC HEALTH ASSOCIATION, 1945.

Appendix B

HEALTH DISTRICTS IN OHIO RECOMMENDED BY UNITED STATES PUBLIC HEALTH SERVICE, 1950.



Existing Health Department Headquarters



Proposed Health Department Headquarters



Health Unit Boundary



Base, Regional, or District Hospital Center



Rural or Community Hospital Facilities

--- Lines of Hospital Integration

Appendix C Finances, Organization, and Services of General Health Districts

District (ranked by 1960 Per Cap. Expenditure)	Type	1960 Per Capita Appropriation	Public Health Levy		Percentage Distribution of Sources of Income, 1960*						Total Income (in thousands)		Sanitation Inspections Per 1000 Pop.		Nursing Visits Per 1000 Pop.		Population		
			Year Paused	Year Failed	Townships, municipalities	State subsidy	Federal Aid	Voted Health Levy	Milk Fees	Plumbing Fees	Other Fees	Other Agencies	1958	1959	1958	1959	1958	1959	
Knox	PT	\$.44		'55, '56 1954,	70.9%	17.3%	0	0	0	0	0	0	11.8%	0	\$10.9	28.7	9.8	25.2	25.2
Noble	PT	.51			61.8	29.7	0	0	0	0	0	0	8.2	0	5.1	No Report	No Report	10.9	10.9
Scioto	PT	.55			89.2	6.2	0	0	.1	.5	.7	0	.7	0	30.6	13.1	10.8	28.4	56.8
Perry	FTCO	.58			63.3	9.7	20.5	0	.1	0	.2	0	.2	0	19.5	20.8	44.3	26.8	26.8
Holmes	PT	.69		1954	76.6	14.1	0	0	4.3	0	0	0	5.0	0	15.5	26.3	11.5	19.6	19.6
Ross	FTCO	.69		1955,	70.2	6.3	13.5	0	.1	0	0	0	9.4	0	28.1	26.7	40.9	17.6	35.2
Lawrence	FTCO	.71		'56, '57 1953,	48.7	4.3	34.9	0	.1	0	0	0	11.5	0	39.9	17.5	40.7	13.6	14.8
Highland	PTCB	.72		'55, '57, '58	70.0	13.4	11.2	0	0	0	0	0	5.8	0	25.0	59.3	8.0	15.5	30.9
Belmont	FTCO	.73			74.8	3.3	8.4	0	6.3	0	0	0	6.6	0	48.7	31.5	10.9	30.3	30.3
Pickaway	PT	.73			82.2	11.2	0	0	0	0	0	0	6.6	0	16.9	22.4	4.5	34.0	34.0
Van Wert	FTCO	.73			79.5	16.2	0	0	0	0	0	0	4.3	0	11.7	2.3	35.2	31.1	31.1
Mercer	FTCB	.74			69.5	14.1	7.1	0	0	0	0	0	9.3	0	26.8	14.6	2.9	33.9	33.9
Adams	FTCO	.75			66.7	10.2	15.6	0	2.0	0	0	0	5.5	0	18.5	54.0	13.3	10.5	21.0
Columbiana	FT	.75		1953,	56.4	4.3	11.3	0	0	0	0	0	28.0	0	44.3	45.8	24.2	52.7	26.3
Guernsey	FTCB	.75		'57, '58, '59 1955,	45.2	11.6	10.8	0	7.3	0	0	0	13.3	0	32.8	45.4	17.1	19.5	39.0
Brown	FTCO	.78		'56, '59	66.2	9.0	11.9	0	4.8	0	0	0	8.1	0	20.9	63.6	104.3	11.9	23.7
Jefferson	FT	.78			75.6	4.3	6.4	0	.1	0	0	0	13.6	0	44.1	23.6	3.7	17.7	26.5
Carroll	PT	.79			75.8	12.3	0	0	0	0	0	0	8.6	3.3	15.5	21.3	27.6	19.5	19.5
Fairfield	FTCO	.79			75.1	7.1	7.1	0	.1	0	0	0	10.7	0	26.6	21.6	59.3	21.7	32.5
Athens	FTCB	.80			67.1	11.7	9.1	0	.9	0	0	0	11.2	0	42.0	44.2	65.8	16.0	23.9
Hardin	PT	.81			72.1	10.9	0	0	7.5	0	0	0	9.6	0	17.4	45.5	13.2	30.8	30.8
Cuyahoga	FTCT	.82			67.7	7.6	4.0	0	.1	0	0	0	4.9	15.7	44.5	21.0	28.0	15.7	35.8
Trumbull	FT	.83			64.6	2.1	5.0	0	0	0	9.6	0	18.7	0	89.6	29.0	3.3	34.7	20.8
Clermont	FT	.85			60.9	2.3	6.4	0	1.7	63.1	0	0	25.1	0	67.6	38.1	6.1	37.8	18.9
Monroe	PT	.85			77.5	15.0	0	0	0	0	0	0	7.5	0	12.7	28.5	16.4	14.9	14.9
Franklin	PTCT	.87			84.0	5.5	0	0	0	0	0	0	10.5	0	53.8	14.8	68.1	11.5	28.8
Sandusky	FTCB	.89		1953, '59	27.8	7.0	6.2	50.3	0	0	0	0	8.7	0	29.5	32.7	42.9	15.4	15.4
Champaign	FTCB	.90			64.4	12.9	6.4	0	2.5	6.8	0	0	7.1	0	40.0	22.6	46.2	15.1	22.6
Licking	PT	.90			90.3	4.7	0	0	0	0	0	0	5.0	0	45.7	27.1	70.9	14.4	22.1
Darke	FTCO	.91		1953	60.4	4.2	31.1	0	.1	0	0	0	4.2	0	135.8	33.3	25.7	17.8	20.3
Stark	FT	.92			71.6	1.4	4.4	0	0	8.1	0	0	14.5	0	130.5	47.2	78.9	40.1	32.0
Allen	FTCB	.94			58.1	3.3	4.7	0	17.3	3.5	0	0	13.1	0	23.9	No Report	No Report	11.5	22.9
Meigs	FTCO	.94			77.9	7.9	10.0	0	.1	0	0	0	4.2	0	34.7	46.9	0.1	36.9	36.9
Ottawa	FTCB	.95			79.9	10.6	0	0	.1	0	0	0	9.4	0	34.7	46.9	0.1	36.9	36.9

