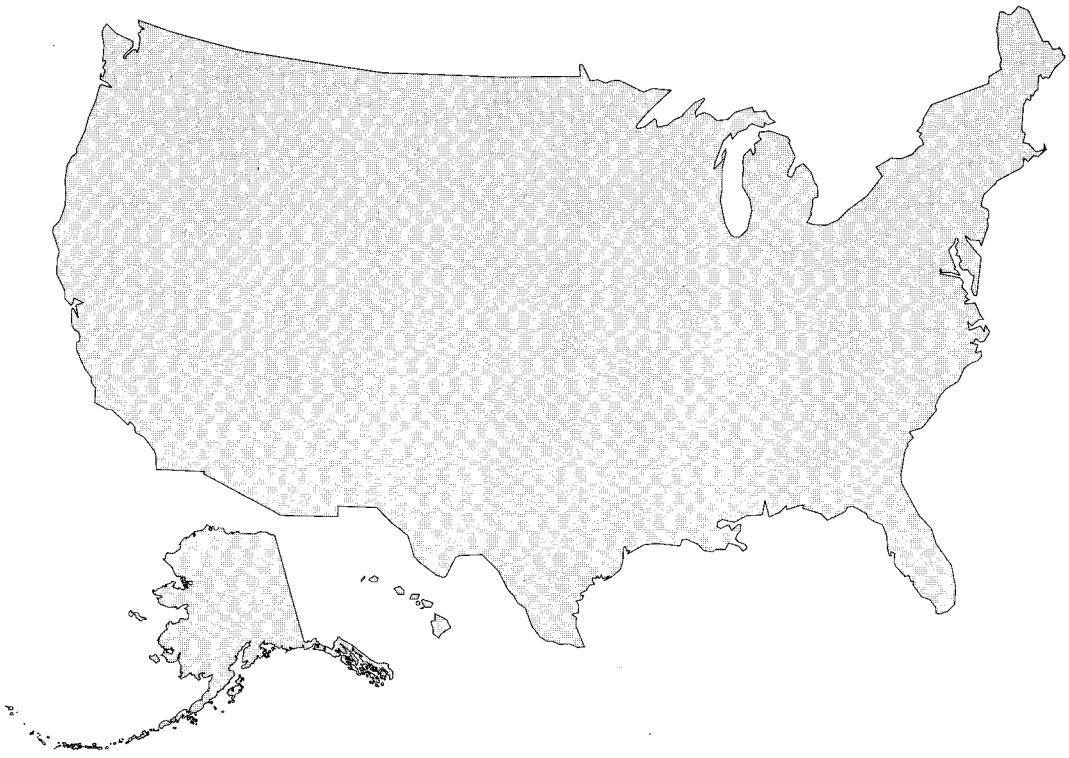
1992-1993 National Profile of Local Health Departments

National Surveillance Series



NACCHO

1995

CDC
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Use of trade names is for identification only and does not constitute endorsement by the Public Health Service or by the U.S. Department of Health and Human Services.

This project was funded by the Centers for Disease Control and Prevention through a cooperative agreement (U50/CCU302718) with the National Association of County and City Health Officials (NACCHO).

1992-1993 National Profile of Local Health Departments

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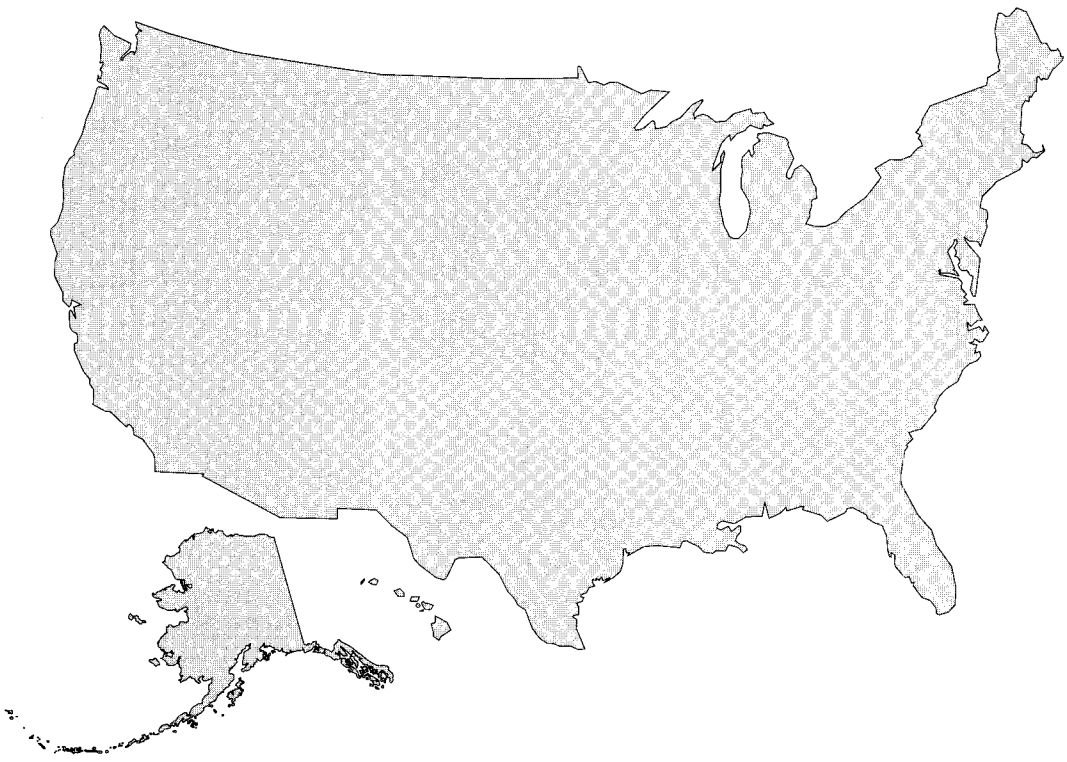

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1995

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MESSAGE FROM THE PRESIDENT

On behalf of the National Association of County and City Health Officials, I am pleased to present the findings from the *1992-1993 National Profile of Local Health Departments.* The *National Profile of Local Health Departments* studies originated in 1989 as an adjunct to the Assessment Protocol for Excellence in Public Health project; the 1992-1993 report is the second to be published and provides a foundation for a nationwide surveillance system of local health departments.

The participation of the nation's local health departments and the support of the Centers for Disease Control and Prevention made this study possible. I would like to thank all the local health officials and staff who took the time to participate in this important endeavor. All local health personnel can and should take pride in their contributions to public health, which are so clearly portrayed in the following pages.

In presenting the second *National Profile of Local Health Departments*, NACCHO has begun to develop a base from which a surveillance system of local health departments can be developed and longitudinal analysis can be conducted. In addition, with critical discussions of health care underway, the knowledge gained from the 1989 and the 1992-1993 studies can be useful to the design of a reformed health system.

The *1992-1993 National Profile of Local Health Departments* provides a greater amount of information than the first study. An additional report on occupational safety and health issues in local health departments will also be published. These data are currently being analyzed, and the findings will be published in Fall 1995. In addition, a report will be released on public health activities in big city health departments.

We hope this document will serve as a helpful resource, and we encourage readers to share its information with others. The book has been designed to be easy to use. Our goal is to offer simple graphical presentations of the most important data, accompanied by brief written explanations to clarify the graphs and charts. Your comments and suggestions are welcome. Please address all communications to the National Association of County and City Health Officials, 440 First Street, N.W., Washington, D.C. 20001.

Mary McGlothlin
President, National Association of County and City Health Officials
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ACKNOWLEDGMENTS

Special thanks are due to the 2,079 local health departments and their representatives who participated in this study and made this report possible. We sincerely hope that the results presented in this report will be of great assistance to them in their work.

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The NACCHO-CDC Cooperative Agreement Project Officer is Nancy Couey-Pegg. Other Project Officers who contributed to this project were Charles F. Bacon, Deane A. Johnson, and David E. Adcock.

This report was prepared by David E. Custer, Data Research Associate; Liza M. Centra, MPA, Research Associate; and Carol K. Brown, MS, Project Manager, under the guidance of Nancy Rawding, MPH, Executive Director.

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EXECUTIVE SUMMARY

The National Association of County and City Health Officials (NACCHO),* in collaboration with the Centers for Disease Control and Prevention (CDC), conducted the *1992-1993 National Profile of Local Health Departments* study and prepared this publication. The second *Profile* study is part of an ongoing effort to provide a comprehensive, accurate description of the activities, capacities, and needs of local health departments (LHDs). The data collected between October 1992 and December 1993 include responses from 2,079 (72%) of the nation's LHDs. Expanding upon the knowledge gained from the first *Profile* study conducted in 1989 by NACCHO and the CDC, this report presents the findings from the 1992-1993 study of LHDs. Information was collected on the activities and services of LHDs in a variety of areas, including services, data collection, policy and planning activities, expenditures, and personnel. In addition, descriptive data on the LHD structure and the top agency executive were requested and analyzed. Wherever possible, comparisons have been made with information collected in the 1989 *Profile* study.

Some key findings are:

- 66% of LHDs serve a jurisdiction with a population fewer than 50,000.
- 73% of LHDs serve a jurisdiction with a local board of health.
- Across all population subgroupings, the mean and median LHD total annual expenditures (adjusted for inflation) have increased since 1989.
- 79% of LHDs have a full-time top agency executive.
- 42% of LHDs have fewer than 10 full-time staff members.
- 70% of LHDs have used *Healthy People 2000* for program and/or organizational planning.
- 96% of LHDs directly provide or contract to provide immunizations.
- 86% of LHDs directly provide or contract to provide tuberculosis services.
- 74% of LHDs directly provide or contract to provide private water supply safety services.
- 80% of LHDs provide restaurant inspection and/or licensing.

* In July 1994, the National Association of County and City Health Officials (NACCHO) was created. It is the result of the combination of the National Association of County Health Officials (NACHO) and the United States Conference of Local Health Officers (USCLHO).

INTRODUCTION

A comprehensive, accurate description of the activities, capacities, and needs of local health departments (LHDs) is essential to understanding the role they play in the nation's health system. LHDs carry the unique oversight responsibility of assessing health status and assuring the health of the residents of a jurisdiction. They are also responsible for the development of policy to protect the health of their community. According to the *Blueprint for a Healthy Community,* LHDs are located "where care is delivered, where patients actually live, where the environment affects health, and where systems operate."[1]

As part of a continuing effort to describe the U.S. local public health system, the National Association of County and City Health Officials (NACCHO), in cooperation with the Centers for Disease Control and Prevention (CDC), conducted its second study of LHDs during 1992 and 1993. At the time the study was developed and information was collected, the organization was named the National Association of County Health Officials (NACHO). In July 1994 the National Association of County and City Health Officials (NACCHO) was created as the result of the combination of NACHO and the United States Conference of Local Health Officers (USCLHO). Throughout the document, irrespective of the time period, the organization is referred to as the National Association of County and City Health Officials (NACCHO).

The knowledge gained through this study is vital in many respects. It provides a baseline description of LHDs and yields a sampling frame for future studies of LHDs and their contributions to the nation's public health. This information is also helpful in assessing progress toward *Healthy People 2000* Objective 8.14, which states: "Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health."[2] In addition, it serves as a baseline for evaluating changes that may occur in the role of LHDs as a result of changing U.S. health policy. With critical discussions of the health care system on-going, a better understanding of the role LHDs play in assuring the health of the community is essential if the vital function of LHDs is to be preserved in the reforming of the health care delivery system.

The first *Profile* study was conducted in 1989 by NACCHO and CDC. The purpose of that effort was to provide information about the activities and capacities of LHDs as part of the developmental phase of the Assessment Protocol for Excellence in Public Health (APEX*PH*) project. One goal of APEX*PH*, a cooperative project of CDC and NACCHO, in collaboration with other major public health organizations, was to develop a self-assessment and planning tool to assist LHDs in more effectively developing capacities to meet the health-related needs of their communities. Therefore, data on current LHD activities and capacities were vital to the project.

Published in 1990, the *National Profile of Local Health Departments*[3] provided the baseline for the APEX*PH* project, a much needed description of the nation's LHDs, and a sampling frame for future studies. The first *Profile* was conducted with a commitment to repeat the nationwide study periodically, thus establishing a surveillance system of LHD activities.

The 1989 dataset has also been used as a resource for several subsequent studies, including *Current Roles and Future Challenges of Local Health Departments in Environmental Health,*[4] and *Primary Care Assessment: Local Health Departments' Role in Service Delivery,*[5] and *Local Health Department Effectiveness in Addressing the Core Functions of Public Health.*[6]

Brief Review of Literature

Considerable efforts have been made to strengthen the nation's public health system over the past twenty years. As part of this process, the need for current and detailed LHD data has been widely cited. The landmark report of the Institute of Medicine (IOM), *The Future of Public Health*, stated, ". . .data on the activities of local health departments are hard to come by."[7] A review of the literature documents few early efforts to collect data on the practices of LHDs. However, the following endeavors are notable.

One early effort to collect data on local public health practice was a survey in 1923 by the American Public Health Association's Committee on Administrative Practice (CAP).[8] The Committee collected data from 83 city health departments on expenditures, organization, and public health practices.

A detailed portrait of LHD practices appeared in 1943 when the CAP published the Health Practices Indices, a pamphlet of charts showing the range of units of practice for participating cities and counties. The charts, used by local health officers for self-appraisals and as a reference in making budgetary appropriations, also included information on budgets, environmental health and personal health services.[9]

In 1945, under the chairmanship of Haven Emerson, M.D., the CAP recommended that for departments to provide public health services most effectively and efficiently, they should provide these services in units (departments) serving no fewer than 50,000 people.[10] The committee clearly recommended consolidation of many small county health departments. In addition, this report suggested that two-thirds of the U.S. population was covered under full-time local health protection.

An increase in the number of LHDs over time has been documented. In 1942, F. W. Kratz counted 1,669 counties with full-time public health departments.[11] The work of Terris and Kramer in 1947 indicated 1,385 full-time departments (including state health districts)[12]; in 1953, Joseph Mountin reported 1,239 LHDs (963 county and 276 city units)[13]; in 1968, the Public Health Service published a study based on work started in 1964 that identified 1,703 local health units[14]; in 1977, C. A. Miller *et al.* identified approximately 1,980 LHDs[15]; and in 1989, the Public Health Foundation, relying primarily on states for their information, reported that nearly 3,000 local health departments existed.[16] NACCHO identified 2,932 LHDs in the *1990 Profile.*[17] The CDC published the *Profile of State and Territorial Public Health Systems: United States, 1990*, and reported 2,876 LHDs.[18]

The literature also provides insight on the assurance activities of LHDs over time. Terris and Kramer's work in 1946 showed that LHDs were moving beyond the traditional boundaries of preventive services and into providing therapeutic services.[19] The results of the Public Health

Service's 1964 study published in 1968 suggested that LHDs were becoming increasingly involved in medical care.[20] The 1977 study by C. A. Miller *et al.* reinforced this finding, concluding that LHDs were extensively involved in rendering health services, including direct personal health services.[21]

A recent research effort by C. A. Miller *et al.* sought to document changes in selected public health departments over the past decade. The study focused on a group of 14 LHDs that were the subjects of intensive case studies between 1979 and 1981. Some preliminary observations from a follow-up study of these departments in 1992 included a growth in budget and staff; increased pressure for services, especially in the area of personal health care; increase in preventive, screening, and categorical programs under public health sponsorship; and drastic changes in patterns of financing.[22]

In 1988, the IOM's *The Future of Public Health* outlined the three core functions of public health as assessment, assurance and policy development.[23] As a further step to ensure that the core functions were being carried out, the CDC developed 10 organizational practices. Bernard J. Turnock *et al.* used these 10 organizational practices in 1992 to describe and measure the effectiveness of Illinois LHD practice. The LHDs were studied again in 1994 to assess changes in, influences on, and results of practice performance. Turnock and his associates found the greatest improvement in the "assess," "analyze," "prioritize," "plan," and "inform" practices, and for the organizational self-assessment measure for the "manage" practice.[24] The researchers then attempted to determine what influences were most responsible for those improvements for each practice. APEX*PH* and its Illinois adaptation, Illinois Plan for Local Assessment of Needs (IPLAN), were cited as the greatest influences on practice performance. Respondents also indicated an increased understanding of internal strengths and weaknesses and community health problems.

