State Laws on Financing and Staffing Local Health Departments

By CLIFFORD H. GREVE, M.S.P.H., and KATHRYN J. CONNOR

This report completes a three-part presentation in Public Health Reports of a study of State laws, regulations, and practices applicable to local health departments, made by the Division of State Grants of the Public Health Service.

The first section, entitled "Provisions of State Laws Governing Local Health Departments" (January 1953, pp. 31–42), described existing laws, regulations, and accepted practices with respect to boards of health, health officers, and the organization of local health departments.

The second section is entitled "General Regulatory Powers and Duties of State and Local Health Authorities" (April 1953, pp. 434–438).

A separate 68-page report entitled "State Laws Governing Local Health Departments" (PHS Publication No. 299) presents in tabular form data by individual States on all aspects of the study.

Thus, a comprehensive report of public health legislation is available as reference material to guide States in planning legislative programs in this field.

The data summarized in these reports are from questionnaires prepared by regional office personnel of the Public Health Service assisted by regional attorneys of the Department of Health, Education, and Welfare. Information relating to procedures carried out by practice in the absence of statute or regulation was collected in personal interviews with State health officers or members of their staffs.

• • •

STATES have fewer laws, regulations, and practices pertaining to the financing and staffing of local health departments than they have for governing the appointment and qualifications of local health officers, the establishment of local health units, or the delegation of broad regulatory powers and duties to State and local health authorities.

Distribution of Costs

In all States, local units of government are permitted to raise local revenues to finance all or part of the cost of local health departments. However, specific or general limitations are frequently placed on this general power either by statute, regulation, or by practice without statutory authority. Some of the limitations may be applicable only to some types of local governmental areas or only under certain conditions.

About two-thirds of the States prescribe methods for allocating the cost of operating local health departments among participating local units of government. Such allocation may involve distribution of costs among counties in district health units, or between county and city in city-county units, or among townships in single-county units. Specific methods for the proportionate distribution of costs

Mr. Greve is chief and Mrs. Connor is an analytical statistician of the analysis and reports section of the Division of State Grants, Bureau of State Services, Public Health Service.

Table 1. Number of States providing for local financial support of health units by statute or practice

Type of provision	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Practice	Statute	Practice	Statute	Practice
Prescribed local percentage of cost [2]	4	6	1	4	3	2
Specific millage limitation on taxation	21	----------	13	----------	8	----------
Special health tax beyond other limitations	23	----------	18	----------	5	----------
Mandatory tax rate or millage	4	----------	2	----------	2	----------
Per capita local appropriation	2	2	2	1	----------	1
Minimum dollar amount	1	3	----------	3	1	----------
Other provisions	26	2	3	1	23	1

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

[2] Authorized by regulation in 1 State.

among local governmental units are established by statute in 26 States, but in 6 of these the method of allocation is applicable only to district health units, and in one other State only to cities and districts. In describing the method of apportionment of funds from local resources among local units of government, States most frequently report the use of a population factor.

Local Financing

Several types of provisions are used by the States to determine the share of total local health department costs which are to be met from local revenues. Eleven States require that a prescribed percentage of the cost of operating each local health department be met from local revenues (table 1).

Local financing of health departments is frequently influenced by statutory tax provisions. Local taxation is based primarily upon real estate valuations. Tax limit provisions in 21 States establish by law a specific millage limitation applicable either to specific taxes for public health purposes or to taxes in general. In either case such provisions place a limit upon local revenues available for public health purposes. Twenty-three States have statutes which permit levy of a specific health tax in excess of other tax millage limitations. In only 4 States does the law require the imposition of a mandatory tax rate or millage for the financing of local public health programs.

Four States require a local per capita appropriation as the share to be borne by local revenues. In 4 States a minimum dollar amount is required of local governments in financial support of the local health department.

Twenty-eight States report other provisions that are applicable to the financial support of local health departments. These are generally contained in statutes but are usually limited in their application. Frequently, a State may have more than one provision applicable to the local financing of health departments.

Nineteen State health officers indicated that local health departments should be supported from the general tax fund, while 21 State health officers thought local financial support should come from special tax provisions. At least 7 health officers thought local financial support should come from both sources.

State Financing

Inadequate local revenue from tax resources requires local health units to depend in part upon State funds and other resources for assistance in financing their health programs. Nearly three-fourths of the States have statutes which authorize the distribution of State funds to local health units (table 2).

