Provisions of State Laws Governing Local Health Departments

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FOR SOME TIME the need for a study of the provisions of State laws applicable to the establishment and operation of local health departments has been apparent from the requests which the Public Health Service has received for information or assistance on this subject. The primary purpose of this study was to secure information that would be useful to States planning legislative programs aimed toward organization and development of local health departments.

Since there are marked variations in patterns of local governments, no model legislation has been developed. However, some type of advisory group composed of representatives of State and local governments as well as the Public Health Service may be established in the near future to develop recommended alternative provisions that may be incorporated into State statutes or regulations.

The field work on the study was accomplished by the regional office personnel of the Public Health Service with the assistance of the regional attorneys. A questionnaire was completed for each State on the basis of an analysis of the State's statutes and regulations. Information on procedures governed by commonly accepted practices was supplied by interviews with State health officers or their representatives. In addition, State health officers were requested to state their opinions of desirable provisions that should be included in statutes.

This preliminary report is confined to a factual analysis of existing laws, regulations, and commonly accepted practices with respect to boards of health, health officers, and the organization of local health departments. Reports relating to financing and staffing of health departments and powers of health officers, boards of health, and health departments are in preparation.

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General Comments

In many States the legislation with respect to local health departments has dealt primarily with boards of health and health officers. Frequently, legislation permitting the organization of health departments as agencies of local government was added in piecemeal fashion. Although conflicting laws were generally repealed, failure to do so in some States has led to marked confusion as to the legal status of health department activities.

The study also reveals that in the absence of statutes dealing with some of the more important aspects of local health department organization, State health departments have been reluctant to prescribe regulations directed to these specific problems.

From the data collected, it is apparent that there are large volumes of statutes applicable only to cities and that these provisions in a

given State may vary markedly from the provisions applicable to counties and districts. It is also apparent that certain types of local governmental units are frequently exempt from general statutory provisions, but are covered by special statutes not generally applicable to all local governmental units.

The existence of specific statutes dealing with various classes of local governmental areas does much to complicate the establishment of local health departments. For example, in one State there are six classes of local governmental areas which may form a local health department, provision being made for each class under a different set of statutes. New legislation introduced under these circumstances frequently only adds another procedure by which local health departments may be formed, rather than clarifying and simplifying the several existing provisions for the formation of local health departments.

Table 1. Number of States having mandatory or permissive statutes for establishing local boards of health, by type of statutory provision [1]

Type of statutory provision	Number of States [2]
Mandatory provisions only	27
Mandatory statute generally applicable to local areas	*24* (5)
Mandatory statute applicable only to cities	*3* (3)
Mandatory and permissive provisions	14
Mandatory in some local areas but permissive in others	*11* (8)
Mandatory under current law but permissive in units established under new legislation	*3* (1)
Permissive provisions only	6
Permissive statutes generally applicable to local areas	*4*
Permissive statutes applicable only to cities	*2* (2)
No mandatory or permissive provisions	1

[1] Since the basic governmental unit in New England is the town, the data for these States have been included in the same category as county data for the other States.
[2] Figures in parentheses indicate the number of States included in the tabulation in which the provision is applicable only to certain local governmental areas or only under certain conditions.

Local Boards of Health

Local boards of health are mandatory by statute in at least some type of local governmental area in 41 States. Six other States have permissive provisions for boards of health applicable to some local governmental areas. There is only one State in which no statutory provision, either mandatory or permissive, is made for boards of health. Regulations for the establishment of local boards of health exist in only two States, and in both of these States statutory requirements also are present. Although provided for by law, local boards of health do not actually function in some States.

Table 1 indicates that in 24 States, boards of health are provided for by mandatory statutes generally applicable only to local areas. Three States have mandatory provisions applicable only to cities. Four States have permissive authority which is generally applicable to local areas, and 2 States have such provisions applicable only to cities. There are 14 States in which it is mandatory for some governmental areas to have boards of health while it is permissive for other areas to have them. There are 3 States in which current statutes require local areas to have boards of health, but legislation recently enacted makes it permissive for newly created health departments to have such boards.

State health officers, when asked to comment on the advisability of local boards of health, almost unanimously expressed the opinion that such a body should exist, but expressions as to its function varied widely. Three State health officers questioned the desirability of a local board, 7 felt it should function as an advisory body only, while 33 felt that it should serve as a policy-making body through the adoption of rules and regulations.