Appendix C

Finances, Organization, and Services of General Health Districts

District (ranked by 1960 Expenditure)	Type	1960 Per Capita Appropriations	Public Health Levy				Percentage Distribution of Sources of Income, 1960*						Total Income (in thousands) 1960	Sanitation Inspections Per 1000 Pop. 1958	Nursing Visits Per 1000 Pop. 1958	Population Per 1000 1959 (thousands)						
			Year Passed	Year Failed	Mills	Townships, Municipalities	State	Federal Aid	Voted Health Levy	Milk Fees	Plumbing Fees	Other Fees					Other Agencies					
Williams	PT	.99				86.3	9.4	0	0	0	0	0	0	0	5.3	0	22.7	16.6	83.4	31.3	31.3	
Paulding	PT	1.00		1953, '54, '55, '56		81.3	10.5	0	0	0	0	0	0	0	7.8	0	17.5	8.8	46.4	17.6	17.6	
Pike	FTCO	1.00	1953, '58		.5	18.8	7.0	0	0	0	0	0	0	0	3.8	0	27.2	14.5	36.6	9.3	27.9	
Warren	FTCB	1.01				48.2	4.6	0	0	0	0	0	0	0	4.3	0	61.3	28.2	43.8	20.7	31.0	
Mahoning	FT	1.04				77.1	2.2	4.5	0	0	0	0	0	0	4.8	0	87.6	5.2	3.1	16.3	16.3	
Madison	FTCB	1.03				64.8	10.0	20.7	0	0	0	0	0	0	4.4	0	38.2	17.4	112.9	7.5	29.9	
Henry	FTCB	1.05				80.1	14.1	0	0	0	0	0	0	0	5.8	0	24.4	41.7	9.0	23.3	23.3	
Putnam	FTCO	1.06				78.9	6.0	5.4	0	0	0	0	0	0	5.2	0	31.5	15.0	46.3	28.4	28.4	
Montgomery	FTCB	1.07				59.8	3.0	10.1	0	0	0	0	0	0	7.4	4.2	234.0	15.6	28.9	17.6	27.7	
Wood	FTCT	1.08				72.1	4.0	18.6	0	0	0	0	0	0	5.2	0	94.7	23.5	60.6	12.0	18.0	
Preble	FTCO	1.09				69.7	4.7	11.7	0	0	0	0	0	0	5.6	3.0	40.8	21.3	58.3	16.7	11.1	
Portage	PT	1.10	1955, '59	1954	.4	16.2	2.7	7.3	0	0	0	0	0	0	14.5	0	69.0	49.1	67.2	11.8	29.4	
Clinton	FTCB	1.12		1953		57.4	10.0	5.1	0	0	0	0	0	0	4.3	0	37.2	28.1	37.3	10.6	15.9	
Miami	FTCO	1.14				74.6	4.0	5.3	0	0	0	0	0	0	5.8	0	45.1	45.2	129.6	14.2	23.7	
Vinton	FTCO	1.15	1954, '59		.5	75.5	13.6	7.0	0	0	0	0	0	0	3.8	0	14.0	31.7	99.4	11.3	No Report	
Lucas	FTCB	1.16				78.7	9.0	3.6	0	0	0	0	0	0	16.2	3.9	151.9	25.3	73.9	11.5	23.0	
Fulton	PT	1.18	1954	1953	.2	43.0	5.0	0	0	0	0	0	0	0	2.0	0	35.0	No Report	7.5	29.8	29.8	
Harrison	FTCO	1.18	1955		.3	13.2	7.9	4.0	0	0	0	0	0	0	9.2	0	24.0	16.9	12.0	9.8	19.5	
Geauga	FT	1.22	1956		.25	26.0	3.8	5.4	0	0	0	0	0	0	27.5	3.6	50.2	57.3	42.0	13.2	13.2	