Methods used to distribute State funds are important in the sharing of State revenue with local units of government. These methods usually fall into two groups: those designed to allocate available funds by some objective method, and those based on subjective judgment. Objective formulas vary widely between

States but, in general, are designed to provide a State-local fiscal relationship which offers security to local health programs. Comments made by State health officers indicate that most of them think it desirable to establish a relationship between local and State funds for allocating the cost of local health units.

One type of objective formula used by one-fourth of the States provides that a percentage of total operating costs of local health units be met from State funds. By a second method of distribution closely related to that of paying a percentage of the total cost, the State pays a percentage of the salaries of all or certain selected employees of local health departments.

Other types of objective formulas are used by 17 States in the distribution of State funds. There was wide variation in the objective methods described, but the use of factors of population and financial need was reported most frequently. Basic grants to each local area, or grants based upon specific health needs, are not uncommon factors employed. As an adjunct to the distribution of State funds, contracts are frequently drawn between State and local officials to legalize the financial agreement made either through the use of subjective judgment or an objective formula.

Payment Procedures

The designation of an official custodian of local health funds is accomplished by law in 33 States, in 8 additional States by common practice, and in 1 State by regulation. Almost universally, the person designated as official custodian of the local health unit funds also disburses the funds. In districts, the treasurer located in the most populous county or in the county housing the headquarters of the local health department is generally the disbursing officer for multicounty units.

The payment of State funds to local health units is made on a reimbursable basis in only 20 States. Six of these States have statutes providing for a reimbursable payment procedure; 13 States do so by practice, and 1 State by regulation.

Actually, the reimbursable principle is frequently achieved by issuing State checks to cover salaries of local health department employees. Thirteen States report that they issue checks against local funds covering salaries of local health department employees, but in only 3 States is this done on the basis of a statutory provision.

Twenty-six States issue State checks to pay the salaries of local health department employees who are paid from State and Federal funds. In conjunction with this procedure, the use of State or Federal funds in local health department budgets is frequently limited to salary items. In 1 State it applies only to the salaries of nurses employed in local health units. In only 13 of the States which pay local employees with State checks does the check indi-

Table 2. Number of States providing for the authorization and distribution of State funds to finance local health units by statute or practice

Type of provision	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Practice	Statute	Practice	Statute	Practice
Authorization for distribution of State funds [2]	35	4	32	2	3	2
Objective methods for distribution of State funds:						
Percent of total cost [2]	6	5	5	4	1	1
Percent of salaries	3	4	2	4	1	----
Other objective formulas [2]	5	11	5	11	----	----

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

[2] Authorized by regulation in 1 State.

268440—53——4

Table 3. Number of States with statutes or practices designating authority for the preparation and approval of local health budgets

Authority [1]	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [2]	
	Statute	Practice	Statute	Practice	Statute	Practice
Budget preparation						
In single governmental areas:						
State health department	2	12	----	9	2	3
Local health officer	5	34	4	29	1	5
Local board of health	11	4	10	2	1	2
In districts:						
State health officer	1	9	1	9	----	----
District health officer	----	14	----	14	----	----
District board of health	13	6	13	2	----	4
Budget approval						
In single governmental areas:						
State health officer [3]	8	20	7	16	1	4
Local board of health [4]	5	17	3	16	2	1
Local legislative body	18	15	15	11	3	4
Local administrative official	3	9	2	4	1	5
In districts:						
State health officer [3]	5	23	5	20	----	3
District board of health [4]	3	12	3	12	----	----
Local legislative body	10	11	8	11	2	----

[1] Budgets are usually prepared and approved by more than one authority.
[2] Refers to States in which provisions are applicable only to some governmental areas or only under some conditions.
[3] Authorized by regulation in 2 States.
[4] Authorized by regulation in 1 State.

cate the source of funds from which the employee is being paid.

Ten States require that local funds for the support of local health units be deposited in State treasuries for disbursement. Three States require local funds to be deposited locally for disbursement by a State health department official or other State disbursing officer.

State funds are paid to local custodians of funds for disbursement in 21 States. Only 8 States have statutes establishing this procedure, and in 1 State new enabling legislation sets up the procedure. The payment of State funds to local custodians is specifically prohibited by law in 2 States.