District Boards of Health

Districts may be defined as a health jurisdiction which encompasses more than a single local governmental area. Such districts may be city-county, multicounty, multicity, or any other combination of local governmental areas. Thirty-six States provide through statute for some type of board of health in districts and one State does so by generally accepted practice.

There are three general types of boards of health established in areas comprising health districts: (*a*) A district board of health repre-

senting all constituent areas within the district; (*b*) both a district board of health and separate boards for each constituent area; and (*c*) a separate board of health for each constituent governmental area within the district (table 2).

Twenty-nine States provide for the first type by statute. Five States have statutory provisions for district boards of health which provide that the district board be composed of members of the several separate boards of health of the individual governmental areas of the district. Under such a plan, each constituent area has a separate board of health and also has representation on the district board. Two States provide by statute for a separate board for each constituent area, and one State does so by commonly accepted practice.

Appointment of Boards

Statutes sometimes name certain local legislative or administrative officials who shall constitute the board of health, or in other instances the responsibility for the appointment of the board may be delegated by law to either the local legislative body or some administrative official. The State health officer or the State board of health appoints local boards of health in a few States. Representatives on district boards of health are generally appointed either by the local legislative body or an administrative official of each constituent governmental unit in the district. Sometimes members of the legislative body or an administrative official of each constituent area serve on the district board.

Almost universally State health officers in commenting on the method of appointing local boards of health indicated that members of such boards should be appointed by the local legislative body or by an administrative officer. A few State health officers pointed out that a primary consideration was that appointments be nonpolitical in nature. The statutes of some States specifically limit the number of board members that may be from the same political party.

Table 2. Number of States in which district boards of health are provided by statute or common practice, by type of board

Type of board	Statute [1]	Common practice
District board representing all constituent areas	29 (2)	
Both a district board and separate boards for each constituent area	5 (3)	
Separate board for each constituent governmental area	2 (1)	1
Total	36 (6)	1

[1] Figures in parentheses indicate the number of States included in the tabulation in which the provision is applicable only to certain governmental areas or only under certain conditions.

Local Board Representation

Table 3 indicates that 34 States have statutes which provide for professional representation on boards of health, but in 15 of these States such provisions are limited to certain areas or conditions in their application. Two States provide for professional representation by commonly accepted practice under certain conditions. Professional representation usually consists of one or more doctors of medicine, but in a limited number of States dentists and pharmacists are also included. By prescribing that certain officials constitute the board of health, some States practically preclude professional representation on such boards. Most State health officers felt that the medical profession should be represented on boards of health, but one-third of them indicated that physicians should not constitute a majority of the membership.

Nearly three-fourths of the States provide that certain local administrative officials shall be members of the board of health by reason of some other county or city office which they hold. In 14 States such provisions are applicable only to certain areas or are qualified as to the conditions under which they are applicable. Frequently, separate statutory provisions applicable to cities or to districts exist in addition to the general statutes.

Two-thirds of the States have statutes which require geographic representation on district boards of health. One State requires such representation through commonly accepted practice without a statutory provision.

Table 3. Number of States having membership or procedural requirements for local boards of health prescribed in statutes or commonly accepted practices which have general or limited application

Membership or procedural requirements	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Common practice	Statute	Common practice	Statute	Common practice
Membership requirements						
Representation:						
Professional	34	2	19	----	15	2
Local administrative officials	34	----	20	----	14	----
Geographic	31	1	23	1	8	----
Local legislative body	23	1	12	1	11	----
General public	19	----	9	----	10	----
Health officer:						
Regular member	16	1	4	----	12	1
Ex-officio member	19	2	7	1	12	1
Not a member	16	4	9	3	7	1
Other requirements						
Residence in health jurisdiction	33	6	25	6	8	----
Eligibility to vote in jurisdiction	13	6	10	5	3	1
Taxpayer in jurisdiction	3	3	1	2	2	1
Procedural requirements						
Meetings:						
Regular	29	----	18	----	11	----
Special [2]	28	5	20	4	8	1
Quorum required [2]	18	9	10	5	8	4
Meetings governed by bylaws [2]	15	4	5	1	10	3
Compensation of board members:						
Travel	17	3	11	1	6	2
Per diem	14	4	6	1	8	3
Salary	7	1	1	1	6	----

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.
[2] One State has regulations governing these items.

