Local Public Health Governance Models in Texas:
Dallas County, Williamson County, Austin/Travis County, and San-Antonio/Bexar County

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Table of Contents

Key Findings .................................................................................................................. 3
Local Public Health Governance Models Permissible Under Texas Law ...................... 3
Case Study 1: San Antonio Metropolitan Health District ................................................. 5
  How the governance model is set up ........................................................................................................ 5
  How the governance model works .......................................................................................................... 7
  How the governance model is evolving ................................................................................................. 7
Case Study 2. Dallas County Health and Human Services Department ......................... 9
  How the governance model is set up ........................................................................................................ 9
  How the governance model works .......................................................................................................... 10
  How the governance model is evolving ................................................................................................. 10
Case Study 3. Austin-Travis County Collaboration ............................................................. 10
  How the governance model is set up ........................................................................................................ 10
  How the governance model works .......................................................................................................... 11
  How the model is evolving ....................................................................................................................... 12
Case Study 4. Williamson County and Cities Health District .............................................. 13
  How the governance model is set up ........................................................................................................ 13
  How the governance model works .......................................................................................................... 14
  How the model is evolving ........................................................................................................................ 15
Key Findings

1. **The origins and evolution of the studied public health entities reflect the dynamics in each community.** The governance models examined differ in how they are set up and work on a day-to-day basis. They have been shaped by multiple factors, including jurisdictional borders and administrative composition of the territories they serve; history of ownership of the public health agenda in the area; interpersonal relationships, political climate, and public attention to public health in the communities; demographic changes and economic growth of the area.

2. **There exists a need for widely adopted principles to democratize accountability and transparency.** Any model-to-model comparisons are difficult to make because of the lack of widely accepted standards and benchmarks in local public health governance. In particular, there appears to be no common set of principles for how cities and counties divide or share public health roles and tasks. Many factors drive local decisions around public health capacity, functions and services, including competition for funding; desire for control and ownership of the agenda; interpersonal and institutional relationships; historic affiliation and results of past negotiations. In addition, all models examined in the study exhibit significant degrees of consolidation of public health powers, capacity, functions and services. Experts interviewed were strong proponents of concentrated ownership and responsibility in public health.

3. **Relationships and institutional inertia drive local public health policy.** Constructive interpersonal and interagency relationships and continuous communication were mentioned as key factors of success in all four cases. This includes relationships between agency leaders and city councils, commissioners courts, boards of directors, as well as mayors or county judges.

4. **COVID-19 has brought local public health to the forefront of policy priorities and is bringing change with it.** In particular, the need for increased collaboration and coordination between entities have become ever more apparent. Because of the increased financial pressure, officials feel the urgency of ramping up the local share of their public health budgets through: a) greater internal allocations and prioritization of public health for investment, and/or b) greater contributions from partner departments or member governments. In terms of legal arrangements, experts mentioned the need to introduce more flexibility into their interlocal agreements to be able to quickly respond to unforeseen circumstances, as well as provisions enabling effective joint response in case of emergencies.

5. **Decentralized public health governance in Texas is a double-edged sword.** The approach brings public health officials close to the local level as service providers but makes it challenging to align efforts and priorities with state and federal authorities.

**Local Public Health Governance Models Permissible Under Texas Law**

Texas Health and Safety Code\(^1\) allows three forms of local public health governing bodies: (1) local health departments for the county, city, or joint county/city jurisdiction; (2) public

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\(^1\) Title 2, Subtitle F “Local Regulation of Public Health”, Chapter 121 “Local Public Health Reorganization Act”. Source: https://statutes.capitol.texas.gov/Docs/HS/htm/HS.121.htm
health districts, and (3) local health units. The code stipulates that while both the governing body of a municipality or the commissioners court of a county may enforce any reasonably necessary public health law, they may choose to cooperate with one another in making necessary improvements and providing services to promote the public health.

A local health unit is defined as a division of municipal or county government that provides public health services but not to the level of the local health department or district. A public health district is a body that can be established by a majority vote of each governing agency and can consist of: two or more counties; two or more municipalities; a county and one or more municipalities in the county; two or more counties and one or more municipalities in those counties. A written cooperative agreement between the members of a public health district sets out the terms of the operation of the district, including its organizational structure, financial administration, as well as various procedures and protocols. A public health district may have an advisory or administrative public health board. Public health districts are different from hospital districts, which have explicit taxing authority under state law. The members of a public health district pay the full cost associated with operating it.\(^2\)

\(^2\) Public health districts are not to be confused with hospital districts which are authorized by Section 9, Article IX of Texas Constitution to provide medical and hospital care for the indigent inhabitants of the district. Unlike public health districts, hospital districts have the power to issue general obligation bonds, revenue bonds, and impose property taxes.
Case Study 1: San Antonio Metropolitan Health District

How the governance model is set up

The City of San Antonio and Bexar County have a fully consolidated local public health agency, San Antonio Metropolitan Health District (Metro Health). Metro Health is a longstanding agency: It was established in 1966 after a decade’s effort to consolidate the city and county health services. The district serves the City of San Antonio and Bexar County. In Bexar County, the district serves both unincorporated areas (15% of the total population served) and cities, unless they opt out.

While Metro Health serves as a city-county health district, it operates as a city department by the City of San Antonio, under the executive direction of the City Manager, overseen by the Mayor and City Council. Metro Health functions under the leadership of a Public Health Director. The director, in consultation with the City Manager, Mayor, and City Council, sets public health policy priorities and guides the overall activities of Metro Health. The district operates strictly within the discretion of city leadership. There is no board or advisory commission. The general public can provide input during the strategic planning (every 4 years) and budget (every year) process. Bexar County can influence decision-making at Metro Health by negotiating with the Public Health Director and its counterparts in the City Council.

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4 Participating cities do not contribute to the Metro Health budget.