Using these 10 organizational practices, James Studnicki *et al.* also researched LHD performance. By using a Florida health unit, the researchers determined the amount of time allotted to each practice in order to build a foundation for comparative performance among LHDs. Studnicki and his associates found that the largest proportion of manpower resources was allocated to program implementation, whereas approximately 10% of the agency resources were devoted to community health assessment and planning.[25]

As stated above, one of the national health objectives for the year 2000 states that 90% of the U.S. population should be served by an LHD effectively carrying out the core functions of public health. C. A. Miller *et al.* hypothesized that the extent to which a local public health jurisdiction is served by an LHD carrying out core public health functions could be measured, as well as the extent to which the functions are performed. C. A. Miller and his associates studied 14 LHDs. Profiles were developed that differentiated performance from one jurisdiction to another. They determined that current definitions of public health practice can be used to evaluate public health performance.[26]

In 1993, a study of all LHDs in six states (395) was conducted with a screening questionnaire for measuring local public health performance. The questionnaire was based on an 84-indicator questionnaire in which each indicator was keyed to the core public health functions of

assessment, policy development, and assurance and ten corresponding practices. Responses were received from 370 (94%) of the sampled LHDs.[27] C. A. Miller *et al.* selected 36 LHDs which were then resurveyed by means of the longer protocol to test the validity of the shorter questionnaire as a screening tool. Findings supported the conclusion that public health core functions can be defined, measured, and monitored.[28]

In an effort to provide a benchmark of LHD effectiveness in addressing the core functions of public health, Bernard J. Turnock *et al.* studied a national random sample to determine self reported compliance with ten public health practice performance measures that operationalize the core functions. Findings of the study suggested that less than 40% of the U.S. population in 1993 is served by an LHD effectively addressing the core functions of public health.[29]

This brief review of the literature suggests that although there was little documentation of local health practices until recently, several research efforts are now beginning to compile and analyze data on LHD activities and performance. These constructive efforts will help lay the groundwork for an improved public health system. It is hoped that the present study will also be useful in this effort.

Methodology

Data Source

The study population for this study comprised the 2,888 LHDs meeting the study definition also used in the 1989 study:

> *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 the state.*

The NACCHO database of LHDs served as the basis for identifying all LHDs including town/township, city, county, city-county, multi-county, and district health departments. For further verification, each state health department was contacted to obtain current lists of names and addresses of LHDs recognized by the state.

The Study Instrument

NACCHO convened a work group in 1992 to develop the second *Profile* study and questionnaire. Participants represented various major public health organizations, including the American Public Health Association, the Association of State and Territorial Local Health Liaison Officials, the Association of Schools of Public Health, CDC, and NACCHO.

The work group wanted to obtain more comprehensive data than was asked for in the 1989 study. It expanded the number and depth of questions concerning the activities of LHDs and included a section on occupational safety and health issues. A pilot questionnaire was sent to a few LHDs to solicit comments and to further refine the questionnaire. Good results were obtained, and minor modifications were made. The final questionnaire was 20 pages in length.

Definition of Local Health Department

One challenge of this and similar projects has been developing a standard "case definition" for an LHD that incorporates the diversity and variety in health departments nationwide, yet provides enough structure for evaluating the functions and characteristics of LHDs. The definition cited above under Data Source has been used for both studies.

This definition has been adapted from two others, one used by C. A. Miller in 1974 and the one used by Association of State and Territorial Health Officers (ASTHO). C. A. Miller's operational definition of a local health department is ". . . an administrative and service unit of local or state government, concerned with health, employing at least one full-time person, and carrying some responsibility for the health of a jurisdiction smaller than the state."[30] The ASTHO definition further restricts the C. A. Miller definition by adding that one or more full-time employees be professional public health employees.[a] NACCHO's definition is less restrictive. For that reason, in the 1992-1993 study, as in the 1989 study, responses were included from units with less than one full-time employee, units that operate on a part-time basis, and independently operating nursing and environmental units.

Although NACCHO has used the same definition in both *Profile* studies (*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 the state*) some modifications in the inclusions and exclusions between the two studies have occurred as a result of gaining a greater understanding of public health structures on a state-by-state basis. Also, the structure of the local health system has changed in some states, thereby changing the number of entities that meet the study definition. A comparison of the inclusions and exclusions in each study is provided for those states with differences.

Comparisons of Inclusions and Exclusions, 1989 vs 1992-1993

- subunits or satellite offices of local health departments--These units were excluded in all states in both 1989 and 1992-1993.

- district units providing support for independent health units--In 1989, all district units (such as the district offices in Alabama, Georgia, Louisiana, Mississippi, New Mexico, South Carolina, Tennessee, and Virginia) were excluded and local units were included.

  In 1992-1993, as in the 1989 study, district health units in Alabama, Georgia, Louisiana, Mississippi, New Mexico, and Tennessee were excluded and local units from these states were included. District units were included, however, in Virginia and South Carolina. In Virginia, district unit responses were included,

[a] The ASTHO definition of a local health department reads as follows: "An official (governmental) public health agency which is, in whole or part, responsible to a substate governmental entity or entities. An entity may be a city, county, city-county, federation of counties, borough, township, or any other type of substate governmental entity. A local health department must: have a staff of one or more full-time professional public health employees (e.g., public health nurse, sanitarian); deliver public health services; serve a definable geographic area; have identifiable expenditures and/or budget in the political subdivision(s) it serves."

and local unit responses were excluded in 1992-1993. Virginia representatives from local units, district units, and the state health department generally agreed that district level units more accurately reflected the study definition. In South Carolina, a consolidation has occurred since the 1989 study; the resulting district units were included.

- sub-state extensions--In the 1989 study, sub-state extensions not considered by the state to be LHDs (such as the units in Delaware, Hawaii, Rhode Island, Vermont, and many in Pennsylvania) were excluded. In the 1992-1993 study, sub-state extensions in Hawaii, Delaware, and Vermont were included on the recommendation of both state and local health representatives. The Rhode Island State Health Department was not included in both 1989 and 1992-1993, as it does not have LHDs. Sub-state extensions in Pennsylvania that are not considered by the state to be LHDs were excluded in both the 1989 and the 1992-1993 studies.

- non-governmental agencies--Agencies in Alaska that provide local health services through non-profit corporations were excluded in both the 1989 and the 1992-1993 studies.

Other changes

- Although no major structural changes occurred in Iowa, the number of entities increased from 11 in 1989 to 107 in 1992-1993, due to the inclusion of public health nursing and board of health service units. These units were included on the recommendation of Iowa state and local representatives, since it was interpreted that they met the study definition.

- Connecticut has experienced a consolidation of public health units since the 1989 study, and the number of LHDs within the state has decreased. In 1992-1993, 101 LHDs were included, compared with 123 in 1989.

- The District of Columbia was included in the *1992-1993 Profile* study, but not in the 1989 study.

Data Collection

In October 1992, NACCHO mailed the 20-page questionnaire to 3,262 local public health units. Follow-up data collection activities included two additional mailings to all non-respondents and direct contact through phone calls from state/local liaisons, NACCHO members, NACCHO staff, and others. Questionnaires were returned to NACCHO for tracking before being sent to CDC for tabulation. Data collection ended in December 1993. Through a collaborative process, NACCHO and CDC edited and cleaned the dataset. By applying the study definition, eliminating duplicates, and removing no longer existing units, the final study population included 2,888.

As the questionnaire was mailed out in late 1992, some LHDs responded in 1992 and others in 1993. Therefore, the dataset has been referred to as 1992-1993. However, these data should not be interpreted as representing a two-year time period.

Data Tabulation and Analysis

Responses were entered into an electronic format using the mainframe version of the SAS program, and univariate analyses were conducted using Paradox software on a microcomputer.

Response Rate

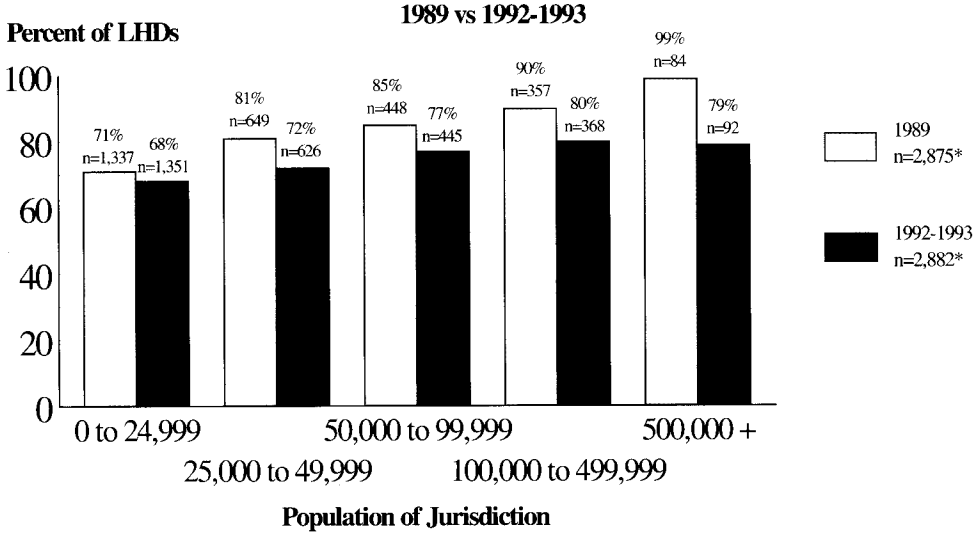
Completed questionnaires were received from 2,079 LHDs that met the study definition, yielding a response rate of 72%. While this response rate is lower than the 77% response rate from the 1989 study, it is an excellent response for a 20-page questionnaire (the 1989 questionnaire was six pages). Responses were received from 49 states and the District of Columbia. Twenty-three states had response rates of 80% or more; of these, six states had 100% response rates. Six states had response rates under 50%, and no state included in the study had a response rate lower than 29%. When the response rate was analyzed by the ten Public Health Service Regions, it was found that eight regions had response rates greater than 65% and two had 58% response rates.

Although the results of a study can be influenced by the characteristics of the nonrespondents, an analysis of the respondents in the 1992-1993 study suggests this problem is minimal. In the 1989 study, the data were skewed toward LHDs that serve more populated jurisdictions. The data, however, were not as skewed in the *1992-1993 Profile*. Figure 1 presents a comparison of the response rate by population of jurisdiction, 1989 vs 1992-1993. Overall, the estimated total population served by the responding LHDs was approximately 85% of the 1990 U.S. Census total (249 million persons). This fact is not to suggest that 15% of the U.S. population does not receive public health services, because these services may be provided by an LHD that did not respond or through another entity that did not meet the study definition.

Figure 1

Response Rate by Population of Jurisdiction

1989 vs 1992-1993



* Excludes LHDs for which population data were unavailable (57 in 1989, 6 in 1992-1993) n= number of respondents

Strengths of Study

The *Profile* series has continued to build the foundation for monitoring and tracking changes in the activities and functions of LHDs. Equally important is the fact that this study has provided a greatly expanded dataset on LHDs, compared with the 1989 study. Key issues addressed in this study are:

- jurisdiction demographics
- budgets and selected sources of revenue
- top agency executive information
- personnel information
- policy and planning activities
- data collection activities
- services information

In addition, a section on occupational safety and health has been included. Selected results from this section are also included in this *Profile*. More detailed results will be published in Fall 1995.

Another strength of this study is that the comprehensive dataset helps provide the capacity for other related research. Already the 1992-1993 dataset has provided information for two stratified random sample studies. The first studied laboratory quality in human immunodeficiency virus (HIV) testing and was conducted by the Laboratory Assurance Program, San Diego State University, in collaboration with the CDC. The dataset was also used as a basis for the Assessment of Chronic Disease Activities in Local Health Departments, a collaborative study conducted by the Association of State and Territorial Chronic Disease Program Directors, the Public Health Foundation, and NACCHO, in cooperation with the CDC.

Information from this *Profile* study was reported in the *Morbidity and Mortality Weekly Report*, November 18, 1994.[31] In addition, a poster session was presented at PREVENTION 94, and three presentations were made at the American Public Health Association's 1994 Annual Meeting. Future plans include using the dataset to generate an in-depth study of tuberculosis activities in LHDs. This study will be conducted by NACCHO, in collaboration with the CDC.

Limitations

As previously discussed, it is difficult to derive an incontrovertible case definition for LHDs. In addition, lack of a common definition limits the ability to compare the results of this analysis directly with those of previous studies, other than the first *Profile* study.

Terminology also causes limitations. Questions may have been interpreted differently by the various respondents. In addition, some questions used in the 1989 study were refined in 1992-1993 to collect more specific information. These changes in terminology limit the ability to perform comparisons between the two datasets.

Reliability Testing

The *1992-1993 Profile* dataset was not formally tested for reliability, although considerable care was taken to validate the dataset. When the 1989 dataset was tested it showed a high degree of

reliability. Other self-reported local public health research on performance and activities has also demonstrated a high degree of reliability, including works by Bernard J. Turnock[32, 33] and C. A. Miller.[34]

Results and Discussion

The results of the study are presented in commentaries at the beginning of each section followed by graphs and charts called "Figures." Please note that some findings from the study are presented in the commentary that are not included in the graphs and charts. In addition, "Fast Facts," highlighting some of the more noteworthy findings, accompany the commentary for each section.

The objective of the *1992-1993 National Profile of Local Health Departments* was to provide a description of the U.S. local public health system and the vital role that LHDs play. As discussed in the review of the literature, few efforts have been made to describe and collect comprehensive data on LHDs and even fewer have attempted to monitor LHDs over time. However, with the possibility of changes to the U.S. health system, reliable data establishing baselines and monitoring trends in public health at the local level are becoming increasingly important. The information in this document updates and expands upon the available knowledge of LHD structures and activities.

This second report in the continuing effort by NACCHO to describe LHDs is also helpful in monitoring progress toward *Healthy People 2000* Objective 8.14 ("increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health"). By producing the second in a series, NACCHO has begun to develop a base from which a surveillance system can be developed and longitudinal analysis can be conducted.

In addition, because LHDs are the governmental presence at the local level with a unique oversight responsibility for health, it is important to understand and monitor the methods by which they carry out this responsibility. The information contained within this report describes the current level of resources and activities. Comparisons with these levels can be made, and needs can be identified. Support and program development, such as technical assistance, leadership development, resource allocation, and other support services can then be tailored to meet the particular needs of each local community.

As part of the process of conducting a comprehensive study of LHDs, their activities and services must be separated into components that appear to be discrete activities. It is important to remember these individual components work together to form an integrated, prevention-oriented local public health system that links with the state and federal governmental levels and other community services.

Activities of LHDs are varied and range from personal health services, environmental services, community health assessment and policy making, communicable disease surveillance,

environmental epidemiology, and chronic disease activities to other emerging environmental and personal health services. When these activities are analyzed in conjunction with other community health-related data, one can gain a composite picture of the services actually available across the country.

The *Profile* is integral to understanding the activities, capacities, and needs of LHDs as they work toward assuring that healthy people live in healthy communities. Further, by providing information over time, the *Profile* series will be able to provide a comprehensive picture of the past and present activities of LHDs, which can be used to project future directions for local public health.

Notes on Analysis

The figures on the following pages present data as national overall frequencies and as percentage distributions by population size. These distributions illustrate the variations that exist among LHDs and provide a framework in which local health officials may compare themselves to departments in similar size jurisdictions. The population variable was used for this analysis because of its relatively high predictive value in relation to the other variables.

Comparison data are also presented, when possible, with results from the 1989 study. In instances where the questionnaire language varied between the two studies, no comparisons were made. Since the study population for both the 1989 and 1992-1993 studies is the entire population of LHDs in the nation, no statistical tests for significance are necessary. Any differences in the various comparisons between the two time periods are real differences.

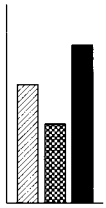
Some caution is necessary in interpreting the comparison data as trend information, since only two data points are represented. Also, some LHDs that responded to the 1989 study did not respond in 1992-1993, and the reverse is also true. However, the response rate for both studies is high (1989, 77%; 1992-1993, 72%), and data reflect the current understanding of the local public health system.

In this study the full population of LHDs was queried. Not all LHDs, however, responded. Therefore, while the full population was queried, the results are presented with the lower case notation ("n") to indicate the number of respondents for each analysis. Furthermore, in many cases some respondents did not answer every item on the questionnaire. In these cases, those LHDs that did not answer the question are excluded from the analysis; therefore, "n" varies slightly.

As stated in the Methodology section of this document, an analysis of the *1992-1993 Profile* dataset suggests the data are not as skewed by population as in the 1989 study. The analysis on the 1989 dataset suggests the data are skewed toward the LHDs serving the larger populations.