There are 23 States in which members of the local legislative body by statute constitute all or some part of the board of health, but in 11 States such representation is limited to certain conditions or areas. In one State this type of representation is established by common practice.

In recent years there has been considerable interest expressed in having the general public represented on boards of health. The questionnaires reveal that 19 States have statutory provisions requiring the general public to be represented, but in 10 of these there are limited conditions under which such representation occurs. There are 8 other States in which representation of the general public is excluded because these States generally have statutory provisions which name specific officials or members of the legislative body to the board of health, with no opportunity for the general public to be represented. It is interesting to note that three-fourths of the State health officers commented that there should be representation of the general public on local boards of health.

One-third of the States have statutory provisions permitting the local health officer to serve as a regular member of the board of health. Twenty-one States permit local health officers to serve as ex-officio members of boards of health. However, the service of health officers as regular or ex-officio members of boards of health is usually limited to certain classes of local areas or only to certain conditions.

It is obvious from the foregoing that there is little uniformity among the States as to the

membership representation on local boards of health. Frequently, more than one of the groups mentioned are represented. Legislative members, local administrative officials, and the medical profession are the most prevalent groups included in membership. In addition, the majority of the States include the health officer as either a regular or ex-officio member of the board, although there are at least 20 States in which he is not a member of boards serving at least some local areas.

Other Membership Requirements

Table 3 also indicates that statutes in more than two-thirds of the States require members of boards of health to be residents of the health jurisdiction. In addition, six States have this requirement in practice. Statutes in about one-quarter of the States require that board members be eligible to vote in the jurisdiction, while six other States make this a practical requirement. Statutes are generally silent with respect to the requirement that board members be taxpayers in the area.

Term of Office

Wide variation exists in the term of office for members of local boards of health, although statutes in most States prescribe the term. About one-third of the States specify terms of 2 years or less. Ten States have statutes calling for an indefinite term of membership for all or some local boards of health. It should be pointed out that a State frequently has statutory provisions which specify a different tenure for members of local boards serving counties and for those serving cities. More than half the States have statutes which provide that the expiration dates for terms of board members shall be staggered so as to give some continuity to the board.

Procedural Requirements

Statutes in 29 States specify that boards of health shall hold regular meetings and indicate the frequency of such meetings, although such provisions are of limited application in 11 States. Predominantly, meetings are held monthly or quarterly, with the latter taking some precedence over the former interval. Slightly more than half the States have statutory provisions establishing a procedure for calling special meetings of boards of health.

Statutory specification of minimum frequency of board meetings was favored by three-fourths of the State health officers. The majority stated that legal provisions should pre-

Table 4. Number of States providing for appointment of local health officers by statute or commonly accepted practice, according to type of appointing authority

Appointing authority	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Common practice	Statute	Common practice	Statute	Common practice
Health officers of single governmental areas:						
State health officer	12	1	[2] 3	1	9	----
State board of health	7	----	2	----	5	----
Local board of health	32	3	23	1	9	2
Local legislative body	22	1	10	1	12	----
Local administrative official	15	2	1	----	14	2
Health officers of districts:						
State health officer	7	5	5	4	2	1
State board of health	2	----	2	----	----	----
District board of health	28	----	25	----	3	----
Local board of health in each unit	4	1	4	1	----	----
Local legislative body in each unit	1	1	1	1	----	----

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.
[2] One State has regulations in addition to statutes covering this authority.

Table 5. Number of States providing for confirmation of local health officers by statute or commonly accepted practice, according to type of confirming authority

Confirming authority	Total states with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Common practice	Statute	Common practice	Statute	Common practice
Confirmation in single governmental areas:						
State health officer	11	7	7	3	4	4
State board of health	9	1	6	1	3	--
Local legislative body	9	1	2	1	7	--
Local administrative official	1	--	--	--	1	--
Local board of health	1	2	1	2	--	--
Confirmation of district health officers:						
State health officer	11	--	9	--	2	--
State board of health	6	--	6	--	--	--
Local legislative body of each unit	4	1	2	1	2	--
District board of health	--	2	--	2	--	--

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.

scribe the minimum number of meetings, with provisions for special meetings whenever local conditions demand.