5 Only a few communities have opted out exclusively for restaurant inspections.
The district's governance model is codified by a series of legislative statutes, at the local and state level\(^6\), and intergovernmental agreements for the provision of countywide public health authority in Bexar County. Three intergovernmental agreements form the basis of cooperation and coordination on public health policy between the City of San Antonio and Bexar County. The first is a Master Interlocal Agreement covering overlapping functions and services and coordination on non-overlapping public health matters. The second agreement assigns the role of Health Authority to the Medical Director of the District and is known as the Interlocal Agreement for the Designation of Health Authority\(^7\). Finally, a third agreement establishes an annual payment from Bexar County's public hospital district (known as University Health System, or UHS) to the City of San Antonio in the sum of $193,000 annually to offset the city's cost of service\(^8\) provision beyond its boundaries.\(^9\) (By contrast, the city's general fund contribution is more than $15 million.)

Metro Health's $43 million budget is financed from federal and state grants (66%) and the city General Fund (33%). The City of San Antonio supports 131 full time positions out of the district's 429 full time equivalent positions (FTEs). In the past 10 years, the City of San Antonio has been trying to improve Metro Health's financial stability by increasing the city

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\(^6\) San Antonio Municipal Code, various chapters. Source: [https://library.municode.com/tx/san_antonio/codes/code_of_ordinances?nodeId=11508](https://library.municode.com/tx/san_antonio/codes/code_of_ordinances?nodeId=11508); Title 2, Subtitle F “Local Regulation of Public Health”, Chapter 121 “Local Public Health Reorganization Act”. Source: [https://statutes.capitol.texas.gov/Docs/HS/htm/HS.121.htm](https://statutes.capitol.texas.gov/Docs/HS/htm/HS.121.htm); some other legislative acts are no longer publicly available since the district was established back in 1966

\(^7\) A local health authority is a physician appointed under the provisions of Local Public Health Reorganization Act, provisions of Local Public Health Reorganization Act, Health and Safety Code, Chapter 121 to administer state and local laws relating to public health within state and local laws relating to public health within the appointing body's jurisdiction. Read more from Texas DSHS here: [https://www.gchd.org/Home/ShowDocument?id=3768](https://www.gchd.org/Home/ShowDocument?id=3768)

\(^8\) Mostly clinical services such as communicable disease diagnosis and treatment.

\(^9\) The University Health System (UHS) pays $193,000 annually to the city on behalf of the county and is widely known to be insufficient.
contribution to its budget, from $11.5 million in 2010 to $15.7 million in 2020\textsuperscript{10}. Bexar County does not contribute a dedicated revenue stream to Metro Health’s budget. Its most significant contribution to public health is owning and operating UHS, which reimburses the City of San Antonio for services to residents of unincorporated Bexar County.

How the governance model works

Metro Health delivers most public health functions, programs and services for the City of San Antonio and Bexar County. Metro Health’s clinical preventive health services are integrated into UHS to enhance joint service planning and delivery. As Metro Health is a standalone public health department, it does not include human services. Coordination with human services, including integration of corresponding data systems, is ensured via oversight by the same Assistant Manager. This has led to better policy outcomes for the city, including being able to address social determinants of health more effectively.

Bexar County has its own Department of Behavioral and Mental Health and runs the Center for Health Care Services focusing on mental health and substance abuse. Historically, it was responsible for the mental and behavioral health across the county because Texas statute enables the county’s commissioners to appoint members to the mental health authority board. However, recently Metro Health has been providing more mental health services resulting in the task-division line becoming increasingly blurry. According to interviews, there is consideration for authorizing the city to coordinate the work of the two departments.

Similarly, the city was originally responsible for animal control and environmental safety in both the city and the county. However, later those functions were separated. In the City of San Antonio, Metro Health provides environmental health and safety functions, while animal health functions as a separate department. Bexar County has its own animal control and environmental services departments covering unincorporated areas. The city and the county have largely harmonized their public health regulations and ordinances and continued to do so during the COVID-19 pandemic.

How the governance model is evolving

The COVID-19 pandemic has become an important reminder of the importance of public health. The San Antonio City Council is considering increasing its contribution to Metro Health to improve preparedness for future emergencies. According to interviewees, this trend is even more important given the history of underfunding public health.

The pandemic has also opened conversations about the need for greater collaboration and a stronger working relationship between the City of San Antonio, particularly Metro Health management, and Bexar County. For example, it has become apparent that people with chronic conditions are disproportionately vulnerable to the new virus; therefore, the city and the county are considering the expansion and joint funding of prevention programs for chronic diseases, potentially involving $3 million of the county’s contribution.

Finally, the social unrest that broke out nationwide during the pandemic has highlighted a close interrelationship between public health and public safety. In an effort to ensure greater coordination between the two, the City of San Antonio will transfer all violence prevention

programs from San Antonio Police Department to Metro Health in 2021. As a result, the district will acquire 20 new employees and $3.6 million in funding.\textsuperscript{11}

Case Study 2. Dallas County Health and Human Services Department

How the governance model is set up

The Dallas County Health and Human Services Department (DCHHS) serves 31 cities in Dallas County, including the City of Dallas. It is a County-administered department under the supervision and guidance of the department director, county administrator and Commissioners Court. The county also appoints a Public Health Advisory Committee, composed of citizen members and representatives of municipal health departments within the county who review community needs in the areas of environmental health, health education and communicable diseases; provide leadership in establishing priorities for the various health issues facing Dallas County; and encourage the coordination and cooperation of all entities seeking to improve the health of county citizens. No specific qualifications are required to become a member of the committee.