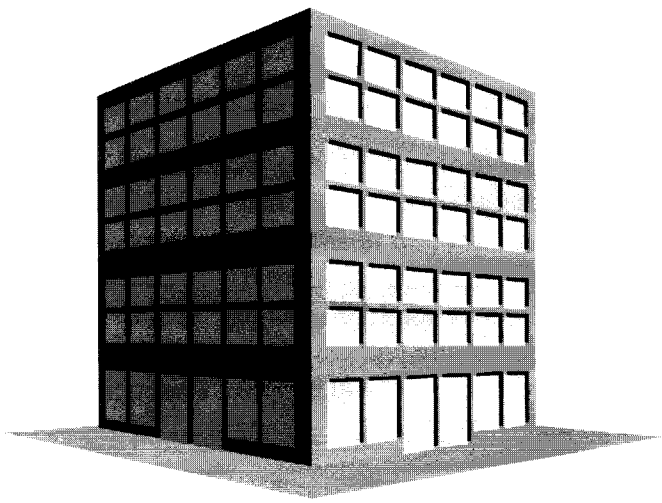
Also included in this document are preliminary data from the occupational safety and health section of the study. These are included to highlight the importance of occupational health and safety and to inform the reader that the dataset includes an entire section on this issue. A full report will be published by NACCHO in Fall 1995.

OVERVIEW OF LOCAL HEALTH DEPARTMENTS



Fast Facts

- 66% of LHDs serve a jurisdiction with a population fewer than 50,000.
- 80% of LHDs serve a county-related jurisdiction.
- 73% of LHDs serve a jurisdiction with a local board of health.
- 88% of the boards of health have statutory authority to establish local health policy, fees, ordinances, regulations, etc., in jurisdictions with a board of health.
- Overall, statutory authority of boards of health is greater in jurisdictions serving fewer than 100,000 people.



Overview of Local Health Departments

Number of Local Health Departments

The map in Figure 2 displays the number of LHDs in each state according to the study definition. In some states, the number of LHDs may differ from the information reported in the *1990 Profile* (Appendix A) due to changes in structure and/or a greater understanding of the local public health structure. (For an in-depth discussion of the study definition and inclusions/exclusions, please see pages 4 and 5.)

Population of Jurisdiction

Figure 3 compares data concerning the distribution of LHDs by the reported population of the jurisdiction. In the 1992-1993 study, the percentage distribution remained essentially the same as in the 1989 study. Forty-four percent (44%) of 1992-1993 respondents reported serving areas with populations under 25,000. Furthermore, LHDs serving jurisdictions with populations between 25,000 and 49,999 make up an additional 22%, thus indicating that two-thirds (66%) of all LHDs serve populations of fewer than 50,000.

Figure 4 displays the types of jurisdictions LHDs serve. In the 1992-1993 study, 56% of the respondents reported serving a county jurisdiction; 13%, city/county; 11%, multi-county; 11%, town or township; 7%, city ; and 2%, other. Overall, 80% of all LHDs are related to a county structure in some way (e.g., county, city/county, or multi-county).

A comparison of the reported type of jurisdiction served in each of the two study periods suggests a number of changes. For example, the data suggest a 7 percentage point decrease in the city/county category, a 4 percentage point increase in the multi-county category, and a 7 percentage point increase in the county category. The reasons for these fluctuations include changes in the inclusions and exclusions between the two study periods, the creation of new LHDs, and mergers of LHDs.

Local Boards of Health

When asked whether a local board of health served the jurisdiction, most respondents (73%) answered "Yes" (Figure 5). Of those who stated they had a local board of health in their jurisdiction, 88% answered that their board of health had statutory authority to establish local health policy, fees, ordinances, regulations, etc. (Figure 6). In addition, 61% of local boards of health have statutory authority to approve the LHD budget. When these data were analyzed by population categories (Figure 6), results suggest the statutory authority of boards of health is greater in jurisdictions serving fewer than 100,000 people. Thirty-five percent (35%) have authority for all of the listed areas.

Personal Health Services Clients by Race and Ethnicity

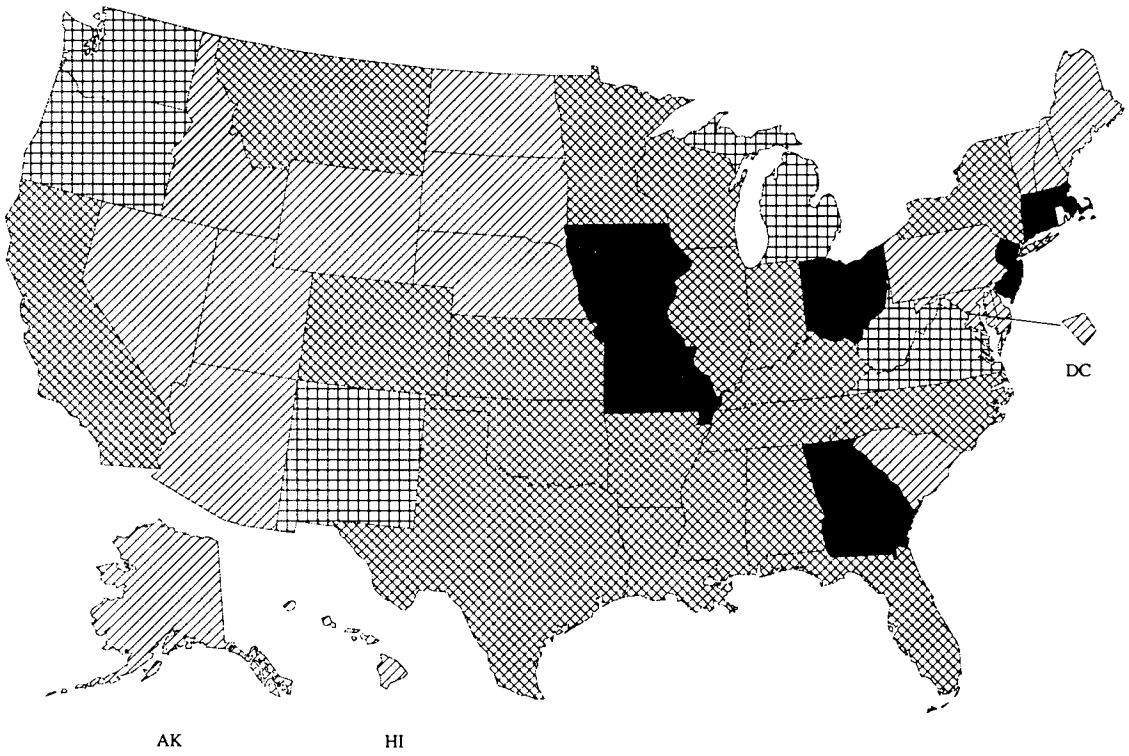
Responding LHDs provided information on the racial composition of their personal health services clients. Although data on the racial and ethnic composition of the jurisdiction were not requested, Figure 7 compares the percentages for personal health services clients with 1990 U.S.

Census information. All information is presented by Public Health Service regions (Appendix B). The overall reported national percentage of personal health services clients are: White, 73.1%; Black, 13.3%; Asian or Pacific Islander, 0.9%; American Indian, Alaska Native, or Aleutian, 0.7%; and other or unknown races, 12%.

Also requested was information on ethnicity. The overall reported national percentage of Hispanic personal health services clients is 6.4%.

Please note this information refers to personal health services and cannot be interpreted as representing the composition of the populations served through the other activities of LHDs.

Figure 2
Number of U.S. Local Health Departments by State
1992-1993



Number of Local Health Departments*
n=2,888

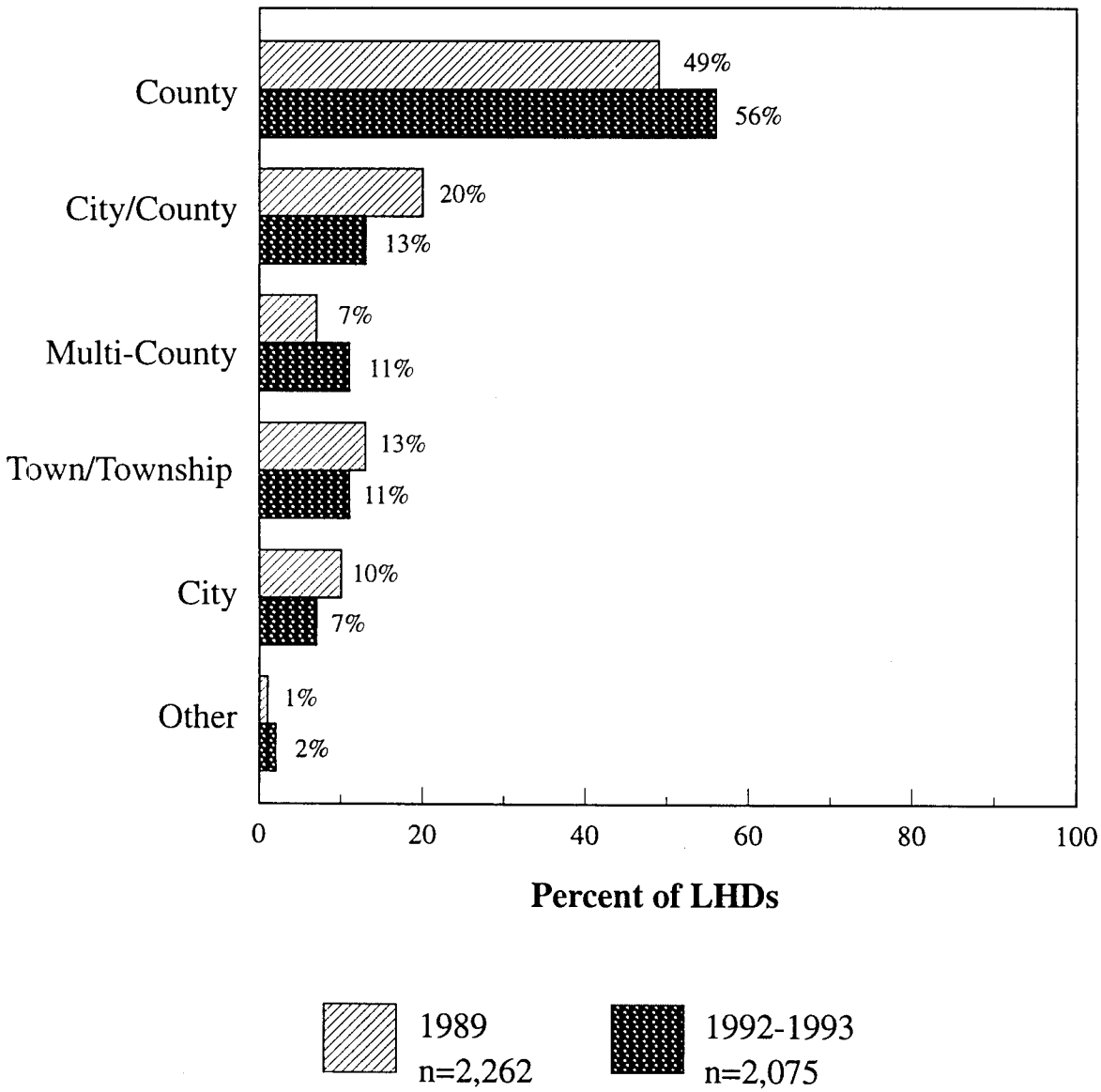
None | 1 to 24 | 25 to 49 | 50 to 99 | 100 or more

*Based on *1992-1993 National Profile of Local Health Departments* study definition. The number of LHDs reported here may differ from data contained in other published sources due to differences in study definition, changes in structure over time, or a different understanding of the local public health system.

Figure 3
U.S. Local Health Departments by Population of Jurisdiction
1989 vs 1992-1993

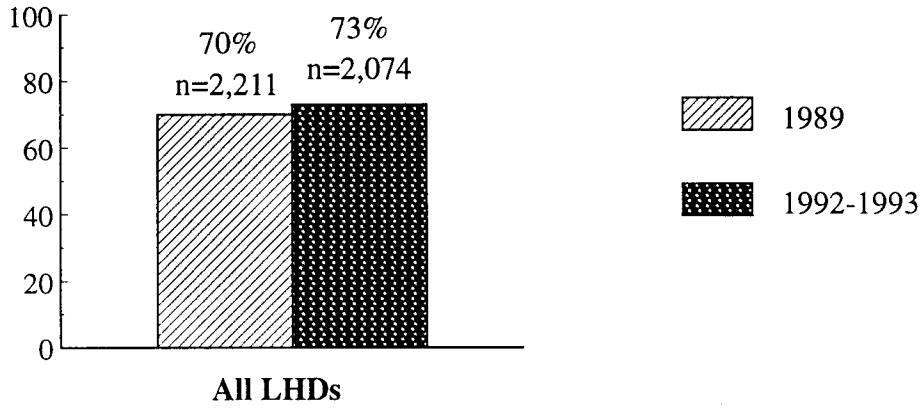
n= number of respondents

Figure 4
U.S. Local Health Departments by Type of Jurisdiction
1989 vs 1992-1993

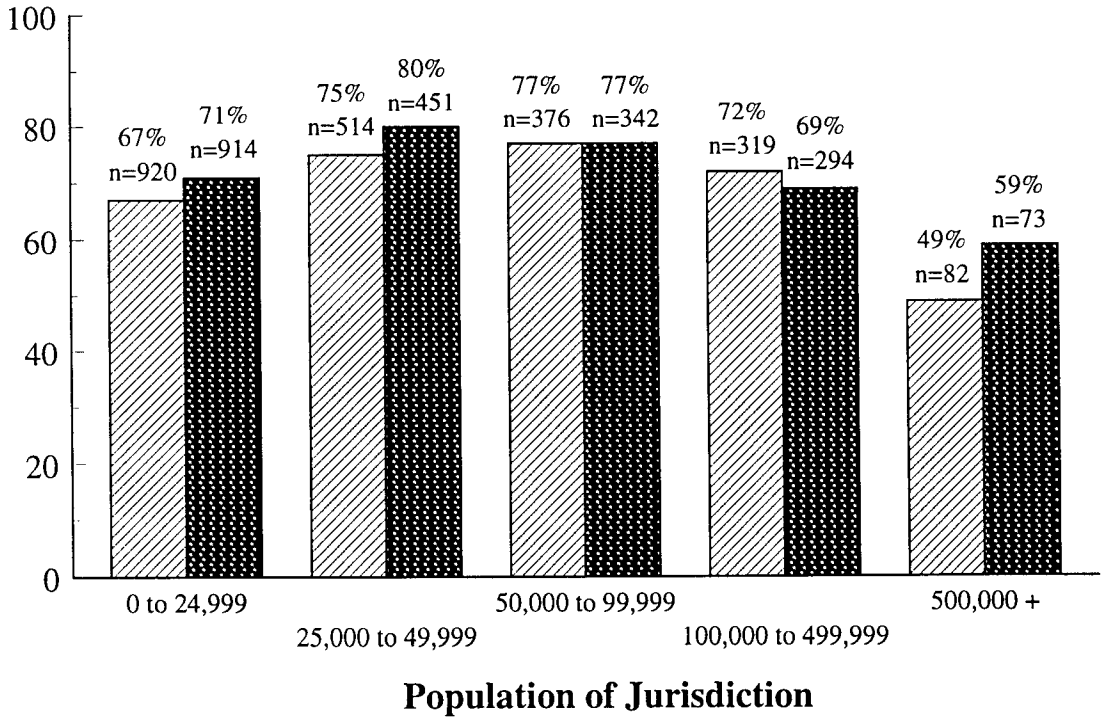


n= number of respondents

Figure 5
U.S. Local Health Departments with a Board of Health
1989 vs 1992-1993



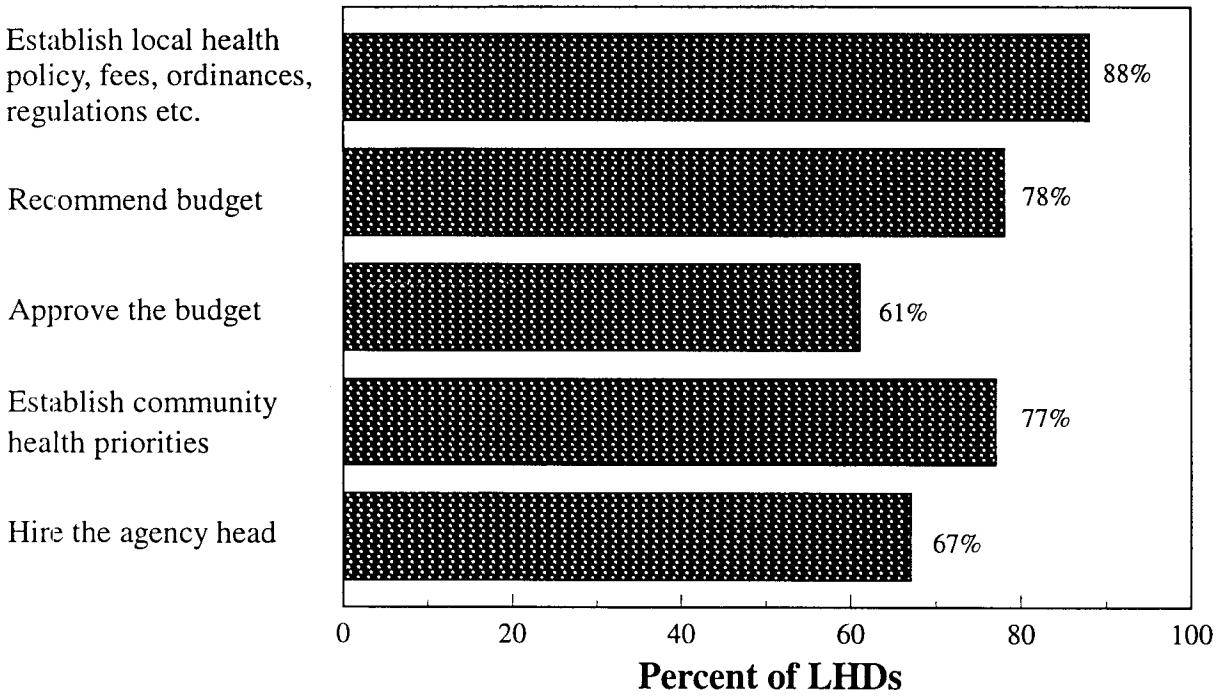
By Population of Jurisdiction



n= number of respondents

Figure 6
Statutory Authority of U.S. Boards of Health in Jurisdictions with a Board of Health
1992-1993