The data indicate that boards of health are required to have a quorum by statute in 18 States and by generally accepted practice in 9 other States. Only 15 States have statutes specifying that deliberations of boards of health be governed by bylaws. In addition, there are four States in which the actions of boards are so governed in practice.

In 20 of the States members of local boards of health are entitled to travel expenses either by statute or by commonly accepted practice. In 14 States they receive per diem by law, and in four other States by accepted practice. In only eight States are members of local boards of health entitled to receive salaries.

Appointment of Local Health Officers

Many States have more than one provision for the appointment of health officers. The methods of appointment are associated generally with the methods for establishing local health departments. Some statutory provision for the appointment of local health officers exists in every State, although such provisions are frequently limited in their application to certain areas or conditions. Table 4 indicates that local health officers serving units other than districts are usually appointed by the local board of health, the local legislative body, or the State health officer. There are 20 States in which either the State board of health or the State health officer may appoint certain local health officers. However, this power is usually limited to instances in which the regular or local appointive machinery breaks down.

Health officers serving districts are appointed under statutory provisions by the district board of health in 28 States and by the State health officer in 7 States. In addition, there are five States in which district health officers are appointed by the State health officer by accepted practice. Local legislative bodies seldom appoint district health officers, and appointment by a local administrative official was not found.

Twenty-nine States have statutory provisions for the confirmation of the appointments of health officers, while nine other States follow this procedure in practice. Generally, the State health officer, State board of health, or the local legislative body is delegated the authority to confirm the appointments of local health officers. Confirmation of the appointment of district health officers occurs infrequently, but where confirmation is required the State health officer or the State board of health is usually delegated this responsibility.

The consensus of State health officers is that the local health officer should be appointed locally—either by the board of health or the legislative body. However, 28 indicate that his ap-

pointment should be confirmed by the State health officer. Twelve others recommend that he should be required to meet specifications of the State health department, but that the appointment should not actually be confirmed. Eight believe that he should be appointed by the State health officer or State board of health.

Other Provisions for Health Officers

In seven States local health officers serving some types of local health departments become deputy State health officers by law. In eight other States they hold this position through commonly accepted practice.

Statutes in nearly three-fourths of the States provide that at least some cities, towns or townships may retain a local health officer even though the governmental area itself becomes part of a larger health jurisdiction. The comments clearly indicate that State health officers generally oppose the retention of a legally designated health officer in minor governmental areas of a health jurisdiction. It is the opinion of State health officers that the health unit director should exercise the authority of health officer throughout the health jurisdiction and that any other health officers should be subordinate to him.

By statutory provisions, local health officers serving at least some types of local health departments are selected in 16 States under a merit system. Seven additional States have regulations to this effect, and eight States select local health officers in this manner by practice. In those States in which the law specifically indicates the manner in which local health officers shall be appointed, such procedures may preclude his selection under a merit system. Thirty-nine State health officers indicate that it is desirable for local health officers to be selected under a merit system.

There is wide variation in the statutory provisions for term of office for local health officers and equally wide variation in the accepted practice where no statutory requirements exist. The questionnaires indicate that local health officers most frequently have either a 2- or 4-year term of office. There has been a definite trend in recent years for the term to be made indefinite. In several of the States with statutory provisions specifying the term of office there is actually no reappointment of health officers at the intervals specified.

Qualifications Required

More than two-thirds of the States require by law that local health officers possess the qualifications for a State license to practice medicine (table 6). In five States this requisite is specified by regulation, and in two States the requirement is by common practice. Most of the States with stipulations that the health officers

Table 6. Number of States prescribing specific qualifications for local health officers by statute, regulation, or common practice

Type of qualification	Total States with provisions			States with provisions generally applicable			States with provisions of limited application [1]		
	Statute	Regulation	Common practice	Statute	Regulation	Common practice	Statute	Regulation	Common practice
Qualified for State license in medicine [2]	34	5	2	27	4	2	7	1	
Required to secure State license in medicine [2]	32	4	4	25	3	4	7	1	
Provisions for temporary licensure in medicine	11	1	2	11	1	2			
Full-time service	31	3	5	12	2	3	19	1	2
Training in public health	17	8	2	7	4	1	10	4	1
Experience in public health	7	10	1	2	8	1	5	2	

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.
[2] Required by regulation in two States as well as by statute.

