

***The State of
Public Health:***

**Local & State
Government
Issues
in Texas**

Report Resulting from House Concurrent
Resolution 44 of the 75th Legislature

December 1998

Foreword

House Concurrent Resolution 44 was passed by the 75th Texas Legislature in 1997. HCR 44 directs the Texas Department of Health, the Lyndon Baines Johnson School of Public Affairs of The University of Texas, The University of Texas-Houston Health Science Center School of Public Health, and the Blackland Research Center and the School of Rural Public Health of The Texas A&M University System, together with local governments, to “study the current role of local governments in providing public health services” and to report their findings and recommendations to the 76th Legislature in January 1999. (See Appendix A for full text of resolution.)

The organizations named in the resolution and representatives of many other interested groups met monthly from August 1997 until November 1998 to discuss the issues and develop a report and recommendations. A steering committee was formed to direct the meetings and overall activities. The HCR 44 workgroup and several subcommittees debated many issues related to public health in Texas and worked on research projects and a questionnaire that was circulated to many organizations for feedback (see Appendix B for questionnaire). The results of these activities are contained in this report. The group’s final recommendations appear in Chapter 5 of this report. We appreciate the legislative support for this resolution that allowed us to study public health in Texas and to develop these recommendations.

William R. Archer, III, M.D.
Commissioner, Texas Department of Health

Edwin Dorn, Ph.D.
Dean, Lyndon Baines Johnson School of Public Affairs, The University of Texas at Austin

R. Palmer Beasley, M.D.
Dean, School of Public Health, Health Science Center, The University of Texas at Houston

Edward A. Hiler, Ph.D.
Vice Chancellor and Dean of College of Agriculture and Life Sciences,
Director of Texas Agricultural Experiment Station and Texas Agricultural Extension Service,
Texas A&M University

Ciro Sumaya, M.D., M.P.H.T.M.
Dean, School of Rural Public Health, Texas A&M University Health Science Center



Acknowledgments and Participants

The HCR 44 steering committee was composed of the following representatives:

- Carol Daniels, M.A., Process Manager, Texas Department of Health
- William Dugas, Ph.D., Resident Director, Blackland Research Center, Texas A&M
- Wayne Farrell, Director, Bell County Public Health District; President, Texas Association of Local Health Officials (TALHO)
- Robert Galvan, Director, Ft. Worth Public Health Department; Texas Municipal League-TAMHO
- Sue Glover, Federal Legislative Analyst, Texas Association of Counties
- Hardy Loe, M.D., M.P.H., Associate Dean, School of Public Health, Health Science Center, University of Texas at Houston
- James Morgan, M.D., M.P.H., Director, Public Health Region 7, Texas Department of Health
- Barbara Quiram, Ph.D., Director, Administrative Services, School of Rural Public Health, Texas A&M University Health Science Center
- Gilbert Ramirez, Dr.P.H., Vice Chair, Department of Public Health/Preventive Medicine, University of North Texas Health Science Center
- Jerry Robinson, M.P.A., Director, City of Laredo Health Department
- Bill Spears, Ph.D., Director, Health Information, Texas Health Care Information Council
- David Warner, M.P.A., Ph.D., Professor, Lyndon B. Johnson School of Public Affairs, University of Texas at Austin



The steering committee wishes to thank the entire work group (listed in alphabetical order below) for participating during this interesting and rewarding process. The steering committee would especially like to thank the following individuals for their contributions. Many thanks to Representative Dianne White Delisi and her staff, Wendy Wyman, Mary Bollinger, Beth Devery, and former staffer Kathleen Gardiner for everything they have done to encourage this process. Thanks to Gyl Wadge Kovalik and Lauren Rivera Jahnke, Planners with the Bureau of State Health Data and Policy Analysis, TDH, who served as the staff for the HCR 44 workgroup. Thanks to Mary Soto and Ahmed Adu-Oppong, also with the Bureau of State Health Data and Policy Analysis, for research performed and to Mary for helping with other tasks at the beginning of this project. Thanks to the public health regional directors and other TDH staff who came to the meetings and provided information. Thanks to Abeer A. DiLuzio at the Blackland Research Center for creating all of the maps except the population map, for which we thank creator Norma McNab at TDH. We wish to express our appreciation to the following people who made presentations at our meetings: Laura Lawlor, House Public Health Committee; Katherine Clossman, Sunset Advisory Committee; Paul Halverson, Centers for Disease Control and Prevention; Lynn Denton, TDH; Susan Steeg, TDH; Ann Henry, TDH; Mary Soto, TDH; Maureen Milligan, Texas Health and Human Services Commission; and Jim Allison, Texas Association of County Judges. We also want to thank our facilitator Jeannie Weaver for helping to keep us on course. The steering committee especially wishes to thank all of the local health department personnel and TDH staff in Texas who work tirelessly to keep all of us safe and healthy.

HCR 44 work group:

Hortencia Andrada, Office of Regional Administrative Services, TDH
William R. Archer III, M.D., Texas Commissioner of Health, TDH
Karen Batory, M.P.Aff., Division Director, Public Health, Texas Medical Association
Chuck Begley, Ph.D., School of Public Health, University of Texas at Houston



Eric Baumgartner, M.D., Chief, Bureau of Managed Care, TDH
Charles Bell, M.D., Director, Public Health Region 1, TDH
Gail Bellamy, Ph.D., Central Texas Partners in Health, Scott & White Hospital
Lanie Benson, M.D., Director, Victoria County Health Department
Mary Bollinger, Representative Dianne Delisi's Office
Ken Bost, Director, Brazos County Health District
Christine Bradshaw, D.O., M.P.H., M.B.A., Office Regional Administrative Services, TDH
Linda J. Breeden, Public Health Region 7, TDH
Bing Burton, Ph.D., Administrator, Denton County Health Department
Barbara J. Clements, Director, Wichita Falls/Wichita County Public Health District
Janice Coates, R.S., TDH and Texas Public Health Association
Pam Crowley, Clerk, House Public Health Committee
Carol Daniels, Process Manager, TDH
Lynn Denton, Division of Communication and Special Health Initiatives, TDH
Beth Devery, R.N., J.D., Representative Dianne Delisi's Office
William Dugas, Ph.D., Resident Director, Blackland Research Center, Texas A&M
Janet Emerson, Director, Waco-McLennan County Public Health District
Miguel Escobedo, M.D., Director, Public Health Regions 9 & 10, TDH
Albert J. Esparsen II, Administrator, Midland Health Department
Wayne Farrell, Director, Bell County Public Health District; President, TALHO
Pat Fowler, Director of Health, Garland; Texas Municipal League- TAMHO
Randy Fritz, CHIP Bureau Chief, Health Care Financing, TDH
Robert Galvan, Director, Ft. Worth Public Health Department, Texas Municipal League-
TAMHO
Kathleen Gardiner, M.P.Aff., former aide to Representative Dianne White Delisi
Sue Glover, Federal Legislative Analyst, Texas Association of Counties
Susan Griffin, M.P.Aff.
Mark Guidry, M.D., TDH, Director, Public Health Region 6 & 5 South
Anne Heiligenstein, Policy Advisor for Health and Human Services, Governor George W.
Bush
Carol Lee Hamilton, J.D., M.P.A., Associate Director, Health Quality and Planning, Tarrant
County Public Health Department
Alecia Hathaway, M.D., Texas Medical Association
Jimmy Helm, Associate Commissioner for Operations, TDH
Ann Henry, Bureau of State Health Data and Policy Analysis, TDH
John Hubbard, Sunset Advisory Commission
Jay Holland, Galveston County Health District
Thomas Hyslop, M.D., M.P.H., Director, Harris County Health Department
Lauren Rivera Jahnke, M.P.Aff., Planner, Bureau of State Health Data and Policy Analysis,
TDH
Michael F. Kelley, M.D., M.P.H., Chief, Bureau Communicable Disease Control, TDH
Gyl Wadge Kovalik, M.P.Aff., Planner, Bureau of State Health Data and Policy Analysis,
TDH
Donald Lee, Executive Director, Conference of Urban Counties
Linda Linville, Bureau of COPC, TDH
Hardy Loe, M.D., M.P.H., Associate Dean, School of Public Health, Health Science Center,
University of Texas at Houston
Sharon Marsh, Houston Health and Human Services Department
Paul K. McGaha, D.O., M.P.H., Director, Public Health Region 4 & 5 North, TDH
Maureen Milligan, Ph.D., Texas Health and Human Services Commission
Demetria Montgomery, M.D., Chief, Bureau of Community Oriented Primary Care, TDH
Jay D. Moore, Director, Environmental Health Services, Brazos County Health District
James K. Morgan, M.D., M.P.H., Director, Public Health Region 7, TDH
Patsy Morris, Office Coordinator, Collin County Health Care Services
Kristine Korn Niemeyer, M.P.Aff., Health Policy Analyst, Texas Medical Association
Jayne Nussbaum, Environmental and Consumer Health, TDH

Patti J. Patterson, M.D., Executive Deputy Commissioner, TDH
Linda Prentice, M.D., Associate Commissioner for Health Care Delivery, Child Health and Safety, TDH
Glen Provost, J.D., M.P.H., Vice President for Health Policy and Planning, Texas Tech University Health Sciences Center
Barbara Quiram, Ph.D., Director, Administrative Services, School of Rural Public Health, Texas A&M University Health Science Center
Gilbert Ramirez, Dr.P.H., Vice Chair, University of North Texas Health Science Center, Department of Public Health/ Preventive Medicine
William S. Riggins, Jr., M.D., Director, Public Health Region 8, TDH
Frank Ringer, Jr., Associate Commissioner for Human Resources and Support, TDH
Jerry Robinson, M.P.A., Director, City of Laredo Health Department
Eduardo Sanchez, M.D., St. David's Healthcare Partnership
Sam Seale, Executive Director, Texas Association of Counties
Diane Simpson, M.D., Ph.D., Associate Commissioner for Disease Control and Prevention, TDH
Brian Smith, M.D., Director, Public Health Region 11, TDH
Suzanne Sparks, Office of Regional Administrative Services, TDH
Bill Spears, Ph.D., Texas Health Care Information Council
Sharilyn Stanley, M.D., Chief Bureau of STD/HIV, TDH
Susan Steeg, TDH, General Counsel
Frank Sturzl, Director, Texas Municipal League
Maria Vega, Chief of Staff to the Deputy Commissioner for Community Health and Prevention, TDH
Becky Waak, Disease Control and Prevention, TDH
David Warner, M.P.A., Ph.D., Professor, LBJ School of Public Affairs, University of Texas at Austin
Beverly Weaver, Director, Dallas City Department of Environmental Health Services
Wendy Miller Wyman, Capitol Associate, Assistant to Representative Delisi
Jessie Yoas, Nursing Leadership Council
James Zoretic, M.D., Director Public Health Region 2/3, TDH



Public Health Acronyms and Terms Used



- AIDS**- Acquired immunodeficiency syndrome
- CDC**- Centers for Disease Control and Prevention (federal level)
- HD**- Health department
- HHS**- Health and human services
- HIV**- Human immunodeficiency virus
- LHD**- Local health department (or district)
- LPHR Act**- Local Public Health Reorganization Act (Texas Health and Safety Code, Chapter 121)
- MCH**- Maternal and Child Health
- Non-participating**- Local health department that does not receive state funds
- Participating**- (see State-participating)
- PHD**- Public health district
- PHHSBG**- Preventive health and health services block grant
- PHR**- Public health region
- State-participating**- Local health department that receives funding from TDH
- STD**- Sexually transmitted disease
- TANF**- Temporary Assistance to Needy Families (previously AFDC)
- TB**- Tuberculosis
- TDH**- Texas Department of Health
- WIC**- Women, Infants, and Children (nutritional program)

Executive Summary

House Concurrent Resolution 44 gave many interested organizations the opportunity to meet and discuss what is working and what is not working with the public health system in Texas. We found that some aspects of the system are satisfactory while others may not be ideal but may be very difficult to change at this time. There are some modifications that could be made immediately, however, that would steer the public health system back on the right path and help to reverse some recent disturbing trends.



There are many places in Texas where it is not clear who to call if you think a restaurant is unsanitary, think your dog may have been bitten by a rabid fox, or think you may have been exposed to a disease such as tuberculosis. *Many cities and counties in Texas have a limited or no public health presence.* In the past several years, Texans have been exposed to rabies, dengue fever, cyclospora, hantavirus, and other communicable diseases. Some have become ill and some have died from these diseases. Tuberculosis, hepatitis A, and some other diseases affect Texans at a higher rate than most other Americans.

The threat of new or unusually virulent diseases is always on the horizon. A recent example is the illnesses and deaths caused by invasive group A streptococcus. From December 1, 1997, to March 31, 1998, 170 strep A cases resulted in 36 deaths statewide, many of them children. It is not known exactly why some people are susceptible to group A strep and others are not or why many more cases than usual occurred in certain areas of the state. Chickenpox is believed to be a risk factor for strep A infection because it weakens the immune system and causes sores that can become infected; the chickenpox vaccine may therefore be an effective preventive measure. Public health officials at all levels coordinated with each other during this time to monitor and investigate the outbreaks and to educate the public and health professionals about this disease and preventive measures.

Environmental problems also have the potential to threaten public health. For example, in July 1997 the Texas Department of Health lifted a consumption advisory against eating fish taken from the lower Brazos River that had been in effect since 1990. Fish in this part of the river along the coast in Brazoria County had been found to contain elevated levels of dioxins, which are suspected of causing cancer, liver abnormalities, and reproductive problems when consumed regularly over a period of time. A Dow Chemical plant in Freeport was identified as a source of the dioxin compounds in the fish, and the company cooperated with officials to correct the dioxin release and reimburse TDH for retesting fish. In April 1996, fishing was banned from Mountain Creek Lake in Dallas County until further notice due to polychlorinated biphenyls (PCBs) found in fish from the lake that were tested by the Navy. The use of PCBs has been banned due to possible effects such as cancer, skin irritations, and reproductive disorders, but the compounds are very long-lasting and continue to contaminate the environment. At the time that this warning was issued, it was one of 14 active advisories or closures to fishing in Texas waters, most of which were in urban and industrial areas.

In 1998, oyster harvesting in Galveston Bay was banned from June to October due to the linking of oysters from the bay to an illness caused by the bacteria *Vibrio parahaemolyticus*. The Texas Department of Health counted 416 cases of the illness from 13 states, including 296 cases in Texas. Cooking destroys the bacteria, and cooler temperatures and water are expected to help control the bacteria, which are more abundant in warm weather in coastal waters worldwide. Another periodic health threat concerning shellfish is "red tide," an algae that releases toxins that kill fish and contaminate shellfish such as oysters. Consumption of the shellfish can cause neurotoxic shellfish poisoning, and cooking does not destroy the toxin. Harvesting of oysters, clams, and mussels from Matagorda Bay to the Rio Grande was banned in fall 1996 and again in fall 1997 extending into the first few months of 1998.



There are several important lessons to be drawn from these examples. Public health, or the lack of it, has the potential to affect every person in Texas. Prevention activities, including environmental monitoring and public health education, are crucial in communities to reduce the incidence of preventable disease and death. These activities must be ongoing, not initiated only during times of crisis. When there is a crisis, time is critical in addressing public health threats. The faster resources can be targeted to isolating the threat and educating the public, the more lives can be saved and suffering can be prevented. When there is a severely underfunded local public health presence or none at all in a community, there is not a functional infrastructure in place, and valuable time is lost in recognizing the threat and mobilizing already stretched state resources.

Public health is commonly confused with publicly funded health care, or indigent care, but these are actually distinct and different activities. Health care, both public and private, can be thought of as direct medical care provided to individuals, while public health is population-based services that are geared toward protecting the health of the public as a whole. Public health and medical care are on opposite ends of a health care continuum that overlaps in the middle, with treatment of individuals for the good of the public (such as giving immunizations or tracking sexually transmitted diseases). Public health efforts are not health services for the needy or other select groups of people—they serve everyone. Most public health activities do not and cannot differentiate as to poverty level or citizenship status. Population-based efforts such as controlling pollution or contagious diseases by definition benefit the *whole* population.

A productive society relies on a safe and healthy population. Public health is the first-line defense in maintaining and improving the public's health status. The success of public health efforts depends on foresight, planning, and the cooperation of health professionals and government officials at all levels. The responsibility for carrying out public health functions falls mostly on the state health department, the state-supported public health regions, and local health departments. The public health regions function as a stopgap when localities do not have a local health department or cannot provide the full range of services needed, but regional offices do not always have the resources or local expertise to provide the level of public health assurance that is needed in communities and that most Texans have come to expect.

Local health departments and their sources of funding are changing, and these changes inevitably affect the provision of public health services. Funding for direct medical services, such as Medicaid and maternal and child health grants, has been helping to cover the overhead for many local health departments and their population-based public health activities, but as these services are contracted out due to new rules, funding problems are often an unintended result. Local, state, and federal funds for public health are becoming more categorical and restrictive or are being cut. Yet, contagious diseases, exposure to toxins, and foodborne illnesses continue to occur and are becoming more prevalent in some places, while new diseases and problems are also emerging. These types of occurrences need the monitoring and control that a local public health presence can provide most effectively.

One reason local public health suffers from underfunding is a lack of clear assignment of responsibilities for public health in Texas. Texas law does not require local governments to provide or assure the provision of public health activities and does not define essential public health functions. The law only lists functions that an entity must do to be called a "local health department" instead of a "local health unit." The vagueness in the current law results in a fragmented and unstandardized system in which some local health departments receive a large majority of their funding from state grants and others receive no direct help from the state, and some localities make an effort to protect the health of their residents while the state public health regions try to provide local public health services in others.

Dramatic gains have been made in public health in the past century, but taking these for granted and letting the public health infrastructure deteriorate is asking for disaster. The problems of the past such as widespread contagious diseases and contaminated food and water have not disappeared; they are waiting to re-emerge wherever cracks form in the public health system. When public health in some areas suffers, the health of the state as a whole suffers. The health of all Texans depends on taking proactive measures to preserve, coordinate, and strengthen the public health system in Texas.



The following is a list of our recommendations; these recommendations along with some additional explanation and comments are found in Chapter 5 of this report.

Recommendation 1: The Texas Legislature should make it public policy that every resident of Texas is entitled to the protection offered by the essential public health services.

Essential Public Health Services are defined as follows:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research new insights and innovative solutions to health problems.

Recommendation 2: The Texas Legislature should provide support, on a recurring per capita basis, from state funds in amounts sufficient to ensure that a system of local public health entities can effectively perform essential public health services. The following sources (and combinations thereof) are some suggested funding options:

- general revenue
- tobacco settlement
- alcohol tax
- tobacco tax
- lottery
- money penalties for civil/criminal convictions for environmental infractions
- federal money
- user fees
- redistribute state funds
- Medicaid Managed Care profit-sharing rebate funds
- fee on the conversion of non-profit health-related entities to for-profit status.

Recommendation 3: The Texas Legislature should provide counties and/or incorporated municipalities with the option of receiving from the state, on a noncompetitive basis, funding for the provision of the essential public health services to residents within their respective jurisdictions. The Texas Department of Health, through its regions, will receive the per capita funding for the counties and/or incorporated municipalities who do not opt to receive these funds and the TDH regions will provide the services. The intent is to augment funds already expended by counties and/or incorporated municipalities to provide essential public health services.



Recommendation 4: The Texas Legislature should allow counties and/or incorporated municipalities to utilize funds provided to them by the state for the purpose of providing essential public health services to contract with each other, the Texas Department of Health, or other entities to perform these services.

Recommendation 5: The Texas Legislature should encourage counties and/or incorporated municipalities to form public health districts, for the purpose of providing essential public health services, that may consist of multiple cities, multiple counties, or a combination of cities and/or counties.

Recommendation 6: The Texas Legislature should require that the governing bodies of counties and incorporated municipalities who receive state funding for essential public health services appoint a local health authority. Local health authorities should be allowed to serve more than one county or incorporated municipality at a time. In counties and/or incorporated municipalities who do not receive these funds and who do not appoint a local health authority, the Texas Department of Health's regional director will serve as the local health authority.

Recommendation 7: The Texas Legislature should require counties and incorporated municipalities who receive state funds for essential public health services to appoint a local board of health. The commissioners court or city council of these counties and incorporated municipalities may elect to serve as the local board of health; however, they are encouraged to appoint advisory boards of health to advise them on public health matters.

Recommendation 8: The Texas Legislature should require the Texas Department of Health to work with state institutions of higher education and local health departments to develop ways to increase the competency and capacity of the state's local public health workforce.

Recommendation 9: The Texas Legislature should require that the Texas Department of Health and local governments receiving state funds for essential public health services, together with other appropriate institutions, to develop local strategic plans which incorporate performance measures and outcome measurements to serve as a basis for evaluation.

Recommendation 10: The Texas Legislature should require that the Texas Department of Health, in cooperation with county and city health departments and districts, conduct periodic assessments of the provision of and level of funding for essential public health services and make recommendations to the Legislature and the Governor.

Table of Contents

I. INTRODUCTION AND ISSUES	1
Definition of Public Health.....	3
II. CURRENT PUBLIC HEALTH SYSTEM IN TEXAS	5
Local Level.....	5
State and Regions.....	17
III. GAPS IN THE PUBLIC HEALTH INFRASTRUCTURE	21
State and National Issues	21
Local Issues	21
Recent Examples	22
IV. DISCUSSION AND CONCLUSIONS	25
V. RECOMMENDATIONS	27
VI. APPENDICES	31
A: House Concurrent Resolution 44	33
B: Methods and Results of Questionnaire	35
C: Regional and Local Public Health Information.....	41
D: Public Health Systems in Selected States	61
BIBLIOGRAPHY	76



Chapter One

Introduction and Issues

A productive society relies on a safe and healthy population. Whether the public health system is seamlessly woven or haphazardly stitched together depends on foresight, planning, and the cooperation of health professionals and government officials at all levels. Public health (defined in the next section of this paper) affects all people and has a rich history. It has been calculated that a majority of the large gain in life expectancy seen in the United States in the last century is due to various public health activities as opposed to improved medical technology. The entities named in House Concurrent Resolution 44, passed by the 75th Texas Legislature, were called upon to study the role of local governments in providing these public health services, and our findings and recommendations follow. We believe that certain actions need to be taken before an unmanageable public health crisis develops.

Many changes are occurring in the way medical care is delivered in Texas, including the growing prominence of managed care in both publicly and privately funded health care systems. There are new priorities, including extending Medicaid coverage to more uninsured people, establishing a “medical home” for those receiving publicly funded care, and the need to conserve resources and maximize their effects. Core public health, or population-based health, serves a parallel and important function that affects everyone, yet it is often overlooked when health and medical care are discussed. Public health includes disease surveillance, outbreak management, prevention activities, and education that are crucial in communities to reduce the incidence of preventable conditions. Many health departments have over time become deeply involved in indigent health care, and while this is important, it is not the direct responsibility of public health. These activities have helped keep some local health departments open and have helped to fund core public health activities. As other providers are becoming more involved in serving Medicaid patients and other groups of patients, however, many local health departments find that additional sources of income are needed in order to maintain the same levels of public health services that they have provided in the past. A fundamental level of capacity for carrying out basic public health functions must be maintained across the state. This is an ongoing problem, particularly in rural areas.