Box 2. Dallas County Health and Human Services Department: Governance Highlights

<table>
<thead>
<tr>
<th>Administration and Accountability</th>
<th>Type of Governance Model:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioners’ Court</td>
<td>Consolidation: county-led department</td>
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<tr>
<td>County Administrator</td>
<td>Type of Public Health Governing Body (per Texas Law)</td>
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<tr>
<td>Director</td>
<td>County department</td>
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<tr>
<td></td>
<td>Public Oversight</td>
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<tr>
<td></td>
<td>Public Health Advisory Committee</td>
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<tr>
<td></td>
<td>• appointed by County</td>
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<tr>
<td></td>
<td>• comprised of citizen members and representatives of municipal health departments within the County</td>
</tr>
<tr>
<td></td>
<td>• review community needs, provide leadership in establishing priorities, support coordination and cooperation</td>
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<td></td>
<td>Key Stakeholders</td>
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<td></td>
<td>• Dallas County Hospital District – Parkland Health and Hospital</td>
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<tr>
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<td>o governed by a Board of Managers appointed by the Dallas County Commissioners’ Court</td>
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<tr>
<td></td>
<td>o consists of eleven members. Ten are selected by individual Commissioner’s Court officials (each member appoints two), while the remaining one serves in an at-large capacity.</td>
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<tr>
<td></td>
<td>o responsible for governing policies and has budgetary oversight for the hospital district.</td>
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</table>

As a much larger health and social services agency, DCHHS is responsible not only for public health, but also public assistance and welfare services. Its Human Services Division provides public assistance to County residents who meet certain income and disability requirements. The programs include, but are not limited to, rental, utility, housing, and nutrition assistance. The Department supplements these County-funded services through state and federal grants. DCHHS provides environmental services and runs the Employee Health Clinic.

The DCHHS budget amounts to $117 million, out of which $71.5 million is allocated to public health. The County finances public health activities from the General Fund (40%), but also receives federal and state grants to offset the costs of public health services (55%). The Department has about 500 FTEs.
DCHHS’s leading role as a provider of public health services in Dallas County is established in a series of interlocal agreements with the City of Dallas and other cities. Cities also have individual agreements on the provision of the professional services of the County’s Health Authority with DCHHS.

How the governance model works

DCHHS consolidates most public health functions, services, and capacity for Dallas County. However, a couple of cities in the county retain their own programs and services. For example, the City of Garland has its own independent health department performing a broad range of public health functions, including immunizations, TB screening, emergency response in case of a disaster or disease outbreak, communicable health disease surveillance, community outreach and education and so on. They coordinate with DCHHS on provision of those services, and still rely on the county to provide others. The Health Department of the City of Richardson provides a limited scope of services, such as restaurant inspections and mosquito control. The City of Dallas does not have its own health department. However, it has its own Office of Community Care (OCC), which oversees the city’s social, human, and supportive services for seniors, children, and other residents to improve their quality and standard of living. In particular, the City of Dallas retained the Women, Infants, and Children (WIC) Program as an integral part of OCC.

The cities agree to make all appropriate federal and state grants, assets, and resources available to the county to enable it to provide public health services for all. The cities reimburse the county or provide in-kind services in the share of the budget that is in excess of federal and state funding for these services. The Dallas County Hospital District, known as Parkland Health and Hospital, delivers and finances certain community health services such as the diagnosis and treatment of sexually transmitted diseases and tuberculosis, well-child and low-birth weight baby clinics, and some laboratory operations. It also funds the Public Health Lab, Preventive Health Division, STD Clinic, and TB Clinic. Furthermore, DCHHS works with Parkland on CHNA/CHIP and data management. The CHNA/CHIP process involves health care executives from the leading hospital systems in Dallas County, as well as representatives from civic organizations and schools.

How the governance model is evolving

The COVID-19 pandemic has added new tasks and priorities to DCHHS’s work (e.g. quarantine housing), but has caused no major changes to the overall model.

Case Study 3. Austin-Travis County Collaboration

How the governance model is set up

Austin Public Health and Travis County Health and Human Services Department (TCHHS) have opted for a collaborative model of public health services delivery. They have shared functions and programs, and service agreements, and cooperate on a needs basis. While Austin Public Health provides the bulk of essential public, environmental and animal health services in the county, TCHHS does most of public health research and planning, and both agencies cooperate extensively on data management.
Austin Public Health operates under the direction of a department director, reporting to the assistant city manager for health and environment and life-long learning, the city manager, the mayor, and city council. The Health and Human Services Committee, which is composed of city council members and the mayor, reviews matters related to public health, animal welfare, sustainable food, etc. TCHHS is managed and supervised by a department director, the county executive for health and human services, and the commissioners court. It does not have any citizen commissions or advisory boards.

An Interlocal Cooperation Agreement between the City of Austin and Travis County for Public Health Services, first executed in 2007 and amended several times since then, defines the relationship between the city and the county in the area of public health. Austin Public Health provides public health, animal health, and environmental safety control services to the City of Austin (including parts of the city that are in Williamson and Hays County) and all residents of Travis County that live outside of Austin (29%), both incorporated and unincorporated. While Austin provides environmental health, nuisance abatement and pool inspection services to unincorporated residents of Travis County according to the interlocal agreement between the city and the county, it has separate agreements for similar services with other municipalities. The Travis County executive has direct accountability for Austin Public Health and services provided to Travis County residents via an interlocal agreement with the City of Austin.

Box 3. Austin-Travis County Collaboration: Governance Highlights

<table>
<thead>
<tr>
<th>Austin – Travis County Collaboration: Governance Highlights</th>
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<tbody>
<tr>
<td><strong>Administration and Accountability</strong></td>
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<tr>
<td>Mayor and City Council</td>
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<tr>
<td>City Manager</td>
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<tr>
<td>Assistant City Manager overseeing health, environment and life-long learning</td>
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<tr>
<td>Director Austin Public Health</td>
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<tr>
<td>Commissioners’ Court</td>
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<tr>
<td>County Executive, Health, Human and Veteran Services</td>
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<tr>
<td>Director Travis County Health and Human Services</td>
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<thead>
<tr>
<th>Type of Governance Model</th>
<th>City-county collaboration</th>
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<tr>
<th>Type of Public Health Governing Body (per Texas Law)</th>
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<tr>
<td>County Department</td>
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**Public Oversight**
- Austin Health and Human Services Committee, comprised of City Council members and Mayor, reviews matters related to public health, animal welfare, sustainable food, etc.