Budgets and Plans

The responsibility for the preparation of local health department budgets is delegated to a wide variety of officials, and such delegation is more frequently based on practice than on statutory provision. In 14 States, local health department budgets for single governmental units such as cities or counties are prepared by the State health department. Local health officers serving this type of unit have some responsibility for the preparation of budgets in 39 States (table 3).

In 10 States district health department budgets are prepared by the State health officers although only 1 State has statutory provisions prescribing this procedure. District health officers prepare their budgets in 14 States, while district boards of health prepare the budgets in 19 States.

After budgets of local health departments have been prepared, there is usually some procedure established for their approval. Provisions for budgetary approval are more frequently established by practice than by statute and may involve more than a single official or agency. The State health officer is responsible for approving local health department budgets in 30 States, and he also has authority in 30

States to approve district health department budgets.

As indicated in table 3, the local board of health is responsible for approving budgets for single governmental units in about half the States. In 33 States the local legislative body has some responsibility for approving budgets. Local administrative officials have responsibility for the approval of budgets in 12 States.

In district health units the budgets are usually approved by the State health officer, but district boards of health have powers of budget approval in 15 States. Local legislative bodies in districts may approve budgets in 21 States.

Almost universally, State health officers commented that local health officers should prepare the budgets with some other local or State authority, or both, having power of approval.

A relatively new procedure of plan preparation requires local authorities to outline their health programs in advance. Less than half of the States have provisions for the preparation of plans either through statutory requirements or in practice. Seventeen States indicated that plans for single governmental health units are prepared in practice.

Twelve States require plans from district health units in practice, while 5 other States have statutory requirements with respect to plans for these units.

The majority of States which require plans from local health units also require that more than one authority approve each plan, and this approval is usually based on practice rather than on regulation or statute. The State health officer is the authority most frequently assigned this responsibility, but in only about a third of the States requiring his approval is it based upon statute.

Staffing Local Health Departments

Staff appointments in local health units usually are made by the local health officer or the local board of health. Frequently, there is joint approval by the local health officer and local board of health in making such appointments. The law in some States requires that certain officials, such as the city and county commissioners, or the State health department be consulted with respect to staff appointments. Thirty-seven States have provisions permitting the local health officer to make staff assignments to local units (table 4). In 20 States the local board of health has statutory appointing authority, but in a dozen States these boards are not the sole possessors of this authority. In 4 States the law limits the appointing authority of local boards of health to city health departments. The questionnaires

Table 4. Number of States providing for staff appointments to local and district health units by statute or practice, according to appointing authority

Personnel appointed by	Total States with provisions		States with provisions generally applicable		States with provisions of limited application [1]	
	Statute	Practice	Statute	Practice	Statute	Practice
In single governmental areas:						
Local health officer	19	18	5	13	14	5
Local board of health	20	6	12	3	8	3
State health department [2]	2	5	1	3	1	2
Local governmental personnel office	2	1	1	----	1	1
Others	11	2	8	2	3	----
In districts:						
District health officer	20	8	12	7	8	1
District board of health	14	1	7	----	7	1
State health department [3]	1	5	1	3	----	2
Each constituent unit	3	----	2	----	1	----
Others	1	1	1	1	----	----

[1] Refers to States in which provisions are applicable only to some governmental areas or only under some conditions.
[2] Authorized by regulation in 3 States.
[3] Authorized by regulation in 2 States.

further reveal that 10 State health departments make staff appointments to local health units.

Predominantly, the responsibility for staff appointments to district health units rests with the district health officer, and in 20 States he has such authority by statute (table 4). The data also indicate that statutes in 14 States provide district boards of health with the responsibility for making staff appointments, but in only 6 States do they perform this duty alone. The State health department appoints personnel to district health units in 8 States. Statutes in 3 States require that appointments to multicounty health units be made by each constituent unit making up a district health department.

In 17 States personnel in district health units serve only the constituent governmental unit to which they are assigned rather than serve throughout the district. This is a statutory requirement in 5 States. Personnel serving in district health units are responsible to the district health officer in 37 States.

Merit System

Personnel of local health departments in the majority of States are employed under some type of merit system. One-third of the States have statutory provisions for a merit system covering local health department employees. Regulations for the establishment of a merit system for local health department personnel exist in 7 States; however, in 2 of these States statutory provisions for this purpose also have been enacted. Several States indicate that a merit system is operated for local areas only if they receive State aid.