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Table 7. Number of States with statutes or commonly accepted practices designating governmental authority to which local health officer is responsible, by type of authority

Type of authority to which health officers are responsible	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Common practice	Statute	Common practice	Statute	Common practice
Responsible authority in single governmental areas:						
State health officer	19	2	18	2	1	--
State board of health	8	--	7	--	1	--
Local board of health	35	4	27	2	8	2
Local legislative body	12	4	6	4	6	--
Local administrative officer	9	2	2	1	7	1
Responsible authority in districts:						
State health officer	13	3	13	3	--	--
State board of health	1	--	1	--	--	--
District board of health	29	3	28	3	1	--
Each constituent governmental area	3	4	2	4	1	--

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.

qualify for a State license actually require them to secure the license. Only 11 States make statutory provisions for temporary licensure of health officers, one additional State provides for such licensure by regulation, and two States do so by practice.

The laws of 31 States require at least some health officers to serve full time though such statutes are generally limited in their application (table 6). In addition, three States have regulations requiring full-time service and five States require it by accepted practice. Frequently, the regulatory requirement or practice of requiring full-time service of local health officers is related to the health department's eligibility for State financial assistance.

Twenty-seven States require public health training of local health officers serving at least some types of health departments. Such requirement is twice as frequently specified by statute as by regulation. Usually, the provision is general, not specifically stating the amount or kind of training required.

Only 7 States require by statute that health officers have experience, but 10 States have regulations requiring experience. The present shortage of qualified health officer personnel has made difficult the enforcement of experience requisites in existing statutes and regulations.

The majority of State health officers were opposed to defining qualifications of local health officers in statutes. The major objection indicated was that specificity in this matter makes conditions too rigid and hampers the recruitment of personnel. Many indicated that qualifications, if defined, should be set forth in State health department regulations rather than in statutes. A number favored a flexible system, with required training and experience commensurate with the size and complexity of the individual health unit. Nearly all State health officers felt that local health officers should be legally licensed physicians. Several State health officers indicated that such items as personality, administrative ability, interest in community health, and ability to get along well with people are more important than specified training or experience backgrounds.

Responsibility of Local Officers

Table 7 indicates that State statutes and practices hold local health officers responsible to several types of governmental authorities. In many instances the health officer is responsible to more than one authority and is frequently responsible to some authority other than the one which appointed him. In most cases when dual responsibility exists, the health officer is responsible to some local authority and to the State health officer. Table 7 indicates that the local health officer is most frequently responsible to

the local board of health or to the State health officer.

The data also reveal that district health officers are infrequently responsible to the separate governmental areas comprising their district, but are usually responsible to the district board of health or to the State health officer.

Governmental Basis of Health Units

For several years health experts have been interested in the types of local governmental areas which may establish health departments. There are now 42 States which have statutes making it possible to establish single county health departments. The six States which have no legal provisions for establishing single county health departments are located primarily in the New England area where the county as a local governmental area has practically no meaning. The establishment of single county health departments is mandatory in four States. Laws governing the establishment of city health units are in effect in 44 States and such units are established in common practice in 1 other State. In eight States it is mandatory for all or some cities to establish local health departments, while in four States cities are not permitted to establish separate health departments.

The fact that most counties in the United States have insufficient population and financial resources to meet the high costs of maintaining a separate local health unit, plus the shortage of qualified health officers, has spurred the development of district health departments to serve more than a single local governmental unit. Legislation is usually necessary to permit local governmental areas to combine and form a district for the operation of a health department. There are now 34 States which have statutes permitting 2 or more counties to form a multicounty health department; in 2 States such districts have been formed without specific legal authority. There are 27 States which have legislation permitting the creation of city-county health departments, and 5 States have established this type of district in practice without specific statutory authority. These foregoing two types of district health departments are the most prevalent, but statutes exist in several States which permit the formation of other types of districts. The laws of 15 States permit multicity units and a like number permit multitown or multitownship units; 11 States permit the combination of cities and townships; 10 States permit the combination of counties, cities, and townships; and 8 States permit the combination of counties and townships. In addition, a few States have established these more unusual types of districts in practice although no statutory authority exists.