The Texas Department of Health is the state agency in charge of protecting the public’s health, but in a state of 254 counties and over 250,000 square miles it cannot do this effectively without local involvement. Communities need to share responsibility for the health of their residents. However, there are thousands of local governments in Texas, including towns, cities, and counties, and a wide variation in population, available resources, and willingness to work cooperatively exists. These factors can cause fragmentation in the system and make coordination difficult. The problem is becoming more acute as local, state, and federal funds to many local health departments are being cut even as contagious diseases, environmental toxins, foodborne illnesses, and other problems are becoming more prevalent and new diseases and problems are emerging that need the monitoring and control that a local public health presence can provide most effectively. Time is crucial in addressing public health dangers. The faster resources can be targeted to isolating threats and educating the public, the more lives can be saved and suffering can be prevented.

A majority of counties in Texas (covering about 20 percent of the state population) do not have local health departments at all, making it that much harder to track diseases and provide education and prevention measures in those areas (see Appendix C for locations and populations). The Texas Department of Health, through its public health regional



We believe that certain actions need to be taken before an unmanageable public health crisis develops.



offices, steps in if there is an emergency, but it does not have enough funding or personnel to provide an everyday presence for more routine local public health activities. The irony of public health is that it is a victim of its own effectiveness. The more effective the prevention, early detection, and education efforts are in an area, the fewer people there are who get foodborne or mosquito-borne illnesses, lead poisoning, tobacco-related illnesses, AIDS, and other conditions, leading to the perception that the local health department does not have much to do and often funds are cut as a result. The public health infrastructure, though invisible at times, must be kept in place and strengthened in some areas in order to maintain and improve the general health and well-being of the public.

Statistics for public health indicators tracked and compiled by the Texas Department of Health show how Texas is doing in certain areas in relation to the rest of the nation. For example, Texas performed better than the U.S. average in several indicators such as the infant mortality rate and reported AIDS cases, but fared worse than the U.S. as a whole in a majority of the indicators such as the suicide rate, lung cancer death rate, cardiovascular disease rate, TB case rate, and percentage of pregnant women not receiving prenatal care in the first trimester.¹ To compound problems, Texas has the highest rate in the nation of people without health insurance—about 24 percent. There are also diseases that have emerged in Texas in the last several years such as hantavirus and cyclospora that require ongoing efforts to prevent and find effective treatments. Diseases more prevalent in some other countries such as drug-resistant tuberculosis and dengue fever pose a very real threat to Texas.

Locally supported health departments have been a vital component of the public health infrastructure in Texas for many years, but in the past few years several have closed and several more have had to cut services, and many more may have to in the near future. Some local health departments (LHDs) have changed their status from state-participating (receiving state funds) to non-participating (completely supported locally), accompanied by a reduction in services, and several were divided or transferred to other agencies. There are at least five current LHDs that remain state-participating but that have experienced a significant decrease in their funding. Many more have experienced smaller cuts in services or downsizing of staff, often due to Maternal and Child Health funding (Title V) changes or cuts in local support. Funding for the delivery of direct clinical services has been helping to support many LHDs and their core activities. However, as these services are contracted out, allowing them to refocus on essential public health functions, funding problems are often an unintended result.

Some local health departments that had to scale back services may have been too small to be cost-efficient. Many health officials believe that more counties and/or municipalities should group together to form public health districts to keep health departments open, effective, and adequately funded (50,000 people is often quoted as the minimum population threshold needed to support an adequate health department²). Some Texas towns are very independent and/or geographically isolated, but methods need to be found to overcome these obstacles to ensure that rural residents derive the same public health benefits that urban areas are more likely to have.

Local health departments are important in public health efforts because they are located in communities and know their communities' problems, concerns, and health needs. The major factor contributing to the observed cuts and closings of local health departments and clinics is changes in local, state, and federal funding, amid a general government-wide climate of tightening funds and services. If local services continue to be cut back, no matter what the cause, many local health officials warn of impending disaster. The Texas Department of Health regional offices and clinics cannot reasonably perform all the functions of an LHD in every community. As more local health departments lose funding and cut services, we move closer to the chance of large outbreaks of diseases once thought

to be under control. In the case of public health and the increasing need to use funds effectively, the old adage could not be more true: “An ounce of prevention is worth a pound of cure.”

Definition of Public Health

Public health is commonly confused with publicly funded health care, or indigent care, but these are actually distinct and different activities. Health care, both public and private, can be thought of as direct medical care provided to individuals, while public health is population-based services that are geared toward protecting the health of the public as a whole. Public health and medical care are on opposite ends of a health care continuum that overlaps in the middle, with treatment of individuals for the good of the public (such as giving immunizations or tracking STDs). Public health efforts are not health services for the needy or other select groups of people—they serve everyone. Most public health activities do not differentiate as to poverty level or citizenship status—population-based efforts such as controlling pollution or contagious diseases by definition benefit the *whole* population.

Public health actions minimize threats to the population from infectious diseases, environmental hazards, poor sanitation, and other problems through prevention programs, public education, restaurant and septic tank inspections, disease tracking, medical intervention, and other methods. Public health, or the lack of it, has the potential to affect every single person in Texas. Even those of us with private health insurance and private doctors would not want to go the grocery store and buy meat that might be contaminated with *E.coli* or fruit that has cyclospora, and then stand in line next to someone who has multi-drug-resistant tuberculosis because he did not take his medications consistently. Occurrences such as these are not prevented by chance, but by deliberate and continuing activities on the part of local and state health departments.

The following is a comprehensive and widely used definition of public health expectations and actions, specifying six public health goals, ten essential public health services, and government’s three core functions. It was adopted by the Essential Public Health Services Work Group of the Core Public Health Functions Steering Committee (made up of numerous public health organizations)³ in fall 1994 and has been published by the Institute of Medicine and others.

Public Health Goals:

- prevent epidemics and the spread of disease
- protect against environmental hazards
- prevent injuries
- promote and encourage healthy behaviors
- respond to disasters and assist communities in recovery
- assure the quality and accessibility of health services

Essential Public Health Services:

- monitor health status to identify community health problems
- diagnose and investigate health problems and health hazards in the community
- inform, educate, and empower people about health issues
- mobilize community partnerships to identify and solve health problems
- develop policies and plans that support individual and community health efforts
- enforce laws and regulations that protect health and ensure safety
- link people to needed personal health services and assure the provision of health care when otherwise unavailable





- assure a competent public health and personal health care workforce
- evaluate effectiveness, accessibility, and quality of personal and population-based health services
- research new insights and innovative solutions to health problems.

These essential public health services were developed as specific means of carrying out three core public health functions that were defined by the Institute of Medicine as the government's role in maintaining the health of the public. These functions are assessment, policy development, and assurance.⁴ *Assessment* includes tasks such as surveillance, data collection, analysis, research, and evaluation. This function allows the health department to know what threats to health exist, whether they are getting better or worse, and whether or not health services in the community are effective. *Policy development* takes into account the public interest and includes planning, setting goals, negotiating, communicating, and persuading. This function results in programs, local ordinances, county orders, or other policies that make it possible to protect the public from diseases, injuries, and public health hazards. *Assurance* involves implementing regulations and ensuring that the necessary services are available to maintain health and safety and to handle crises. The health department makes certain that some organization, agency, or group of practitioners is providing the necessary services to protect health.

Among all of the duties listed above that are legitimate public health concerns, many consider some of these functions to be absolutely essential or core public health functions. Functions that are not means-tested (i.e., they do not depend on an individual's income) and that are population-based are the root of public health. These are the goals, functions, and essential services that are regarded as necessary in each local community to protect the health of that community's population. These include activities such as the following:

- protecting human health from environmental risks
- assuring the safety of food, drugs, and water
- preventing the spread of diseases and epidemics
- providing epidemiologic investigations of public health risks
- providing disease and health status surveillance
- educating, informing, and empowering people and communities about health issues.

While it may be easy to understand the general purpose of public health, it is difficult to formulate a short and concise definition. The HCR 44 group has not attempted to formulate a new all-encompassing definition but rather has modified the Institute of Medicine list of essential public health services to use as a guide in funding public health activities in the state of Texas (see Chapter 5, Recommendation 1, for modified list).

¹ TDH, Healthy People 2000 Indicators, pp. 2-21.

² Allen Koplin, "The Future of Public Health: A Local Health Department View," 1990.

³ Adopted by the Essential Public Health Services Work Group of the Core Public Health Functions Steering Committee, Fall 1994. *Members:* American Public Health Association, Association of State and Territorial Health Officials, National Association of County and City Health Officials, Institute of Medicine (National Academy of Science), Association of Schools of Public Health, Public Health Foundation, National Association of State Alcohol and Drug Abuse Directors, National Association of Mental Health Program Directors, U.S. Public Health Service (Centers for Disease Control and Prevention, Health Resources and Services Administration, Office of the Assistant Secretary for Health, Substance Abuse and Mental Health Services Administration, Agency for Health Care Policy and Research, Indian Health Service, Food and Drug Administration).

⁴ IOM, *The Future of Public Health*, pp. 43-45.

Chapter Two

Current Public Health System in Texas

Local Level

Local health departments in Texas come in a wide variety of shapes and sizes. There are 64 local health departments in Texas that receive state funding (called “state-participating” or just “participating”), down from about 70 in 1990. These are comprised of eight city health departments, 31 county health departments, and 25 public health districts (including city-county and county-county districts). There are over 80 local health departments that receive no state funding; these are called “non-participating”. Several of these are large, full-service departments, but most are small and provide mainly environmental services such as animal control and septic tank inspections. Non-participating health departments do not receive state funds or assistance, but are still eligible for certain federal funds. (See Figure 1 for map of local health departments.) Most local health departments were established after World War II with special development money, though there are records of several health departments and old local public health statutes dating back to the early 1900s.

The current local public health statute, the Local Public Health Reorganization Act (Chapter 121 of the Texas Health and Safety Code), was passed by the Texas Legislature in 1983 and amended in 1985. It repealed some outdated provisions of state law and provided guidelines on terminology and formation of local public health entities, but it did not change the state’s permissive stance on public health services provided by local governments. The law states in Chapter 121.031: “(t)he governing body of a municipality or the commissioner’s court of a county may establish a local health department by majority vote.”¹

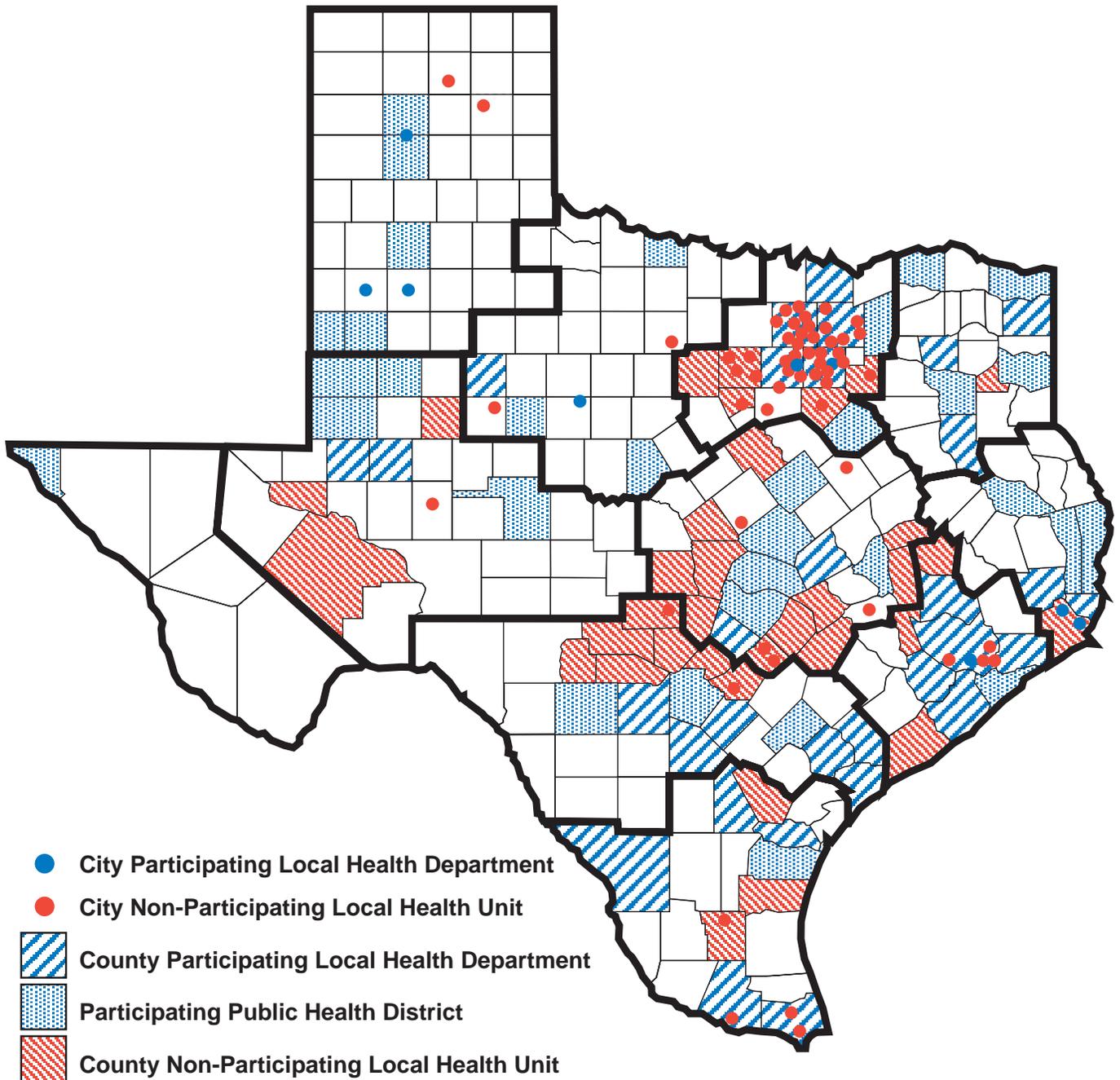
The Local Public Health Reorganization (LPHR) Act does not define public health or essential services, though it does provide a list of six activities that a local governmental entity must provide at a minimum to be officially termed a “local health department” or “public health district”. A public health district acts like a local health department; the only difference is that it is formed by more than one local government, i.e., two or more counties, two or more municipalities, a county and one or more municipalities, or two or more counties and one or more municipalities.² The optional minimum services stated in §121.032 are the following:³

1. personal health promotion and maintenance services
2. infectious disease control and prevention services
3. environmental and consumer health programs for the enforcement of health and safety laws relating to food, water, waste control, general sanitation, and vector control
4. public health education and information services
5. laboratory services
6. administrative services.



Most local health departments were established after World War II with special development money, though there are records of several health departments and old local public health statutes dating back to the early 1900s.

Figure 1.
Participating and Non-Participating
Local Health Departments



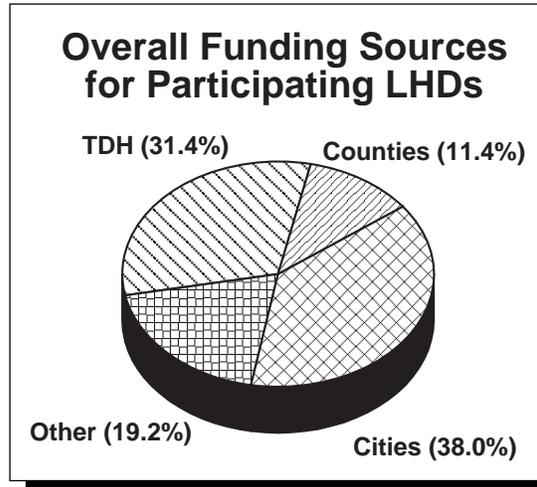
Source: Texas Department of Health, 1998
 Created by: Blackland Research Center

A local public health entity that performs some of the six services specified in the LPHR Act but not all of them is termed a “Local Health Unit” in the Act. To be termed a “state-participating” local health department/district, TDH contracts with the LHD and provides state funds in return for the LHD providing certain public health services and reporting as specified in the contract. The law says that to be participating, the LHD must provide annually to TDH information about “services provided, staffing patterns, and funding sources and budgets.”⁴ Even though these health departments have contracts with the state, they are autonomous and are accountable to their local city and/or county officials. The law does not require TDH to contract with local health departments, nor does it specify any funding mechanisms.



Local Funding

In FY 1997, participating local health departments received, on average, 31.4 percent of their funding from TDH (including federal pass-through grants), 38.0 percent of their funding from cities, 11.4 percent of their funding from counties, and 19.2 percent of their funding from other sources (such as Medicaid, Medicare, fees charged, nonprofit foundations, etc.).⁵ Some local health departments were established by either a city or a county, so they get support from only one of these sources, not both. This local funding comes from city and/or county revenue obtained from local property taxes or other sources such as the locality’s share of the state sales tax or development fees. See Table 1 for data on budget sources



for all participating local health departments for Fiscal Year 1997. Non-participating health departments receive most of their funding from their respective cities or counties, with some having additional sources such as Medicaid reimbursements, fees collected, and special state or federal grants.

The state funding that participating local health departments receive consists of categorical grants and “triple-zero” money. Triple-zero money is the state funding that goes to participating LHDs for specific uses (until recently LHDs could use it for any health-related purpose). It is the funding that defines a state-participating health department; it is the only funding that all participating LHDs get from the state and non-participating health departments cannot receive. Non-participating LHDs can get certain federal funds through the state or directly from the federal government, but this is not common. Triple-zero money comes from state general revenue (73.52 percent) and the federal Preventive Health and Health Services Block Grant, or PHHSBG (26.48 percent) and is named after the TDH budget number for these funds (000).

Triple-zero funds are the foundation of participating LHDs’ state funding and contracts. In the past triple-zero could be used for any public health purpose by a local health department, and was commonly used to fill in the funding gaps that more specific grants could not cover. It was given on an “historical” basis, not specifically linked to population or outcomes. Starting with the fiscal year beginning September 1, 1996, some guidelines were attached to triple-zero money for the first time. These are specified in the annual contracts with participating LHDs. In the latest guidelines, 73.52 percent of the triple-zero money (the general revenue portion) has to be used for one or more of the ten essential public health elements listed in the contract, and the other 26.48 percent (the PHHSBG funds) must be used for cardiovascular and cancer prevention programs only. LHDs have to submit their plans on how they will use the funds in advance or risk losing them. In the past, the PHHSBG portion could be used for several programs in addition to cardiovascular and cancer prevention, but TDH decided that

**Table 1. Self-Reported Funding Sources for Participating Local Health Departments
Fiscal Year 1997 (September 1, 1996 - August 31, 1997)**

Local Health Department	TDH	City	County	Other	Total Funding
Abilene Public Health District	1,827,394.00	963,615.00	90,990.00	65,350.00	2,947,349.00
City of Amarillo Dept. of Health	945,061.00	115,263.00		654,850.00	1,715,174.00
Andrews City-County HD	231,468.24		325,788.99	51,162.79	608,420.02
Angelina County and City Health District	755,192.00	41,710.00	348,390.00	337,800.00	1,483,092.00
Atascosa County HD	57,644.08		17,482.00		75,126.08
Austin-Travis Co. Dept of Health & Human Services	5,673,150.00	35,053,731.00	5,347,942.00	18,605,289.00	64,680,112.00
Beaumont City HD	948,457.00	1,491,276.00			2,439,733.00
Bell County Public Health District	2,263,538.00	240,917.00	110,036.00	476,438.00	3,090,929.00
Brazoria County HD	489,732.00		878,831.00		1,368,563.00
Brazos County HD	418,218.00	280,396.00	381,742.00	340,607.00	1,420,963.00
Brownwood-Brown County HD	34,766.00	109,868.00	50,500.00	2,675.00	197,809.00
Calhoun County HD	150,694.00		153,974.00	5,000.00	309,668.00
Cameron County HD	4,411,923.00		3,637,835.00		8,049,758.00
Cass County HD	23,496.00		6,970.00	712.25	31,178.25
Chambers County HD	31,763.24		147,097.09		178,860.33
Cherokee County HD	345,470.22		75,959.04	39,864.84	461,294.10
Collin County Hlth Care Services	75,442.00		1,466,238.00	105,995.00	1,647,675.00
Corpus Christi-Nueces Co. PHD	2,968,066.00	3,013,584.00	1,033,986.00	322,750.00	7,338,386.00
Corsicana-Navarro Co. PHD	533,633.39	28,416.67	13,266.00	273,475.64	848,791.70
Cuero-Dewitt County HD	50,472.00	24,971.00	29,728.00	92,913.00	198,084.00
Dallas City Dept of Health & Human Services	8,546,072.00	8,078,845.00		3,697,277.00	20,322,194.00
Dallas County HD	5,578,159.00	37,500.00	1,957,410.00	49,778.00	7,622,847.00
Denton County HD	533,661.00		529,000.00	519,457.00	1,582,118.00
Ector County HD	390,521.00		727,812.00	42,648.00	1,160,981.00
El Paso City-County HD	4,390,722.00	64,613.00	64,612.00		4,519,947.00
Fort Bend County HD	89,381.42		796,316.00		885,697.42
Fort Worth Dept of Public Health	5,407,280.00	6,082,680.00			11,489,960.00
Galveston County HD	<i>Nav</i>	<i>Nav</i>	<i>Nav</i>	<i>Nav</i>	<i>Nav</i>
Grayson County HD	981,268.00	2,400.00	40,000.00	865,484.00	1,889,152.00
Greenville-Hunt County HD	97,584.00	213,487.00	162,520.96	49,694.22	523,286.18
Hardin County HD	308,864.00		66,805.00	24,800.00	400,469.00
Harris County HD	7,507,087.00		11,501,589.00	10,233,981.00	29,242,657.00
Hidalgo County HD	2,672,904.64		2,847,548.71	294,514.68	5,814,968.03
Houston Dept of Health & Human Services	15,029,742.00	55,190,665.00		10,859,546.00	81,079,953.00

Local Health Department	TDH	City	County	Other	Total Funding
Jackson County HD	31,036.00		158,606.00		189,642.00
Jasper-Newton County PHD	1,687,879.00		78,030.00	105,755.00	1,871,664.00
City of Laredo HD	4,465,158.00	2,596,805.00	182,000.00	43,128.00	7,287,091.00
Live Oak County HD	51,992.00		45,561.00		97,553.00
Lubbock City HD	401,009.00	1,652,517.00		241,836.00	2,295,362.00
Marshall-Harrison County Health Dist.	218,177.00	43,841.00	49,245.00	17,323.00	328,586.00
Medina County HD	187,726.00		61,994.00	20,159.00	269,879.00
Midland Health Dept.	104,040.00	1,136,059.00	38,543.00		1,278,642.00
Milam County HD	122,225.05		442,490.00	70,314.02	635,029.07
Montgomery County HD	998,387.00		259,284.00	1,074,372.00	2,332,043.00
Orange County HD	464,570.00		29,000.00	464,377.00	957,947.00
Paris-Lamar County HD	474,351.00	137,995.00	137,994.00	85,000.00	835,340.00
Plainview-Hale County Hlth Dist	157,110.27	60,169.68	59,930.50		277,210.45
Port Arthur City HD	928,951.00	492,303.00			1,421,254.00
San Angelo-Tom Green Co HD	1,355,437.00	813,054.00	120,483.00	1,146,249.00	3,435,223.00
San Antonio Metro Hlth Dist	10,895,351.00	12,840,833.00	144,420.00	11,294,712.00	35,175,316.00
Hays County HD	775,146.00		633,059.00		1,408,205.00
San Patricio County HD	991,627.00		685,177.00	76,276.00	1,753,080.00
Scurry County HD	94,037.00		84,231.00		178,268.00
Smith County Health District	1,952,060.56	1,060,188.45	404,574.89	550,073.18	3,966,897.08
South Plains PHD	714,755.00		231,463.00	113,141.00	1,059,359.00
Sweetwater-Nolan County HD	414,011.00	15,000.00	16,500.00	86,992.00	532,503.00
Tarrant County HD	6,094,709.00		3,207,411.00	3,162,385.00	12,464,505.00
Texarkana-Bowie Co. Family Health Center	527,093.32	258,500.00	55,000.00	228,192.14	1,068,785.46
Uvalde City-County HD	62,709.00	84,050.00	69,135.00		215,894.00
Victoria County HD	774,003.00	702,333.00	405,970.00	223,101.00	2,105,407.00
Waco-McLennan County PHD	1,830,478.00	2,024,525.00		887,469.00	4,742,472.00
Wichita Falls-Wichita County PHD	1,456,314.00	2,003,669.00	93,000.00	575,597.00	4,128,580.00
Williamson County & Cities PHD	1,161,969.00	147,665.00	446,311.00	730,496.00	2,486,441.00
Wood County HD	75,898.00		96,099.00		171,997.00
GRAND TOTAL	113,237,035.43	137,103,444.80	41,045,880.18	69,209,009.76	360,595,370.17

Source: TDH, Office of Regional Administrative Services, 1998.



this portion needed to be made more specific and measurable to include in the state application to the Centers for Disease Control and Prevention for this federal block grant.