**Key Stakeholders**
- Travis County Hospital District – Central Health
  - Board of Managers is made up of Travis County residents who volunteer for the role.
  - Four of the managers are appointed by the Austin City Council and another four are appointed by the Travis County Commissioners Court. Both governmental bodies jointly appoint the ninth manager.

Austin Public Health has 532 FTEs and a budget of $42 million, with 75% from the city’s general fund, and 25% from federal and state grants. Such budget composition is reflective of the high priority the City of Austin is placing on public health. TCHHS has 200 FTEs and a budget of $55 million, 85% of which is from the county’s general fund and 15% of which comes from federal and state grants and. About 33% of the budget is spent on public health as opposed to social services.

**How the governance model works**
Travis County does not have its own public health, animal health, and environmental safety control functions. Instead, it relies on Austin Public Health to provide those in return for compensation. The amount of compensation is calculated based on the cost-based model spelled out in the interlocal agreement. The cost-based model replaced the fixed-price compensation structure of the original 2007 version of the agreement as a more transparent and flexible approach. The city and the county continue to work on perfecting the financing model.

TCHHS is responsible for public health research and planning for both departments, whereas data management is performed jointly. Austin Public Health and TCHHS take a coordinated approach to human services provision: While the former focuses on serving the urban core, the latter prioritizes remote and rural areas. They also jointly perform CHA/CHIP, while also engaging a wide circle of community organizations and hospital system partners in the process.

**How the model is evolving**

The onset of the COVID-19 pandemic has raised awareness of certain limitations in the current model. First, because Travis County does not have a staffing infrastructure, officials felt limited in their ability to respond and realized that they need to have a plan to ramp up in the case of emergencies. The interlocal agreement itself does not cover emergencies, and while the city and county recognized the need to revise it, that effort has just begun, with lawyers working up new provisions to cover future emergencies, almost a year since the pandemic started. Also related to the pandemic, the county is negotiating with the city for a payment from its CARES Act dollars. Considering the county relies on the city to be nimble and fast to respond, leaders understand the city spent a lot of money and feel the need to step in and help compensate them.

Finally, the pandemic has served as an opportunity to put public health in the spotlight and the organizations hope to raise greater awareness about its importance.
Case Study 4. Williamson County and Cities Health District

How the governance model is set up

In Williamson County, public health services are provided in a consolidated fashion by a health district operating as a separate governmental entity under Texas Law. Williamson County and Cities Health District (WCCHD) serves the entire population of Williamson County, about 600,000 people in total. WCCHD dates back to 1943 and until 1989 operated as the Williamson County Health Department. In 1989, it was reorganized into a health district. Originally it consisted of Williamson County and the cities of Cedar Park, Georgetown, Round Rock, and Taylor. Liberty Hill, Hutto, and Leander joined in 1992, 2007 and 2013, respectively.

WCCHD members appoint representatives who serve as directors of the Williamson County Board of Health, WCCHD’s main administrative authority. The board currently represents the 13 largest cities in Williamson County. Each member city with a population larger than 15,000 people is entitled to one representative. Member cities with a population of less than 15,000 people join together and appoint two directors to represent them on the board. Williamson County Commissioners’ Court appoints two directors. Non-member cities, such as Thrall, Weir, and Jarrel, are still served by WCCHD and are represented by the two board members appointed by the commissioners court. Even if combined, the population of these smaller cities would not be enough to meet the membership threshold; therefore, they remain ineligible to join as full members and get their own “seat at the table”. As a public health district whose jurisdiction is defined by the administrative borders of Williamson County, WCCHD serves both incorporated and unincorporated residents of the county. Non-member cities that are located partially in other counties (e.g. Bartlett, Pflugerville, Thorndale) and member cities with parts in other counties (Cedar Park, Leander, Round Rock) are served based on address by either WCCHD or their county’s local health agency.

As WCCHD’s main governing body, the Board of Health defines the rules and policies to promote public health in Williamson County in compliance with the Texas law. Board directors must be United States citizens and must have resided in Williamson County for at least three years. Directors serve staggered three-year terms and can serve for consecutive terms. They do not receive compensation. WCCHD does not have any other form of public oversight or technical advisory committee. However, WCCHD encourages public comment during board meetings, which are held every two months and are open to the public. The board appoints an executive director, who manages the day-to-day operations of the district and reports to the board. The executive director is also an ex-officio non-voting member of the board.

Healthy Williamson County Collaborative is a health and wellness coalition composed of community members and organizations affiliated with health care, education, government, business, non-profit, and faith communities. Its activities are defined by the biennial CHNA/CHIP. WCCHD coordinates community group alliances within the county for creation and distribution of the CHNA/CHIP.

Box 4. Williamson County and Cities District: Governance Highlights

WCCHD’s operating budget for FY2021 is $10.4 million. Federal and state grants and contracts (Texas Department of State Health Services, Medicaid/Medicare, WIC Nutrition) account for 41% of the revenues, other grants and contracts (NACCHO, Episcopal Health Foundation, WCCHD Service Fees, St. David’s Foundation) constitute 32%, Williamson County contributes 15%, and member cities provide 8%. In terms of expenditures, 81% of the budget is allocated to various public health functions, and 19% is spent on indigent care. The district has 108 FTEs.

The Cooperative Agreement between Williamson County and Cities is the main legal document that governs the health district model. Other agreements, contracts and MOUs are put in place for specific services as needed. For example, within the integrated vector management program, WCCHD contracts mosquito spraying to an outside company, and Round Rock opts out of participating.

How the governance model works

WCCHD provides a full spectrum of public and environmental health services to the county. The members of the district contribute on a per capita basis to cover the cost to operate the district. WCCHD has four regional offices located in Cedar Park, Georgetown, Round Rock, and Taylor. Each regional office provides core public health services, as well as unique services reflecting the needs of their respective community. Health equity is one of the most important priorities of WCCHD’s work. The district targets additional support toward designated health equity zones—areas experiencing challenges such as low income, food deserts, lack of access to essential infrastructure and services, etc.