Methods of Establishment

There are several methods by which local health departments may be established. Local health departments serving either single units of government or those serving multiple governmental areas are most frequently established through action of the local legislative body or, in district areas, of each constituent legislative body within the district (table 9). The second most popular method is by referendum of electorate. This method is permitted by law in 16 States with respect to single governmental

Table 8. Number of States having permissive or mandatory authority for the establishment of local health departments, by type of governmental area [1]

Type of governmental area	Permissive authority [2]		Mandatory authority [2]	
	Statute	Practice	Statute	Practice
Counties	38 (2)	------	4 (2)	------
Cities	36 (4)	1	8 (5)	------
Towns or townships	16	1	2 (1)	------
Districts:				
Multicounty	[3] 34 (1)	2	1	------
City-county	27	5	------	------
Multicity	15	2	------	------
Multitownship	15 (2)	2	------	------
City-township	11	3	------	------
County-city-township	10 (1)	3	------	------
County-township	[3] 8 (1)	2	------	------

[1] Authority for establishing local health departments is not prescribed by regulation in any State.

[2] Figures in parentheses indicate the number of States included in the tabulation in which the provision is applicable only to certain governmental areas or only under certain conditions.

[3] In 1 State statute is applicable under certain conditions and practice is applicable in other situations.

Table 9. Number of States providing specific procedures for the establishment of local health departments by statute or commonly accepted practice

Type of procedure	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Common practice	Statute	Common practice	Statute	Common practice
Single governmental areas:						
Action of local legislative body	37	4	22	3	15	1
Referendum of electorate	16	1	13	----	3	1
Action of State legislature	5	----	3	----	2	----
Action of State health officer	4	2	3	2	1	----
Other procedures	2	1	----	----	2	1
Multigovernmental areas:						
Action of local legislative body of each constituent unit	35	----	22	----	13	----
Referendum of electorate	17	----	14	----	3	----
Action of State health officer	8	4	6	4	2	----
Approval of local authorities required	3	2	3	2	----	----
Action of State legislature	2	----	2	----	----	----
Other procedures	6	----	6	----	----	----

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.

areas and in 17 States with respect to multiple governmental areas. This plan normally requires that a certain percentage of electors submit a petition asking that the question of creating a local health department be placed upon the ballot. Local health units of either the single-unit type or district type are infrequently established by action of State health officers or State legislatures, although such methods are permitted by law in several States.

It is the opinion of State health officers that the establishment of local health departments is a matter for local determination. A few State health officers indicated that State legislative action should make them mandatory. Local legislative action or local referendum, or a combination of the two, were deemed by State health officers as the most expedient methods for initiating action to establish local health departments. The same general methods were favored for the establishment of district health departments. More State health officers, however, felt that in order to foster some logical plan for state-wide districting, such departments should be subject to the approval of the State health officer.

Dissolution of Local Units

Statutes usually fail to specify the manner in which local or district health departments may be dissolved. In 15 States there are no statutory provisions for the dissolution of health units. Action by the local legislative body is the most frequent method employed to dissolve a health department; 15 States have such statutory authority with respect to single governmental units and 13 States with respect to multigovernmental units. Such action is taken by commonly accepted practice in 13 States for single county units and in 11 States with respect to district health departments (table 10). Referendum of the electorate is the second most popular method for dissolving local health departments, with 6 States making this method applicable to single governmental areas. Seven States provide by statute for the dissolution of districts by referendum action of the electorate of the whole jurisdiction while 6 States provide for referendum of electorate of each constituent area. In several States it is most difficult to dissolve a local health department once established.

State health officers feel that dissolution should be by the same procedure as establishment. Several indicated, however, that a health department should be in operation for at least a reasonable period of time before dissolution should be permitted. Many who indicated that establishment should be by either referendum or local legislative action were of the opinion

that dissolution should not be permitted without referendum. The majority of State health officers felt that the desirability of withdrawing from a district should be determined by each governmental unit. However, they also felt that provisions should be made for a waiting period, or a period following notification of withdrawal, to allow for adjustment in the remainder of the unit.

Table 11 indicates that only 4 States require all governmental units within a county or district health jurisdiction to join the health department. There are 10 States in which statutory provisions permit any type of city to remain outside county or district health departments; 10 additional States permit cities of specified population size to do so, and 7 States permit cities to remain outside the county or district unit if they have a health department of their own. There are a few States in which towns may also remain outside the county or district health department. On the other hand, almost three-fourths of the States permit cities and towns to join the county or district health jurisdiction, and 9 additional States do so in practice without statutory provisions.