All LHDs
n=1,519



By Population of Jurisdiction

	0 to 24,999 n=650	25,000 to 49,999 n=360	50,000 to 99,999 n=263	100,000 to 499,999 n=203	500,000 + n=43
Establish local health policy, fees, ordinances, regulations, etc.	89%	90%	89%	77%	74%
Recommend budget	82%	82%	75%	69%	58%
Approve the budget	63%	66%	64%	48%	35%
Establish community health priorities	77%	79%	81%	72%	58%
Hire the agency head	63%	74%	73%	66%	56%

n= number of respondents

Figure 7

Racial and Ethnic Composition of U.S. Local Health Department Personal Health Services Clients Compared to U.S. Census Data by Public Health Service Region

1992-1993

Public Health Service Region*		Race										Ethnicity		
		White		Black		American Indian[c]		Asian/Pacific Islander		Other/Unknown		Hispanic		
	n=	Clients[a]	Census[b]	Clients	Census	Clients	Census	Clients	Census	Clients	Census	n=	Clients	Census
Region 1	253	72.6%	94.4%	3.0%	2.9%	0.5%	0.3%	0.9%	1.2%	23%	1.2%	245	4.2%	2.72%
Region 2	103	75.8%	76.9%	9.9%	14.7%	0.2%	0.1%	2.0%	3.7%	12.1%	4.6%	100	7.6%	11.0%
Region 3	85	72.8%	73.8%	18.5%	23.2%	0.3%	0.2%	1.2%	1.7%	7.2%	1.1%	84	5.9%	2.6%
Region 4	495	61.4%	76.2%	32.4%	22.1%	0.2%	0.4%	0.3%	0.8%	5.7%	0.5%	474	2.3%	2.3%
Region 5	362	81.9%	87.8%	5.2%	9.1%	0.6%	0.5%	1.4%	1.3%	10.9%	1.3%	351	3.2%	2.8%
Region 6	166	59.5%	76.6%	18.7%	13.6%	1.1%	3.6%	0.7%	1.1%	20.0%	5.1%	176	18.1%	3.9%
Region 7	224	87.6%	92.1%	3.1%	5.3%	0.2%	0.6%	0.5%	1.0%	8.6%	1.0%	212	3.8%	2.1%
Region 8	112	84.7%	92.4%	0.8%	1.2%	2.8%	3.6%	0.2%	1.0%	11.5%	1.8%	108	11.7%	5.5%
Region 9	50	64.4%	66.9%	3.6%	4.9%	4.3%	2.1%	3.3%	19.0%	24.4%	7.1%	53	29%	15.6%
Region 10	59	83.1%	87.8%	1.8%	2.3%	2.1%	5.0%	2.0%	2.8%	11%	2.1%	58	11.8%	3.6%
U.S.	1,909	73.1%	80.3%	13.3%	12.1%	0.7%	0.8%	0.9%	2.9%	12%	3.9%	1,861	6.4%	9.0%

[a] Clients: Personal Health Services Clients as reported by LHDs in 1992-1993.

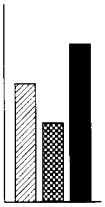
[b] Census: 1990 U.S. Population as reported by U.S. Bureau of the Census.

[c] American Indian includes Alaska Native and Aleutian.

* See Appendix B for a list of states in each region.

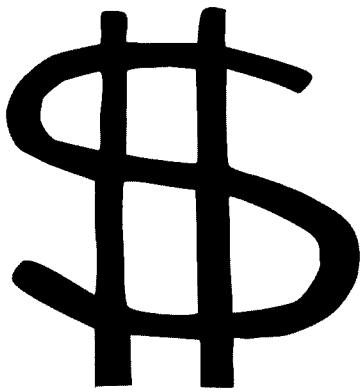
n= number of respondents

TOTAL ANNUAL EXPENDITURES



Fast Facts

- Across all population subgroupings, the mean and median LHD total annual expenditures have increased since 1989, adjusted for inflation.
- 50% of LHDs spend less than $500,000 annually.
- 40% of funding for all LHDs comes from state sources (including federal pass throughs).
- The estimated total U.S. LHD expenditure is $8 billion. This is approximately 1% of total U.S. health care expenditures of approximately $800 billion.
- Local public health expenditures per capita are estimated to be $32 per year or approximately $0.09 per day.



Total Annual Expenditures

Total Annual Expenditures

The annual expenditures of LHDs were determined (Figure 8). Thirteen percent (13%) of responding LHDs reported annual expenditures under $100,000. Fifty percent (50%) reported annual expenditures under $500,000, and 34% reported annual expenditures greater than $1,000,000.

The expenditure information was adjusted for inflation (to constant 1993 dollars) using the implicit price deflator for gross domestic product. Overall, both the mean (Figure 9) and median (Figure 10) annual expenditures increased for LHDs in jurisdictions of all population sizes. Caution is necessary when interpreting this information. While these data show a net increase in funding from the previous study, they do not address other factors relating to services provided, health outcomes, and related functions. Furthermore, the increase in funding is only based on two time periods and therefore is not necessarily indicative of a trend. Additional information, which is not available, is required to evaluate this change in comparison with changes over similar time periods prior to these studies. (Please note that Figures 9 and 10 use a logarithmic scale.)

Some LHDs did not indicate the fiscal year for which the information was provided, and these LHDs were excluded from the comparison of expenditures between the two study periods. Also excluded were two LHDs serving populations of 500,000 or more that did not undergo a budgetary programmatic change in the nature of the health department but used a different reporting method for the 1992-1993 study from the one they used in 1989.

Local public health expenditures per capita are estimated to be $32 per year or approximately $0.09 per day. To conduct this analysis, mean annual expenditures were used to estimate the total national expenditures of U.S. LHDs ($8 billion in constant 1993 dollars). U.S. Census population data (1990) provided the basis for per capita estimates.

Moreover, analysis suggests that LHD expenditures comprise approximately 1% of the total national health care expenditures of approximately $800 billion in constant 1993 dollars. These computations are based on the total national health care expenditures for 1991 (most recent data available), as reported by the Office of National Health Statistics.[35]

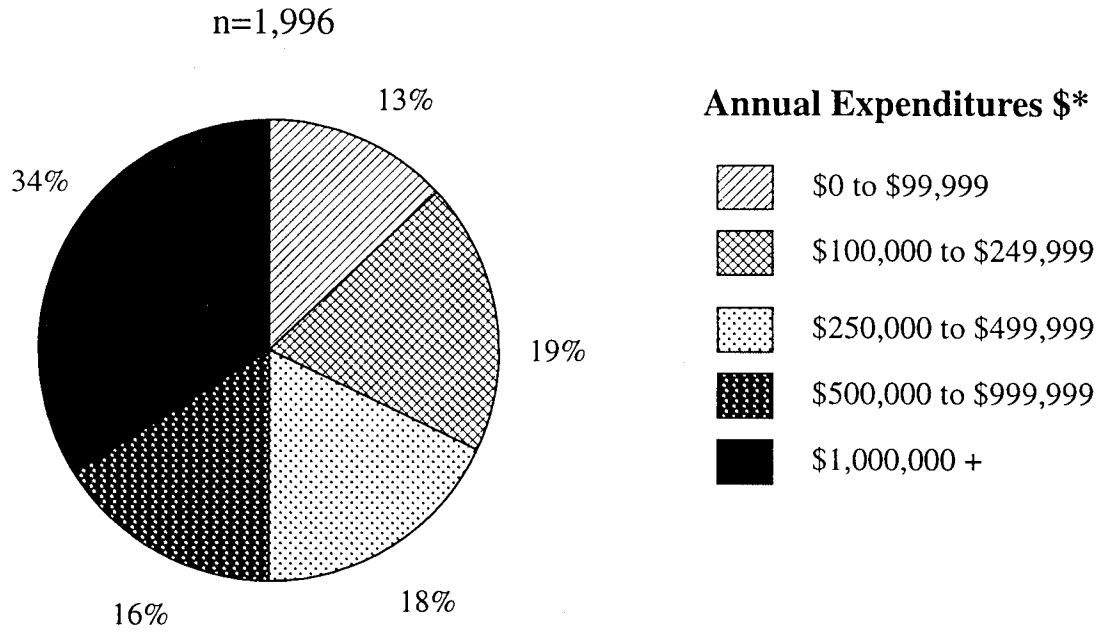
Source of Funding

The 1989 study did not seek sources of funding data; therefore, no comparisons can be made. Figure 11 demonstrates that respondents reported the highest percentage (40%) of their funds come from state sources (includes pass throughs from Federal sources). Local sources provide 34%; Federal sources, 6%. Nearly three-fourths (74%) of LHDs' funding comes from state and local sources. When Medicare and Medicaid are combined, these sources provide 10% of total funding. Selected fees provide another 7%, and other sources account for 3%.

The amount of revenue from Medicaid may change in the future as the Medicaid population increasingly enrolls in managed care plans. According to the Health Care Financing Administration, approximately one-fourth of Medicaid recipients were enrolled in managed care arrangements as of June 1994.[36] The role of LHDs as Medicaid managed care providers is not clear at this point; however, if LHDs do not participate in Medicaid managed care arrangements, they will receive less revenue from Medicaid in the future.

Sources of funding were also analyzed by population of the jurisdiction (Figure 11). The data suggest as population size increases, state and local funding combined increases and the Medicare/Medicaid proportion of funding decreases. Income from fees remains fairly steady across all population categories.

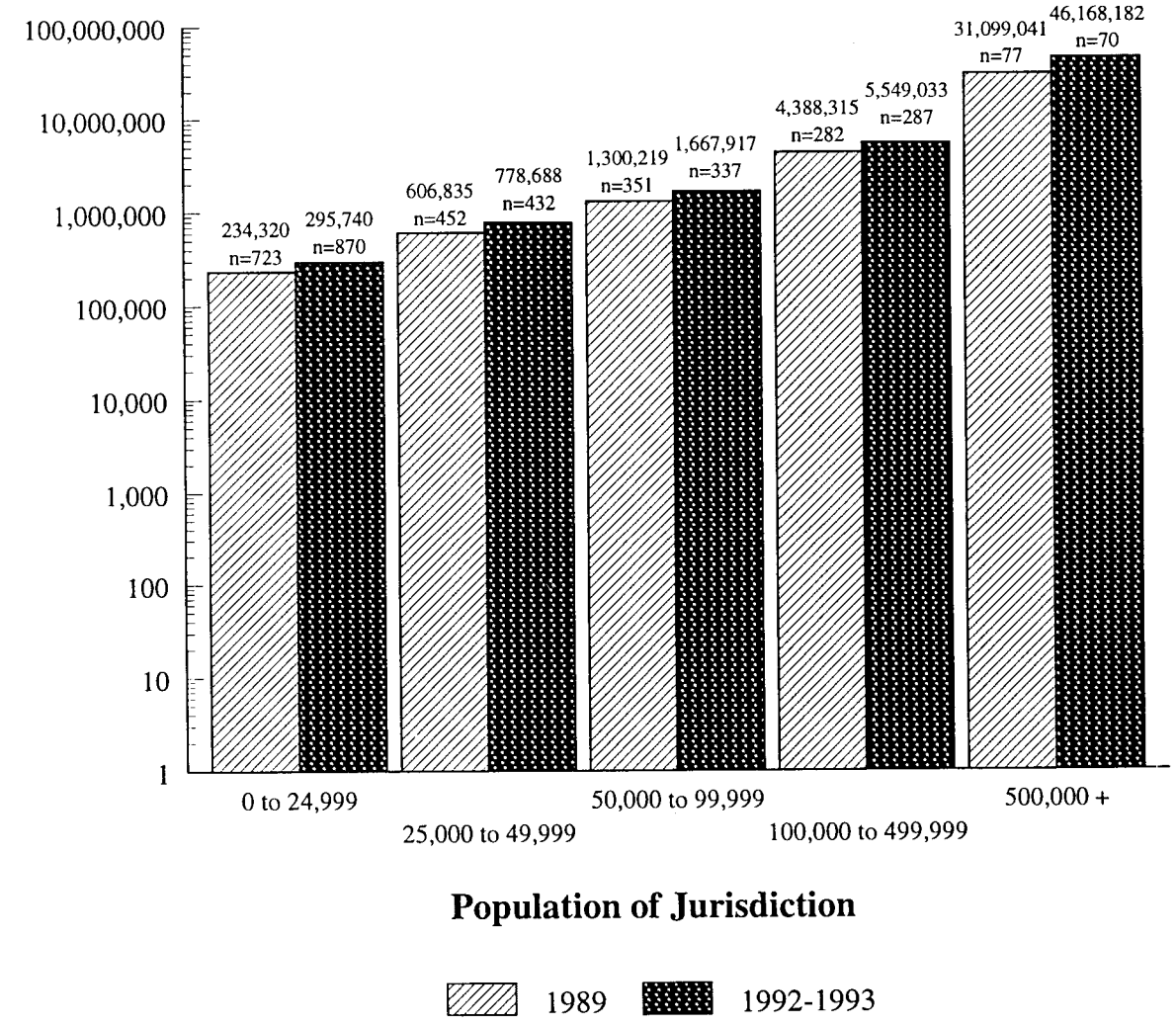
Figure 8
U.S. Local Health Departments by Total Annual Expenditures
1992-1993



*Constant 1993 U.S. Dollars

n= number of respondents

Figure 9
Mean Annual Expenditures of U.S. Local Health Departments by Population of Jurisdiction
1989 vs 1992-1993