Ashtabula	FTCO	1.24				82.8	2.0	3.3	0	0	0	0	0	0	9.3	0	73.7	16.4	60.1	10.5	17.4	
Clark	FT	1.24	1957		.3	31.2	3.4	4.7	0	0	0	0	0	0	6.8	0	56.2	80.0	44.1	10.9	21.9	
Greene	FTCB	1.31	1954, '58	1953	.3	30.1	5.0	7.0	0	0	0	0	0	0	14.5	0	114.4	35.0	55.6	20.6	20.6	
Coshocton	PT	1.32				72.1	7.8	0	0	0	0	0	0	0	6.3	0	24.4	13.8	14.5	18.5	18.5	
Morgan	FTCO	1.34				80.4	12.4	3.6	0	0	0	0	0	0	3.2	0	15.3	15.3	13.2	10.9	10.9	
Crawford	FTCO	\$1.35				75.6	6.4	3.1	0	0	0	0	0	0	9.2	0	29.5	69.9	27.6	10.7	No Report	
Jackson	FTCB	1.36	1953, '58		.5	11.7	12.0	6.1	0	0	0	0	0	0	11.1	0	47.5	41.6	42.3	16.5	16.5	
Gallia	PT	1.37				90.8	7.1	0	0	0	0	0	0	0	2.0	0	26.8	21.4	45.9	9.8	19.6	
STATE AVERAGE, 1959		1.38																				
Huron	FTCB	1.39	1959		.3	43.7	6.4	4.5	0	0	0	0	0	0	7.6	.9	59.2	25.6	131.9	11.4	22.8	
Logan	FTCB	1.39				70.0	7.0	4.0	0	0	0	0	0	0	7.9	9.2	50.4	34.8	168.0	11.7	17.5	
Wayne	PTCO	1.41	1956, '58		.1	74.4	5.0	0	0	0	0	0	0	0	3.9	0	78.8	16.9	24.4	14.4	24.1	
Hancock	PT	1.42	1959			87.0	7.0	0	0	0	0	0	0	0	5.8	0	26.4	27.4	9.6	10.6	21.3	
Richland	FTCO	1.42	1955		.5	25.8	2.7	3.6	0	0	0	0	0	0	10.8	0	70.1	55.5	80.9	9.3	18.6	
Wyandot	PT	1.42	1959	1958	.2	33.7	6.1	0	0	0	0	0	0	0	6.3	0	31.0	32.4	22.9	11.0	21.9	
Tuscarawas	FTCB	1.44	1953		.3	34.9	6.1	4.8	0	0	0	0	0	0	4.1	0	34.9	21.7	55.8	7.8	15.9	
Morrow	FTCO	1.46	1953, '58		.4	29.0	6.2	1.9	0	0	0	0	0	0	3.0	0	30.6	23.0	63.0	10.1	20.1	

Appendix D

State Subsidy Distribution In Other States

Statutes in 39 states authorize allocation of state funds to local health districts. Seventeen of these states have provisions for distribution of state aid by a formula; 12 by a percentage of the total cost of local health services and seven by a percentage of local salaries. The methods of distribution in some of the states are as follows:

ALABAMA—State aid 55% of budget to poorest counties down to 25% state aid to richest counties; computed on assessed valuation.

ARIZONA—Population and financial need.

ARKANSAS—Minimum local participation of \$1,000 is required with local funds to total at least 50% but under no circumstances may local share be less than 33%.