The contracts with LHDs also specify what additional funding they will receive from the state. Additional funding is categorized into 16 programs that receive state and/or federal funding. Examples are Occupational Health, Sexually Transmitted Diseases, WIC (Women, Infants, and Children program), Dental, Tuberculosis, and Injury Prevention.⁶ No LHD receives all of these funds, rather each receives a different combination depending on their needs and the funds available. All of these programs have various performance and reporting requirements.

Local Health Authority and Local Board of Health

The Local Public Health Reorganization Act provides for the appointment of a local health authority. According to §121.021 of the LPHR Act, “a health authority is a physician appointed under the provisions of this chapter to administer state and local laws relating to public health within the appointing body’s jurisdiction.” Qualifications and duties of a health authority are listed in the Act. The health authority must take the official oath and the appointment is for two years (they can be appointed to successive terms). The Act also lists provisions for delegation of authority and for-cause removal of health authorities.

In jurisdictions that have established a local health department, the director of the LHD is automatically the local health authority if the director is a physician, otherwise, the director must appoint a physician to serve in this capacity (the same applies to public health districts). In areas without a local health department, “(t)he governing body of a municipality or the commissioners court of a county that has not established a local health department or a public health district may appoint a physician as health authority to administer state and local laws relating to public health in the municipality’s or county’s jurisdiction” (emphasis added). The Texas Board of Health may require a regional director to perform the duties of a health authority in areas of the region where there is no local health authority or the health authority fails to perform the required duties.

Section 121.034 of the Act allows a city or county government that establishes a local health department to have the option of creating “an administrative or advisory public health board and the appointment of representatives to that board.” It states that the director of the LHD is an ex officio nonvoting member of any public health board established for the local health department. When public health districts are formed, the members must develop and sign a “cooperative agreement” stating the terms of operation of the district, and this agreement may provide for the creation of an advisory or administrative public health board. If the district chooses to have a public health board, guidelines are provided.⁷ As with a local health department director, district directors are ex-officio nonvoting members of any public health boards established locally.

Local Services

Local health departments and districts provide a variety of services for the populations in their jurisdiction, and the mix of services varies for each department. A small rural local health department may provide only a few services, such as septic tank inspections, immunizations, vital statistics, and environmental complaint investigations. On the other hand, a large metropolitan health department may provide a system of health clinics for uninsured and poorer people and social/community services such as job programs, youth programs, case management, and housing assistance, as well as the more standard environmental, animal control, and population-based health services.

Following are profiles of five local health departments to help in understanding the activities of a local health department and how each is similar and different. An attempt was made to represent a range of types of local health departments, including city, county, city/county districts, participating, non-participating, small, large, and various geographic locations.

Bell County Public Health District

Public Health Region: 7 (central Texas)

Service area: Bell County; Cities of Killeen, Temple, Belton, Harker Heights, Troy, Rogers, Little River/Academy, Morgan's Point, and Holland

Main services provided:

1. Clinic services
 - Family Planning
 - Maternity
 - Immunizations
 - Tuberculosis
 - Sexually Transmitted Diseases
 - WIC
 - HIV
2. Environmental services
 - Food Service Inspections
 - Food Manager Certification
 - Food Handler Training
 - On-site Sewage Regulation
 - School Inspections
 - Nuisance Abatements
 - Code Enforcement
 - Water Protection
 - Vector Control
 - Rabies Control

Number of employees (FTEs): 79

<i>Total FY 1997 budget:</i>	\$3,090,929	(100%)
from TDH:	\$2,263,538	(73.2%)
from cities:	\$240,917	(7.8%)
from county:	\$110,036	(3.6%)
from Medicaid:	\$109,076	(3.5%)
from fees:	\$291,228	(9.4%)
from other sources:	\$76,134	(2.5%)

1996 Bell County estimated total population: 222,146

Black:	19.6%
Hispanic:	15.0%
Anglo:	61.9%
Other:	3.6%

Population per square mile: 209.8

Socioeconomic indicators for Bell County:

Unemployment rate (1996):	4.9%
Unduplicated count of Medicaid recipients (1996):	21,333
Average monthly food stamp participants (1996):	22,046
Average monthly TANF recipients (1996):	5,760
Estimated median household income (1993):	\$26,504
Estimated percentage of people in poverty (1993):	19.6%

Perspective on most important local public health issues faced — Wayne Farrell, Director:

1. A clear concise definition of "public health" needs to be formulated, especially with the issue of indigent health care so often being misapplied as "public health."
2. A funding mechanism to support essential public health services at the local level needs to be supported by the Texas Legislature.
3. All Texas cities and counties should be served by local public health departments or health districts for the provision of essential public health services to every resident of the state.
4. Chapter 121 of the Texas Health and Safety Code should be revised to ensure these objectives are obtained.

Sources: TDH, Office of Regional Administrative Services, "Local Agency Budget and Expenditure Report FY 97"; TDH, Bureau of State Health Data and Policy Analysis, County Fact Sheet for Bell County, 1996; US Census Bureau, webpage <http://www.census.gov/cgi-bin/hhes/saipe93/estimate.html>, tables C93-48 and A93-48; Wayne Farrell, Director, Bell County Public Health District, July 1998.

Brazos County Health District

Public Health Region: 7 (central Texas, eastern side)

Service area: Brazos County (including cities of Bryan and College Station)

Main services provided:

1. Personal Health Services
 - Immunizations
 - Child health examinations
 - Adult health screenings for glucose and blood pressure
 - Communicable disease control and investigations
 - Tuberculosis elimination
 - Sexually transmitted disease diagnosis and treatment
 - HIV testing and counseling
 - Worksite wellness
2. Environmental Health Services
 - Food service establishment inspections
 - Child care facility inspections
 - On-site sewage facility permits and inspections
 - Subdivision plat review
 - Food handler training and certification
 - Certified food manager registration
 - Environmental investigations
3. Laboratory Services
 - Bacteriological analysis of public and private water
 - Infectious disease testing
4. Health Education Services
 - Community resources referrals
 - Health education materials and resources
 - Health education programs and exhibits

Number of employees (FTEs): 26.5

<i>Total FY 1997 budget:</i>	\$1,480,169	(100%)
from TDH:	\$480,492	(32.46%)
from cities:	\$281,436	(19.01%)
from county:	\$377,634	(25.51%)
from Medicaid:	\$47,600	(3.22%)
from fees:	\$217,979	(14.73%)
from other sources:	\$75,028	(5.07%)

1997 Brazos County estimated total population: 134,558

Black:	10.2%
Hispanic:	12.4%
Anglo:	70.5%
Other:	6.9%

Population per square mile: 235.7

Socioeconomic indicators for Brazos County:

Unemployment rate (1997):	3.2%
Unduplicated count of Medicaid recipients (1997):	12,362
Average monthly food stamp participants (1997):	10,620
Average monthly TANF recipients (1997):	2,997
Estimated median household income (1997):	\$27,000
Estimated percentage of people in poverty (1993):	19.9%

Perspective on most important local public health issues faced — Ken Bost, Director:

1. We agree with the effort to standardize the essential public health services.
2. The following are also issues we support:
 - Necessary/appropriate monetary resources for public health supported by reliable funding.
 - The implementation of the ten essential public health services at the local/district level.
 - Establishment of a direct link between the local/district level and the state health department central office.

Sources: TDH, Bureau of State Health Data and Policy Analysis, County Fact Sheet for Brazos County, 1996; US Census Bureau, webpage <http://www.census.gov/cgi-bin/hhes/saie93/estimate.html>, tables C93-48 and A93-48; Ken Bost, Director, Brazos County Health District, August 1998.

City of Garland Health Department

Public Health Region: 3 (north east Texas)

Service area: City of Garland

Main services provided:

- Immunizations
- Food service inspections
- Air quality control
- Hazardous material spill response
- Animal control
- Communicable disease investigation and control
- Well child exams
- Child care facility inspections
- Water quality control
- Environmental noise control
- Vector control

Number of employees (FTEs): 32

<i>Total FY 1997 budget:</i>	\$1,803,858	(100%)
from TDH:	\$121,332*	(7%)
from city:	\$1,115,665	(62%)
from county:	-0-	-0-
from Medicaid:	\$20,000	(1%)
from fees:	\$509,000	(28%)
from other sources:	\$37,861	(2%)

*The City of Garland Health Department is classified as non-participating because it does not receive state triple-zero money or other normal TDH grants; however, Garland, Plano, and Richardson share a special TDH grant that is used for immunizations only.

1998 City of Garland total population: 201,824

Black:	9%
Hispanic:	11.3%
Anglo:	69.6%
Other:	10.1%

Population per square mile for Dallas County: 2,270

Socioeconomic indicators for City of Garland:

- Unemployment rate (1997): 2.6%
- Unduplicated count of Medicaid recipients (1997): n/a
- Average monthly food stamp participants (1997): 687
- Average monthly TANF recipients (1997): 306
- Estimated median household income (1997): \$43,081
- Estimated percentage of people in poverty (1997): 8.2%

Perspective on most important local public health issues faced — Pat Fowler, Director:

1. Although support for public health continues to decline, expectations and demands for service have never been greater. I do not know if local (municipal) public health programs can continue to survive without support from other sources.
2. The public health system in Texas is fragmented and needs refinement and coordination if we are to get the most out of all agencies providing services.
3. Indicators of performance must be identified and tracked to delineate the success and failure of public health programs.

Source: Pat Fowler, Director, City of Garland Health Department, August 1998.

Harris County Public Health and Environmental Services

Public Health Region: 6 (south east Texas)

Service area: Harris County (excluding Houston)

Main services provided:

- Epidemiology
- Health Planning
- Maternal Health
- Lead Poisoning Control
- Nutrition/Chronic Disease
- Animal Control
- Immunization
- Refugee Health Services
- AIDS/HIV services
- Substance Abuse Surveillance
- Family Planning
- Sexually Transmitted Disease
- Tuberculosis Control
- Consumer Health
- Waterborne Illness
- Pollution control
- Health Education
- Dental Health
- Intentional/Unintentional Injury Surveillance
- Mosquito Control

Number of employees (FTEs): 464.5

<i>Total FY 1997 budget:</i>	\$29,246,657	(100%)
from TDH:	\$6,121,446	(20.9%)
from city:	-0-	-0-
from county:	\$11,501,589	(39.3%)
from Medicaid:	\$219,995	(.76%)
from fees:	\$1,165,646	(4.0%)
from other sources:	\$10,237,981	(35%)

1998 Harris County estimated total population: 3,238,034

Black:	17.9%	
Hispanic:	29.5%	
Anglo:	47.1%	
Other:	5.5%	

Population per square mile: 1,903

Socioeconomic indicators for Harris County:

- Unemployment rate (1998): 2.16%
- Unduplicated count of Medicaid recipients (1997): 266,644
- Average monthly food stamp participants (1997): 333,101
- Average monthly TANF recipients (1997): 118,149
- Estimated median household income (1998): \$36,404
- Estimated percentage of people in poverty (1998): 13.5%

Perspective on most important local public health issues faced — Thomas Hyslop, M.D., Director:

1. Insufficient services or places to refer uninsured clients with positive tests or high risk factors.
2. Need better methods to cause behavior change.
3. Need better public health approach to drugs/alcohol and domestic abuse.
4. Reorienting staff from clinical to community focus.
5. Capability to do any types of assessment.
6. Need better knowledge to improve community input into public health programs.
7. Poor transportation for clients.
8. Language and cultural issues.
9. Funding shortage to cover uninsured and underinsured, for essential services, infrastructure.

Source: Thomas Hyslop, Director, Harris County Public Health and Environmental Services, August 1998.

City of Laredo Health Department

Public Health Region: 11 (south Texas)

Service area: City of Laredo, Webb County by interlocal agreement

Main services provided:

1. Personal Health and Disease Prevention Services
 - Prenatal care
 - Well child clinic
 - Family planning clinic
 - Neural tube defects project
 - Childhood immunization clinic
 - Breast and cervical cancer control project
 - "La Familia" Community oriented primary care program
 - School based primary care program
 - Tuberculosis elimination program
 - "Los Dos Laredos" binational TB elimination project
 - Hansen's disease (leprosy) program
- HIV/STD Program
 - HIV/AIDS Education and risk reduction component
 - HIV/AIDS Preventive counseling and partner elicitation component
 - HIV/AIDS Health and social services component
 - HIV/AIDS Ryan White care consortia component
 - Housing opportunities for persons with AIDS component
 - Sexually transmitted diseases (STD) clinic
2. Health Protective Services Division
 - Sanitation, solid waste, wastewater, vector control, air quality, hazardous substance, restaurant, motels, pools, hotels, inspections, rodent control, mosquito control, recreational facilities
 - Animal control program
 - Food handler's training program

3. Public Health Nutrition Services Division
 - Nutrition counseling
 - Women, Infants, and Children (WIC) program
4. Public Health Education and Health Promotion
 - "Buena Vida" project program
 - Maternal and child health Title V/ education project
5. Central Registration, Billing
 - EMS ambulance collections
6. Vital Statistics
7. Administration

Number of employees (FTEs): 171

<i>Total FY 1997 budget:</i>	\$7,005,499	(100%)
from TDH:	\$4,183,243	(59.7%)
from city:	\$1,932,007	(27.6%)
from county:	\$110,000	(1.6%)
from Medicaid:	\$212,121	(3.0%)
from fees (self and Medicare):	\$87,559	(1.2%)
from other sources:	\$480,569	(6.9%)

1997 Webb County estimated total population: 186,221

Black:	< 1%
Hispanic:	94.9%
Anglo:	4.4%
Other:	< 1%

Population per square mile: 52.8

Socioeconomic indicators for Webb County:

Unemployment rate (1998):	10.1%
Unduplicated count of Medicaid recipients (1998):	39,966
Average monthly food stamp participants (1998):	52,235
Average monthly TANF recipients (1998):	10,577
Estimated median household income (1996):	\$25,000
Estimated percentage of people in poverty (1996):	36.1%

Perspective on most important local public health issues faced — Jerry Robinson, Director.

Local Public Health Organizational Issues:

1. Lack of funding for population-based, essential public health services.
2. Border problem: insufficient funding to help the undocumented permanent residents and the threat that all public resources will be ruled illegal to use to help such residents.
3. Inconsistent state and federal policies with multiple, simultaneously conflicting rules to follow to provide public health services.
4. Lack of required, uniform, morbidity reporting from the private medical sector.
5. State separation of most environmental health activities and funding into a separate state bureaucracy that sets its own agenda without regard to larger health issues.
6. Lack of sufficiently trained staff to work at the local level.

Local Public Health Border-Related Problems:

1. Poverty; insufficient education; inadequate employment; inadequate housing; insufficient access to potable water and sewage disposal.
2. Overpopulation of people in this natural resources-poor area of the state.
3. Insufficient enforcement of environmental regulations.
4. Inability of local governments to provide sufficient amount of basic public services.
5. Pollution of Rio Grande river.
6. Transit of hazardous materials through and storage in populated areas.
7. Air quality.
8. High levels of communicable, infectious, and chronic disease.
9. Health professional shortage area for all medical/dental practitioners.

Sources: TDH, Office of Regional Administrative Services, "Local Agency Budget and Expenditure Report FY 97"; Jerry Robinson, Director, City of Laredo Health Department, July 1998.

State and Regions

The Texas Department of Health (TDH) began operations in the late 1800s as the Texas Quarantine Department, with its main responsibilities being disease quarantine and sanitation. TDH underwent many additions and reorganizations in the subsequent years, adding vital statistics collection and numerous health-related programs. Today, TDH performs many public health services such as disease surveillance, laboratory analysis, health promotion and education, consultation, health planning, data collection and analysis, vital statistics, and environmental regulation. TDH also provides direct health care services through its regional offices and network of clinics in rural areas without local health departments or other local providers.

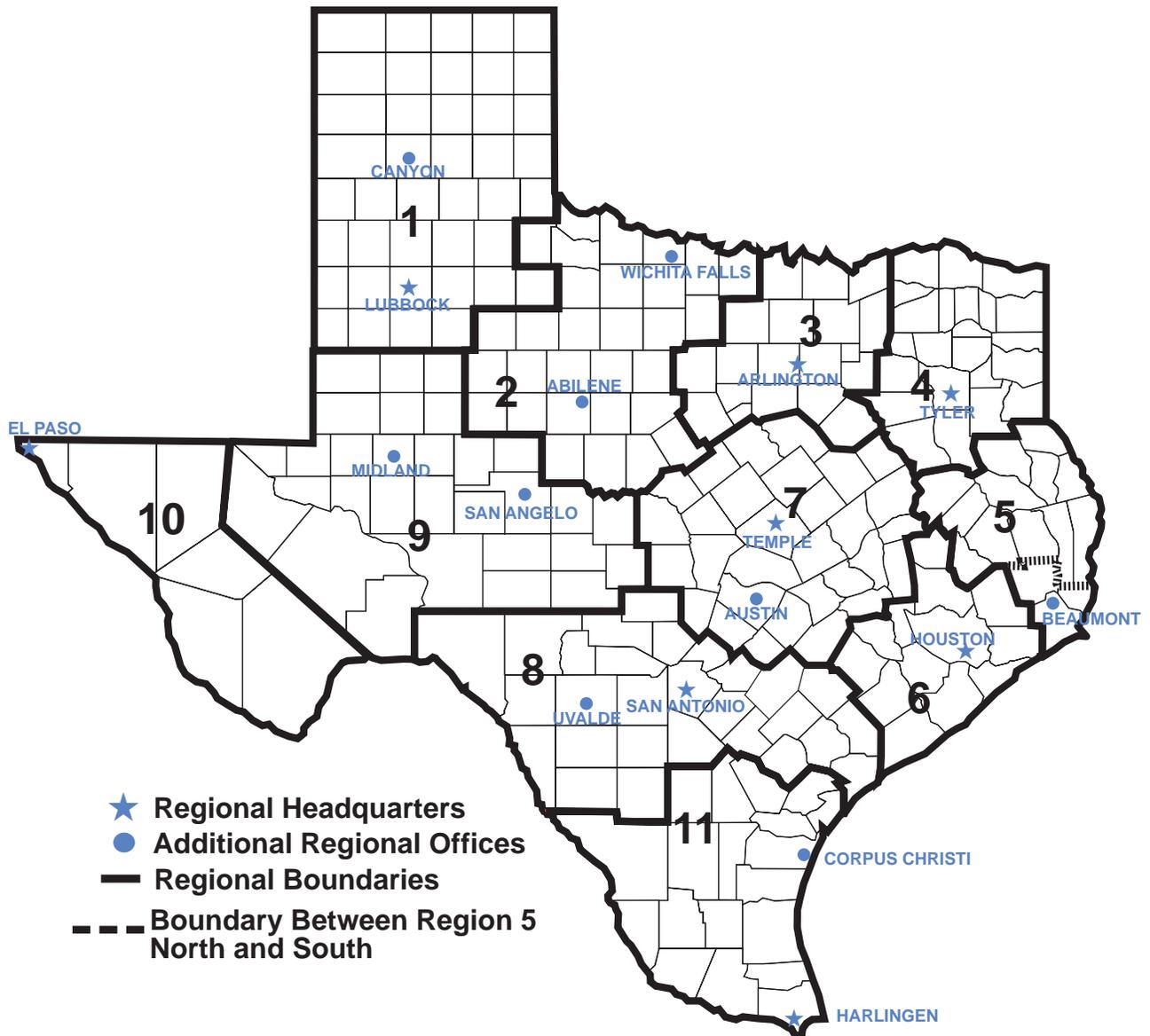
The public health regions were initiated in the 1970s after a need was recognized for regional services spread around the state. The public health regions are extensions of TDH and are supported by federal and state funds. The regional boundaries have been redrawn several times, and there are currently eleven public health regions in Texas combined under eight directors (who by law must be physicians). The locations of the regional offices are Lubbock and Canyon (PHR 1); Arlington, Abilene, and Wichita Falls (PHR 2 and 3); Tyler (PHR 4 and 5 North); Houston and Beaumont (PHR 6 and 5 South); Temple and Austin (PHR 7); San Antonio and Uvalde (PHR 8); El Paso, Midland, and San Angelo (PHR 9 and 10); and Harlingen and Corpus Christi (PHR 11). See Figure 2 for a map showing the regional boundaries, headquarters, and additional offices. The regions' main purpose, then as well as now, was to provide public health services in areas with no local health departments, including core public health services, direct health care, and regulatory services. Regional offices were also designed to provide assistance to the LHDs in their regions, especially in emergencies.

Public health regions provide a variety of services, such as the Birth Defects Monitoring Program, dental care, emergency medical services (EMS) planning and provider certification, drug and medical device safety, general sanitation, immunizations, meat inspection, tobacco prevention, tuberculosis control, and many more (see Table 2 for summary). Most of the regions offer the same programs, except for special programs addressing problems specific to certain regions, such as border health and seafood safety, or programs that are operated out of a few regions only, such as the cancer registry. For Fiscal Year 1998, TDH is funding a total of 45 regional programs with a total budget of almost \$103 million, including both state and federal funds.¹³ Each of the regions' budgets is between about seven and 16 million dollars for the 30 to 40 programs it operates. The regional programs coordinate with TDH headquarters and with local health departments and other health agencies in the region to give technical advice and training in these areas. The regional programs offer back-up support in places that already have local entities providing these services and they perform some public health services in areas with no local public health presence. See Appendix C for profiles of each region, along with other data.



The regions' main purpose is to provide public health services in areas with no local health departments and to provide assistance to the local health departments in their regions.