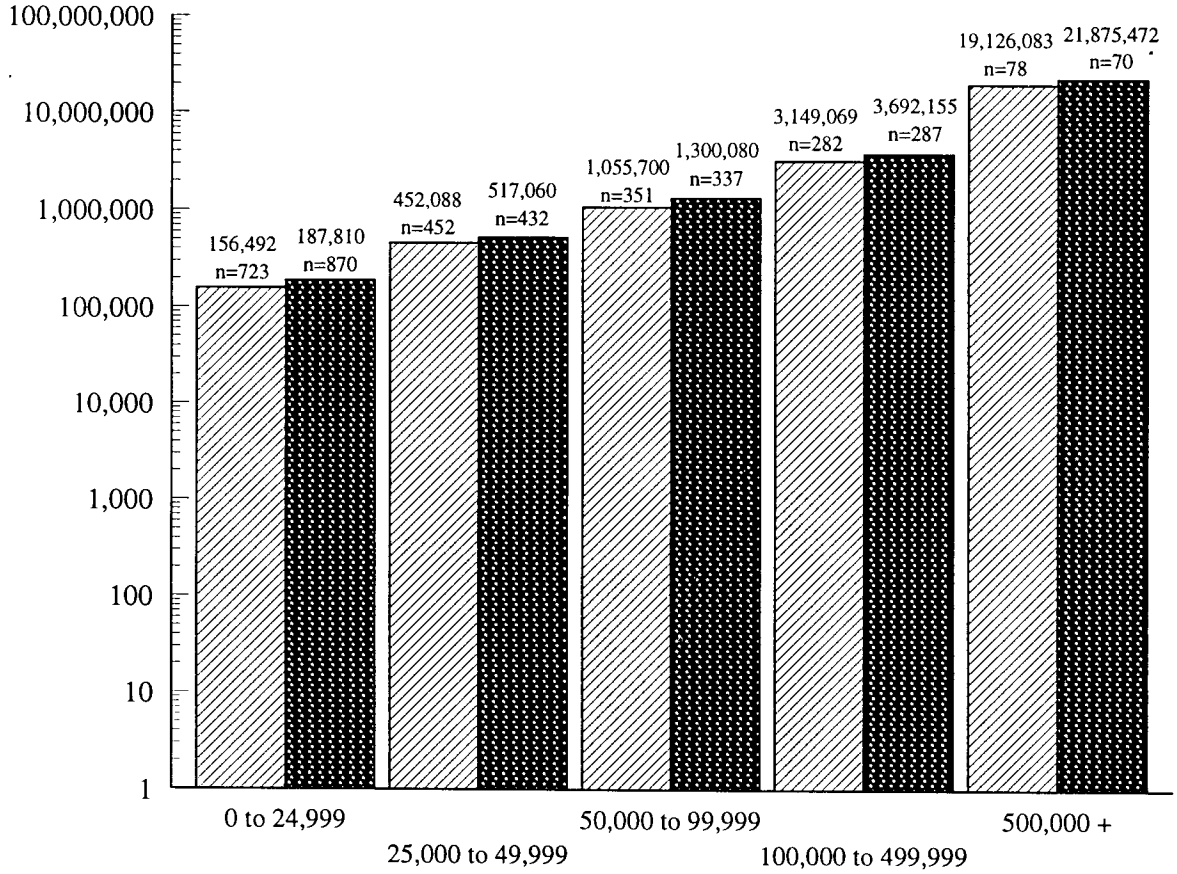


*Constant 1993 U.S. Dollars

n= number of respondents

Figure 10
Median Annual Expenditures of U.S. Local Health Departments by Population of Jurisdiction
1989 vs 1992-1993

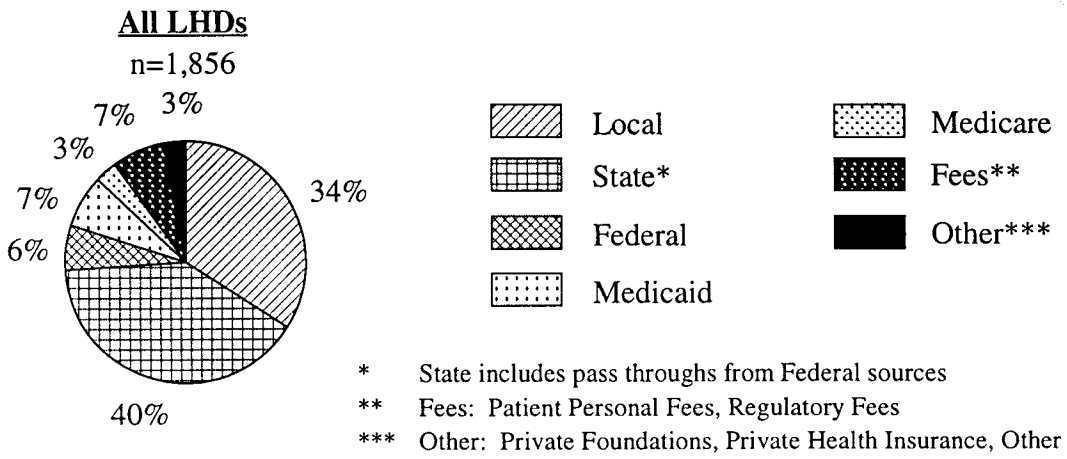
Annual Expenditures $*
Logarithmic Scale



*Constant 1993 U.S. Dollars

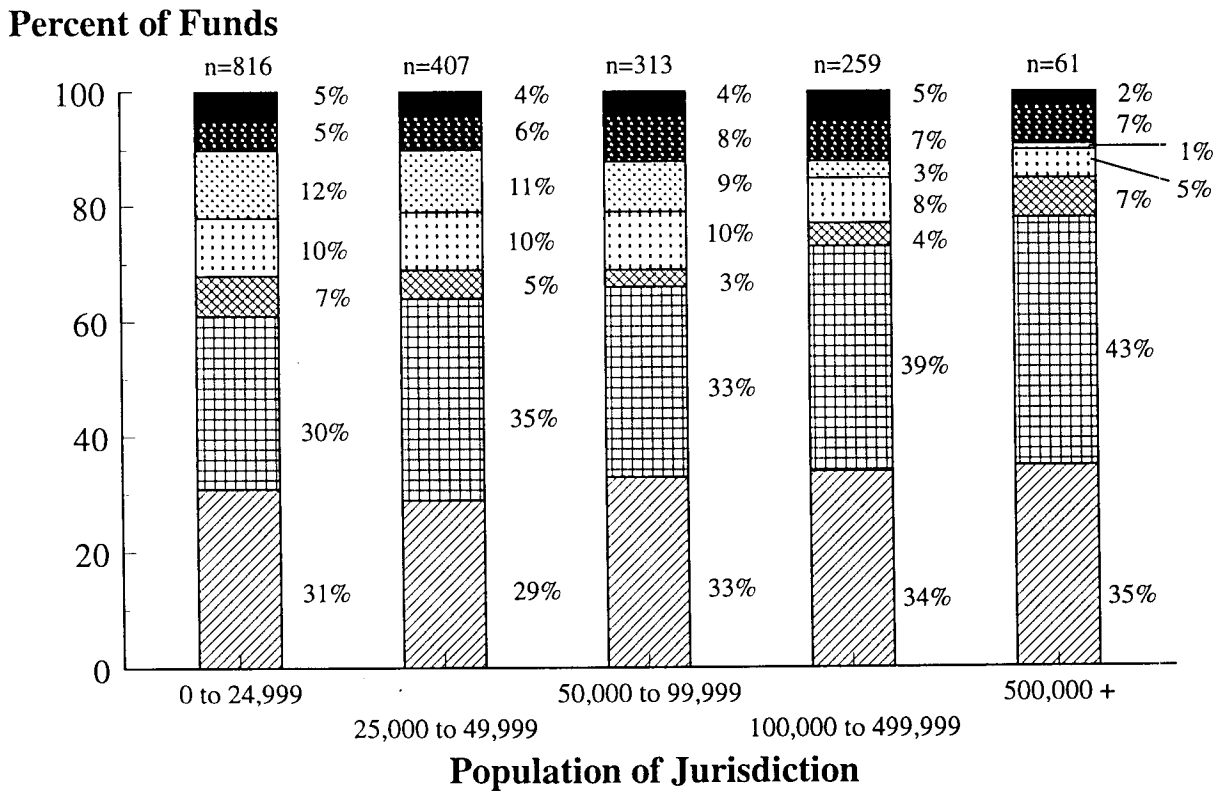
n= number of respondents

Figure 11
U.S. Local Health Department Funds by Source
1992-1993



* State includes pass throughs from Federal sources
** Fees: Patient Personal Fees, Regulatory Fees
*** Other: Private Foundations, Private Health Insurance, Other

By Population of Jurisdiction

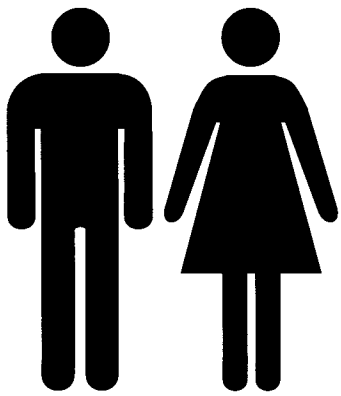


n= number of respondents

TOP AGENCY EXECUTIVE

Fast Facts

- 79% of LHDs have a full-time top agency executive.
- 60% of LHD top agency executives are male.
- 96.3% of LHD top agency executives are White.
- 95% of LHD top agency executives are non-Hispanic.
- 43% of LHD top agency executives have been in their current position less than 5 years.
- 37% of LHD top agency executives have a medical degree (MD, DO, DVM, DDS).



Top Agency Executive

Local Health Departments were questioned about the full-time status, tenure, degrees, gender, race, and ethnicity of the top agency executive. Similar information was requested in the 1989 study. The information, however, pertained to the local health officer. The top agency executive and the local health officer are often but not always the same individual. Therefore, no comparisons are made between the two studies in this section.

Full-Time Status

Figure 12 examines the percentage of LHDs with a full-time top agency executive. Seventy-nine percent (79%) of all LHDs report a full-time top agency executive. As demonstrated, the percentage of LHDs with a full-time top agency executive increased as the population of the jurisdiction increased. Whereas 69% of LHDs serving populations fewer than 25,000 reported a full-time agency executive, almost all (96%) of the responding LHDs serving populations of 500,000 or more reported a full-time top agency executive. The remaining 4% (3 of 73 LHDs) retain a part-time top agency executive. Most of the respondents in all population categories reported having a full-time agency executive, even in the category of LHDs serving populations under 25,000.

Gender

The gender of top agency executives is summarized in Figure 13. The percentage of LHDs reporting males in the top agency position is 60%; females, 40%. In the smaller jurisdictions of populations under 25,000, the reported male/female ratio is approximately 1:1, whereas in the population category of 100,000 to 499,999, the male/female ratio is approximately 3:1.

Race/Ethnicity

The reported race of top agency executives is White in 96.3% of LHDs, and the reported ethnicity is non-Hispanic in 95% of LHDs (Figure 14). As the size of the jurisdiction increases, the likelihood of reporting a non-White top agency executive increases. In the largest population category of 500,000 or more, the percentage of LHDs reporting a White top agency executives is 80%; Black, 14% (Figure 15).

Tenure

Figure 17 summarizes the length of time the top agency executive has served in that position. Most (68%) top agency executives have been in their current position fewer than ten years, and 43% fewer than five years. However, the data cannot be interpreted to mean that most of the top agency executives have fewer than ten years of total experience as a top agency executive, since this information pertains only to the current position. When categorized by population of jurisdiction, the data suggest LHDs that serve populations of 500,000 or more are least likely to have top agency executives who have been serving in that role for ten years or more (Figure 17).

Degrees

The degrees of top agency executives are summarized in Figure 18. Respondents indicated 37% of top agency executives have a medical degree (MD, DO, DVM, DDS). Of those with medical degrees, 11% have a medical degree in combination with an MPH or DrPH, and 1% have a medical degree in combination with selected graduate degrees (MEd, MPA, MBA, MS, or PhD). While the data suggest that 17% of top agency executives have an MPH or DrPH, it cannot be interpreted that only 17% have a graduate degree in public health, as other graduate degrees in public health are awarded and not included in these analyses. Also, the reader is cautioned not to interpret the data to suggest that the medical degree categories include all possible combinations. It is possible for the top agency executive to hold a medical degree in combination with another graduate degree not selected for these analyses. In such cases, this individual would fall within the "Other Degree/Other Combination of Degrees" category.

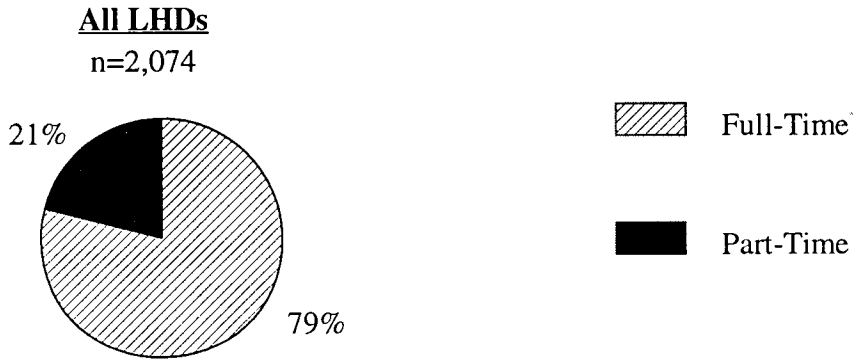
Figure 19 indicates the degrees of top agency executives by population subgroupings. As the population of the jurisdiction increases, the likelihood the top agency executive holds a medical degree in combination with a graduate public health degree also increases. Analysis also suggests that as the population increases it is less likely the top agency executive holds a medical degree or BSN only. In fact, no responding top agency executive in the 500,000 or more population category holds a BSN only.

In addition to requesting information about degrees held by the top agency executive, the *1992-1993 Profile* also asked, "If MD/DO was checked, is the degree required for the position?" Seventy-seven percent (77%) of the respondents stated that the degree was required for the position.

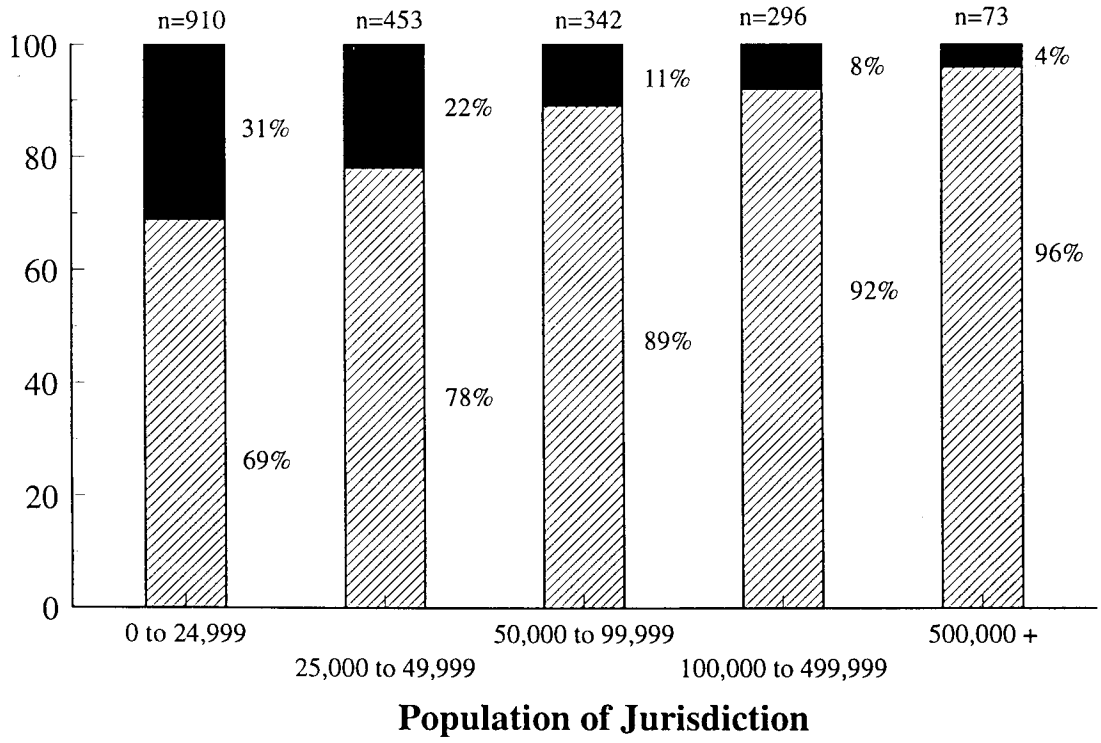
Figure 12

Full- and Part-Time Work Status of Top Agency Executives in U.S. Local Health Departments