The district provides social services, but only within a limited scope of management of the Williamson County indigent health program and the maintenance of a health care hotline, in which staff assist residents in applying for food benefits, support services, job training, transportation services, immigration, access to schools, etc. WCCHD leverages the network of organizations within the Healthy Williamson County Collaborative to provide other social and individual care services, such as housing assistance and mental health support. Animal control services are not integrated in WCCHD.
Although the district is not directly accountable to Williamson County or member cities, the executive director is deeply invested into day-to-day relationships with mayors and city councils of member cities, as well as with their representatives in the board. The direct line to cities has proven to be effective in program and intervention development and implementation, as can be seen through the district’s COVID-19 efforts. Reporting to a board, rather than a commissioner’s court, has allowed WCCHD to be efficient, effective, and nimble as a government agency and helped to prevent the agency and its activities from being overly politicized. The district exercises the “no community left behind” policy and ensures active communication even with its smallest communities both directly and through board representatives. The governance setup has also proven effective in making the voices of the poorest communities heard. Longstanding members of the board ensure continuity and institutional memory of the organization.

How the model is evolving

No changes were made to the governance model during the time of the COVID-19 pandemic. While more funding has become available thanks to federal acts and other grant opportunities, WCCHD’s funding structure has not changed.
Appendix: Miscellaneous Documents about Governance

https://www.health.state.mn.us/communities/practice/resources/chsadmin/governance-powersduties.html

Difference between Governance Structure and Organizational Structure

- **Governance structure** describes the way in which governing bodies are legally organized to do their work. Minnesota statutes and rules identify two options for counties and cities to organize themselves to do the work of public health:
  - Community health boards, or
  - Human service boards organized under Minn. Stat. § 402

- Community health boards can be composed of single counties, provided the county meets a minimum population requirement of 30,000 residents. Community health boards can also be formed by multiple counties. Multi-county community health boards are formed through joint powers agreements, which allow the community health boards to work across political boundaries. A two-county community health board is possible if the counties share a border and have a combined population greater than 30,000. Community health boards of three or more counties are possible if the counties are contiguous; there is no minimum population requirement for community health boards with three or more counties. County boards (and in a few cases, city councils) may appoint elected officials and citizen members to these governing structures.

- **Organizational structure** is a term used to describe the way in which a local health department is organized within a city or county. Unlike governance structures, which are dictated by statute, organizational structures are locally determined. Public health in Minnesota operates under many different organizational structures. In some locations, public health exists as a standalone department; in others, it is organized alongside social services as part of a human services agency. There are also counties in Minnesota in which a hospital is contracted to provide public health services. Visit the MDH Center for Public Health Practice online for a current and comprehensive list of the state's public health organizational and governance structures."
Governance Health Structures
Public health governance structures vary from state to state. The relationship between state health agencies and regional/local public health departments also differs across states. These structural differences have important implications for the delivery of essential public health services. Identifying these differences is integral to understanding the roles, responsibilities, and authorities across levels of government for services provided within the community.

Types of governance health structures:

- Centralized or largely centralized structure: Local health units are primarily led by employees of the state
- Decentralized or largely decentralized structure: Local health units are primarily led by employees of local governments.
- Mixed structure: Some local health units are led by employees of the state and some are led by employees of local government. No single structure predominates.
- Shared or largely shared structure: Local health units might be led by employees of the state or by employees of local government. If they are led by state employees, then local government has the authority to make fiscal decisions and/or issue public health orders; if they are led by local employees, then the state has authority.

https://www.naccho.org/uploads/downloadable-resources/chartbook_COMPLETE.pdf
National Association of County and City Health Officials/NACCHO (2001)
“NACCHO has identified five major categories used to describe the variation in LPHA type: county, city, city-county, township, and multi-county/district/regional. County LPHAs are the most common type of LPHA, and serve individual counties throughout the country. County LPHAs range in size from small rural counties to large metropolitan counties such as Los Angeles County. County LPHAs may or may not serve all geographic areas within the county, for example a city within a county may be served by a municipal LPHA. City public health agencies are municipal public health departments that serve the geographic boundaries of their cities. These may be small cities, as well as large urban areas such as Kansas City, MO, or New York City. City-county public health agencies represent jurisdictions where a city and its surrounding county are joined together to form a LPHA, for example Wichita-Sedgwick Health Department, KS, or Seattle-King County Health Department, WA. City-county public health agencies often have a dual reporting structure, where the LPHA director is accountable to both a city council and a county commissioner/county executive.”

Township health departments serve townships across the U.S., and are usually located in states with strong “home-rule” or “town-meeting” political systems such as Connecticut, Massachusetts and New Jersey.”

“‘Multi-county’ health departments are LPHAs serving more than one county, and often span large geographic areas in the western United States. For example, Northeast Colorado Health District serves six counties in the northeastern part of Colorado. The geographic area of this LPHA is roughly equivalent in square miles to the state of Vermont. The multiple county LPHA category also includes regional or district LPHAs. These are health departments that serve multiple counties, and health directors may be responsible to multiple county boards of health, or a combined board of health representative of all the counties in the district. The multiple county category also includes regional offices of the state health department that act as the LPHAs in their areas. Examples of this type of LPHA are found in several states including Alabama, Arkansas, Mississippi, New Mexico, Tennessee, and Vermont.”