Figure 2.
Public Health Regions
and Regional Offices



Source: Texas Department of Health, 1998
 Created by: Blackland Research Center

Table 2. Summary of Services Provided by Each Public Health Region

Service/Program	Public Health Region							
	1	2/3	4/5N	6/5S	7	8	9/10	11
AIDS/HIV	X	X	X	X	X	X	X	X
Birth Defects		X		X		X	X	X
Cancer Registry	X	X		X		X	*	
Chronically Ill and Disabled Children	X	X	X	X	X	X	X	X
Chronic Diseases	X	X	X	X	X	X		X
Community Oriented Primary Care	X	X	X	X	X	X	X	X
County Indigent Health Care Program	X	X	X	X	X	X	X	X
Dental Services	X	X	X	X	X	X	X	X
Drugs and Medical Devices	X	X	X	X		X	X	X
EMS	X	X	X	X	X	X	X	X
Family Planning	X	X	X	X		X	X	
General Sanitation	X	X	X	X	X	X	X	X
Health Education	X	X	X	X	X		X	X
Health Facility Compliance/Licensure	X	X	X	X			*	
Immunizations	X	X	X	X	X	X	X	X
Manufactured Foods	X	X	X	X	X	X	X	X
Meat Safety Assurance	X	X	X	X	X	X	X	X
Medical Transportation	X	X	X	X	X	X	X	X
Medically Dependent Children's Program	X	X	X	X	X	X	X	X
Milk and Dairy	X	X	X	X	X	X		X
Neural Tube Defects							X	X
Nutrition training (non-WIC)	X	X	X	X	X	X	X	X
Product Safety	X	X	X	X	X	X	X	
Radiation Control	X	X	X	X	X	X	X	X
Residency Training				X		X		
Retail Foods	X	X	X	X	X	X	X	X
Seafood Safety				X	X	X		X
Sexually Transmitted Diseases	X	X	X	X	X	X	X	X
Social Work	X	X	X	X	X		X	
Texas Health Steps	X	X	X	X	X	X	X	X
Tobacco Prevention/Control	X	X	X	X	X	X	X	X
Toxic Substances Control	X	X	X	X	X	X	X	X
Tuberculosis Control	X	X	X	X	X	X	X	X
Vendor Drug	X	X	X	X			X	
Vision and Hearing	X	X	X	X	X	X	X	X
Women, Infants, Children (WIC)	X		X	X	X		X	
Zoonosis Control	X	X	X	X	X	X	X	X

**PHR 9/10 is included in the Cancer Registry and Health Facility Licensure programs operated by PHR 1*

Source: Descriptive Brochures created by each Region, 1997; TDH, Office of Regional Administrative Services.



¹ Texas Health and Safety Code, §121.031.

² Ibid., §121.041.

³ Ibid., §121.032(b).

⁴ Ibid., §121.005(b).

⁵ TDH, Local Health Agency Budget and Expenditure Report FY 97.

⁶ TDH, Actual Total Local Health and Expenditure Report FY 96.

⁷ Texas Health and Safety Code, §121.022 - §121.025.

⁸ Ibid., §121.033 and §121.045

⁹ Ibid., §121.028.

¹⁰ Ibid., §121.007(c).

¹¹ Ibid., §121.046(a).

¹² Ibid., §121.046(e).

¹³ Texas Department of Health, summary of regional budget information from Office of Regional Administrative Services, 1998.

Chapter Three

Gaps in the Public Health Infrastructure

State and National Issues

There are a variety of gaps and problems occurring in the public health infrastructure with varied consequences. One issue that is gaining state and national attention is the threat of a bioterrorism attack (intentional spread of virulent diseases or other biological agents into civilian populations) and how best to be prepared if this were to happen. Experts agree that an important part of this preparation is a system of state and local public health departments that have adequate information systems and can act quickly if needed. Departments that are underfunded do not have an adequate capacity for communication, coordination, vaccines, and expertise, and thus are not likely to be able to act in time. These abilities are also needed to respond to natural disasters, not just man-made ones. Medical personnel and public health workers would be the first to recognize and respond to a biological attack. However, most of the proposed federal money for this cause would go to the National Guard and other military branches. Also, the federal response plans are geared toward chemical attacks (such as the nerve gas that was released in a Tokyo subway in 1995) more than biological attacks.¹ Possible diseases that could be spread by terrorists and that would create massive medical problems and public fear are anthrax, ebola, bubonic plague, and smallpox. Smallpox vaccines are no longer routinely given since the disease was declared eradicated in 1980, but there are reports that the former Soviet Union was working on smallpox for germ warfare and that some of their stock may be missing.²

Another issue is the increasingly restrictive and competitive nature of public health funding, with several consequences, seen especially with large funding sources such as Medicaid and Title V. One result of more restrictive funding is that local health departments can no longer cost-shift funds to subsidize core services, so these services may decrease. With more competition for direct care services (i.e., the trend to privatize, with grants opened for competitive bid to private providers), local health departments and units have to spend more time applying for grants and funding, and will likely get less as the money is spread between more providers than before. Though these moves were designed to increase quality and accountability, they still pose problems for local health departments trying to maintain population-based services instead of, or in addition to, personal health care services.

The state public health regional offices are supposed to step in and help when there is no local health department, but the regional offices' funding and therefore their programs are very specific and categorical. People living in areas without local health departments may call their regional offices to report such things as a local environmental complaint or animal control problem, but if these problems do not fit into one of the regional programs or specializations, it is sometimes difficult to find an appropriate person to handle the call. Citizens may believe that the regional office is their local health department, but this is not the case. TDH regional offices and clinics cannot perform local services as efficiently as a local health department can because they were designed for specific services and do not have field offices in every county. Regional offices therefore work better as a complement of, and not a replacement for, local health departments.

Local Issues

Local health departments that change from participating to non-participating are not required by state law or TDH contracts to perform the minimum core public health functions anymore, and often can only afford to provide selected services (often those for which they can charge fees such as various inspections). Some local governments have contracted



One issue that is gaining state and national attention is the threat of a bioterrorism attack and how best to be prepared if this were to happen.



their local health services out to private entities such as universities, for-profit organizations, or non-profit clinics, to reduce cost and duplication of services. However, the “public health” services transferred are almost always direct care, such as maternal and child health, not core population-based services, which are not as concrete or profitable. When there are functions that are no longer being performed by a local health department or other local provider, the city and county has an increased risk of a disease outbreak or other health crisis, even if this is not apparent initially. The remaining services are sometimes picked up by the regional office, but when more local emergencies begin to occur, the regional offices will not be able to address the growing need. When money or services are cut from a local health department, the region has to cover more services with the same amount of funding, stretching its resources thinner and thinner. Local health departments need adequate and consistent funding in order to remain proactive and maintain programs to prevent illness and injury.

There is much variability in local health department funding, services, and demographic characteristics. There tends to be a correlation between areas with higher income/lower unemployment and more (and better-funded) public health services. This is somewhat expected because more local tax revenue and other local funding is available in higher-income areas, and these are often urban areas with large populations. However, poorer areas that need the most services (both individual and community) do not have the revenue to fund many services nor the population to support them, and are left behind. Some LHDs in areas with more funding and larger populations have also suffered as funds that have traditionally gone to the health department are now parceled out among more providers.

The provision of public health services is fragmented across the state. The system needs some modifications so that the people and communities who are in most need of services do not slip through the cracks. When public health in some areas suffers, the health of the state as a whole suffers.

Recent Examples

Several events have happened in the past few years that illustrate the importance of having an adequate local health infrastructure and what can happen without one. Significant syphilis outbreaks occurred in Beaumont-Port Arthur, which had a limited local health department, and in Waxahachie, which had no local health department. In Beaumont-Port Arthur, the LHD did not have the capacity and resources to do adequate surveillance, investigation, follow-up, and treatment of the syphilis cases. In Waxahachie, a concerned local doctor collaborated with TDH STD staff to provide a temporary infrastructure for managing the outbreak, which ended up involving HIV as well. In both cases, the lack of adequate local infrastructure allowed the outbreak to spread and impeded its timely control. Waxahachie is near the Dallas area and has an expanding population—it is in one of the largest communities without a local health department, and illustrates a situation that will probably become more common in growing areas without LHDs.

Over the past few years, El Paso County significantly cut funding to the El Paso City-County Health District and the health district lost grant funds from the Title V Maternal and Child Health block grant. Subsequent to these funding changes, personnel layoffs and a reduction in services occurred, and immunization rates for children in El Paso dropped from 81 percent in 1994 to 64 percent in 1996. Compared to the costs associated with treating children who develop vaccine-preventable diseases, the costs of administering timely immunizations are very small.

In Cold Spring Independent School District, San Jacinto County, a nurse at a school

noticed a rapidly growing absentee rate as many children were getting sick. There was no local health department and only two doctors in the county, so the state region sent in a team to investigate. They did interviews, took samples, and completed other investigational activities and ultimately found that a viral agent was responsible. If the disease had been something more serious, the delay would have been even worse and could have caused more illness or even death. There are many other situations that are quite common where a local health infrastructure is needed for adequate prevention efforts, such as tracking down people in need of gamma globulin injections after exposure to a hepatitis outbreak or having enough personnel trained in giving immunizations to cover school children in an area.



Another situation that is having large public health ramifications is the lack of indoor plumbing and potable water in many communities along the border and in other places throughout Texas. It is estimated that almost 400,000 people live in poor areas without adequate water and other services. Plans involving water pipes, sewer services, and federal grants have been in the works for years, but only a few people have benefitted so far due to delays, hook-up fees, turf battles, poor oversight, and other factors.³ Though many of the problems are political, the residents in these areas suffer much more than other areas of the state from diseases associated with unsafe water and other unsanitary conditions.⁴ For example, the statewide rate for hepatitis A was 18.2 cases per 100,000 in 1996, but the rate in public health Region 10 (El Paso area and west border region) was 32.2, and Region 11 (south Texas border including Laredo area) was 54.1.⁵ One county, Val Verde, along the border in Region 8, had a rate six times the state average in 1996: 108.3 per 100,000.⁶ (Incidentally, the Del Rio-Val Verde County Health Department was closed in late 1995.) Similarly, rates of bacterial gastrointestinal disorders are higher in the border region. The shigellosis rate was 14.5 for the state and 40.6 in Region 11 in 1996, and salmonellosis was measured at 14.8 for the state but 27.4 in Region 10.⁷

As one can see, an adequate local public health infrastructure, or a lack of one, can greatly affect the local community and other communities. The consequences of one event can be inconvenience or mild suffering, but the next event could be swift and deadly. The crux of the issue is that no one knows what will happen ahead of time or how serious it will be. Therefore, adequate prevention and preparation are the only ways to prevent possible widespread tragedy.

¹ Austin American-Statesman, "Health Units Ill-Prepared to Ward Off Germ Attack," August 3, 1998, pp. A1, A5.

² Ibid., p. A5; Ibid., "With No Vaccine, Smallpox Terror Worries Expert," August 3, 1998, p. A5.

³ Ibid., "Scant Relief from Filth, Disease for the Poorest of Texans," July 12, 1998, pp. A1, A8.

⁴ Ibid., "Disease Rates Show Cost of Sewer, Water Woes," July 13, 1998, p. A5.

⁵ Texas Department of Health, "Epidemiology in Texas: Annual Report 1996," pp. 141, 143.

⁶ Ibid., p. 129.

⁷ Ibid., pp. 141, 144.

Chapter Four

Discussion and Conclusions

Public health is the foundation of a healthy society. Without public health activities such as environmental monitoring, disease tracking and investigation, immunization programs, and public education campaigns on disease prevention and healthy habits, medical care would be more expensive and less effective. The consequences of effective public health are hard to see but can be measured in areas such as increased productivity through decreased time lost from work or school, decreased preventable deaths and disabilities, and decreased consumption of resources, as well as monetary savings. Conversely, the failure of the public health system can have a significant negative economic impact on communities.

In summary, public health, or population-based health, is extremely important to the health of communities as a whole and not just to the poor. Yet, public health services are often left in the shadows when the spotlight is turned on rising health care costs, reforming government programs, health insurance, managed care, and other such issues. Caring for the sick often receives more attention than preventing illnesses in the population, but initial investments in prevention will often pay off in the long run in money saved and lives improved.

There are some basic tenets that characterize an effective local public health system and that summarize why we believe it is so important to assure that essential public health functions are carried out well in every community:

- All direct public health actions should happen at the local level if they happen at all.
- No person should lack essential public health protection.
- The presence of a functioning health department in every local community would eliminate any gaps in the surveillance, prevention, and control of public health threats, such as communicable diseases, from one community to the next.
- Local populations would have direct oversight of public health practice to assure that resources are used for local priorities and problems.

We need to focus equal attention on core public health, where it is now, where it needs to be in the future, and how it can get there from here. There are a variety of issues, obstacles, and priorities, and all of these need to be reconciled for the good of the state as a whole. Improved local public health services, including surveillance, environmental inspections, immunizations, and public education, would help to prevent and control many of the health problems the state and the nation are currently facing, and often at lower cost. It is sometimes hard to observe the benefits of public health, and it may not always be a popular spending alternative when there are other immediate concerns, but Texas must take a new perspective to preserve what we have and to continue to make health improvements.

The long-term outlook required to build and support a public health infrastructure is often overshadowed by other urgent and competing concerns. Many policy-makers and local public officials are not as familiar with public health as they are with other state and local services and are therefore hesitant to fully fund it when faced with competing priorities. Not only do other public services such as road construction and police and fire protection compete with public health for funding, personal health care issues also seem more immediate and threatening to many policy-makers and their constituents.

Dramatic gains have been made in public health in the past century, but taking these for granted and letting the public health infrastructure deteriorate is a recipe for disaster. The problems of the past such as widespread contagious diseases and contaminated food and water have not disappeared; they are waiting to re-emerge wherever cracks form in the public health system. The physical health, mental health, and economic health of all Texans depends on taking proactive measures to preserve, coordinate, and strengthen the public health system in Texas.



The consequences of effective public health are hard to see but can be measured in areas such as increased productivity through decreased time lost from work or school, decreased preventable deaths and disabilities, and decreased consumption of resources, as well as monetary savings.

Chapter Five

Recommendations

Recommendation 1

The Texas Legislature should make it public policy that every resident of Texas is entitled to the protection offered by the essential public health services.



Essential Public Health Services are defined as follows:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research new insights and innovative solutions to health problems.

Recommendation 2

The Texas Legislature should provide support, on a recurring per capita basis, from state funds in amounts sufficient to ensure that a system of local public health entities can effectively perform essential public health services. The following sources (and combinations thereof) are some suggested funding options:

- general revenue
- tobacco settlement
- alcohol tax
- tobacco tax
- lottery
- money penalties for civil/criminal convictions for environmental infractions
- federal money
- user fees
- redistribute state funds
- Medicaid Managed Care profit-sharing rebate funds
- fee on the conversion of non-profit health-related entities to for-profit status.

Recommendation 3

The Texas Legislature should provide counties and/or incorporated municipalities with the option of receiving from the state, on a noncompetitive basis, funding for the provision of the essential public health services to residents within their respective jurisdictions. The Texas Department of Health, through its regions, will receive the per capita funding for the counties and/or incorporated municipalities who do not opt to receive these funds and the TDH regions will provide the services. The intent is to augment funds already expended by counties and/or incorporated municipalities to provide essential public health services.



Recommendation 4

The Texas Legislature should allow counties and/or incorporated municipalities to utilize funds provided to them by the state for the purpose of providing essential public health services to contract with each other, the Texas Department of Health, or other entities to perform these services.

Recommendation 5

The Texas Legislature should encourage counties and/or incorporated municipalities to form public health districts, for the purpose of providing essential public health services, that may consist of multiple cities, multiple counties, or a combination of cities and/or counties.

Recommendation 6

The Texas Legislature should require that the governing bodies of counties and incorporated municipalities who receive state funding for essential public health services appoint a local health authority. Local health authorities should be allowed to serve more than one county or incorporated municipality at a time. In counties and/or incorporated municipalities who do not receive these funds and who do not appoint a local health authority, the Texas Department of Health's regional director will serve as the local health authority.

Recommendation 7

The Texas Legislature should require counties and incorporated municipalities who receive state funds for essential public health services to appoint a local board of health. The commissioners court or city council of these counties and incorporated municipalities may elect to serve as the local board of health; however, they are encouraged to appoint advisory boards of health to advise them on public health matters.

Recommendation 8

The Texas Legislature should require the Texas Department of Health to work with state institutions of higher education and local health departments to develop ways to increase the competency and capacity of the state's local public health workforce.

Recommendation 9

The Texas Legislature should require that the Texas Department of Health and local governments receiving state funds for essential public health services, together with other appropriate institutions, to develop local strategic plans which incorporate performance measures and outcome measurements to serve as a basis for evaluation.

Recommendation 10

The Texas Legislature should require that the Texas Department of Health, in cooperation with county and city health departments and districts, conduct periodic assessments of the provision of and level of funding for essential public health services and make recommendations to the Legislature and the Governor.

Comments about Recommendations

We believe the Legislature should encourage all local and state agencies and governments to promote and maximize administrative efficiency, cost-effectiveness, collaboration among units of government, and partnerships between the Texas Department of Health and local entities in providing public health services.

We believe that a stable source of state funding is needed as a base for local public health activities because the current funding varies widely across the state, with some localities receiving no state funding at all. A reformulated and standardized source of state funds would provide greater stability at the local level, assure continuity of disease control and protection of health, and would provide greater state oversight of the health status of its citizens. Regarding the tobacco lawsuit settlement, we believe that the most efficient use of money gained due to treating tobacco-related illnesses is to use a portion of it (or gains from a permanent endowment) to fund essential public health activities that involve prevention and education on unhealthy behaviors such as tobacco use, thus helping to curb continuing tobacco use and taxpayer funding for the treatment of resulting illnesses.

The formation of public health districts allows several municipalities to plan, organize, and deliver public health services in accordance with the distribution of the population served rather than in relation to city or county boundaries, which are often artificial service areas. Districts also allow pooling of resources that can lead to more effective and efficient operations. Local Boards of Health provide greater local input to public health policy development and service delivery. Local oversight allows assessment by those who are the recipients of service. Having local Boards of Health enhances the “ownership” of the public health effort by the community.

While Texas law gives the ultimate responsibility for public health to the state, some essential public health services are better overseen at the state level and some are more appropriate for local governments. We realize this delineation is not always clear, and while we do not believe it should be defined in legislation, we believe this issue deserves further study.



Appendices

APPENDIX A

**H.C.R. No. 44
1997**



HOUSE CONCURRENT RESOLUTION

WHEREAS, Public health services are vital to all Texans in search of healthy lives, families, and communities; and

WHEREAS, A public health infrastructure in each community creates a better standard of living by preventing disease, ensuring a healthy environment, and promoting physical, mental, and social health; and

WHEREAS, City, county, and state health departments provide public health services, and the roles of state and local governments in providing such services may not be clearly defined; and

WHEREAS, No special mechanism exists for local authorities to support or fund public health services, and this absence has resulted in a decline in local support of public health; and

WHEREAS, A strong public health infrastructure is vital to the economic growth of the state in order to ensure a healthy population; now, therefore, be it

RESOLVED, That the 75th Legislature of the State of Texas hereby direct the Texas Department of Health, the Lyndon Baines Johnson School of Public Affairs of The University of Texas, The University of Texas-Houston Health Science Center School of Public Health, and the Blackland Research Center and the School of Rural Public Health of The Texas A&M University System, within their existing resources and in conjunction with city and county governments, to study the current role of local governments in providing public health services; and, be it further

RESOLVED, That the agencies submit a full report of their findings and recommendations to the 76th Legislature when it convenes in January 1999; and, be it further

RESOLVED, That the secretary of state forward an official copy of this resolution to the commissioner of health, the dean of the Lyndon Baines Johnson School of Public Affairs, the dean of The University of Texas-Houston Health Science Center School of Public Health, the directors of the Blackland Research Center and the School of Rural Public Health, the chancellor of The Texas A&M University System, and the chancellor of The University of Texas System.

APPENDIX B

Methods and Results of Questionnaire



In June 1998, the HCR 44 Workgroup mailed approximately 250 questionnaires to work group members, all local health departments (both state-participating and non-state-participating), and other stakeholders identified by the workgroup. Workgroup members also disseminated additional questionnaires via meetings and newsletters to local elected officials and other stakeholders in their areas. As of September 30, 1998, 100 responses had been received. Following are the questions sent, a tally of the responses, and a list of the respondents. **Please note that this was not a scientific survey and we do not claim the sample size or responses to be statistically significant.**

Each question on the questionnaire had space under it to add further comments, and the wide variety of sentiments expressed showed that there are many different ideas of what constitutes “public health” and what should be and should not be done to improve the public health system in Texas. Since many of the comments did not agree with one another, no one answer could be reached for each question and thus everyone who responded may not agree with the resulting recommendations. However, the workgroup carefully considered the responses in informing their deliberations.

Feedback Questionnaire

Q1. Should the Texas Legislature make it public policy that every resident of Texas is entitled to essential public health services?

In an effort to define public health and its associated activities, the HCR 44 workgroup proposes to adopt the following list of essential public health services (developed in 1994 by the national Public Health Functions Steering Committee), with one caveat added in a footnote to item seven:

Essential Public Health Services:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable*
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research new insights and innovative solutions to health problems.

* The HCR 44 workgroup believes that providing direct personal health services and “safety-net” indigent care is a crucial activity but that these are not core functions of public health, particularly on the state level.

Number responding: 97	Number marked “yes”: 76	Percent marked “yes”: 78
-----------------------	-------------------------	--------------------------



- Q2.** Do you think this definition/list of essential public health services or a similar one should be incorporated into state law?
- | | | |
|-----------------------|-------------------------|----------------------------|
| Number responding: 97 | Number marked "yes": 69 | Percent marked "yes": 71.1 |
|-----------------------|-------------------------|----------------------------|
- Q3.** Do you have any comments on or changes to this list of essential public health services?
- | | | |
|-----------------------|-------------------------|--------------------------|
| Number responding: 90 | Number marked "yes": 50 | Percent marked "yes": 56 |
|-----------------------|-------------------------|--------------------------|
- Q4.** Should the Texas Legislature provide support, on a recurring basis, from state funds in amounts sufficient to ensure that a system of local public health entities can effectively perform essential public health services?
- | | | |
|-----------------------|-------------------------|----------------------------|
| Number responding: 95 | Number marked "yes": 86 | Percent marked "yes": 90.5 |
|-----------------------|-------------------------|----------------------------|
- Q5.** Should the Texas Legislature mandate that each county and incorporated municipality (city and town) in Texas provide the essential public health services to its residents?
- | | | |
|-----------------------|-------------------------|--------------------------|
| Number responding: 88 | Number marked "yes": 41 | Percent marked "yes": 47 |
|-----------------------|-------------------------|--------------------------|
- Q6.** Should the Texas Legislature provide incorporated municipalities (cities and towns) with the option of receiving from the state, on a non-competitive basis, funding for the provision of the essential public health services to its residents?
- | | | |
|-----------------------|-------------------------|----------------------------|
| Number responding: 95 | Number marked "yes": 71 | Percent marked "yes": 74.7 |
|-----------------------|-------------------------|----------------------------|
- Q7.** Should the Texas Legislature provide counties with the option of receiving from the state, on a non- competitive basis, funding for the provision of the essential public health services to residents within their respective jurisdictions and outside incorporated cities and towns?
- | | | |
|-----------------------|-------------------------|----------------------------|
| Number responding: 96 | Number marked "yes": 79 | Percent marked "yes": 82.3 |
|-----------------------|-------------------------|----------------------------|
- Q8.** Should the Texas Legislature allow counties and incorporated municipalities (cities and towns) to utilize funds provided to them by the state for the purpose of providing essential public health services to contract with each other, the Texas Department of Health, or other entities to perform those services?
- | | | |
|-----------------------|-------------------------|----------------------------|
| Number responding: 95 | Number marked "yes": 82 | Percent marked "yes": 86.3 |
|-----------------------|-------------------------|----------------------------|
- Q9.** Should the Texas Legislature allow counties and incorporated municipalities (cities and towns) to form public health districts, for the purpose of providing essential public health services, that may consist of multiple cities and towns, multiple counties, or a combination of cities, towns, and/or counties?
- | | | |
|-----------------------|-------------------------|----------------------------|
| Number responding: 93 | Number marked "yes": 74 | Percent marked "yes": 79.6 |
|-----------------------|-------------------------|----------------------------|
- Q10.** Should the Texas Legislature mandate that the Texas Department of Health provide essential public health services for residents in those areas of the state in which the county or incorporated municipality (city or town) with jurisdiction exercises the option not to perform public health services and not to receive state funds for that purpose?
- | | | |
|-----------------------|-------------------------|----------------------------|
| Number responding: 95 | Number marked "yes": 66 | Percent marked "yes": 69.5 |
|-----------------------|-------------------------|----------------------------|

Q11. Should the Texas Legislature mandate that the Texas Department of Health, in cooperation with county and city health departments and districts, conduct periodic assessments of the level of funding available for the provision of essential public health services and make recommendations to the Legislature and the Governor?