1992-1993

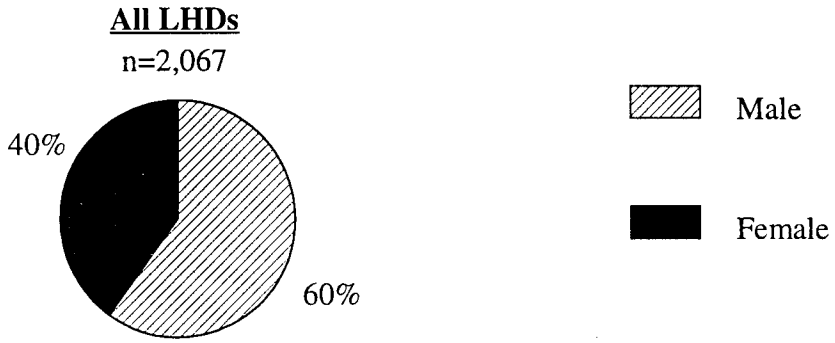


By Population of Jurisdiction

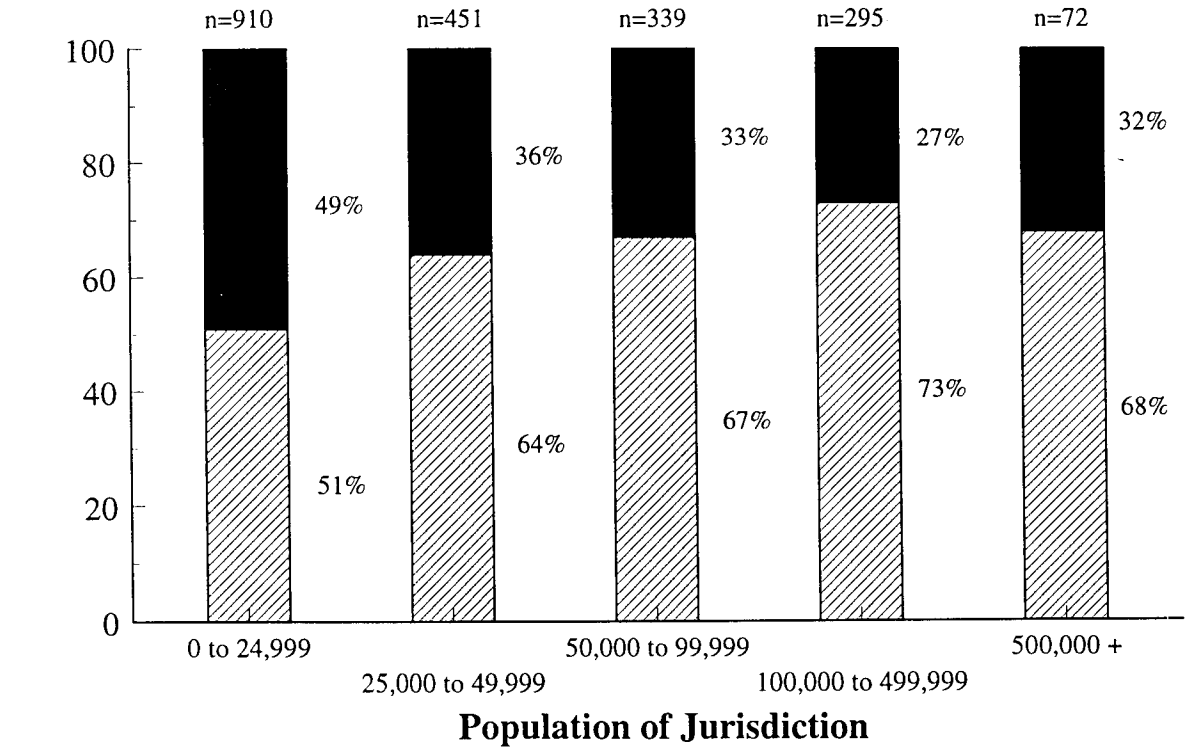


n= number of respondents

Figure 13
Gender of Top Agency Executives in U.S. Local Health Departments
1992-1993



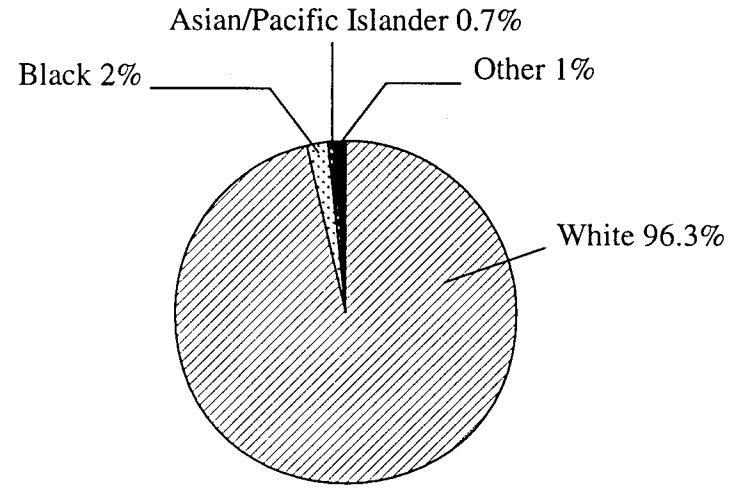
By Population of Jurisdiction



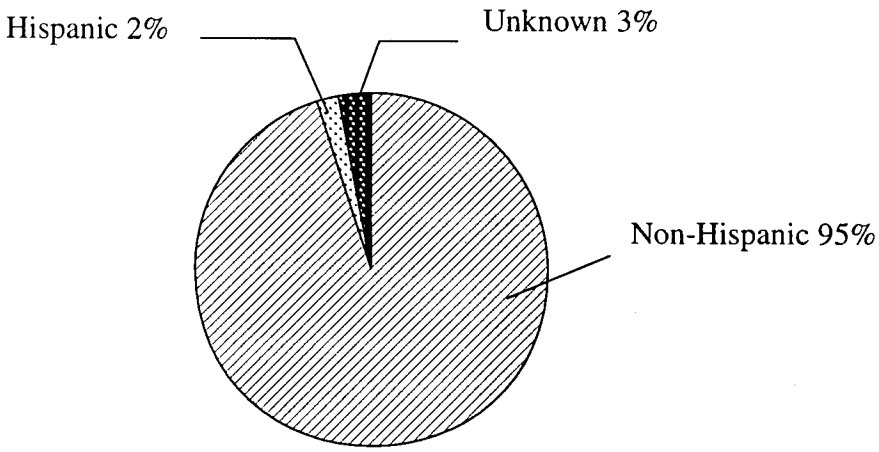
n= number of respondents

Figure 14
Race and Ethnicity of Top Agency Executives in U.S. Local Health Departments
1992-1993

Race
n=2,066



Ethnicity
n=2,015

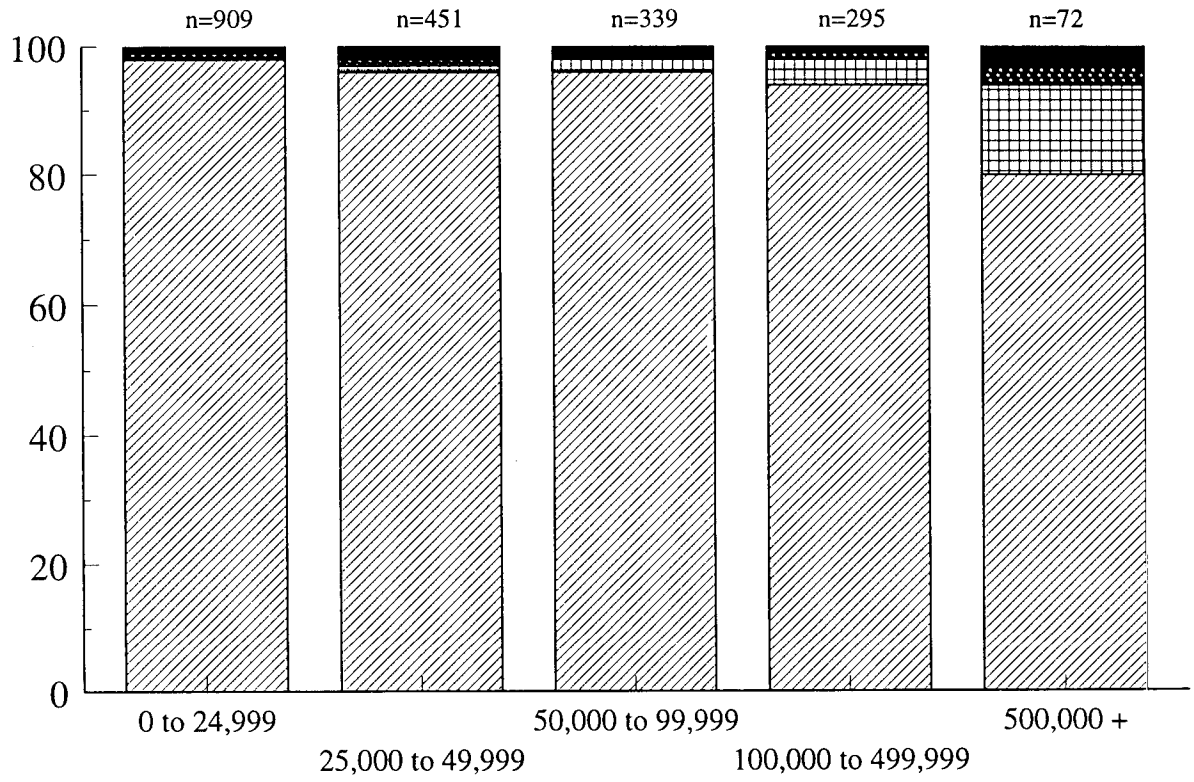


n= number of respondents

Figure 15

Race of Top Agency Executives in U.S. Local Health Departments by Population of Jurisdiction

1992-1993



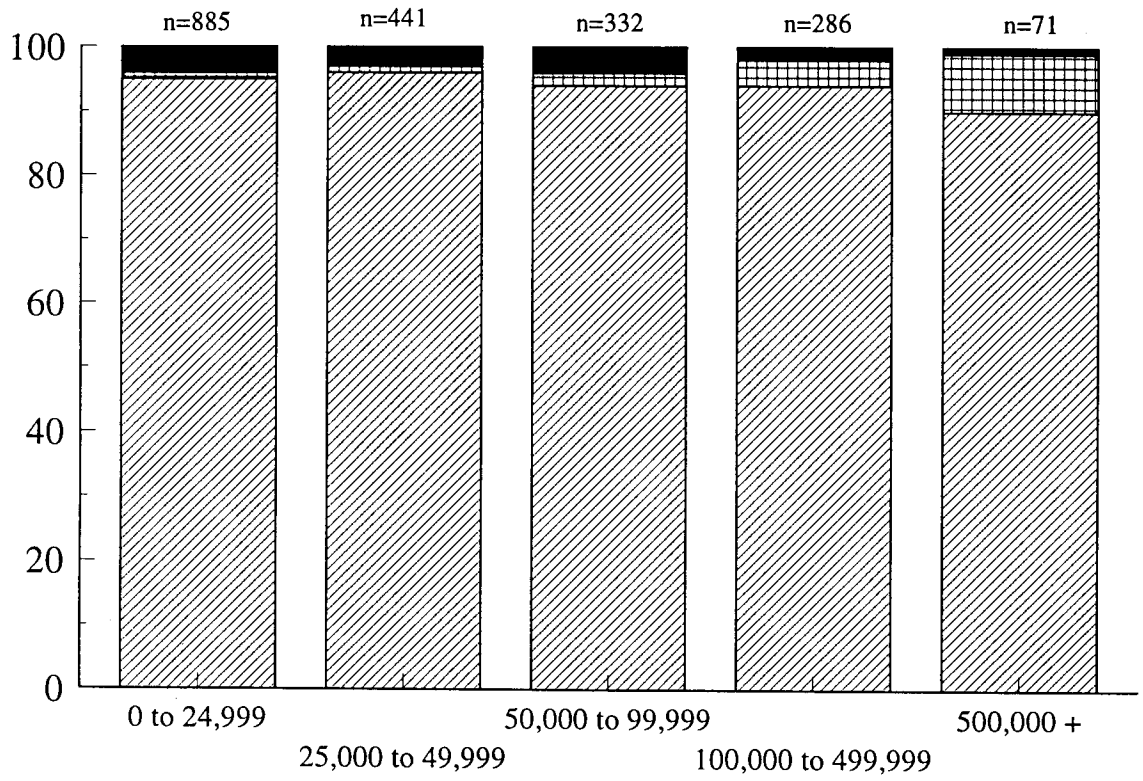
	0 to 24,999	25,000 to 49,999	50,000 to 99,999	100,000 to 499,999	500,000 +
White	98%	96%	96%	94%	80%
Black	0.4%	1.0%	2.0%	4.0%	14.0%
Asian/Pacific Islander	0.6%	1.0%	0.0%	1.0%	3.0%
Other	1.0%	2.0%	2.0%	1.0%	3.0%

n= number of respondents

Figure 16

Ethnicity of Top Agency Executives in U.S. Local Health Departments by Population of Jurisdiction

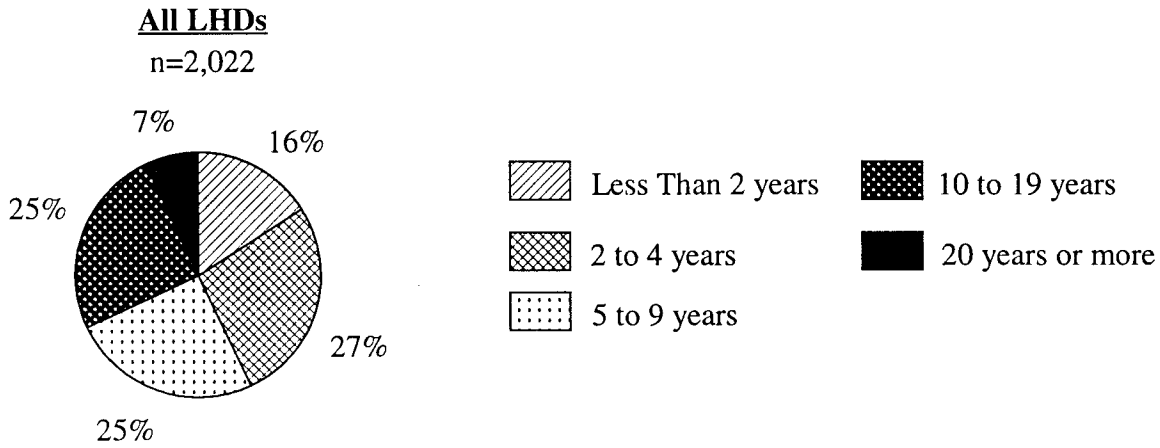
1992-1993



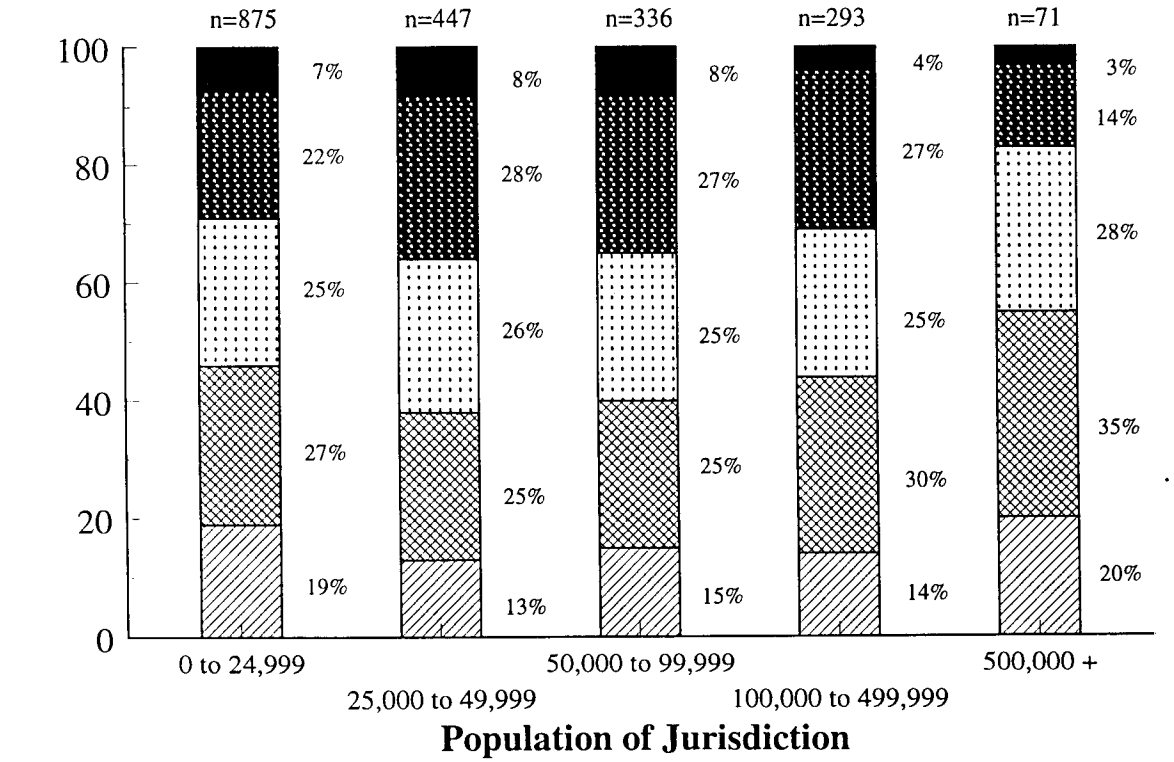
	0 to 24,999	25,000 to 49,999	50,000 to 99,999	100,000 to 499,999	500,000 +
Non-Hispanic	95%	96%	94%	94%	90%
Hispanic	1%	1%	2%	4%	9%
Unknown	4%	3%	4%	2%	1%

n= number of respondents

Figure 17
Tenure of Top Agency Executives in U.S. Local Health Departments (Years Through 12/93)
1992-1993