Statutory provisions require that districts serve contiguous local governmental areas in

Table 11. Number of States having provisions of statute and practice permitting local governmental areas to remain outside county or district health jurisdiction, by type of local governmental area

Type of governmental area permitted to remain outside county or district health jurisdiction [1]	Statute	Common practice
None	4	
Cities of any type	10	
Cities of certain classes or population size [2]	10	
Cities with a health department	7	
Any city, county, or town	5	2
Cities or towns	4	2
Towns	2	

[1] Since the basic governmental unit in New England is the town, the data for these States have been included in the same category as county data for the other States.
[2] One other State has statutory provision permitting counties of certain population size to remain out of districts.

Table 10. Number of States providing specific procedures for the dissolution of local health departments by statute or commonly accepted practice

Type of Procedure	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Common practice	Statute	Common practice	Statute	Common practice
Procedures in single governmental areas:						
Action of local legislative body	15	13	9	10	6	3
Referendum of electorate	6	3	4	3	2	
Action of State health officer		7		5		2
Approval of local authorities required		4		3		1
Action of State legislature	3		1		2	
Other procedures	10		10			
Procedures in district areas:						
Action of local legislative body of each constituent unit	13	11	9	9	4	2
Referendum of electorate of whole jurisdiction	7	1	5	1	2	
Referendum of electorate of each constituent area	6	2	5	2	1	
Action of State health officer	2	8	1	8	1	
Approval of local authorities required	2	6	1	6	1	
Action of State legislature	1		1			
Other procedures	7		7			

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.

Table 12. Number of States prescribing criteria by statute, regulation, or commonly accepted practice that must be met in order to be eligible for State financial assistance

Criteria prescribed	Total States with provisions			States with provisions generally applicable			States with provisions of limited application [1]		
	Statute	Regulation	Common practice	Statute	Regulation	Common practice	Statute	Regulation	Common practice
Mandatory staffing	[2] 6	4	11	4	4	10	[2] 2	----	1
Specific services	3	4	12	1	4	7	2	----	5
Plan required	2	1	15	2	1	12	----	----	3
Plan must have State approval.	2	1	12	2	1	12	----	----	----
Minimum population	2	2	5	1	2	3	1	----	2

[1] Refers to States where provisions are applicable only to some governmental areas or under some conditions.
[2] In 1 State mandatory staffing is required of districts by statute and of other local health departments by practice.

22 States; 5 additional States require such an arrangement by commonly accepted practice.

Only 5 States have statutory limitations as to the number of governmental areas which may combine to form health districts. Also, such limitations are infrequently imposed in practice.

State Financial Assistance

There has been some interest in recent years in the development of criteria which local health departments should meet in order to be eligible for financial assistance from the State. Such criteria generally include mandatory staffing requirements. Table 12 indicates that such staffing requirements are specified by statute in six States and by regulation in four others. In practice, there are 11 additional States which require local health departments to employ certain types of personnel.

A second criteria involves basic services which local health departments are required to render. Nineteen States have some requirements with respect to basic services, but in only 12 States are they generally applicable and in those they are usually applied in practice rather than by statute.

Local health departments infrequently are required by statute to submit a plan of action. However, nearly one-third of the States require such plans in practice. If a plan is required of the local health department, it is generally subject to approval by the State.

Criteria for State financial assistance sometimes include a minimum population which the department should serve, but only nine States require local health departments to serve a minimum population.

Summary

While most States have some statutory provisions for the creation of boards of health, the appointment of local health officers, and the establishment of local health departments, there is wide variation between the several States in the details of the statutory provisions. Basically, statutes provide for boards of health either appointed by or composed of members of the local legislative body, or local administrative officials. These boards generally have the responsibility of designating the local health officer who directs the local health department program. The health officer is usually responsible to the authority which appointed him, but, in addition, may be responsible to other local authority and particularly to the State health officer.

Most States have statutory provisions which permit the establishment of county or city health departments through action of the local legislative body or through popular referendum. Only about three-fourths of the States, however, have such legislation permitting the establishment of health districts serving more than a single local governmental area.