Number responding: 93	Number marked "yes": 81	Percent marked "yes": 87.1
-----------------------	-------------------------	----------------------------

Q12. Should the Texas Legislature require that the Texas Department of Health and local entities receiving state funds for essential public health services develop strategic plans for the delivery of essential public health services?

Number responding: 95	Number marked "yes": 76	Percent marked "yes": 80
-----------------------	-------------------------	--------------------------

Q13. Should the Texas Legislature require that the Texas Department of Health and local governments receiving state funds for essential public health services, together with other appropriate institutions, develop performance measures and outcomes measurements to serve as a basis for evaluation?

Number responding: 87	Number marked "yes": 63	Percent marked "yes": 72.4
-----------------------	-------------------------	----------------------------

Q14. Should the Texas Legislature require that the Texas Department of Health, together with other appropriate institutions, assure the competence and capacity of the local public health workforce?

Number responding: 89	Number marked "yes": 61	Percent marked "yes": 68.5
-----------------------	-------------------------	----------------------------

Q15. If new funds are needed for improving the essential public health services infrastructure, what do you think the best source(s) for these funds would be?

- 84 people/organizations responded with one or more funding suggestions

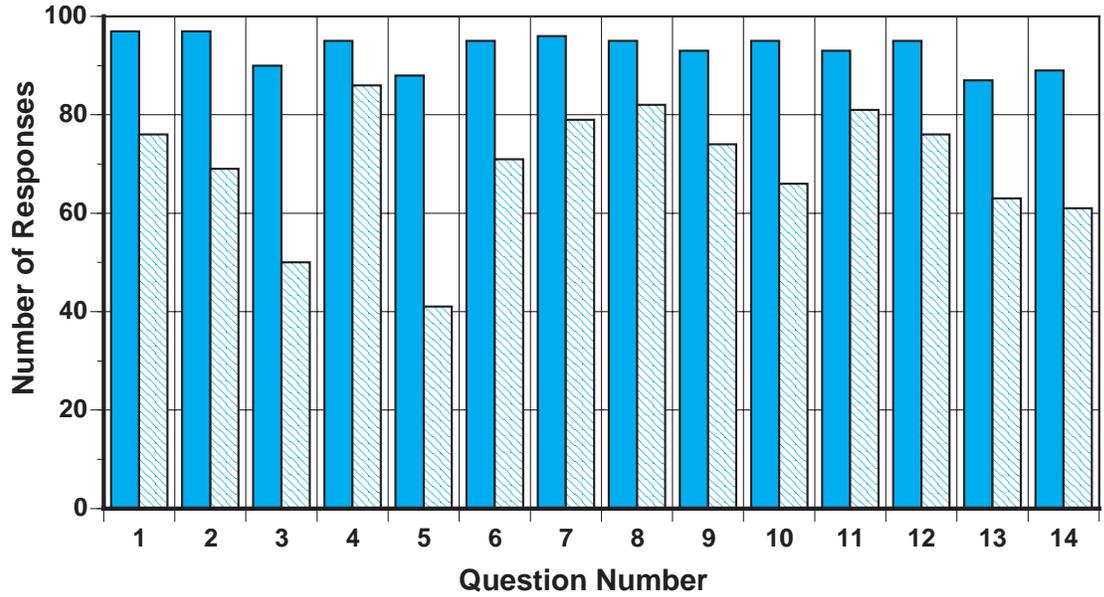
Q16. What other concerns and/or ideas would you like to share with our group?

- 60 people responded with additional comments

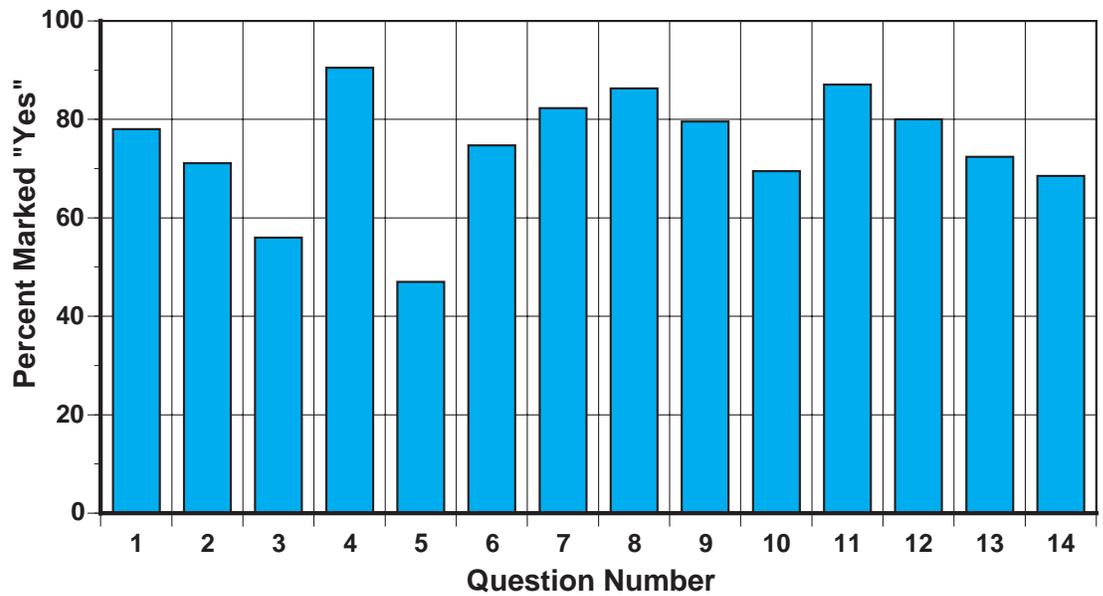




Total Responses / Number Marked "Yes"



Percent of Questions Answered "Yes"



List of People and/or Organizations Responding to HCR 44 Questionnaire

Anonymous (28 respondents)
Barbara Clements, Wichita Falls-Witchita County Public Health District
Brazos County Health District
Mike Phillips, City of Wylie
Nursing Leadership Council
Bing Burton, Denton County Health Department
Janet Emerson, Waco-McLennan Public Health District
Beverly Weaver, Dallas Health Department
Carolyn Fruthaler, Grayson County Health Department
Ingrid Holmes, Beaumont Public Health District
Tim Hayfield, City of Richardson
Mike Loving, San Angelo-Tom Green Health Department
Veda White, Community Oriented Primary Care, Texas Department of Health
Albert Esparsen, Midland Health Department
Mark Race, Texas Rehabilitation Commission
Kevin Collins, Angelina City and County Health Department
Don Ware, Sweetwater-Nolan County Health Department
Abilene-Taylor County Public Health District
Stephen Schwartz, Texas Dental Association
Robert Devell, Greenville-Hunt County Health Department
Leo O’Gorman, Brazoria County Health Department
Pat Fowler, Texas Municipal League and Garland Health Department
Perryton Health Center
Carol Lee Hamilton, Tarrant County Health Department
Charles Reinhardt
Robb Nance, City of Irving
Thomas Hyslop, MD, Harris County Health Department
Turning Point Alliance, Tarrant County (12 members)
Eileen Morrison, University of Mary Hardin-Baylor faculty
Texas Medical Association
D.E. Sciarrini, Smith County Public Health District
Jerry Robinson, City of Laredo
Doug Goodman, City of Lubbock
Janice Coates, Texas Public Health Association
Melanie Botloff, MD, Jasper-Newton County Public Health District
Frances Simmon, Jasper-Newton County Public Health District
Gerald Johnson, Upshur County Indigent Health Care
BJ Conrad, Bosque County Judge
Lanie Benson, Victoria Health Department
Lon Shower, Newton County Judge
Diane Gillit, South Plains Public Health District
Scurry County Health Unit
El Paso Turning Point Partnership
John Cordray, Panola County Judge
Harrison Stafford II, Jackson County Judge
Clay County Judge
Lewis Browne, MD, Gregg County Health Authority
Coalition of Health Services, Inc.
San Antonio Metropolitan Health District
Harvey Laas, Executive Director, Health Alliance of Waller County, Inc.
American Lung Association of Texas
Ronald Hopping, OD, Immediate Past President of Texas Optometric Association

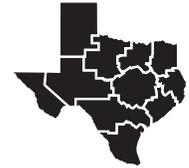




Marianne S. Dwight, Texas Association of Community Health Centers
Jensie Madden, Director, Texas League of Women Voters
Ralph Kimmich, President, Texas Business Group on Health
Paul McGaha, DO, TDH Region 4/5 N
James Zoretic, MD, TDH Region 2/3
Brian Smith, MD, TDH Region 11
Charles Bell, MD, TDH Region 1
George E. Byars, Jr., Blanco County Judge
Tommy Stanaland, Kent County Judge
Preston Combest, Camp County Judge
Helen Walker, Victoria County Judge
Ron Martinez, Shackelford County Judge
Sherill Ragsdale, Coleman County Judge
Young County
Dallas Brewer, Yoakum County Judge
Hays County
Grayson County
Ricky Fritz, Scurry County Judge
Shackelford County Community Resource Center
Galveston County Health District
Lee Hamilton, Taylor County Judge
Ben G. Raimer, MD/ Texas Statewide Health Coordinating Council

APPENDIX C

Regional and Local Public Health Information *Including Populations and Public Health Presence by County*



Each public health region is described below, followed by a list of all of the counties in that region, their populations, and any TDH regional offices and participating and non-participating local health departments and districts in that county (denoted by P and NP, respectively, next to the name). This list attempts to show population-based public health services only and thus does not include the TDH clinics or other personal health care services (unless they are part of an entity also offering other services). The list does include TDH field offices, extensions of the region that sometimes act as local health departments where there is a need, but these may be as small as one part-time employee. Located at the end of this appendix is a map showing the population range of each county (projected for 1999) and a map showing locations of local health departments and districts (repeated from Chapter 2), so the two can be compared.

1999 Estimated Populations:

Texas 19,995,428
Metropolitan 16,950,419
Non-Metropolitan 3,045,009

Estimated Population of counties with county and/or city local health departments:
17,903,470

Estimated Population of counties with no local health departments: 2,091,958*

**Note:* These estimates were calculated by adding the populations of all counties with any type of locally funded health department (city or county, participating or non-participating), then subtracting from the total estimated Texas population. This *understates* the total number of Texans without adequate local public health services because county residents outside the service area of city health departments and LHDs that are not adequately funded for all of the essential public health services (such as most non-participating LHDs) are not taken into account here due to incomplete data.

Public Health Region 1

Est. 1999 pop. 770,443



PHR 1 covers 41 counties and over 40,000 square miles of the Texas Panhandle and South Plains. The regional headquarters is located in Lubbock and there is one subregional office in Canyon. In addition, there are four field offices that offer immunizations and STD/HIV services in rural communities. The largest cities in PHR 1 are Amarillo and Lubbock, both of which house major regional medical centers and teaching institutions.

The Texas Panhandle is known for its flat plains, an economy primarily based on agriculture and ranching, and a number of health facts that set it apart from other regions. The teen birth rate, rate of low birth-weight births, and incidence of late prenatal care are all higher than the state average. Additionally, infant deaths and suicides rates rank above the statewide average. PHR 1 has had three cases of hantavirus since 1995. The regional Zoonosis Control program manager developed the first draft of a Hantavirus Investigation Preparation protocol and equipment tool list for field investigations.

The Mason-Hanger plant (in Pantex) is one of the few nuclear weapon dismantling operations in the nation. Located northeast of Amarillo, the plant employs over 3,000 people, operates its own Emergency Medical Services and fire emergency systems, and manages the long-term storage and safekeeping of plutonium. TDH and PHR 1 staff regularly interact with the plant and participate in annual emergency preparedness exercises. The PHR 1 Cancer Registry and the Health Facility Licensing and Compliance program cover three public health regions (1, 9, and 10). As part of this arrangement, these employees travel hundreds of miles each month conducting case and medical record audits and health facility surveys.

Region 1—Counties, Populations, and Local Public Health Presence

Armstrong County (pop. 1,977)
Bailey County (pop. 7,467)
Borden County (pop. 817)
Briscoe County (pop. 1,916)
Carson County (pop. 6,436)
Castro County (pop. 9,585)
Childress County (pop. 6,855)
Cochran County (pop. 4,826)
Collingsworth County (pop. 3,394)
Crosby County (pop. 7,630)
Dallam County (pop. 5,500)
Deaf Smith County (pop. 20,166) - Hereford: Regional field office (TDH)
Dickens County (pop. 2,465)
Donley County (pop. 3,532) - Clarendon: Regional field office (TDH)
Floyd County (pop. 8,809)
Garza County (pop. 5,302)
Gray County (pop. 22,683) - Pampa City Department of Sanitation (NP)
- Borger City Hall (NP)
- Pampa: Regional field office (TDH)
Hale County (pop. 35,190) - Plainview-Hale County Health District (P)
Hall County (pop. 3,682)
Hansford County (pop. 5,857)
Hartley County (pop. 4,877)
Hemphill County (pop. 3,660)
Hockley County (pop. 24,555) - Levelland: South Plains Public Health District (P)
Hutchinson County (pop. 24,883)

King County (pop. 381)
Lamb County (pop. 14,663)
Lipscomb County (pop. 3,063)
Lubbock County (pop. 226,185) - Lubbock City Health Department (P)
- Lubbock: Regional headquarters (TDH)
Lynn County (pop. 6,864)
Moore County (pop. 18,983)
Motley County (pop. 1,438)
Ochiltree County (pop. 9,110)
Oldham County (pop. 2,211)
Parmer County (pop. 10,472)
Potter County (pop. 106,888) - covered by City of Amarillo Department of Health (P)
Randall County (pop. 107,723) - City of Amarillo Department of Health (covers whole county) (P)
- Canyon: Regional office (TDH)
Roberts County (pop. 1,022)
Sherman County (pop. 2,950)
Swisher County (pop. 8,596) - Tulia: Regional field office (TDH)
Terry County (pop. 13,830) - South Plains Public Health District (P)
Wheeler County (pop. 5,396)
Yoakum County (pop. 9,421) - South Plains Public Health District (P)



Public Health Region 2/3

Est. 1999 pop. 5,899,641



PHR 2/3 in north Texas is comprised of 49 counties. The population of these counties increased by an estimated 9.5 percent from 1990 to 1995, according to the U.S. Census Bureau. Region 3, which contains the Dallas-Fort Worth metroplex, experiences many problems characteristic of urban areas, including higher incidence rates of AIDS, STDs, and hepatitis B and C. It also suffers from higher rates of suicide and traffic fatalities than much of the state. In Region 2, there is the other extreme—most of the counties in this area are rural, bringing different issues and challenges.

Within PHR 2/3, there are 14 state-participating local health departments and at least 45 non-participating departments. There are also 16 local governments who provide public health environmental services by contracting with consulting sanitarians. While the participating LHDs offer a variety of services such as communicable disease prevention, immunizations, and nursing services, the non-participating departments offer mostly environmental health services such as restaurant inspections. About half of the 49 counties in PHR 2/3 do not have the benefit of a participating or non-participating LHD, and subsequent to the downsizing of TDH field offices, the number of counties each TDH field office is called upon to serve has increased dramatically. There were 26 field offices in 1992, down to 10 as of October 1998. This means that the field office personnel in counties without a local health department are called upon to provide essential public health functions and assist in emergencies or outbreaks that may arise.

In May 1997, a foodborne illness outbreak investigation illustrated both strengths and weaknesses in Region 2/3's cooperation with local health departments during an epidemiologic investigation. After a Collin County high school group had a banquet at a Dallas hotel, over 100 of the 195 attendees became ill with gastroenteritis. City of Dallas sanitarians acted promptly to inspect the hotel's kitchens, and the Texas Department of Health, City of Plano, and Collin County Health Care Services joined in a cooperative effort to interview the attendees. City of Dallas staff also mailed questionnaires to the attendees. Ultimately, over 75 percent of the attendees were interviewed about their food recall and symptoms, yielding excellent information for sanitarians to share with hotel management. Each agency performed its job well; however, initial delays in organizing and coordinating the effort between agencies may have meant that useable patient specimens were not collected in time, and there was duplication of effort between mailed questionnaires and telephone interviews.

PHR 2/3 has a large number of public and private organizations that contract to perform many of the maternal and child health functions that TDH formerly provided through the field offices. These organizations cover such areas as Title V (maternal and child health), Title X (family planning), and Title XX (family planning). While they perform some functions that the field offices once provided, they do not cover public health functions such as immunizations, STD and HIV tracking, and TB elimination. In an outbreak situation, the communities in the region rely heavily on regional staff, TDH headquarters, and local health authorities; however, not all of the counties in the region have designated local health authorities.

Region 2/3—Counties, Populations, and Local Public Health Presence

Archer County (pop. 8,321) - Archer City: Regional field office (TDH)

Baylor County (pop. 4,126)

Brown County (pop. 34,075) - Brownwood-Brown County Health Department (P)

Callahan County (pop. 11,905)

Clay County (pop. 9,957)

Coleman County (pop. 9,331)

Collin County (pop. 412,131) - Collin County Health Department (P)

- City of Allen Environmental Health Department (NP)
- City of Plano Environmental Health Department (NP)
- City of Frisco Environmental Health Department (NP)
- City of Wylie Code Enforcement (NP)
- City of Celina- Contract Consulting Sanitarian (NP)

Comanche County (pop. 13,188)

Cooke County (pop. 32,391) - Cooke County Health Department (NP)

- City of Gainesville Health Department (NP)
- Gainesville: Regional field office (TDH)

Cottle County (pop. 2,135)

Dallas County (pop. 2,172,486) - Dallas City Department of Environmental Health Services (P)

- Dallas County Health and Human Services (P)
- City of Garland Health Department (NP)
- City of Grand Prairie Environmental Services (NP)
- City of Rowlett Code Enforcement (NP)
- City of Irving Environmental Health Department (NP)
- City of Carrollton Environmental Health Department (NP)
- City of Mesquite Environmental Health Department (NP)
- City of Farmers Branch Environmental Health Department (NP)
- City of Addison Environmental Health Department (NP)
- City of Coppell Code Enforcement Department (NP)
- City of Richardson Environmental Health Department (NP)
- City of Desoto Environmental Health Department (NP)
- City of Duncanville Code Enforcement (NP)

Denton County (pop. 400,525) - Denton County Health Department (P)

- City of Denton Environmental Health Department (NP)
- City of the Colony Inspection Department (NP)
- City of Lewisville Health and Zoning Department (NP)
- City of Lake Dallas Code Enforcement (NP)
- City of Flower Mound Environmental Health Department (NP)
- City of Aubrey- Contract Consulting Sanitarian (NP)
- City of Krum- Contract Consulting Sanitarian (NP)
- City of Pilot Point- Contract Consulting Sanitarian (NP)
- City of Corinth- Contract Consulting Sanitarian (NP)
- City of Crossroads- Contract Consulting Sanitarian (NP)
- City of Hackberry- Contract Consulting Sanitarian (NP)
- City of Little Elm- Contract Consulting Sanitarian (NP)
- City of Oak Point- Contract Consulting Sanitarian (NP)
- City of Trophy Club- Contract Consulting Sanitarian (NP)

Eastland County (pop. 17,565)

Ellis County (pop. 118,619) - Ellis County Environmental Health Department (NP)

- City of Ennis Code Enforcement (NP)
- City of Waxahachie Health Department (NP)

Erath County (pop. 30,878) - City of Stephenville- Contract Consulting Sanitarian (NP)

Fannin County (pop. 25,844)

Fisher County (pop. 4,660)

Foard County (pop. 1,692)

Grayson County (pop. 97,164) - Grayson County Health Department (P)

Hardeman County (pop. 5,012)

Haskell County (pop. 6,557)

Hood County (pop. 41,511) - Hood County Health Department (NP)

- City of Granbury Code Enforcement (NP)
- Granbury: Regional field office (TDH)

Hunt County (pop. 72,522) - Greenville-Hunt County Health District (P)



Jack County (pop. 6,850)

Johnson County (pop. 134,298) - City of Cleburne Code Enforcement (NP)
 - City of Burleson Environmental Health Department (NP)
 - Cleburn: Regional field office (TDH)

Jones County (pop. 18,968) - Stamford: Regional field office (TDH)

Kaufman County (pop. 70,384) - Kaufman County Health Department (NP)
 - City of Kaufman- Contract Consulting Sanitarian (NP)
 - City of Terrell- Contract Consulting Sanitarian (NP)
 - Terrell: Regional field office (TDH)

Kent County (pop. 995)

Knox County (pop. 4,731)

Mitchell County (pop. 9,128) - City of Colorado Inspection Department (NP)

Montague County (pop. 16,074) - Bowie: Regional field office (TDH)

Navarro County (pop. 43,829) - Corsicana-Navarro County Public Health District (P)

Nolan County (pop. 16,995) - Sweetwater Nolan County Health District (P)

Palo Pinto County (pop. 26,872) - Mineral Wells: Regional field office (TDH)
 - City of Mineral Wells Health Department (NP)
 - Palo Pinto County Public Works Department (NP)

Parker County (pop. 91,916) - Parker County Health Department (NP)
 - City of Weatherford Health Department (NP)
 - City of Aledo- Contract Consulting Sanitarian (NP)
 - City of Springtown- Contract Consulting Sanitarian (NP)
 - City of Willow Park- Contract Consulting Sanitarian (NP)

Rockwall County (pop. 39,410) - City of Rockwall Code Enforcement (NP)

Runnels County (pop. 11,423) - Winters: Regional field office (TDH)

Scurry County (pop. 19,271) - Scurry County Health Department (P)

Shackelford County (pop. 3,165)

Somervell County (pop. 6,391)

Stephens County (pop. 9,069) - Breckenridge: Regional field office (TDH)

Stonewall County (pop. 1,951)

Tarrant County (pop. 1,506,790) - Arlington: Regional Headquarters (TDH)
 - Fort Worth Department of Public Health (P)
 - Tarrant County Health Department (P)
 - City of Arlington Health Department (NP)
 - City of Euless Health Department (NP)
 - City of North Richland Hills Environmental Health Department (NP)
 - City of Hurst Code Enforcement (NP)
 - City of Grand Prairie Environmental Health Department (NP)
 - City of Grapevine- Contract Consulting Sanitarian (NP)

Taylor County (pop. 123,333) - Abilene Public Health Department (P)
 - Abilene: Regional office (TDH)

Throckmorton County (pop. 1,809)

Wichita County (pop. 128,063) - Wichita Falls: Regional office (TDH)
 - Wichita Falls-Wichita County Public Health District (P)

Wilbarger County (pop. 15,300)

Wise County (pop. 42,047)

Young County (pop. 17,069) - City of Graham Inspection Department (NP)



Public Health Region 4/5 North

Est. 1999 pop. 1,301,578

Public Health Regions 4 and 5 North encompass 35 counties in northeast Texas: Region 4 covers 23 counties in the north and Region 5N includes 12 counties from Region 5. The regional headquarters is located in Tyler. There are nine state-participating local health departments and one non-participating unit in the region. East Texas has historically depended on the land and its resources (lumber, cotton, and crude oil), though the regional economy is beginning to diversify.