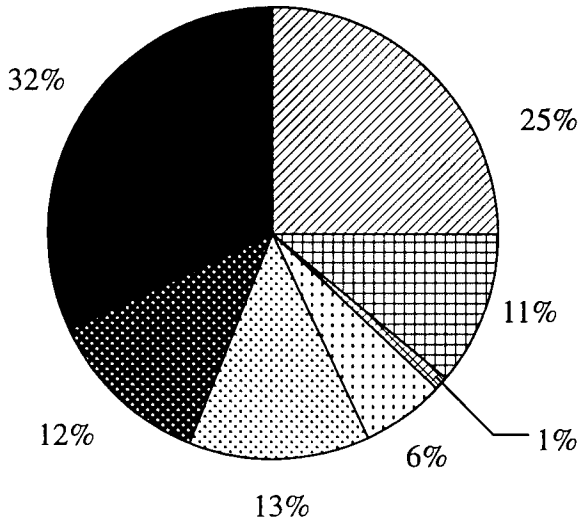
By Population of Jurisdiction



n= number of respondents

Figure 18
Degrees of Top Agency Executives in U.S. Local Health Departments
1992-1993

All LHDs
n=1,829



- Medical Degree
- Medical Degree & Graduate Public Health Degree
- Medical Degree & Selected Graduate Degree
- Graduate Public Health Degree Only
- Selected Graduate Degree
- BSN
- Other Degree/Other Combination of Degrees

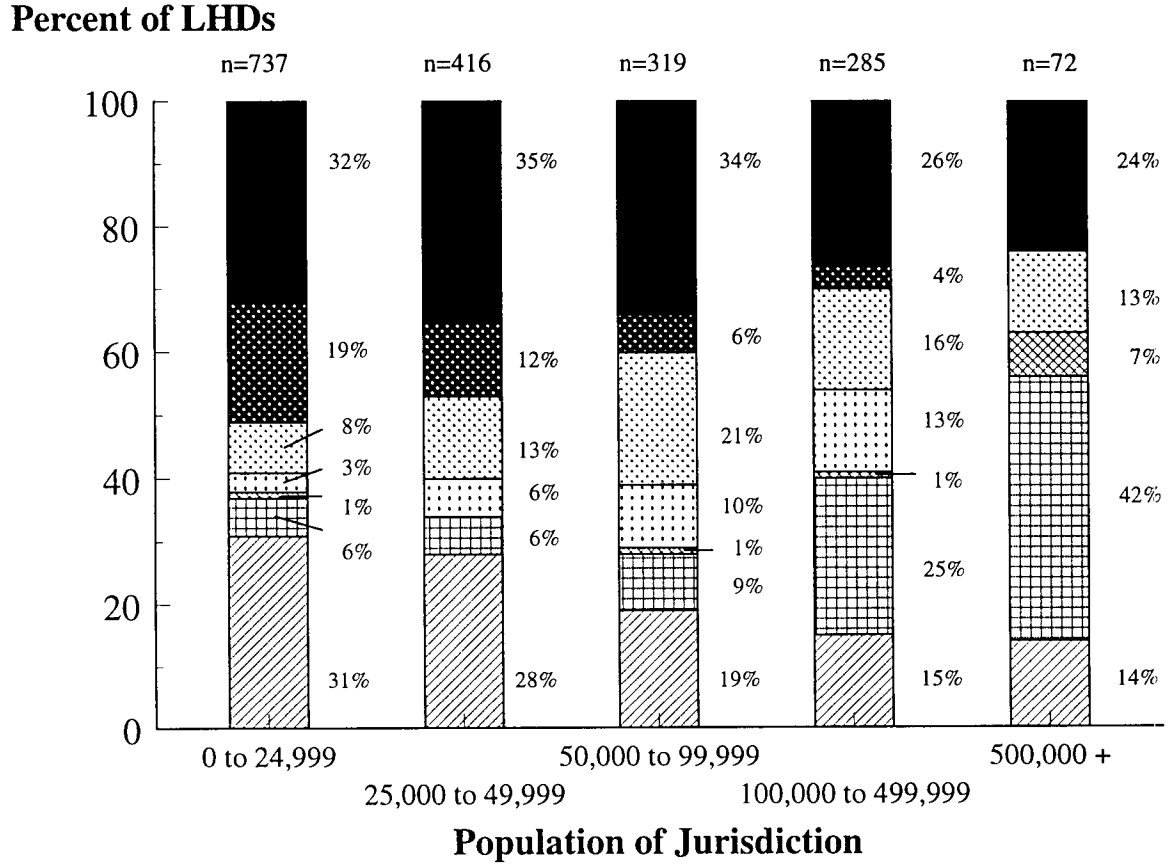
Medical Degrees: MD, DO, DVM, DDS
Graduate Public Health Degrees: MPH, DrPH
Selected Graduate Degrees: MEd, MPA, MBA, MS, PhD

n= number of respondents

Figure 19

Degrees of Top Agency Executives in U.S. Local Health Departments by Population of Jurisdiction

1992-1993



Medical Degree

Medical Degree & Graduate Public Health Degree

Medical Degree & Selected Graduate Degree

Graduate Public Health Degree Only

Selected Graduate Degree

BSN

Other Degree/Other Combination of Degrees

Medical Degrees: MD, DO, DVM, DDS
Graduate Public Health Degrees: MPH, DrPH
Selected Graduate Degrees: MEd, MPA, MBA, MS, PhD

n= number of respondents

PERSONNEL

Fast Facts

- 42% of LHDs have fewer than ten full-time staff members.
- 33% of LHDs have 25 or more full-time staff members.
- 74% of LHDs in the under 50,000 population category have fewer than ten employees.
- 90% of LHDs in the 500,000 or more population category have 100 employees or more.

Personnel

Full-Time Employees

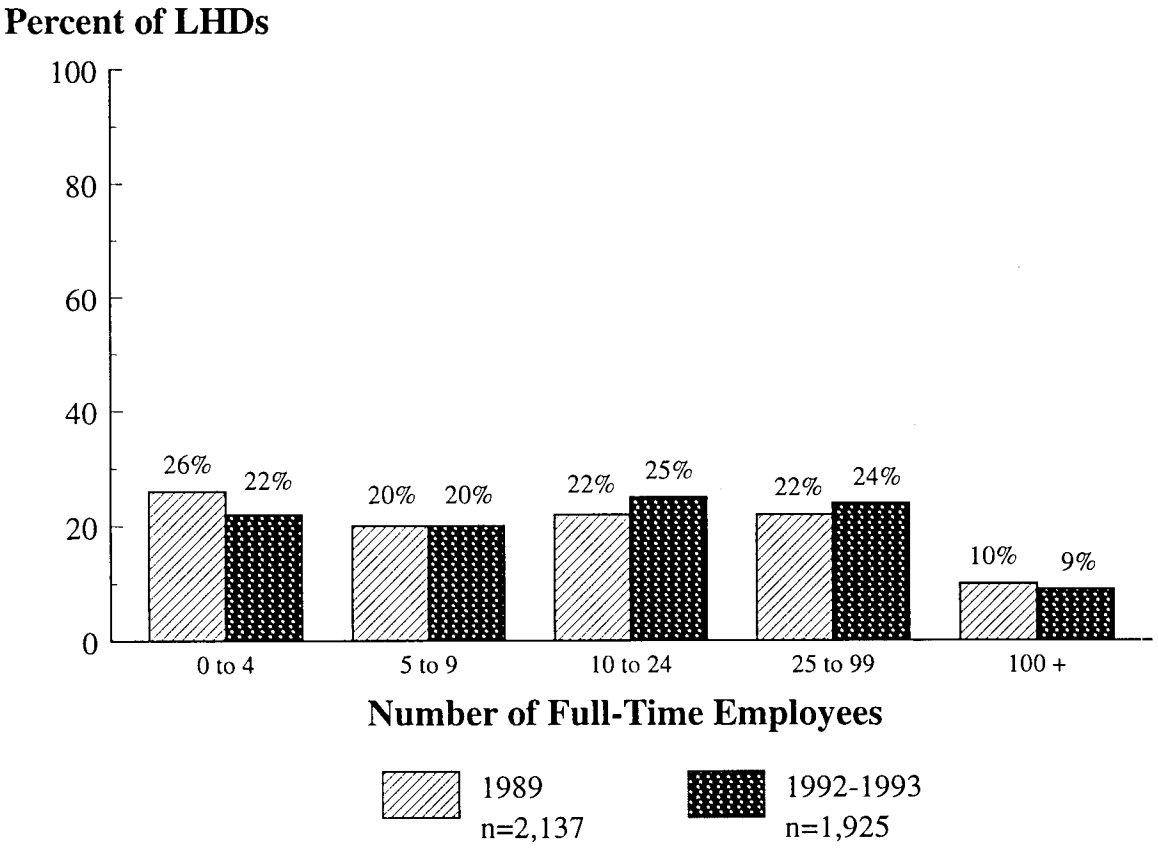
As demonstrated on Figure 20, in 1992-1993 42% percent of all responding LHDs have fewer than ten full-time staff members. Approximately one-third (33%) of LHDs have 25 or more full-time staff members. As the figure demonstrates, full-time staffing levels are essentially unchanged from the 1989 study.

The number of full-time employees by population of the jurisdiction was also examined. In the under 50,000 population category, 74% of LHDs have fewer than ten employees, whereas in the largest population category of 500,000 or more, 90% of LHDs reported 100 employees or more.

Figure 20

U.S. Local Health Departments by Number of Full-Time Employees

1989 vs 1992-1993



By Population of Jurisdiction

		0 to 24,999 n=817	25,000 to 49,999 n=431	50,000 to 99,999 n=326	100,000 to 499,999 n=282	500,000 + n=69
Number of Employees	0 to 4	44%	15%	1%	0%	1%
	5 to 9	30%	24%	10%	1%	0%
	10 to 24	22%	40%	31%	8%	3%
	25 to 99	4%	21%	54%	54%	6%
	100 +	0%	0%	4%	37%	90%

n= number of respondents

POLICY AND PLANNING ACTIVITIES

Fast Facts

- 70% of LHDs have used *Healthy People 2000* for program and/or organizational planning.
- 12% of LHDs have used PATCH for program and/or organizational planning.
- 47% of LHDs have used *Healthy Communities 2000: Model Standards* for program and/or organizational planning.
- 32% of LHDs have used APEX*PH* for program and/or organizational planning.
- 32% of LHDs have a long-term plan setting health priorities.

Policy and Planning Activities

Use of *Healthy People 2000*

When asked about their planning activities, 70% of the responding LHDs reported using *Healthy People 2000: Objectives for the Nation* (*HP2000*) for program and/or organizational planning (Figure 21). Furthermore, Figure 21 indicates that LHDs serving larger populations are more likely to use *HP2000* than are those serving smaller jurisdictions. Of the respondents in the under 25,000 population category, 59% reported using the document, compared with 92% in the 500,000 and more population category.

Use of Planning Tools

Approximately half of the respondents (47%) have used *Healthy Communities 2000: Model Standards* (Figure 22). The first iteration of *Model Standards* was released in 1979. By comparison, about one-third (32%) of the respondents reported using the *Assessment Protocol for Excellence in Public Health* (APEX*PH*) (Figure 23), released in 1991; 12% reported using *Planned Approach to Community Health* (PATCH) (Figure 24), released in 1987; and 6% reported using *Healthy Cities*, initiated in 1988 (Figure 25).

The population subgroupings in Figures 22-25 demonstrate increased use of *Healthy Communities 2000: Model Standards*, APEX*PH*, PATCH, and *Healthy Cities* as the population of the jurisdiction increases (Figures 22-25).

Long-Term Planning

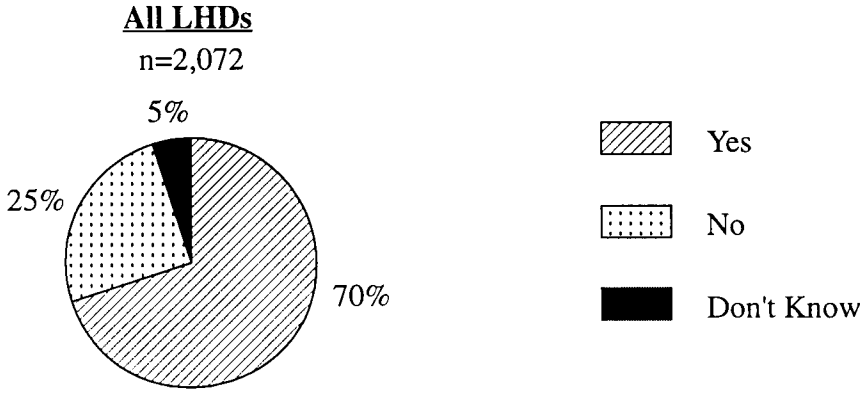
When asked whether they have a long-term plan (5-7 years) for setting health priorities, 32% responded "Yes" (Figure 26). Furthermore, as size of the population served increases, the likelihood of having a long-term health priority plan also increases.

Figure 27 demonstrates that of those respondents who state they have a long-term plan (5-7 years) setting health priorities, 66% have used a planning model, such as *Healthy People 2000*, *Model Standards*, PATCH, or APEX*PH*, to develop the plan.

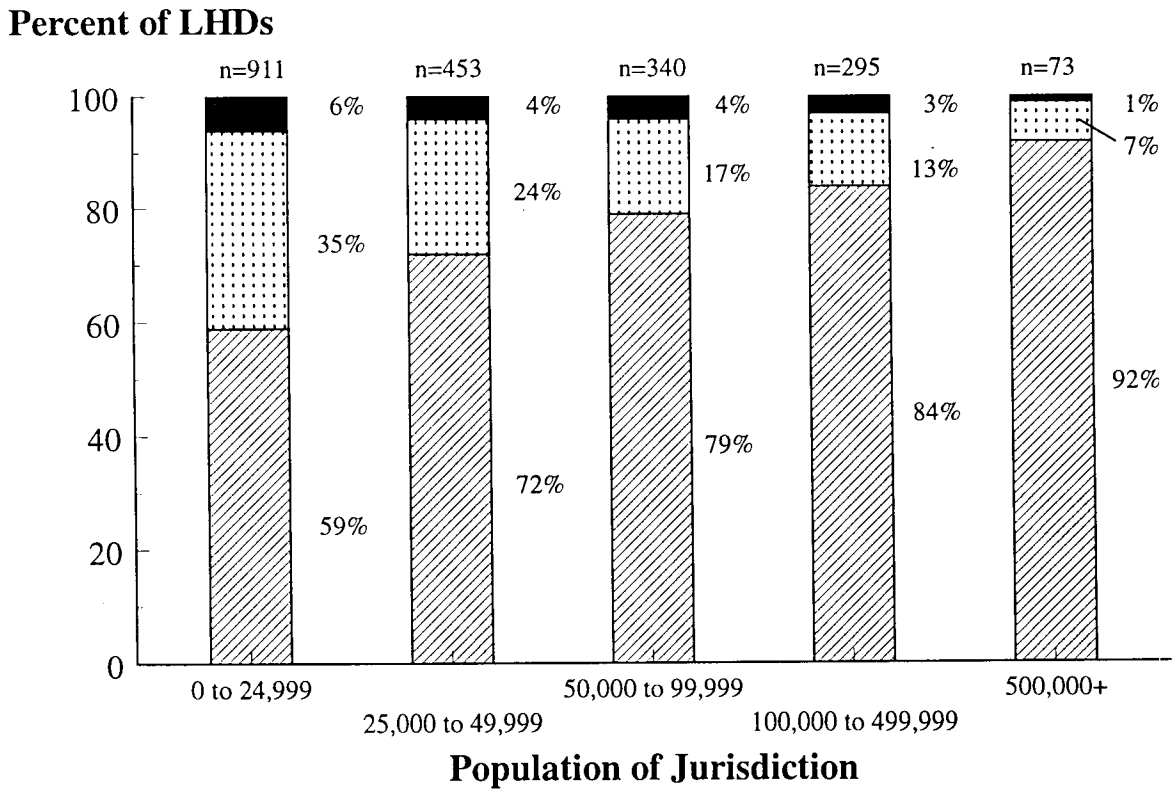
Figure 21

Use of *Healthy People 2000* for Program and/or Organizational Planning in U.S. Local Health Departments