LPHA TYPES
Survey data demonstrate that 60% of LPHAs are county-based. The remaining are city/municipal (10%), city-county (7%), town/township (15%), and multi-county/district/regional (8%). These percents are similar to data collected in NACCHO’s 1992-1993 Profile studies, suggesting that there have been few changes over the past eight years in the types of jurisdictions LPHAs serve.”

https://www.nap.edu/read/10548/chapter/5#108
The State and Local Governmental Public Health Infrastructure

Although the states carry the primary constitutional responsibility and authority for public health activities in the United States, public health administration first began in cities in the late eighteenth century (Rosen, 1993). The burgeoning social problems of industrial cities convinced legislatures to form more elaborate and professional public health administrations within municipal governments (Duffy, 1990). City boards of health were established to obtain effective agency supervision and control of health threats facing the population. Only after the Civil War did states form boards of health. County and rural health departments emerged in the early twentieth century (Ferrell and Mead, 1936). Today, there are more than 3,000 local public health agencies, 3,000 local boards of health, and 60 state, territorial, and tribal health departments (CDC, 2001b)."

Structure and Governance of State and Local Public Health Agencies

The organization and authority granted to state and local public health agencies vary substantially across the country. Every state has an agency with responsibility for public health activities. That agency may be an independent department or a component of a department with broader responsibilities, such as human services programs. In 31 states, the state health officer is also the head of the larger health and human services agency (Turnock, 2000). Physicians and nurses often lead state public health agencies. At the local level, however, general managers with business training rather than formal training in public health or medicine may lead public health agencies."

“States differ in terms of the relationship between the state agency and the agencies serving localities within the state. In some states (e.g., Arkansas, Florida, Georgia, and Missouri), the state public health infrastructure is centralized, meaning that the state agency has direct control and authority for supervision of local public health agencies. In other states (e.g., California, Illinois, and Ohio), local public health agencies developed independently from the state agency, in that they are run by counties or townships (rather than the state) and report directly to local boards of health or health commissioners or are governed by cooperative agreements. Still other states (e.g., Iowa and North Dakota) have no local public health agencies and the state public health agency is preeminent (Fraser, 1998)."

In a recent report on the local public health agency infrastructure, the National Association of County and City Health Officials (NACCHO) (2001d) identified five types of local public health agencies (see Figure 3–1)."

“The most common arrangement is a local public health agency (LPHA) serving a single county, ranging from small rural counties (e.g., Issaquena County, Mississippi, with a population less than 1,000) to large metropolitan counties (e.g., Los Angeles County, with a population approaching 10 million). LPHAs may also serve single cities of various sizes (e.g., Kansas City, Missouri, and New York City). A combined city–county local public health agency is also found (e.g., Seattle-King County, Washington). Township local public health agencies are common in states with strong “home-rule” political systems (e.g., Connecticut, Massachusetts, and New Jersey). City or township health agencies may operate within counties that are also served by county health agencies.”

“Multicounty local public health agencies often span large geographic areas in the western United States. For example, the Northeast Colorado Health District serves six counties, an
area roughly equivalent in size to that of the state of Vermont. In these local public health agencies, health directors may be accountable to multiple county boards of health or to a combined board of health whose membership represents the counties or other units covered by the local public health agency. The multicounty local public health agency category also includes state health department regional offices that act as local public health agencies, an arrangement found in several states (e.g., Alabama, New Mexico, Tennessee, and Vermont)."

“The governance of state and local public health agencies generally fits one of three models. In a cabinet model, the head of the agency is appointed by and answers to the governor, mayor, or other executive authority. Under a board-of-health model, the state or local health director reports to an appointed board representing constituencies served by the department. In many cases, however, a board of health functions in a strictly advisory capacity, with no oversight authority. Under an “umbrella” model, the public health agency is part of a larger agency, and the health director either heads the agency or reports to its head. There are considerable variations within these three models.”

“Even with this great variability in governance at both the state and local levels, there are no data to suggest what an “ideal” state and local agency governance structure might be. Thus, it would be important for state agencies to examine their present governance structures and evaluate mechanisms to make these structures more effective. Doing so should serve to build and strengthen relationships with local public health agencies, coordinate efforts for the delivery of the essential public health services and crisis response services, integrate essential health information, and respond to the changing health needs of the population.”

Figure 3-1. Types of local public health agencies across U.S.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4243791/
Leider et al. (2014)

Members of the big cities health coalition in 2014
<table>
<thead>
<tr>
<th>Primary Metropolitan Area Served</th>
<th>LHD Name</th>
<th>State</th>
<th>2013 Population</th>
<th>Jurisdiction Type</th>
<th>Health and Human Services Agency Status</th>
<th>Has a Local Board of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlanta</td>
<td>District 3, Unit 2: Fulton County Health District</td>
<td>Georgia</td>
<td>949,599</td>
<td>County</td>
<td>HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>Baltimore City Health Department</td>
<td>Maryland</td>
<td>619,493</td>
<td>City</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Boston</td>
<td>Boston Public Health Commission</td>
<td>Massachusetts</td>
<td>625,087</td>
<td>City</td>
<td>Not HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>Chicago</td>
<td>Chicago Department of Public Health</td>
<td>Illinois</td>
<td>2,707,120</td>
<td>City</td>
<td>Not HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>Cleveland</td>
<td>Cleveland City Department of Public Health</td>
<td>Ohio</td>
<td>393,806</td>
<td>City</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Dallas</td>
<td>Dallas County Health &amp; Human Services</td>
<td>Texas</td>
<td>2,542,649</td>
<td>County</td>
<td>HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Denver</td>
<td>Denver Health and Hospital Authority</td>
<td>Colorado</td>
<td>619,968</td>
<td>County</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Detroit</td>
<td>Detroit Health Department</td>
<td>Michigan</td>
<td>706,585</td>
<td>City</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Houston</td>
<td>Houston Department of Health and Human Services</td>
<td>Texas</td>
<td>2,145,146</td>
<td>City</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>Los Angeles County Department of Public Health</td>
<td>California</td>
<td>9,285,379</td>
<td>County</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Miami</td>
<td>Florida Department of Health in Miami-Dade County</td>
<td>Florida</td>
<td>2,554,766</td>
<td>County</td>
<td>HHS A</td>
<td>No</td>
</tr>
<tr>
<td>New York City</td>
<td>The New York City Department of Health and Mental Hygiene</td>
<td>New York</td>
<td>8,244,910</td>
<td>City</td>
<td>Not HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>Philadelphia Department of Public Health</td>
<td>Pennsylvania</td>
<td>1,536,471</td>
<td>County</td>
<td>Not HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>Phoenix</td>
<td>Maricopa County Department of Public Health</td>
<td>Arizona</td>
<td>3,880,244</td>
<td>County</td>
<td>Not HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>San Antonio</td>
<td>San Antonio Metropolitan Health District</td>
<td>Texas</td>
<td>1,756,153</td>
<td>County</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
<tr>
<td>San Diego</td>
<td>County of San Diego HHS and Public Health Services</td>
<td>California</td>
<td>3,140,069</td>
<td>County</td>
<td>HHS A</td>
<td>No</td>
</tr>
<tr>
<td>San Francisco</td>
<td>San Francisco Department of Public Health</td>
<td>California</td>
<td>812,826</td>
<td>County</td>
<td>Not HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>San Jose</td>
<td>Santa Clara County Public Health Department</td>
<td>California</td>
<td>1,809,378</td>
<td>County</td>
<td>HHS A</td>
<td>No</td>
</tr>
<tr>
<td>Seattle</td>
<td>Public Health—Seattle &amp; King County</td>
<td>Washington</td>
<td>1,969,722</td>
<td>County</td>
<td>Not HHS A</td>
<td>Yes</td>
</tr>
<tr>
<td>Washington, District of Columbia</td>
<td>Government of the District of Columbia Department of Health</td>
<td>District of Columbia</td>
<td>617,996</td>
<td>City</td>
<td>Not HHS A</td>
<td>No</td>
</tr>
</tbody>
</table>