Region 4 leads the state in the rate of motor vehicle deaths and stroke deaths. Not coincidentally, a higher percentage of the population uses alcohol, tobacco, and has a sedentary lifestyle. Region 4 is second in the rate of lung cancer deaths and cardiovascular disease deaths, and deaths from suicide and breast cancer also rank high relative to the rest of the state. A high rate of inadequate prenatal care is reflected in a high infant mortality rate—the fourth highest of the 11 regions. Positive health status indicators point to a decreased rate of tuberculosis and a decrease in the incidence of syphilis. The teen pregnancy rate is dropping and no measles cases were reported in Region 4 in 1996.

The region was faced with a meningococcal outbreak over the past several years. The health care delivery staff and volunteers from other programs coordinated several mass clinics in which more than 73,000 meningitis vaccinations were given. The media proved very helpful in these crises. The Centers for Disease Control and Prevention sent a representative to do a surveillance investigation in an effort to control the outbreaks.

PHR 4/5 North will face many challenges in the future. Sixteen percent of the population is more than 65 years of age. The region has the largest rural population of any public health region in the state with no large urban areas, thereby making transportation a barrier to obtaining health care. The per capita income is below state average and the unemployment rate is higher than state average. The local public health infrastructure is fragmented, which presents an opportunity for the region to be more involved in promoting community coalitions and initiatives.

Region 4/5N—Counties, Populations, and Local Public Health Presence

Anderson County (pop. 52,173)
Angelina County (pop. 74,170) - Angelina County and Cities Health District (P)
Bowie County (pop. 84,842) - Texarkana-Bowie County Family Health Center (P)
- Texarkana: Regional field office (TDH)
Camp County (pop. 10,721)
Cass County (pop. 29,898) - Cass County Health Department (P)
Cherokee County (pop. 43,788) - Cherokee County Health Department (P)
Delta County (pop. 4,844)
Franklin County (pop. 8,124)
Gregg County (pop. 108,145) - Gregg County Health Department (NP)
Harrison County (pop. 63,293) - Marshall-Harrison County Health District (P)
- Marshall: Regional field office (TDH)
Henderson County (pop. 74,837)
Hopkins County (pop. 29,689)
Houston County (pop. 22,588)
Jasper County (pop. 31,778) - Jasper-Newton County Public Health District (P)
Lamar County (pop. 43,888) - Paris-Lamar County Health Department (P)
Marion County (pop. 10,380)
Morris County (pop. 12,846) - Daingerfield: Regional field office (TDH)
Nacogdoches County (pop. 56,727) - Nacogdoches: Regional field office (TDH)



Newton County (pop. 14,493) - Jasper-Newton County Public Health District (P)
Panola County (pop. 23,718)
Polk County (pop. 37,792)
Rains County (pop. 8,001)
Red River County (pop. 13,815)
Rusk County (pop. 45,951)
Sabine County (pop. 10,201)
San Augustine County (pop. 7,974)
San Jacinto County (pop. 20,786)
Shelby County (pop. 21,870) - Center: Regional field office (TDH)
Smith County (pop. 168,355) - Tyler: Regional Headquarters (TDH)
- Smith County Public Health District (P)
Titus County (pop. 25,353)
Trinity County (pop. 12,769)
Tyler County (pop. 18,559) - Woodville: Regional field office (TDH)
Upshur County (pop. 33,364) - Gilmer: Regional field office (TDH)
Van Zandt County (pop. 42,850) - Canton: Regional field office (TDH)
Wood County (pop. 33,002) - Wood County Health Department (P)

Public Health Region 6/5 South

Est. 1999 pop. 4,918,250

Public Health Region 6/5 South (PHR 6/5S) is located in Southeast Texas. There are thirteen counties in PHR 6 and three counties in PHR 5 South (Hardin, Jefferson, and Orange). Geographically, the sixteen-county area of Region 6/5S extends from the western Louisiana border, as far west as Columbus and as far north as Huntsville. Its southernmost border includes the Galveston and Matagorda Bays. Ethnically and geographically diverse, the region includes urban, multinational, suburban, rural, and agricultural jurisdictions. Region 6/5S is also home to some of the nation's largest petroleum and chemical industries. An estimated 25 percent of all Texans reside in Public Health Region 6/5 South. This region is one of the most populous in the state (Houston is the fourth largest city in the nation) and the population continues to increase.



The regional headquarters, located in Houston, administers about 36 programs providing services predominately within its 16-county area, but often extending into other areas. In total, Region 6/5S will administer about \$18 million of state and federal funds in FY 98. Regional public health programs provide the programmatic performance activities (predominately health assessments and assurances) distinctly linked to state health policies and regulations. Regional administrative oversight ensures the delivery of comprehensive public health practices and a local/regional perspective in the development, management, and evaluation of preventive public health policies and programs. A regional satellite office, located in Beaumont, houses branches of several programs.

There are currently three regional (public health nursing) clinics, located in Colorado, Austin, and Liberty Counties. Prior to September 1995, the region operated seven sites. However, as a result of Title V initiatives, operations of four sites were contracted out during 1995 and 1996. The number of public health nurses in the regional clinic operations decreased from 32 to the current staff of seven. Staff in regional nursing clinics provides a variety of essential public health services based upon local community needs and emerging public health concerns. In addition to addressing a variety of community health issues, all three clinics provide immunizations, tuberculosis prevention and control, and referrals of patients with sexually transmitted diseases to regional HIV/STD program staff. Furthermore, nursing clinic staff assist other regional staff in responding to individual reportable disease investigations, disease outbreaks, and other public health hazards and disasters.

TDH regional staff works closely with both city and county public health workers, particularly in three areas: 1) the surveillance, epidemiology, and investigation of disease outbreaks and other health hazards, 2) initiating a coordinated public health response, and 3) implementing control measures (such as rabies exposure risk assessments, public education, and medical consultation). In disaster situations, a local public health presence can provide timely dissemination of life-saving precautions as well as providing and coordinating locally available manpower and other resources. Municipalities and counties that cannot meet the demands for environmental health services have requested assistance from the regional office. In counties without a local public health presence, regional staff responds directly to local citizen concerns including water quality, food safety, sanitation and hygiene, immunization services (such as tetanus shots after wounds), mosquito control, zoonotic/animal concerns, and chemical and electrical hazards.

In November 1997, a major foodborne outbreak occurred in Beaumont. Guests at a convention experienced a sudden onset of vomiting and diarrhea after dining at a banquet in a local hotel. Out of over 600 people attending the banquet, approximately half became ill. A regional sanitarian housed in the Beaumont satellite office responded promptly to a call for assistance from the Beaumont Public Health Department. The state sanitarian was instru-

mental in collecting food samples early in the investigation and submitting them to the TDH lab in Austin. Lab analysis revealed *Staphylococcus aureus* enterotoxin.



Region 6/5 N—Counties, Populations, and Local Public Health Presence

- Austin County (pop. 20,739) - Bellville: Regional field office (TDH)
- Brazoria County (pop. 222,046) - Brazoria County Health Department (P)
- Chambers County (pop. 20,841) - Chambers County Health Department (P)
- Colorado County (pop. 18,173) - Columbus: Regional field office (TDH)
- Fort Bend County (pop. 320,963) - Fort Bend County Health Department (P)
- Galveston County (pop. 233,547) - Galveston County Health District (P)
 - Bacliff: Regional field office (TDH)
- Hardin County (pop. 42,625) - Hardin County Health Department (P)
- Harris County (pop. 3,268,099) - Houston: Regional Headquarters (TDH)
 - Harris County Health Department (P)
 - Houston Health and Human Services Department (P)
 - Baytown Health Department (NP)
 - City of Bellaire (NP)
 - City of Deer Park (NP)
 - Hedwig Village Health Department (NP)
 - Pasadena Health Department (NP)
- Jefferson County (pop. 236,153) - Beaumont: Regional office (TDH)
 - Beaumont: Regional field office (TDH)
 - Beaumont City Health Department (P)
 - Jefferson County Health and Welfare (NP)
 - Port Arthur City Health Department (P)
- Liberty County (pop. 59,945) - Cleveland: Regional field office (TDH)
- Matagorda County (pop. 38,462) - Matagorda County Hospital District (NP)
- Montgomery County (pop. 235,384) - Montgomery County Health Dept (P)
- Orange County (pop. 82,022) - Orange County Community Health Center (P)
- Walker County (pop. 52,256) - Walker County Hospital District (NP)
- Waller County (pop. 26,037) - Waller County Hospital District (NP)
- Wharton County (pop. 40,958)

Public Health Region 7

Est. 1999 pop. 1,989,767

The boundary of Public Health Region 7 encompasses a 30-county area covering 25,755 square miles of Central Texas. The area offers many recreational sites; maintains a strong agricultural, industrial and military economy; serves as home for several colleges and universities; and is served by many outstanding medical care facilities. The regional headquarters are in Temple with sub-offices in Austin and Waco. PHR 7 also provides nursing and other services in 17 county field offices. The region's FY 1998 budget is about \$9.8 million.



Central Texas has a very diverse economy supported by technological, manufacturing, and industrial commercial enterprise. Agriculture is also predominant, providing livestock and a variety of small grain production along with fruit and vegetable products. Dissected by the Interstate-35 corridor, industrial and technology centers are primarily found along I-35, while agriculture is the driving force behind the economy of the outlying rural counties of the region.

Region 7 is home to seven participating local health departments. Additionally, 19 other county and city agencies offer a variety of environmental health services that include restaurant and food service inspection, wastewater complaint investigation, septic systems inspection, and emergency management. According to the latest publication of Texas Healthy People 2000, Health Status Indicators, PHR 7 reports three key health indicators that are above state averages. The high categories are Lung Cancer Deaths, Incidence of Acquired Immunodeficiency Syndrome, and Motor Vehicle Crash Deaths.

Region 7—Counties, Populations, and Local Public Health Presence

Bastrop County (pop. 53,506) - Bastrop County Department of Sanitation (NP)

- Bastrop: Regional field office (TDH)
- Elgin: Regional field office (TDH)

Bell County (pop. 211,924) - Temple: Regional Headquarters (TDH)

- Bell County Public Health District (P)

Blanco County (pop. 7,257) - Blanco County Courthouse (NP)

Bosque County (pop. 16,148) - Bosque County Courthouse (NP)

- Meridian: Regional field office (TDH)

Brazos County (pop. 121,438) - Brazos County Health District (P)

Burleson County (pop. 15,318)

Burnet County (pop. 27,877) - Burnet County Courthouse (NP)

- Marble Falls County Courthouse (NP)
- Marble Falls: Regional field office (TDH)
- Burnet: Regional field office (TDH)

Caldwell County (pop. 32,039) - Caldwell County Health Department (NP)

- City of Luling Health Department (NP)
- City of Lockhart (NP)
- Lockhart: Regional field office (TDH)
- Burleson: Regional field office (TDH)

Coryell County (pop. 76,679) - City of Copperas Cove (NP)

- Copperas Cove: Regional field office (TDH)
- Gatesville: Regional field office (TDH)

Falls County (pop. 18,826) - Marlin: Regional field office (TDH)

Fayette County (pop. 20,350) - Fayette County Department of Sanitation (NP)

Freestone County (pop. 17,034) - Fairfield: Regional field office (TDH)

Grimes County (pop. 22,783) - Grimes County Courthouse (NP)

- Navasota: Regional field office (TDH)

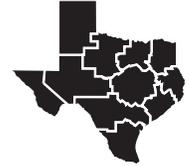


Hamilton County (pop. 7,331) - Hamilton: Regional field office (TDH)
Hays County (pop. 86,860) - Hays County Health Department (P)
Hill County (pop. 28,831) - Hillsboro: Regional field office (TDH)
Lampasas County (pop. 14,515) - Lampasas County Commissioners Court (NP)
- Lampasas: Regional field office (TDH)
Lee County (pop. 14,749) - Lee County Courthouse (NP)
Leon County (pop. 15,580) - Centerville: Regional field office (TDH)
Limestone County (pop. 21,692) - City of Mexia (NP)
- Mexia: Regional field office (TDH)
Llano County (pop. 12,423) - Llano County Department of Natural Resources (NP)
Madison County (pop. 11,968) - Madison County Courthouse (NP)
- Madisonville: Regional field office (TDH)
McLennan County (pop. 192,865) - Waco-McLennan County Public Health District (P)
Milam County (pop. 23,284) - Milam County Health Department (P)
- Cameron: Regional field office (TDH)
Mills County (pop. 4,446) - Mills County Judge (NP)
Robertson County (pop. 16,996) - Hearne: Regional field office (TDH)
San Saba County (pop. 5,463)
Travis County (pop. 647,366) - Austin: Texas Department of Health state headquarters
- Austin: Regional office (TDH)
- Austin-Travis County Department of Health and Human Services (P)
Washington County (pop. 29,154) - Brazos River Authority (NP)
- City of Brenham (NP)
- Brenham: Regional field office (TDH)
Williamson County (pop. 215,065) - Williamson County and Cities Public Health District (P)

Public Health Region 8

Est. 1999 pop. 2,076,931

Public Health Region 8 encompasses 28 counties in central south Texas, extending from the Mexican border across to the Gulf of Mexico. About half of the region's population resides in the region's largest city, San Antonio. The regional headquarters are located in San Antonio, with a sub-office in Uvalde and 12 clinics spread across the region. PHR 8 operates 38 programs with an FY 1998 budget of almost \$13.4 million.



There are currently nine state-participating local health departments in Region 8 and ten non-participating ones, plus the Upper Guadalupe River Authority, which is involved in water safety. Four participating LHDs have closed or changed their status to non-participating in the last few years; these were Dimmit County, Wilson County, Zavala County, and Del Rio-Val Verde County. Five TDH clinics in PHR 8 closed in 1996, due to reasons such as grants ending and Title V funds going to other providers.

Most of the public health indicators that are higher in PHR 8 than the statewide averages are those associated with contaminated food and water, such as hepatitis A, campylobacteriosis, salmonellosis, and shigellosis. This is due to the fact that Region 8 includes some counties with higher poverty rates, including those along the Texas-Mexico border, and many of these areas have problems obtaining clean water for drinking and cooking.

There is an interesting pilot project operating in Region 8 called the Local Public Health Pilot Project. It is located in Bandera County and began in June 1998. The purpose of the pilot is to develop innovative ways of providing essential public health services at the local level in areas without a local health department. A group called the Core Team, consisting of a public health nurse, a registered sanitarian, a community services aide, and a clerk, is responsible for delivering essential public health services emphasizing prevention. The Core Team will function as public health generalists, and when they encounter problems requiring additional expertise they will call on state specialists called the Extended Team. The Core Team will spend time interacting with local agencies and groups and will help improve communications. A local advisory health board will also be appointed by the county judge and commissioners to advise the commissioners' court and to inform the community and help them set health priorities.

Region 8—Counties, Populations, and Local Public Health Presence

- Atascosa County (pop. 36,915) - Atascosa County Health Department (P)
- Bandera County (pop. 13,915) - Bandera County Permits and Inspections (NP)
 - Bandera: Regional field office (TDH)
- Bexar County (pop. 1,360,411) - San Antonio: Regional Headquarters (TDH)
 - San Antonio Metropolitan Health District (P)
 - San Antonio: Regional field office (TDH)
- Calhoun County (pop. 20,099) - Calhoun County Health Department (P)
- Comal County (pop. 73,767) - Comal County Health Department (NP)
- DeWitt County (pop. 20,314) - Cuero-DeWitt County Health Department (P)
- Dimmit County (pop. 11,251) - Carrizo Springs: Regional field office (TDH)
- Edwards County (pop. 2,497)
- Frio County (pop. 16,456) - Pearsall: Regional field office (TDH)
- Gillespie County (pop. 19,776) - Gillespie County Courthouse (NP)
- Goliad County (pop. 6,509)
- Gonzales County (pop. 18,192)
- Guadalupe County (pop. 84,277) - Guadalupe County Environmental Health (NP)
 - City of Seguin Health Inspections (NP)
 - Seguin: Regional field office (TDH)



Jackson County (pop. 13,204) - Jackson County Health Department (P)
Karnes County (pop. 15,715) - Karnes: Regional field office (TDH)
Kendall County (pop. 18,938) - Kendall County Department of Development (NP)
- Boerne: Regional field office (TDH)
Kerr County (pop. 41,958) - Upper Guadalupe River Authority, Division of Water Quality and
Environmental Health Services (NP)
- Kerrville: Regional field office (TDH)
Kinney County (pop. 3,341)
La Salle County (pop. 6,408)
Lavaca County (pop. 18,055) - Hallettsville: Regional field office (TDH)
Maverick County (pop. 44,277) - Eagle Pass: Regional field office (TDH)
Medina County (pop. 34,164) - Medina County Health Department (P)
Real County (pop. 2,518) - Real County Department of Sanitation (NP)
Uvalde County (pop. 25,872) - Uvalde City-County Health District (P)
- Uvalde: Regional office (TDH)
- Uvalde: Regional field office (TDH)
Val Verde County (pop. 44,190) - Del Rio: Regional field office (TDH)
Victoria County (pop. 80,441) - Victoria County Health Department (P)
Wilson County (pop. 29,726) - Wilson County Health Department (P)
- Floresville: Regional field office (TDH)
- Goliad: Regional field office (TDH)
Zavala County (pop. 13,745) - Zavala County Health Department (NP)

Public Health Region 9/10

Est. 1999 pop. 1,351,345

PHR 9/10 consists of 36 counties from El Paso across to central Texas and along the border, covering 61,428 square miles. It is funded by TDH with state and federal funds for 34 programs totaling slightly over \$10 million in FY 1998. The regional headquarters is in El Paso and there are two regional offices, in Midland and San Angelo. There are also five TDH clinics in the region.



Counting the 11 counties represented by participating and non-participating city and county health departments, 25 counties are left without local public health departments, including most of the border counties. Regional staff step in and provide public health services if there is an emergency in areas without their own LHDs, but they do not have a presence in every county and cannot provide as timely a response in emergencies as local personnel could. They also cannot provide the routine preventative services that may have been able to prevent the outbreak or emergency in the first place.

The botulism outbreak in El Paso in April 1994 (the largest ever recorded in Texas) demonstrates the timeliness and effectiveness of a local health presence. Two suspected botulism cases were reported to the LHD on a Sunday morning and an investigation was immediately initiated. Botulism was confirmed in time to treat all of the infected people properly and prevent any deaths, and the source was traced to a specific restaurant in time to prevent it from opening that day and possibly infecting more people. Though TDH and the CDC eventually sent in extra staff to help, the timeliness of the first response is critical in safeguarding the health of the public in situations like these. If this had happened in Crockett County, for instance, there are no TDH regional offices or LHDs close by, so staff would have had to travel from other counties after they found out about it on Monday, and more people probably would have been affected and become seriously ill.

The uninsured rate is high in this region. Many people seek cheaper health services across the border in Mexico. The border area of the region experiences TB infection rates that are well above the state average, and diabetes, lack of prenatal care, and air pollution rates are also above the state average. Drug-resistant TB and many other communicable diseases are a significant problem on the Mexican side of the border, and it takes a concerted effort to control them in Texas, since the border is a boundary in name only, with millions of crossings a year.

Region 9/10—Counties, Populations, and Local Public Health Presence

Andrews County (pop. 15,532) - Andrews City-County Health Department (P)
Brewster County (pop. 10,814) - Alpine: Regional field office (TDH)
Coke County (pop. 3,434)
Concho County (pop. 3,296)
Crane County (pop. 5,146)
Crockett County (pop. 4,310)
Culberson County (pop. 4,101)
Dawson County (pop. 15,790) - South Plains Public Health District (P)
Ector County (pop. 128,421) - Ector County Health Department (P)
El Paso County (pop. 755,339) - El Paso: Regional Headquarters (TDH)
- El Paso City-County Health and Environmental District (P)
Gaines County (pop. 14,970) - South Plains Public Health District (P)
Glasscock County (pop. 1,601)
Howard County (pop. 31,921) - Big Spring-Howard County Health Department (NP)
Hudspeth County (pop. 3,347)
Irion County (pop. 1,741)



Jeff Davis County (pop. 2,184)
Kimble County (pop. 4,121)
Loving County (pop. 116)
Martin County (pop. 5,425)
Mason County (pop. 3,388)
McCulloch County (pop. 8,836) - Brady City Health Inspector (NP)
- Brady: Regional field office (TDH)
Menard County (pop. 2,292)
Midland County (pop. 127,868) - Midland: Regional Office (TDH)
- Midland County Health Department (P)
Pecos County (pop. 17,617) - Pecos County Health Department (NP)
Presidio County (pop. 8,502)
Reagan County (pop. 5,148) - City of Big Lake (NP)
Reeves County (pop. 17,050)
Schleicher County (pop. 3,249)
Sterling County (pop. 1,532)
Sutton County (pop. 4,506)
Terrell County (pop. 1,522)
Tom Green County (pop. 110,054) - San Angelo - Regional office (TDH)
- San Angelo-Tom Green County Health District (P)
Upton County (pop. 4,817)
Ward County (pop. 13,551) - Ward County Health Officer (NP)
Winkler County (pop. 9,047)

Public Health Region 11

Est. 1999 pop. 1,687,473

The Texas-Mexico border's health conditions are said to be among the worst in the United States. Public Health Region 11 encompasses 19 counties located in the triangle between the Mexico border and the gulf coast in south Texas. There are estimated to be over 100,000 undocumented persons in the 1,000 colonias in the lower Rio Grande Valley, though reliable numbers are difficult to obtain. The percent of uninsured persons ranges from 20 to 44 percent, in addition to Medicaid-eligible populations of up to 24 percent in some counties on the border. This suggests that limited access to personal health care leaves a vulnerable high-risk population in terms of prenatal, preventive, and primary health care.

