Non-mutually exclusive Models and Options: Governance and Accountability

DRAFT FOR PHWG DISCUSSION
10.23.06

Note: *Models described below are not mutually exclusive.*

Boards of Health

Boards of Health are typically appointed state, county, or local/city bodies that oversee the state's or county/city's health department. Boards of Health can exist at any level, independently. State boards are usually appointed by Governor and/or legislature. The state health officer in this model reports to the state Board of Health. County boards are typically appointed by the county commissioners/supervisors. Hence, state boards are accountable to the Governor and/or legislature, county boards to the County government and so forth.

Membership of Boards of Health, especially at the state level, is often defined in statute (e.g. consumer, physician with public health background etc).

Authority and responsibility of Boards of Health vary. Some Boards (especially state) have full voting responsibility for major policy and program decisions, including for example hiring and firing of senior staff, managing public health budgets, policy making (e.g. vending machines in schools, immunization policies, and vital records), planning, and advocacy/public education. Boards of Health can also have more limited advisory authority to the state, county or local/city health department/agency. In states with Boards of Health, state public health statutes often define the scope of authority and responsibility for each of the levels in the system.

Maine had a state Board of Health which was abolished in the 1960's. Boards of Health could be established at the state, county, regional/district, and/or municipal level.

<u>Potential Pros and Cons</u>

- Boards (especially at the state level) that have members appointed by Governor and/or legislature create a system with greater <u>political</u> accountability.
- Politicizing public health could create political and policy divisions, especially over contentious issues such as abortion, family planning, etc.
- Advisory Boards may be less accountable but are less likely to become embroiled in politics.
- Do states with Board structures have better or worse public health system performance?

Centralized System with Administrative and/or Service Districts; Includes powers to delegate authority

Centralized public health districts or regions can be administrative and/or service delivery. In a centralized service delivery system, the state public health agency has extensive control over local level public health authorities and often serves as the governing body. Typically, the regional managers/district administrators report directly to a local liaison housed within the state public health agency. Staff members of the public health districts/regions are employees of the state or hired though contractual arrangements.

Centralized systems may include a per capita budget base. However, in some instances (e.g., Vermont), the categorical programs decide how much money to give local public health districts (with the exception of emergency preparedness).

In Vermont, Local Health Officers relate to the district offices for technical assistance, support, and training. A Local Health Officer may also relate to the state-local liaison's office, depending on the issue.

Potential Pros & Cons

- All citizens in each region/district are provided with the same level of public health services
- No local control, governance, or authority

Regional Entities with Independent Statutory Authority

Under this structure, state statutes would accord regional entities with specific authority and responsibility for a defined set of public health functions. The regional entities could include counties, clusters of counties, districts, or municipalities. Counties are the regional entity in the majority of states with independent public health agencies/departments. These regional entities are often governed by a regional board (see above). Typically state health departments contract with these regional public health agencies to perform specific functions and services.

Potential Pros & Cons

- Regional entities with statutorily defined authority and responsibilities could enhance accountability at the "local"/regional level.
- To be responsible for core public health functions, these independent regional entities will need to have a critical mass of capacity and funding. It is not clear where that will come from.
- What effect would establishing independent, statutory authority for regional entities have on the seamlessness of functioning from state to regional to local?

Shared and Mixed Systems

In a **shared** organizational model the local health department operates under the shared authority of the state health agency, the local government, and local boards of health (e.g., Georgia).

Georgia Example[1]:

- A review of *Section 31-3-4 of the Georgia Code* shows that County Boards of Health are fully empowered by law to assume their responsibilities. This statute provides basic information on how a Board operates within the guidelines of the law including the statutory authority and powers given to County Boards of Health.
- County Boards of Health are given the legal authority needed to perform their many responsibilities, including the authority to establish and adopt bylaws for their own governance. What is not clearly laid out in the statute is the delineation of the role of the Board and the function of the District Health Director and the county public health staff.
- Typically, Board of Health governance functions include:
  - Establishing bylaws for their own governance;
  - Approving the selection of the District Health Director who shall be a physician;
  - Recording true and correct minutes (for any policy, action or resolution adopted);
  - Establishing broad agency direction and priorities;
  - Adopting a budget;
  - Adopting policies, rules and regulations;
  - Resolving conflicts on public health issues;
  - Periodically reviewing the agency's performance and providing feedback to the District Health Director.
- The selection of the District Health Director is a shared responsibility. The Director is appointed by the DHR Commissioner in collaboration with the Director of the Division of Public Health. The CBOH must approve the selection. In multi-county districts each CBOH is authorized to appoint one of its members to represent the CBOH at a joint meeting called by the commissioner to approve the selection.
- The District Health Director's primary function and duty is to manage the staff and resources of the Board of Health toward achieving its mission, goals and objectives as approved by the Board, and in compliance with federal, state and county rules and regulations.
- Each CBOH receives an annual allotment of state dollars through a Grant-In-Aid process spelled out in a document called the Master Agreement. Prior to the beginning of the state fiscal year, County Boards of Health are advised by the Division of Public Health how much grant-in-aid their county will receive for the coming year and the amount of required "match" funds that must be contributed by that county.

In a **mixed** system, state and local health services are provided by a combination of the state health agency, local government, boards of health or health departments in other jurisdictions (e.g., California, Texas).

[1] Source: Board of Health Handbook for Members of County Boards of Health in Georgia. Georgia Department of Human Resources, Division of Public Health. July 2004. Accessed on 10/23/06. Available at: http://health.state.ga.us/pdfs/publications/bohhandbook.04.pdf