Abbreviations: HHS A, health and human services agency; LHD, local health department.
Ohio law provides for three kinds of local health departments: general health districts that each serve a single county, city health departments, and combined districts in which a city has merged with the general health district.

Today, Ohio has 113 health districts, the majority of which are run by counties. Each of Ohio’s 88 counties has one. Those districts oversee public health for cities that have done away with their own health departments, and for villages and townships.

The remaining 25 districts serve individual cities. Cleveland, Columbus and Cincinnati maintain their own health departments, as do several smaller cities. Akron and Toledo, along with most smaller cities in suburban or rural parts of the state, have combined their departments into their counties’ general health districts.

Ohio also has a state health department.

County districts are their own political entities. City departments are an arm of city government. Unlike some other states, Ohio’s local health departments function completely independent of the state’s health department.

Who runs them?
Every health department in the state answers to a board.

Boards for city departments are typically appointed by the mayor and confirmed by the City Council. Boards for county-run departments are appointed by advisory councils comprised of elected officials in the county governments, cities, villages and townships they serve.”

Hoornbeek et al. (2019)

Although LHDs are authorized and structured by differing state statutes and constitutional provisions, all 50 states deliver public health services at the local level. However, the governing structures and approaches through which these services are provided differ by state… Some states, such as Vermont and Arkansas, deliver public health services through a centralized state agency that provides local public health services. Other states, such as Wisconsin and Ohio, have decentralized structures in which LHDs are parts of local governments under state laws. Still other states provide local public health services through hybrid structures, which have characteristics of both centralized and decentralized systems” (Hoornbeek et al., 2019, p. 103).

“A 2012 review of the structure and organization of local and state public health agencies classified 19 states as decentralized, 13 as centralized, and 18 as hybrid” (Hoornbeek et al., 2019, p.103).

“Although these classification schemes provide a broad sense of the variation in structures used to deliver state–local public health services, they do not convey fully the unique structures and processes used in each state. Some states organize public health service delivery at the county level, whereas other states organize services at the level of townships, cities, and substate regional arrangements” (Hoornbeek et al., 2019, p.103).

“States also vary in how they can consolidate LHDs. For example, in Ohio, LHDs may enter into contractual mergers under which 1 LHD provides services for another health district or they may merge local health districts altogether. Municipalities in Connecticut may choose to
enter into a unified health district arrangement allowable under Connecticut law” (Hoornbeek et al., 2019, p.104).

“Using the definition of an LHD as “an administrative or service unit of local or state government, concerned with health, and carrying some responsibility for the health of a jurisdiction smaller than a state,” the size of the survey frames used by NACCHO suggest that the number of LHDs decreased from 1932 in 1990 to 2533 in 2016. Although we believe that the decrease in the number of LHDs surveyed over time is partially attributable to LHD consolidations, it may also have resulted from other factors, including changes in the ways in which NACCHO and/or the states identify local organizational units. Consequently, it seems likely that LHD consolidation does not account for all of the decrease in the number of LHDs surveyed by NACCHO over time, despite previous suggestions that consolidations of LHDs in the United States could potentially diminish the number of LHDs ‘from approximately 3000 to an estimated 500-1000 entities.” (Hoornbeek et al., 2019, p. 105).

“In some states, however, LHD consolidations are certainly occurring. For example, in the 2005 and 2016 NACCHO surveys, the number of LHDs queried decreased in Connecticut and Ohio, where consolidations are known to have occurred” (Hoornbeek et al., 2019, p. 105).

“In Minnesota, for example, 3 independent health departments in the west-central portion of the state consolidated to form a single department, Horizon Public Health, in 2015” (Hoornbeek et al., 2019, p. 105).


Governmental Public Health: An Overview of State and Local Public Health Agencies (Salinsky, 2010)

ORGANIZATION OF STATE AND LOCAL PUBLIC HEALTH AGENCIES

The broad flexibility states have in defining their public health role has led to a highly varied and somewhat fragmented governmental public health infrastructure throughout the nation. Despite this heterogeneity, the following narrative broadly describes governmental public health in the United States, while noting important variations.