The border area is epidemiologically unique. Immigration, sub-tropical climates, and migrant work pose elevated risks for communicable disease such as resistant tuberculosis, Hansen's disease (leprosy), dengue, typhus, hepatitis A, and cholera. Genetics and diet yield a high prevalence of Type 2 diabetes. Lead contamination, PCB in fish from canals, mercury in large gulf fish, red tide from dinoflagellates, and *Vibrio* infection of shell fish are among the environmental concerns in this region.

PHR 11 has headquarters Harlingen, a sub-office in Corpus Christi, and 14 field offices (there are also state clinics in the region). PHR 11 programs and services are aimed at targeted intervention in the areas of prevention, regulatory activities, epidemiology, communicable disease surveillance, and environmental health. Small Towns Environmental Projects have worked jointly with several isolated colonias to develop means for sewage treatment and potable water supplies. Binational tuberculosis agreements with surveillance have identified high rates of multi-drug resistance and primary resistance which have lead to federal allocation of funding for international control efforts. At the same time, high costs of treatment of drug-resistant tuberculosis have taxed the capacity of the aging state chest hospitals. After a prolonged drought and economic losses in the ranch and farm communities, threats of hurricane and floods have focused disaster preparedness activities.

Region 11—Counties, Populations, and Local Public Health Presence

- Aransas County (pop. 19,610) - Rockport: Regional field office (TDH)
- Bee County (pop. 29,325) - Bee County Health Department (NP)
 - Beeville: Regional field office (TDH)
- Brooks County (pop. 8,959) - City of Falfurrias Health Department (NP)
 - Brooks County Welfare Clinic (NP)
 - Falfurrias: Regional field office (TDH)
- Cameron County (pop. 328,158) - Harlingen: Regional Headquarters (TDH)
 - Cameron County Health Department (P)
 - Brownsville City Health Department (NP)
 - Harlingen City Health Department (NP)
- Duval County (pop. 14,676) - San Diego: Regional field office (TDH)
- Hidalgo County (pop. 528,300) - Hidalgo County Health Department (P)
 - McAllen Health Department (NP)
 - Edinburg: Regional satellite office (TDH)
 - McAllen: Regional satellite office (TDH)
- Jim Hogg County (pop. 6,290) - Hebbronville: Regional field office (TDH)
- Jim Wells County (pop. 39,837) - Alice: Regional field office (TDH)
- Kenedy County (pop. 520)
- Kleberg County (pop. 32,089) - Kingsville-Klebury County Health Unit (NP)
 - Kingsville: Regional field office (TDH)
- Live Oak County (pop. 10,026) - Live Oak County Health Department (P)





McMullen County (pop. 866)

Nueces County (pop. 315,965) - Corpus Christi: Regional office (TDH)

- Corpus Christi-Nueces County Public Health District (P)

Refugio County (pop. 8,166) - Refugio: Regional field office (TDH)

San Patricio County (pop. 67,988) - San Patricio County Health Department (P)

Starr County (pop. 61,722) - Rio Grande City: Regional field office (TDH)

Webb County (pop. 182,195) - City of Laredo Health Department (P) (covers whole county
by interlocal agreement)

- Laredo: Regional satellite office (TDH)

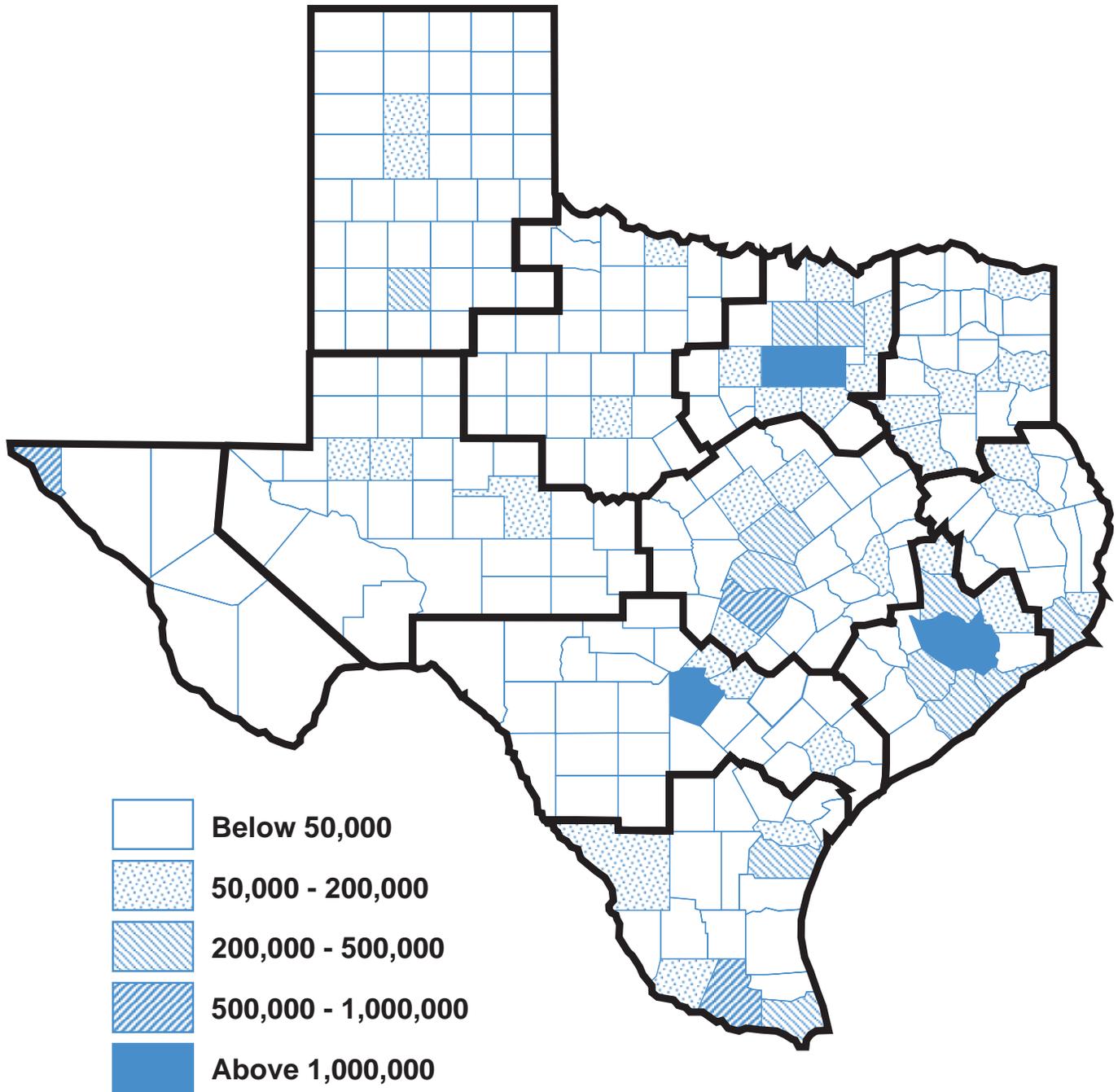
Willacy County (pop. 19,915) - Raymondville: Regional field office (TDH)

Zapata County (pop. 12,866) - Zapata: Regional field office (TDH)

Sources for regional profiles and county information: Public Health Regional Directors and regional and local personnel, 1998; Office of Regional Administrative Services, Texas Department of Health, 1998.

Source for 1999 Populations: Texas State Data Center, Texas Population Estimates and Projections Program, Texas A & M University.

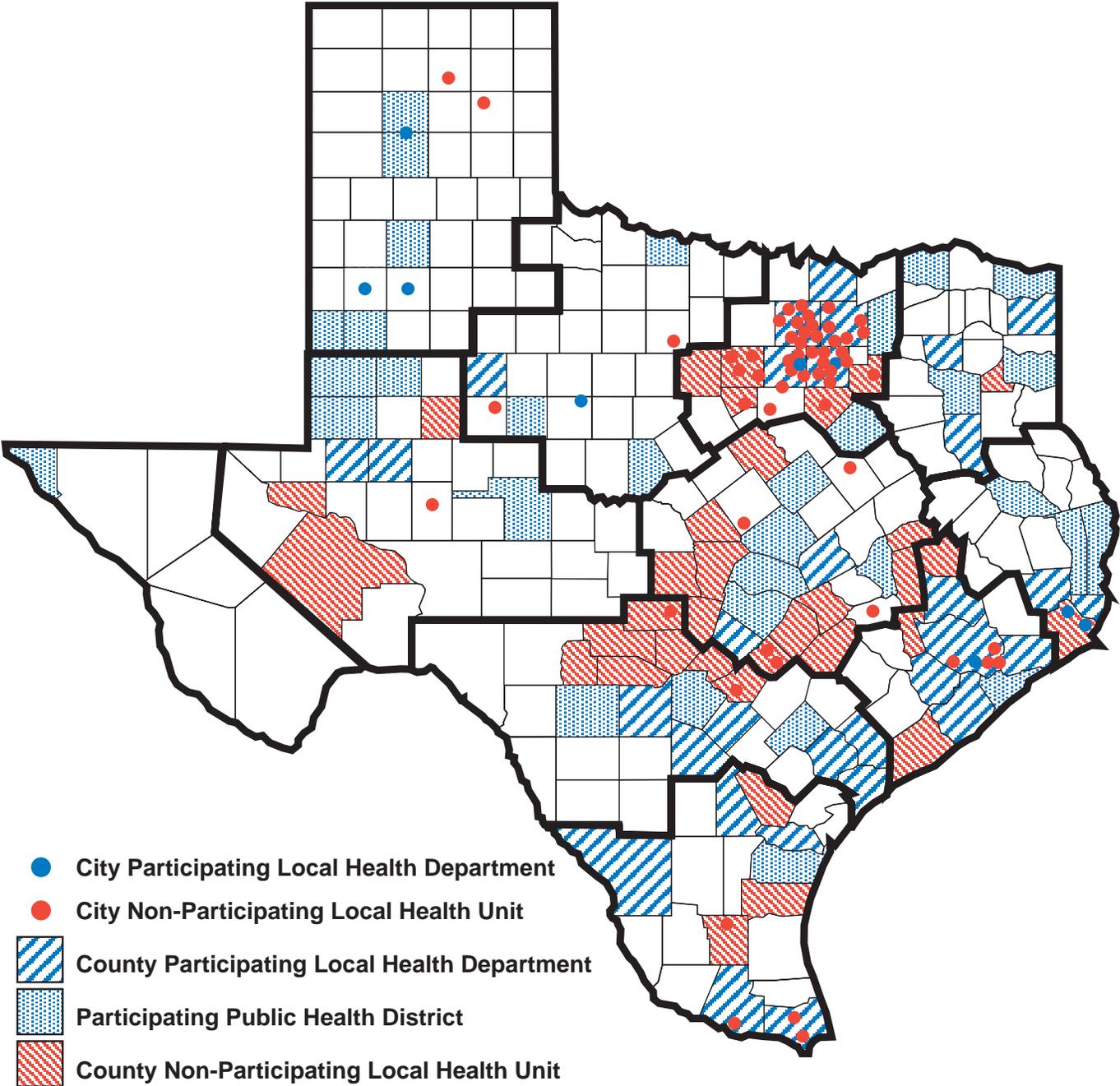
Texas Population by County, 1999



Data Source: Texas State Data Center, Texas Population Estimates and Projections Program, Texas A & M University

Created by: Bureau of State Health Data and Policy Analysis, TDH.

Participating and Non-Participating Local Health Departments



Source: Texas Department of Health, 1998
Created by: Blackland Research Center

APPENDIX D

Public Health Systems in Selected States

Ten states were examined in this study by TDH staff to see how their state and local public health systems work and how they handle the related issues of funding, statutory requirements, and accountability in public health. The states are California, Colorado, Florida, Minnesota, New York, North Carolina, Oklahoma, South Carolina, Washington, Wisconsin. These were chosen for a variety of reasons including population size, demographics, and state-local administrative structure. Information was obtained by interviewing appropriate officials in each state health department via conference call during March 1998. Interview questions covered issues such as the relationship of local health departments to the state, enabling statutes, funding mechanisms, evaluation of local and state infrastructure, accountability, local health authority, local default, and role negotiation.



Summary of Public Health Systems in Other States

State	Summary of Public Health System
California	Mixed administrative structure; public health model based on home rule; counties required to provide LHDs with minimum services, or to contract with the state for these services
Colorado	Decentralized administrative structure; home rule public health model granted under the state constitution; counties required to have local board of health and at least a part-time public health nurse
Florida	Centralized administrative structure; model based on home rule; all local services provided by the state, counties contribute varying amounts
Minnesota	Decentralized structure; home rule; every county is covered by a LHD, required to have a local board of health, LHDs supported in part by local tax levy for public health
New York	Mixed structure; public health model based on home rule authority; counties required to have health departments and local boards of health
North Carolina	Shared administrative structure; no home rule authority; law requires counties to have a LHD for be part of a health district
Oklahoma	Mixed administrative structure; no home rule authority; all local services provided by the state (exception granted for two city health departments), counties contribute to funding, counties not required to have LHD
South Carolina	Centralized administrative structure; home rule model of public health; all local services provided by the state through 13 districts, local contributions not required
Washington	Shared administrative structure; home rule model; all counties covered by LHDs, law requires county boards of health, local contribution varies
Wisconsin	Decentralized administrative structure; home rule model; no requirement for LHD, majority of LHD budget generated locally; law defines activities LHDs have to do to be considered level 1, 2, or 3



CALIFORNIA



Relationship of Local Health Departments to the State

California has 61 local health jurisdictions: 58 county and three city health departments. The local health departments are independent from the state, and the local health officers are appointed by the local governing bodies. The health officer must be a physician, except in Los Angeles, where an exception was granted. The health officer is supposed to be the LHD director, but this is not enforced. The state health department and the local health officers both have broad responsibility for public health. The LHDs are autonomous and are not under state authority except for a few requirements such as reporting certain communicable diseases to the state. There are no regional core public health services, but there are regions for several programs such as emergency management and air quality.

Provision of Public Health Services

State statute requires that a county have a LHD, have a local health officer, and provide certain services listed, but the specifics of most programs are not well-defined in the law (more specifics provided in the contracts). There are a few local boards of health (about six), and some local advisory groups. There has been no problem with counties defaulting. Both the state and LHDs do core public health services; different LHDs may also do other services and be organized in different ways (e.g., some do environmental services, some do mental health, some do personal/direct health services, and in other counties these may be handled by agencies other than the LHD). California has 11 small rural counties which in effect contract with the state for public health services: these counties provide funds to the state, and in return the state provides public health nursing and environmental services in these areas using state employees. There are also other state employees who work in LHDs to lend their expertise.

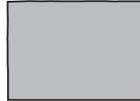
Funding Mechanisms

An average of about five percent of the LHD budgets comes from local government (though this varies widely), and the rest is from state and federal categorical grants. A current bill in the legislature would increase the state contribution to LHDs to 60 cents per capita or \$100,000, whichever amount is greater (this would be for core functions, not categorical programs, which are separate). The state is doing some surveys to support this legislation to increase funding.

Evaluation of Local and State Infrastructure and Accountability

Problem areas receive attention, but there is currently no systematic evaluation of public health infrastructure or state health department functions. There is a legislative analyst's office and special commissions that may periodically study public health, but there has been no comprehensive evaluation yet. There are several organizations for local health officers and directors to meet and influence policy. The state feels that it is hard to market and publicize public health except when there is a crisis, and then any extra funding received is usually categorical. The state health department wants to increase funding for the "generic" core public health services so they can increase functions such as monitoring and surveillance.

COLORADO



Relationship of Local Health Departments to the State



The delivery of public health in Colorado is based on a partnership between the state and the 63 counties. Colorado has three types of local health entities with which contracts are negotiated: county or district health departments, regional health departments (currently there is one regional health department which crosses six county boundaries in a rural area of Colorado), and county nursing services (39 counties have no formal health department, but do provide nursing services). Counties are required at a minimum to have a part-time county nurse. Local entities are autonomous and local control is a high priority in the state political process. There are local boards of health in 14 counties that are appointed by the county commissioners. In the 39 counties with only nursing services, the county commissioners act as the local board of health. The state acts a safety net for the provision of services not provided by the counties.

Provision of Public Health Services

Colorado legislative staff suggested that the department refine and clarify the wording of the core public health services into specific service statements that would be more understandable to the general public. A state task force has taken the 10 essential services and worked them into the following list.

Colorado Basic Public Health Services

1. Preventing Epidemics and the Spread of Disease

Programs contributing to this service include:

- Immunizations
- TB
- HIV/AIDS
- STD reporting/tracking
- Epidemiology (tracking and follow-up)
- Environmental/water, sewage sanitation, air quality
- Food service safety/consumer protection
- Women's health

2. Protecting against environmental hazards

Programs contributing to this service include:

- Water safety
- Air quality
- Consumer Protection
- Toxic waste

3. Providing assessment and evaluation of community health status

Programs contributing to this service include:

- Public health nursing
- Prevention programs
- EPSDT
- Chronic disease programs
- Vital records/health statistics
- Women, Infant, Children (WIC) program
- Epidemiology



4. Preventing illness and injury

Programs contributing to this service include:

- Consumer Protection
- Air quality control
- Hazardous materials
- Water quality
- Child health
- Immunization program
- Bicycle helmet safety
- Prevention programs

5. Promoting healthy behavior

Programs contributing to this service include:

- Public health nursing
- Women's health
- Health education/prevention programs
- Heart disease program
- Diabetes program
- Child, adolescent and school health programs
- WIC program

6. Responding to disasters and assisting communities in recovery

Programs contributing to this service include:

- Emergency medical services
- Water
- Air
- Hazardous materials
- Consumer protection
- Epidemiology
- Public health nursing

7. Assuring the Quality and Accessibility of Health Services

Programs contributing to this service include:

- Health facilities
- Health care program for children with special needs
- Rural health
- Migrant health
- Child, adolescent and school health programs

Funding Mechanisms

There are two systems for funding local health. The first is a system for organized county or district health departments. Funding to these entities is on a per capita basis. State funding currently averages \$1.23 per capita. State statute requires a \$1.50 per capita contribution on the part of the local governments, although most local governments contribute far more. The second system is designed to fund the 39 counties offering county nursing services. In these counties, the state reimburses 16 percent of the total salary and benefits for the county nurse. Of the total funds for public health, the state provides 9.8 percent (\$20.5 million) via the general revenue fund, counties provide 24.1 percent (\$50.7 million), and federal funds amount to 66.1 percent, or \$138.9 million. Federal funds flow through the state health department.

Evaluation of Local and State Infrastructure and Accountability

A task force has been convened to refine the objectives and develop an evaluation process. This work will be completed in June 1998. The Colorado legislature is interested in increasing funding for public health if performance measures are tied to those dollars and bureaucracy is minimized. The state health department is working on both performance-based objectives and a new funding formula, based on per capita funding with a minimum of \$20,000 for the smaller counties. This performance-based system would require each health department to maintain a portfolio that would include their objectives, indicators, and outcomes. The state would support local health departments through their technical assistance role. At the present time, the state does not evaluate core public health functions, but rather focuses evaluation resources toward measuring the Colorado Year 2000 health objectives.



FLORIDA

Relationship of Local Health Departments to the State



There are 67 counties in Florida, and each has a local health department. Each LHD is a state entity. There is a central state office and no regional system. The Florida state health department was recently separated from a consolidated health and human services agency, and the health department now has about 13,000 employees; mental health services may be combined with the state health department in the next several years. The establishment of LHDs is provided in statute, along with a physician as director or consultant. Florida does not have local boards of health, but they do require a local health authority (there are about 55 LHD directors, as some have responsibility for more than one county).

Provision of Public Health Services

The law says LHDs will have programs in communicable disease control, family health services, environmental health, and primary care. Local policy-making varies widely with the LHDs. Some set policy more than others, and LHDs are allowed to set fees locally through the county government. Florida does not have state and local boards of health, and some people feel these are needed to help insulate public health from politics.

Funding Mechanisms

The amount of local funding contributed to the LHDs budgets varies widely, but about 15% of the state local public health budget comes from county funds. A county/state contract is made each year to set out the funding responsibilities of each party. There are formulas for allocating program funding based on poverty levels and specific needs in the area. The state is currently discussing ways to tie funding to core public health functions. The state money used for local public health provision is state general revenue; the overall health department budget is about \$700 million, and general revenue is about a quarter of that.

Evaluation of Local and State Infrastructure and Accountability

There is not a formal evaluation process for the state health department, but there is for the LHDs. The seven largest counties are audited annually by central office on 14 health indicators (process and outcomes) using paper audits and site visits. The remaining counties are visited every three years. The state is developing an accreditation system. Community involvement is important and is expected of LHDs. Community assessment is not required but is being done by some LHDs and other entities.



MINNESOTA



Relationship of Local Health Departments to the State

Minnesota has a stand-alone health department that includes environmental services but does not include mental health or Medicaid. It has a budget of around \$200 million, over half of which is federal funding. There are 49 local health departments; they cover the whole state and are partners with the state. They are mostly operated by counties, though a few are by cities. There are no state employees working in LHDs, but the state can lend its expertise during major outbreaks or other crises. Minnesota has state staff working in district offices in functions such as restaurant and nursing home inspections, direct services, consulting to LHDs, and environmental services. Local health departments in Minnesota are independent. There are not many state mandates, and local planning and prioritization are emphasized. Before 1976, there were many local health authorities for many overlapping jurisdictions such as towns, cities, and counties, but starting in 1976 the previous local health authorities were phased out and a new, more standardized system was put into place.

Provision of Public Health Services

LHDs are not traditionally the safety net providers or primary care providers, but there are a few community clinics, and some LHDs have services such as home health visits. State law establishes the Community Health Services System. This system is similar to the Assessment Protocol for Excellence in Public Health (APEX) model where counties and others can participate in a community health board and can get state funding for it. Counties must have a local board of health that serves as the health authority, and if these are established as community health boards, the county can get extra funding under Community Health Services (all local boards are currently community boards; there are no boards of health that are not). To form a community health board, the county must have a population of 30,000 or more (if it does not, it can join with neighboring counties), must submit a public health plan, must have a local advisory committee that meets three times per year, must do community assessment, must list goals and community resources, must submit annual expenditure and activity reports to the state, must employ a physician medical director, and other requirements.

The state has a strong advisory committee that works on developing state/local public health policy. They created a document clarifying core activities and roles for state and local public health entities in disease prevention and control, and it is being pilot-tested now with several LHDs to get their opinions. The document should be finalized by this summer and may become a part of the community health services requirements (there is a state-local cooperative agreement now but it is not very detailed). They hope to eventually expand it to include roles and expectations of private entities involved in public health, in addition to the state and local governmental entities.

Funding Mechanisms

The funding for local health departments is made up of state general revenue, federal grants, fees, Medicaid reimbursements, and a local tax levy for support of local public health (collected and distributed by the state, and localities must match it dollar for dollar).

Evaluation of Local and State Infrastructure and Accountability

Evaluation is not a strong point in the system. LHDs submit community health plans, which the state reviews for legal requirements, and LHDs also submit reports of their public health activities and expenditures. The state is developing performance guidelines

and strategies, and is looking for ideas on how to evaluate local effectiveness. The state is looking at the issue of public health accreditation and wants to find out what others are doing in this area.