CALIFORNIA—California health and safety code:

1. Health districts serving one or more counties receive a basic allotment of \$16,000 per county or 60 cents per capita per county, whichever is the lesser.

2. If a county is divided into two or more local health districts the basic allotment is divided in proportion to the population served.

3. No funds are given to any city of less than 50,000 population for the maintenance of an independent health department.

4. The balance of the state health appropriation is allotted on a per capita basis to each local health district in proportion that the population of the local district bears to the total population of all qualified local health districts in the state.

5. No funds are allotted to any local health district which has failed to appropriate from local funds an amount equal to at least twice the per capita allotment specified in the preceding paragraph (4).

6. No funds are allotted to any local health district whose professional and technical personnel and whose organization and program do not meet the state department of public health standards.

7. Local health districts' standards are promulgated by the state department of public health after consultation with and approval by the California conference of local health officers.

8. Provisional approval may be given by the state department of public health to a county health department which meets minimum standards but which does not serve all cities of less than 50,000 population.

FLORIDA—Per capita grant varied by population size with required per capita local contribution and system of bonus for excess local contribution and penalties for deficiencies in local contributions.

GEORGIA—Percentage of state participation varies with population, with most populous areas receiving the smaller percentage.

ILLINOIS—\$1.00 subsidy for \$3.00 local money or 30¢ per capita, whichever is the lesser. Special need subsidy added in poorer counties to equalize available resources to approximate \$1.20 per capita state wide.

IOWA—State pays \$1,200 toward salary of one nurse or \$1,800 toward salary of two nurses. Pays \$1,350 toward salary of sanitarian.

KENTUCKY—State board of health allots to each county or district health department such amount as just and equitable share of all funds available; therefore, no allotment to be less than \$2,500.

LOUISIANA—Total amount available for allocation to local districts is divided by population—this per capita amount is used as general basis and then modified by financial need of area.

MAINE—One-third of salary, but not over \$800 for approved full-time local health officer. Percentage of salary of nurse paid directly to nurse.

MICHIGAN—Fixed amount allocated to each county.

MINNESOTA—No standard formula, funds allocated on basis of needs in specific programs.

MONTANA—\$1,000 plus 50¢ per capita in counties with population of 8,000 or less. \$5,000 plus 10¢ per capita in counties with population of more than 8,000. Total state participation not to exceed 35% of total budget.

NEBRASKA—Based on need, population, and ability to pay.

NEW HAMPSHIRE—Only as part of cost of specific joint programs.

NEW JERSEY—Priority of need and availability of funds.

NEW MEXICO—Allocation based on need.

NEW YORK—Fifty per cent of amount of money expended by a county not organized as a county or part-county health district; 50% of amount of money expended by health department of a city of over 50,000 population; 75% of the first \$100,000 expended and 50% of all money expended in excess of \$100,000 by a county or part-county health department.

NORTH CAROLINA—Based on population, financial, and specific program needs.

OKLAHOMA—Fifty cents per capita, based on population, provided that not more than \$10,000 shall be allocated to any one county. Each county must provide funds equal to net proceeds of county tax levy of .3 mill in $\frac{1}{4}$ of counties having lowest per capita assessed valuation, .6 mill in $\frac{1}{4}$ of counties having highest per capita assessed valuation, and .5 mill in all other counties.

PENNSYLVANIA—Initial grant equal to 50¢, but no initial grant shall exceed $6\frac{1}{4}$ cents times population. Limited to annual grant of 50% or not more than 75¢ per capita.

SOUTH CAROLINA—\$6,000 flat to each county and balance on per capita basis.

TENNESSEE—\$7,500 minimum to each county, balance of need of county made up by state board of health from funds available.

VIRGINIA—Basic local share of \$4,500 for one health officer, one sanitarian, one nurse, and one clerk.

WASHINGTON—Grant to those counties whose mandatory .4 mill levy is below the mean, of such amount as necessary to bring it up to the mean, except in cities of over 100,000 population, matching of local funds other than the mandatory 14 mill levy, but not to exceed \$1.75 per capita total budget, in inverse proportion to the assessed valuation of taxable property, using as a base a 1 to 1 ratio for the mean assessed valuation; additional funds distributed for special problems.

WISCONSIN—\$1,000 to each county employing one or more nurses.

WYOMING—Allocation based on need.

SOURCES: U.S. Public Health Service, *State Laws Governing Local Health Departments*, (Public Health Service Publication Number 299, 1953)

Information on California and New York is based on current materials from the Health Departments of those states.



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