Each of the 50 states and the District of Columbia have established a state health agency that serves as the locus of state governmental public health activity. In most states (55 percent), the health agency is an independent agency. Some of these independent health agencies focus exclusively on public health, while others include additional health care–related responsibilities, such as administration of Medicaid. In 45 percent of states, the state health agency is a component of a broad umbrella or super agency that includes a wide mix of functions, such as social services, long-term care, or insurance regulation, in addition to traditional public health functions.

Further complicating characterization efforts are the variety of organizational models states have adopted for governing their relationship with public health agencies at the local level. As described in the text box on state-local relationships and Figure 2, these organizational
relationships can be characterized as centralized, decentralized, or hybrid models. However, even under the most decentralized models, states may retain direct control over specific functions rather than delegate these activities to local officials.

Whether administered by local or state government, local public health agencies usually have direct operational responsibility for providing many, if not most, of the public health services available within a given jurisdiction. Although nearly all U.S. residents are served by a local health department, the capacities of these local agencies and the services they provide vary dramatically.

Local health departments serve jurisdictions of different types and sizes. Of the 2,794 local health departments in the United States, most (60 percent) serve counties; some (18 percent) serve a city, town, or township; some (11 percent) serve a joint city/county jurisdiction; and some (9 percent) serve a multicounty region.9 As shown in Figure 3, most local health agencies (64 percent) serve jurisdictions with small populations (under 50,000 people). However, nearly half of the U.S. population receives public health services from the 140 local health departments that serve large jurisdictions (500,000 or more people).
Figure 2.2 | Percent of United States population served by LHDs

- Small (<50,000): 9% (LHDs) vs 61% (population)
- Medium (50,000–99,999): 33% (LHDs) vs 37% (population)
- Large (500,000+): 6% (LHDs) vs 52% (population)

N=2459

- Throughout this report, small LHDs are classified as those that serve populations of fewer than 50,000 people; medium LHDs serve populations of between 50,000 and 500,000 people; and large LHDs serve populations of 500,000 or more people.
- Although only 9% of all LHDs are classified as large, they serve about half of the U.S. population.
- The majority of LHDs are small, but together, they serve less than 10% of the U.S. population.
Figure 2.3 | Geographic jurisdictions served by LHDs, by size of population served

<table>
<thead>
<tr>
<th>Size of population served</th>
<th>Percent of LHDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>All LHDs</td>
<td></td>
</tr>
<tr>
<td>County*</td>
<td>70%</td>
</tr>
<tr>
<td>City or town</td>
<td>19%</td>
</tr>
<tr>
<td>Multi-county</td>
<td>8%</td>
</tr>
<tr>
<td>Other**</td>
<td>3%</td>
</tr>
</tbody>
</table>

- **Small (<50,000)**
  - County: 71%
  - City or town: 24%
  - Multi-county: 3%
  - Other: 2%

- **Medium (50,000–499,999)**
  - County: 67%
  - City or town: 11%
  - Multi-county: 14%
  - Other: 7%

- **Large (500,000+)**
  - County: 70%
  - City or town: 6%
  - Multi-county: 23%
  - Other: 1%

*County includes city-counties
**Other includes LHDs serving multiple cities or towns
N=2,459

Approximately two-thirds of LHDs are county-based, and an additional 8% serve multiple counties. One-fifth of LHDs serve cities or towns.

Large LHDs are less likely to serve cities or towns but are more likely to serve multiple counties than small LHDs.

Figure 2.4 | Type of LHD governance, by state

- Local (all LHDs in state are units of local government)
- State (all LHDs in state are units of state government)
- Shared (all LHDs in state governed by both state and local authorities)
- Mixed (LHDs in state have more than one governance type)

- Of the 2,459 LHDs included in the 2019 Profile study population, 1,887 are locally governed, 404 are units of the state health agency, and 168 have shared governance.
- In 30 states, all LHDs are locally governed. These states are referred to as decentralized.
- All LHDs in Florida, Georgia, and Kentucky have shared governance.
- All LHDs in Arkansas, Delaware, Hawaii, Mississippi, New Mexico, South Carolina, and Virginia are units of the state health agency. These states are referred to as centralized.

Figure 2.6 | LHDs with a local board of health (LBOH), by size of population served and type of governance

<table>
<thead>
<tr>
<th>Percent of LHDs with a local board of health</th>
<th>Advisory</th>
<th>Governing</th>
<th>No LBOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>All LHDs</td>
<td>20%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Size of population served</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small (&lt;50,000)</td>
<td>29%</td>
<td>51%</td>
<td>29%</td>
</tr>
<tr>
<td>Medium (50,000-400,000)</td>
<td>21%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Large (500,000+)</td>
<td>19%</td>
<td>38%</td>
<td>43%</td>
</tr>
<tr>
<td>Type of governance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>33%</td>
<td>9%</td>
<td>58%</td>
</tr>
<tr>
<td>Local</td>
<td>18%</td>
<td>63%</td>
<td>19%</td>
</tr>
<tr>
<td>Shared</td>
<td>11%</td>
<td>41%</td>
<td>48%</td>
</tr>
</tbody>
</table>

n=1,466

- Seventy percent of LHDs have a local board of health (LBOH).
- A larger proportion of small LHDs have LBOHs compared to large LHDs.
- Locally governed LHDs are more likely to have a LBOH compared to LHDs that are state-governed or with shared governance.
- A higher proportion of LHDs have LBOHs with a governing role compared to an advisory role. However, state-governed LHDs are more likely to have an advisory LBOH than a governing body.

FIGURE 2.3
Geographic jurisdictions served by LHDs

- Approximately two-thirds of LHDs (69%) are county-based and an additional 8% serve multiple counties. One-fifth of LHDs (20%) serve cities or towns.
- Large LHDs are less likely to serve cities or towns but are more likely to serve multiple counties than small LHDs.

https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html
This contains links to all state health departments.

https://www.naccho.org/membership/lhd-directory
This contains links to all local (city and county) health departments.
References