NEW YORK

Relationship of Local Health Departments to the State



The state of New York has 58 local health units. Of these 58 units, 57 are county units and one is a city health department, the City of New York Health Department, which serves five boroughs (Bronx, Manhattan, Queens, Brooklyn, and Staten Island). County health units are required by state statute (Article VI) and all local health departments are autonomous in their organization and management.

Provision of Public Health Services

The state recognizes two levels of service delivery within the local health units: full service health units offering five basic services and less than full service health units, which do not offer the environmental health services. The five basic services offered by full service units are environmental health, family health, disease control, health education, and community health assessment (a variety of programs exist under these main categories). The state intervenes to provide environmental health services for the less than full service units through regional offices.

Both full service and less than full service health units may also provide optional services and other public health services. At this time, optional and other services are reimbursed at the same rate. "Optional services" include dental health services, home health services, regulation of radioactive equipment, housing hygiene, other environmental services, emergency medical services, long-term home health care, laboratories, and early intervention administration and service coordination. "Other services" include vector control, inpatient TB, medical examiner services, and medical examiner laboratory.

Article VI requires local boards of health. Counties with a population less than 250,000 are required to have a public health director. Counties with a population greater than 250,000 are required to appoint a commissioner, who must be a medical doctor. Some counties have established a board of health, while others use elected boards (such as a commissioners court) to oversee the provision of public health services. The state health department is under the leadership of a Commissioner of Health.

Each county is required biennially to submit a municipal public health services plan. The plan includes:

- an estimate of and description of their immediate and long term needs for public health services
- description of the unit's public health goals and objectives
- description of the programs for achieving those goals
- projected two-year plan of expenditures necessary to implement the programs
- general description of the availability of health services
- number of staff required to provide the services
- fee and revenue plan
- evidence that the governing body of the municipality has adopted the plan.

At the end of each year a performance report is submitted. The plan and the performance report are reviewed by state staff for appropriateness and achievement. The state provides the basic structure for the plan and there is little negotiation in its development. For



counties unable to provide full services, the state can withhold funds and contract with private entities or provide the services through the state. Recently, there has been a trend toward the merging of county services, but multiple counties are not merging to provide public health services.

Article VI provides for a shared responsibility between the county and the state. The state of New York has convened a committee of state and county public health leaders to examine their public health law (Article VI). They are examining options for translating their categorical services into language similar to core public health services.

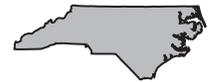
Funding Mechanisms

State Aid for General Public Health Works is the state statute that allows for state reimbursement to counties for the provision of public health services. In New York state, local health units offer a variety of basic and optional services for which state funding is provided, related to the five required areas. Full service health units are reimbursed at an annual flat rate of \$450,000, while less than full service are reimbursed \$306,000. Expenditures on the required services over the flat rate are picked up by the state health department at a rate of 36%. The remaining expenses (optional and other services) are paid by the state health department at a rate of 30%. In 1994, the local health unit contributions accounted for \$768 million of the \$820 million spent on local public health services.

Evaluation of Local and State Infrastructure and Accountability

No particular tool is used for community health assessment in the state of New York. The basic elements of the assessment include demographics, identifying populations at risk, problem identification, and a link to the strategies employed in the public health services plan. APEX was used in the development of the New York community assessment.

NORTH CAROLINA



Relationship of Local Health Departments to the State

There are 110 counties in North Carolina and 86 local health departments (some are multi-county districts). Public health became part of the state department of health and human services in October 1997; previously, it was a part of the environmental services department. State law requires counties to have a LHD or to be a part of a health district for provision of public health services. Each LHD is autonomous, though the state provides certain standards, guidelines, recommendations, and state and federal funding. The state has regional staff who provide services such as consulting and technical assistance, nursing, and administrative/support functions to LHDs.

The state health department provides additional resources and expertise when needed (such as during an outbreak), under the direction of the county. There is a history of local autonomy, and the county usually calls the state or another county for help, and not vice versa (the state tries not to step in uninvited). The state has home rule for counties and districts.

Funding Mechanisms

There is variation in the sources of funding of LHDs, but it generally includes state funding (including federal pass-through grants), local tax revenue, fees, and reimbursements from Medicaid, Medicare, and private insurance. The percentage of local contribution varies widely, with larger municipalities usually contributing more. Federal grants come through the state, state money is added, then the funds are distributed according to factors

such as population. The contract addenda list total state and federal funds for a program and the attached requirements (“deliverables”) that both parties negotiate and agree on.

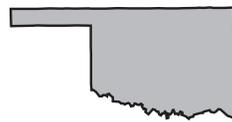
Evaluation of Local and State Infrastructure and Accountability

State statute lists essential functions of public health and provides for a centralized assessment function. Policy development is both a state and local responsibility; there is some state legislation, but some issues are handled better as local ordinances. Localities are supposed to inform the state of any new local ordinances that affect public health. The local health authority is often the LHD administrator. The administrator is not required to be a physician, so not many are, since it is more expensive for the LHD. Some departments have a separate medical director under contract.

There is no official consequence or penalty if LHDs default on their responsibilities, and the state health department is currently looking at how to handle this issue. They want to find a solution that does not further harm the population of the area by withdrawing funding. The state health department tries to hold LHDs accountable and work with them on areas that may need to be improved. In 1993, legislation passed that held LHDs more accountable for performance (for use of state dollars). A task force was appointed and accountability indicators developed, but then the legislature had a large turnover and no one has asked since about the indicators (the LHDs did not all “buy in” to the indicators).



OKLAHOMA



Relationship of Local Health Departments to the State

Oklahoma has a system where the local health departments are direct extensions of the state (there are no regional entities). The public health system at all levels is managed entirely by the state. There are 77 counties in the state, and about 70 of those have local county health departments, the first of which opened in the 1930s. The only exceptions are Oklahoma City and Tulsa, which have autonomous city/county health departments by statute; they are independent as far as setting policy though they sometimes receive supplies from the state. The employees of the rest of the county health departments are state employees.

Provision of Public Health Services

Each county health department has a local board of health that serves as the local health authority. This local board does not have much responsibility since the state board of health sets most of the policy. Each LHD has an administrator who is often an environmental specialist or nurse, and the administrator sometimes serves as director for more than one county health department. The administrators can serve on state committees as well as give feedback through the Deputy Commissioner of Local Health Services, who serves as their contact point at the state health department. This Deputy Commissioner is one of five Deputy Commissioners who all meet with the Health Commissioner periodically to discuss relevant issues from their areas.

Funding Mechanisms

The county health departments receive state funding for various programs, but the state does not contract with them since the LHDs are part of the state health department. The counties contribute to their LHD by raising funds through a millage or a local sales tax; the percent of the budget that comes from the county varies widely. To determine how much state money to allocate to the county health departments, the Director of Local Health Finance in the state health department has budget meetings with the local administrators



to work out the budgets. About five to seven counties have no local funding and no health department. The state does not fill in the gap in these counties; they must make arrangements with neighboring counties if they want their residents covered. It is not mandatory for a county to have a local health department, but if a county desires one, the state will help set it up if the county agrees to partially fund it.

Evaluation of Local and State Infrastructure and Accountability

If a county health department is not performing adequately, it is considered a management issue and the administrator may be replaced, but it is not considered a local default with responsibility going back to the state, since it is already operated by the state. The evaluation of services falls to the local programs to ensure they are operating properly. The state has auditors for financial audits and records consultants for checking records to ensure programs are following guidelines. It is the responsibility of the local administrator to evaluate overall effectiveness. There are state resources available to help administrators with tasks such as evaluation and community assessments. County health departments can lose funds for certain programs if it is felt they are not operating the programs properly, but the whole department would not be in danger of closing.

There are no state requirements for performance or outcomes in public health. It is the perception of the state health department that it does not currently have adequate data collection and processing capabilities, though they are attempting to remedy the situation. As it is now, they cannot gather much reliable data and analyze it, therefore, the system is not strong on oversight.

SOUTH CAROLINA



Relationship of Local Health Departments to the State

South Carolina is a relatively small state compared to Texas (30,111 square miles). The forty-six counties in the state are divided into 13 health districts. Each district, which contain 2 to 6 counties each, may have multiple sites in the form of public health clinics. The reasoning of how the districts were originally designed has been somewhat obscured, though it is known that they were formed in the 1960s and are a mixture of urban and rural populations. All districts are run by a district health director; about half of these directors are physicians, and the other half are required to have a medical director on staff. In addition, each district has an administrator and directors of nursing, social work, nutrition, health education, and environmental health. Depending on how the district is structured, they may also have a home health care director or systems coordinator.

All public health staff in South Carolina are state employees. The system is completely centralized. At one time, there were county health departments, local health directors, and local boards of health, but the system was centralized by state statute over 25 years ago. Today, there are a few local boards of health, but these are a remnant from earlier years; they do not play a major role in the implementation of health department services. There is a governor-appointed Board for the Department of Public Health and Environmental Control. The board chair serves at the pleasure of the Governor, and the Commissioner of Health reports directly to the chairman of the Board. South Carolina uses a cabinet form of government. The Commissioner of Health attends cabinet meetings, but the Department of Public Health is not a cabinet agency, largely due to the potential conflict between the regulatory role of the agency and the appointment of a commissioner.

Provision of Public Health Services

In South Carolina there is a trend to move primary care medical services into medical homes and partner with local physicians. There is very low penetration of managed care in the state. There are only 2-3 licensed managed care organizations that accept Medicaid patients. The enrollment in these agencies is very low. The state is currently focused on the provision of categorical services, but is attempting to broaden its perspective. The state is very involved in developing Healthy People 2010, healthy communities, community assessment, quality assurance, and Turning Point. The state health department has traditionally used a vertical program management philosophy, but is attempting to work horizontally within the agency. Quality assurance is the starting point for this horizontal approach; all QA has been consolidated into one process. A newly designed unit of the state health department, Community Health, considers the community as the patient and works with the categorical programs to design interventions that will impact the community as a whole.

Funding Mechanisms

The local contribution for public health in South Carolina is very small. Some counties provide facilities where state staff can provide public health services and others contribute funds for indigent care. The state statute does not require a local contribution for public health. In many counties there is noticeable antagonism between the county council (elected officials) and the state. Of the total funds for public health, approximately 30 percent are state contribution, 30 percent are federal categorical funds, 30 percent are earned funds (primarily Medicaid), and 10 percent are from other sources (primarily fees and permits).

South Carolina is struggling with how to fund core public health services that lie outside categorical public health. The state is attempting to merge the core public health services into categorical services. At the current time, there is a monitoring function between the central office and districts, but no actual contracting.



WASHINGTON

Relationship of Local Health Departments to the State



Washington has 34 local health departments and districts. About one-third are city-county health districts as opposed to health departments, and four of these are multi-county health districts. The other health districts have an arrangement that sets up a health district and makes the county health department accountable to the district instead of the county commissioners. The rules are set out by statute. The responsibility for local public health falls on the county, therefore the whole state is covered with no gaps. Cities are not allowed to have their own health department, except for Seattle and Tacoma, which are allowed to have city-county health departments. The state health department therefore has overlapping jurisdictions with the local health departments, and the state tries to cooperate and work in partnership with the LHDs. There are no regional services in Washington except some minimal environmental and septic tank services. Several LHDs are directed by physicians, but most LHDs have a director who is an administrator (such as a person with a masters in public administration) and employee a physician as a part-time consultant.

Each county or health district is required by law to have a board of health, and the majority of its members have to be local elected officials (recent legislative changes allow some non-elected members as long as they are not the majority). The primary responsibilities of the boards of health are public health services, policy, and budgets. The state health depart-



ment is helping county commissioners to understand public health by traveling around the state and meeting with them and with boards of health. Many county commissioners end up on the local board of health as part of their elective duty but do not know much about public health. The county boards of health operate under an open meetings act and community groups can come and listen or present issues.

Funding Mechanisms

Local health departments/districts receive funding from various sources: on average, about 58 percent of their budgets is directly from the local government (but can vary widely), about 25 percent is state funds, and the remaining portion is federal. Most of the federal grants are passed through the state health department, but some come to the LHDs through other state departments such as Medicaid and environmental agencies. The state health department is currently wrestling with the issue that there is no minimum amount for localities to contribute to public health. The state wants to increase the amount contributed by the low spenders, but localities usually do not have the extra money.

Provision of Public Health Services

In Washington, it is difficult for the state to set statewide standards because of the diversity among the LHDs. Geographical and political differences also impede the implementation of a single standard (there was recent legislation on land use and septic tank regulations that did not pass). In 1993 the state passed health reform legislation that required a “Public Health Improvement Plan” and addressed core functions. The state and LHDs developed documents addressing core functions and relied heavily on the IOM definitions, though some of these were somewhat difficult for the LHDs to understand and relate to (especially ones that were not a directly funded activity). Every LHD was required to do a self-assessment, following broad guidelines.

LHDs traditionally provided some direct services such as immunizations, family planning, STD services, and EPSDT. The state health department is trying to get private providers to do the “safety net” functions but it is difficult to find funding for the remaining core functions. The state converted Medicaid to managed care several years ago, so those patients now have a medical home with a private physician. The state is trying to rewrite the state administrative code for public health, because it is outdated, and they are including the 10 essential public health services.

Evaluation of Local and State Infrastructure and Accountability

Each state and local program has its own mechanisms for evaluating the effectiveness of public health, so evaluation takes place to fulfill state and federal requirements. The state has what they call a “consolidated contract” with the LHDs that includes the state and federal funds for the LHD, so they are all contained in one contract, but each program has separate reporting requirements. The state official interviewed feels the state is missing an overall evaluative capacity due to the categorical focus. When a local health department in Washington defaults on its responsibility to provide public health services, the responsibility goes back to the county, not the state. The challenge the state health department is facing is getting consensus on performance standards so they can hold elected officials responsible and can appeal to the legislature for more funding.

WISCONSIN

Relationship of Local Health Departments to the State



There are 72 counties in Wisconsin and 110 local health departments. The local structure includes both city and county health departments. The LHDs are traditionally very autonomous and there is a strong history of local control. This is in part due to the fact that most of the LHDs have been in existence longer than the state health department. There is not much in the state statutes that governs LHDs or their relationship with the state.

The Department of Health and Family Services is the overarching state department, and it has a Division of Health that contains the Bureau of Public Health. The Bureau, which is being divided into public health and Medicaid, in effect serves as the state health department. It has a staff of about 350 people, about 275 of which are central and about 75 which are regional. The total budget for the Bureau is about \$200 million. Central office distributes the grant funds while the regions monitor the grants and do some negotiation on behalf of the state categorical programs.

There are five regional offices which are managed by a public health team that consists of a regional director, public health nurse consultant, WIC nutritionist, health educator, sanitarians, and clerical staff. The regional staff provide assurance and training of LHDs and they represent the state health department in meetings with county boards, city councils, and local elected and appointed officials. The five regional directors report directly to the Bureau Chief.

Some public health responsibilities fall to the local boards of health, some to the health officer/authority, and some to the health department. The local health officers don't have an organized association nor is there a strong public health association in the state. Wisconsin has strong home rule (counties, not cities) and most counties have county executives (elected) or county administrators (appointed). The county executive has the powers and duties of the board of health if he/she so chooses. Many cities and counties have consolidated human services departments, not freestanding health departments. Some see combined departments as harmful for public health, but it can also give health departments more power because they become larger agencies. In the early 1990s, legislation was passed that required counties to designate someone to oversee local disease control.

Provision of Public Health Services

In 1989, Wisconsin was one of the first states to develop year 2000 health objectives. In the early 1990s, changes were made to the public health statutes due to a grassroots effort (LHDs and the state medical society were involved). The revisions included a distinction between level 1, level 2, and level 3 LHDs. All LHDs have to be at least a level 1, which has minimal requirements such as a board of health, health officer, communicable disease control, and a public health nursing program (the state has not officially assessed level 1 LHDs to see if they are meeting all requirements). If LHDs choose to be level 2 or 3, they must achieve level 1 plus extra objectives from the year 2000 plan. They must demonstrate that they are striving to achieve one objective in each of the seven categories for level 2, and three objectives from each category for level 3.

The state is in the process of further defining the administrative rules relating to the levels, since there are currently no incentives for reaching level 2 or 3, except local pride. The state may eventually attach extra funding to the levels, but there is currently no mechanism for evaluation. The health department is currently writing the 2010 state public health plan, as required in the revised statutes. They are examining the shortfalls of the year 2000 plan, and the new plan will probably have more categories and fewer objectives (the statutes pertaining to LHDs will have to be changed to match it).





LHDs are required to do a local needs assessment process, with the benefit of increased ownership in the community. The LHDs can use any process they wish, but the state suggests that they use APEX, and most do. The state health department wants to use an APEX-type assessment for themselves as well. The state health department may review the local needs assessments to identify state policy and program priorities.

If a LHD does not have the capacity to handle a situation such as an outbreak, the state can step in and help, but the state's philosophy is that the local health officer is still the point person and in charge. The state laboratory is part of the University of Wisconsin, not the state health department. Through an agreement, money is set aside in the lab budget for state use, and LHDs can use it at no charge (the lab does both environmental and clinical testing). No local government has gone into "default," and refused to perform public health services, but if one did, the law allows the state health department to send in state employees and charge the county for the cost.

Local health departments are active in building local partnerships. The most influential grassroots health organizations in the state are private nonprofit family planning providers such as Planned Parenthood. The LHDs host legislative breakfasts to which they invite local officials and representatives. These partnerships help the LHDs to influence state and local policy.

Funding Mechanisms

There is no state funding specifically appropriated for local public health; the state funding is pass-through federal money. About 60-70 percent of each LHD's budget is generated locally and about 30-40 percent is federal pass-through grants from the state. The main two sources of funds are the maternal and child health block grant and the preventive services block grant. There are formulas for distributing the funds to the LHDs, and some of the money also goes to nonprofit health providers. Some LHDs are Medicaid vendors, especially for EPSDT, and some also receive funding for home health care. Though the state does not give state money directly to LHDs, they do give shared revenue to local governments in the form of property tax relief, and most localities use part of this revenue for public health.

Evaluation of Local and State Infrastructure and Accountability

There is currently no systematic way for the state to evaluate public health. Each program evaluates itself, but the state health department wants to change this so they can demonstrate that they are doing a good job and are focused on outcomes. The state health department is looking more at outputs and compliance measures, due to the difficulty of evaluating outcomes for prevention. The state health department ran into problems with their Year 2000 plan because they could not measure many of the objectives.

TDH STAFF

Interviewers: Mary Soto, Ahmed Adu-Oppong, Christine Bradshaw

Writers: Lauren Jahnke, Mary Soto

SOURCES

California: Eileen Eastman, Secretary of the California Conference of Health Officers

Colorado: Judy Robinson, Ph.D., Director of Nursing, Colorado Department of Health

Florida: Leslie Beitsch, M.D., Assistant State Health Officer, Florida Department of Health

Minnesota: Pat Lind, Manager, Community Services Division, Minnesota Department of Health

New York: Marie Miller, Article VI Program Manager, New York State Department of Health

North Carolina: Dr. Joy Reed, Director, Office of Public Health Nursing and Professional Development, North Carolina Department of Health and Human Services

Oklahoma: Mike Ewald, Local Health Services, Oklahoma State Department of Health

South Carolina: Sarah Balcersek, Local Liaison for Health Services, South Carolina Department of Health

Washington: Joan Brewster, Office of the Secretary, Washington State Department of Health

Wisconsin: Mike Phrang, Director, Local Health Services, Wisconsin Department of Health and Social Services





BIBLIOGRAPHY

- Austin American-Statesman. "Disease Rates Show Cost of Sewer, Water Woes." July 13, 1998. pp. A5.
- _____. "Health Units Ill-Prepared to Ward Off Germ Attack." August 3, 1998. pp. A1, A5.
- _____. "Scant Relief from Filth, Disease for the Poorest of Texans." July 12, 1998. pp. A1, A8-A10.
- _____. "With No Vaccine, Smallpox Terror Worries Expert." August 3, 1998. p. A5.
- Bost, Ken, Director, Brazos County Health District. Fax providing information about Brazos County Public Health District. August 1998.
- Farrell, Wayne, Director, Bell County Public Health District. Faxes and e-mail messages providing information about Bell County Public Health District. July 1998.
- Fowler, Pat, Director, City of Garland Health Department. Faxes and e-mail messages providing information about City of Garland Health Department. August 1998.
- Griffin, Susan. "The Future of Public Health in Texas." Professional Report, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin. November 1997.
- Hyslop, Thomas, MD, Director, Harris County Health Department. Fax providing information about Harris County Health Department. August 1998.
- Institute of Medicine (IOM). *The Future of Public Health*. National Academy Press: Washington, D.C. 1988.
- _____. *Healthy Communities: New Partnerships for the Future of Public Health*. National Academy Press: Washington, D.C. 1996.
- Jahnke, Lauren R. "Preserving and Strengthening the Public Health Infrastructure in Texas for the 21st Century." Professional Report, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin. May 1997.
- Koplin, Allen. "The Future of Public Health: A Local Health Department View." *Journal of Public Health Policy*. Vol. 11 (Winter 1990). pp. 421-437.
- Robinson, Jerry, Director, City of Laredo Health Department. Faxes providing information about Laredo Health Department. July 1998.
- Texas Department of Health (TDH). "Actual Total Local Health and Expenditures Report FY-96." Office of Regional and Administrative Services. Austin, Tex. May 1996.
- _____. County Fact Sheets (for Bell, Brazos, Dallas, Harris, and Webb Counties). Bureau of State Health Data and Policy Analysis. Austin, Tex. 1996.
- _____. *Epidemiology in Texas: Annual Report 1996*. Associateship for Disease Control and Prevention. Austin, Tex. 1997.
- _____. "Local Health Agency Budget and Expenditure Report FY 1997 (Part 1)." Office of Regional and Administrative Services. Austin, Tex. 1998.

_____. "Services Offered by Local Health Units, Departments, and Districts." Office of Regional and Administrative Services. Austin, Tex. July 1996.

_____. "Texas' Healthy People 2000 Health Status Indicators by Public Health Region, 1990-1993." Publication of the Bureau of State Health Data and Policy Analysis. Austin, Tex. March 1996.

Texas Statewide Health Coordinating Council, Ad Hoc Committee on Local Health Departments and Hospital Closures and/or Reconfigurations. *Assuring a Strong Health Safety Net in Texas: The Impact of Local Health Department and Hospital Changes on Texans and Recommendations for Preparing for the Twenty-first Century*. Austin, Tex., February 1997.

United States Census Bureau. Tables containing Estimated Median Income and Percent in Poverty by State/County. Webpage <http://www.census.gov/cgi-bin/hhes/saipe93/estimate.html> (Tables C93-48 and A93-48). Data released January 1998.

Vernon's Texas Codes Annotated. Health and Safety Code. Title 2 (Health), Subtitle F (Local Regulation of Public Health), Chapter 121 (Local Public Health Reorganization Act). West Publishing Co.: St. Paul, Minn. 1992.



Lyndon Baines Johnson School of Public
Affairs, The University of Texas at Austin

School of Public Health, Health Science
Center, The University of Texas at Houston



Blackland Research Center,
Texas Agricultural Experiment Station,
The Texas A&M University System

School of Rural Public Health,
Texas A&M University Health Science Center