In the questionnaires States were requested to specify the type of merit system applicable to their local health department employees. A total of 31 States indicated that the State merit system was extended to cover local employees. In 14 States this was accomplished by statute. In 10 States such a procedure was carried out in practice and in 7 States by regulation. Four States administer a separate merit system for local health unit employees, but these are operated either on the basis of practice or by regulation.

Seven States have statutes providing for a locally administered merit system, but in 6 of these States such provisions are limited in their application. Nine States provide for locally administered merit systems by practice with more than half of these having limited application. In one State regulations provide for a locally administered merit system of limited application.

There are 11 States in which local health department employees are, either by practice or by regulation, State employees and therefore employed under the merit system applicable to State employees.

Compensation Plans and Retirement Systems

More than two-thirds of the States have statutory provisions for a statewide compensation plan applicable to local health department employees. In addition, all except one of the remaining States have compensation plans established by regulation or by practice. It should be pointed out, however, that only 5 States indicated that the statewide compensation plan provided for differences in various sections of the State.

There is wide variation between States in the authority named to establish compensation plans. By statutory provision in 22 States the local boards of health establish such plans. A few States name the local health officer, the State health officer, or the State board of health as the establishing authority although few reported this as a statutory provision. In one-third of the States the law requires some other authority, such as the State personnel board or city or county commissioners, to establish the compensation plan.

Placing of local health unit employees under a retirement system is authorized by law in 33 States. Not all local health unit personnel in the same States are covered by the same retirement system. The laws in many States provide for an extension of State retirement plans or the purchase of social security benefits, or both. Local health employees infrequently come under a locally administered retirement plan.

Summary

Local governments in all States are permitted to raise revenue from local resources for the

support of local public health services, but insufficient local revenue necessitates the allocation of State funds to carry on local public health programs. In this connection, States frequently distribute their funds by some subjective formula rather than according to an objective formula. This report shows that requirements for financing local health units are most frequently carried out by statutory provisions. On the other hand, the establishment of payment procedures and planning activities, such as the preparation and approval of local health unit plans and budgets, is usually done by accepted practice.

Payment procedures usually provide for the designation of an official custodian of local health funds, and he is usually the person who distributes the money. Although State funds are often paid on a reimbursable basis, few States follow this procedure by law. More than half the States permit the issuance of State checks to pay local employees.

Statutory provisions generally govern the appointments of personnel to local health unit staffs. These appointments are usually made by one or more authorities but are frequently the responsibility of the local or district health officer and the local or district board of health. The State health departments seldom have the responsibility for assigning local personnel. It is the law in several States that the county or city commissioners, the board of supervisors, or the governing legislative body make local staff appointments.

Although the majority of States report that local health unit personnel are covered by some type of merit system, this coverage rarely is based on statute. Statewide compensation plans, which have been adopted in all but one State, usually are established by local boards of health according to law. The law in two-thirds of the States requires that local health unit employees be placed under a retirement system. Essentially the same number of States report the extension of State retirement plans as report the purchase of social security benefits for local health employees. A few States report the existence of both systems, while some States provide for a locally administered retirement plan.

A Date Book Invitation

RHODE ISLAND. A regular attendance of 75 was attracted to a 1952–53 series of nurses' conferences in Providence by an effective date book device. Since 1950, the bureau of public health nursing in the State health department has worked to develop ways of getting the public health aspects of nursing included in the basic nursing curriculum. The date book was another step in this direction.

The booklet was prepared by the bureau, and the series was sponsored by the bureau and by the State nursing league. Meetings were free and were held monthly in Providence hospitals.

The booklet was sent to social workers, faculty members of schools of nursing, and others who teach basic nursing students. Titled "We Need Rhode Island's Social and Health Agencies—And They Need Us," it announced that the conferences were designed to acquaint members with the health and social resources available in Providence. For each meeting, the subject, the time, and the place were listed on a separate page. Small (about 6¼" by 4¼"), inexpensive (mimeographed), the date book also contained title and introduction pages.

Speakers represented such agencies as the State cancer and heart societies, the Providence police, school, and social welfare departments, and the University of Rhode Island. Typical subjects included discussions on community resources for treating drug, alcohol, and mental health problems; on the availability of child welfare services and rehabilitation for the handicapped; on industrial participation in maintaining community health; and on the success achieved by interagency cooperation.