1992-1993



By Population of Jurisdiction

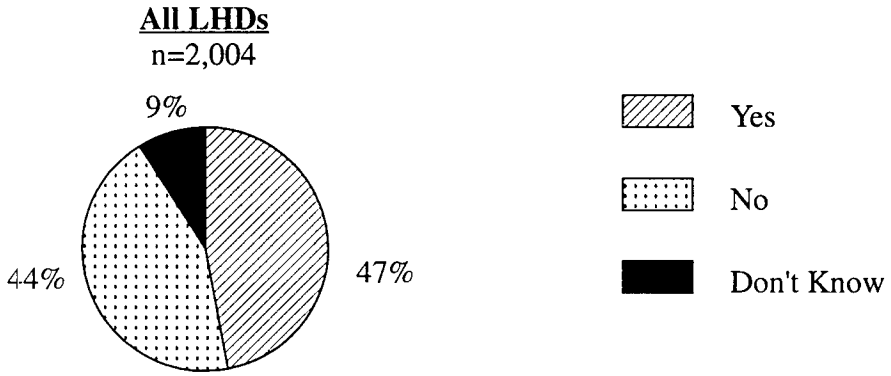


n= number of respondents

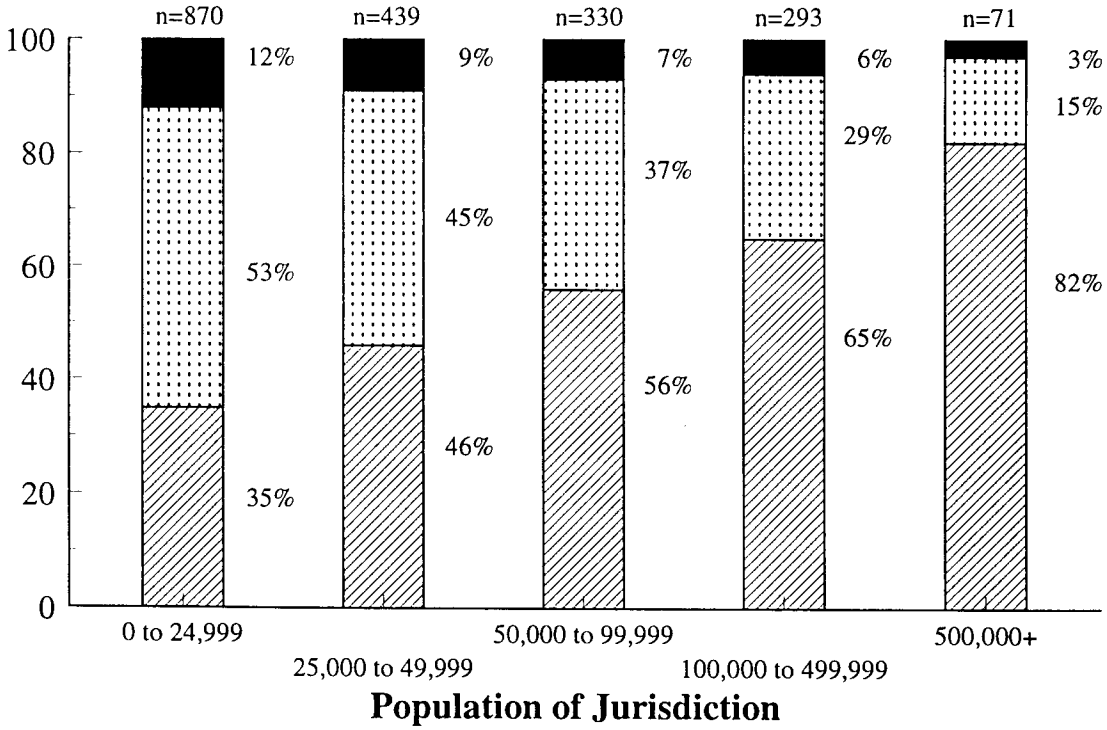
Figure 22

Use of *Healthy Communities 2000: Model Standards* for Program and/or Organizational Planning in U.S. Local Health Departments

1992-1993



By Population of Jurisdiction

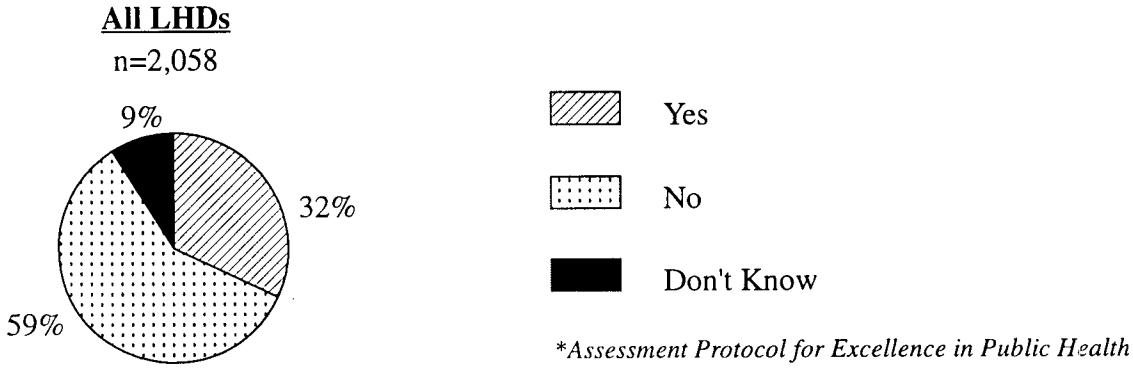


n= number of respondents

Figure 23

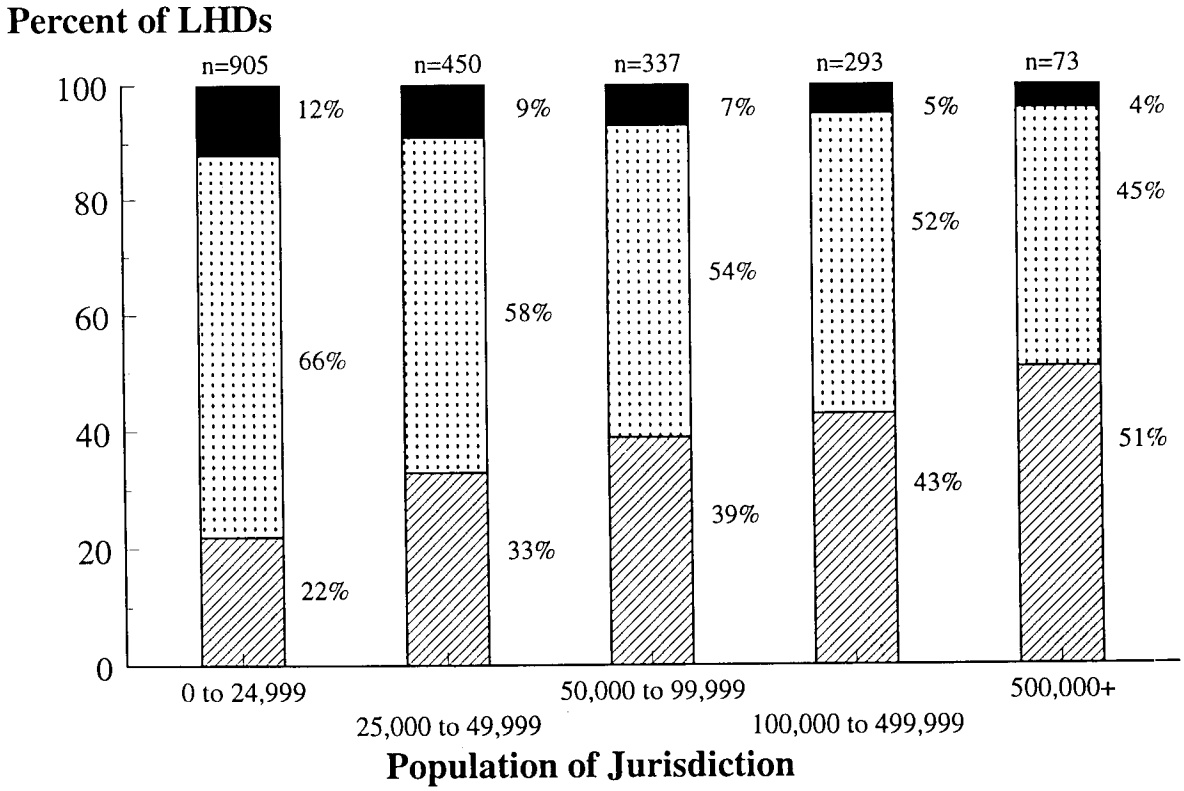
Use of APEX*PH** for Program and/or Organizational Planning in U.S. Local Health Departments

1992-1993



Assessment Protocol for Excellence in Public Health

By Population of Jurisdiction

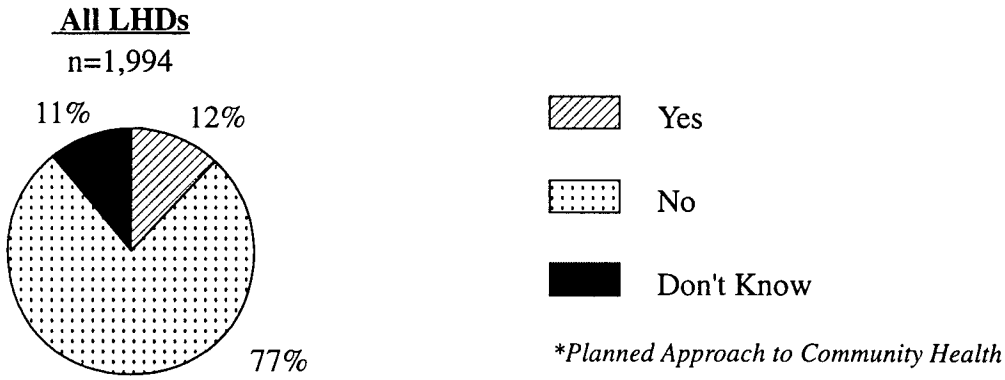


n= number of respondents

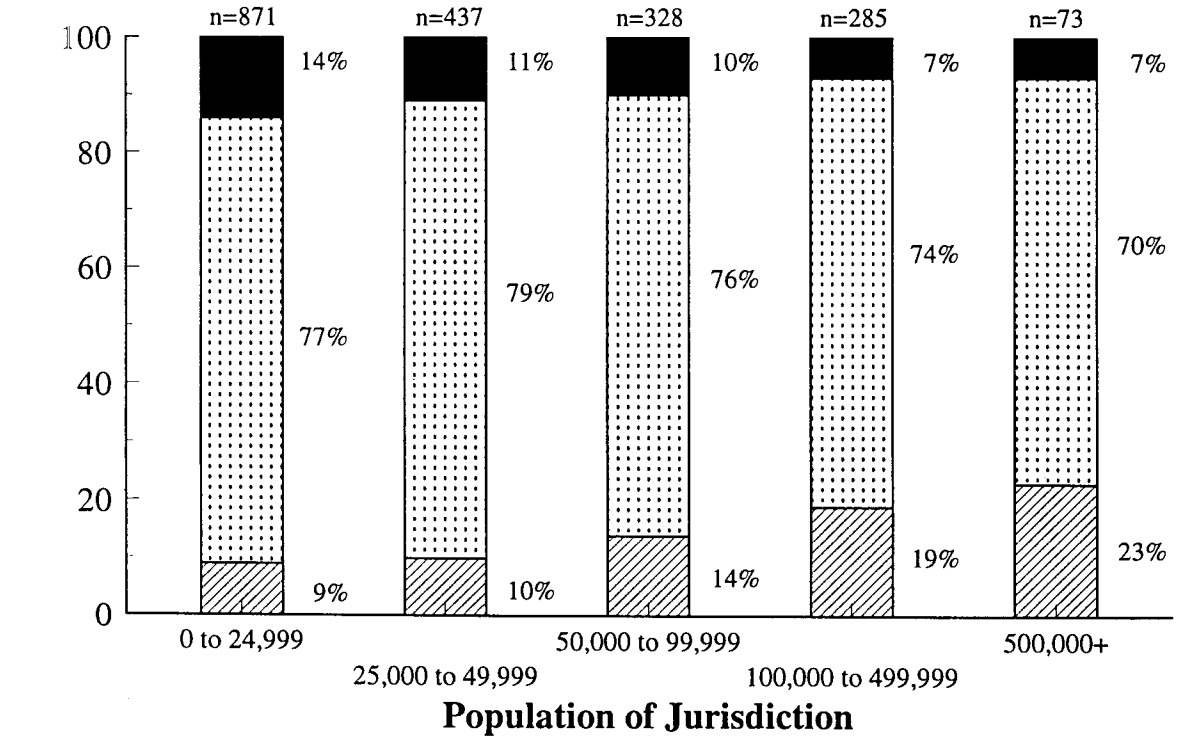
Figure 24

Use of PATCH* for Program and/or Organizational Planning in U.S. Local Health Departments

1992-1993



By Population of Jurisdiction

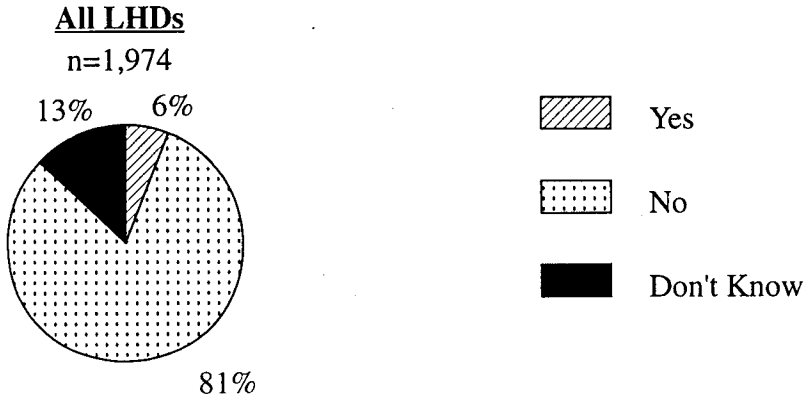


n= number of respondents

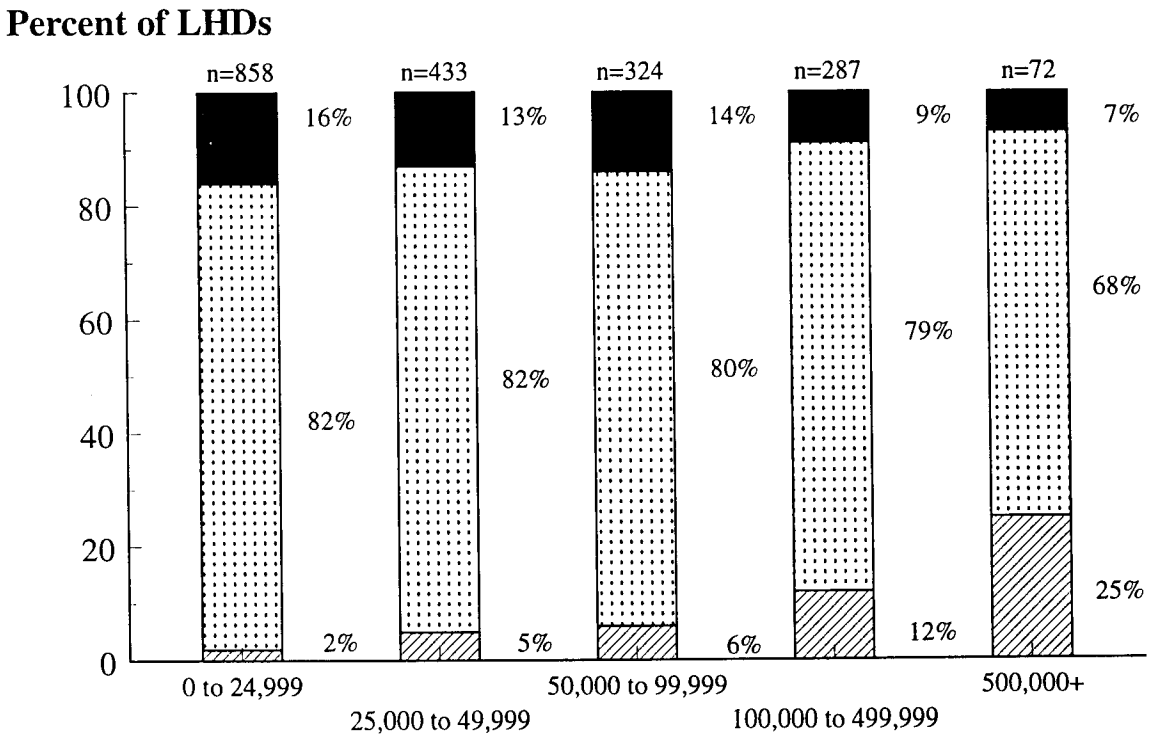
Figure 25

Use of *Healthy Cities* for Program and/or Organizational Planning in U.S. Local Health Departments

1992-1993

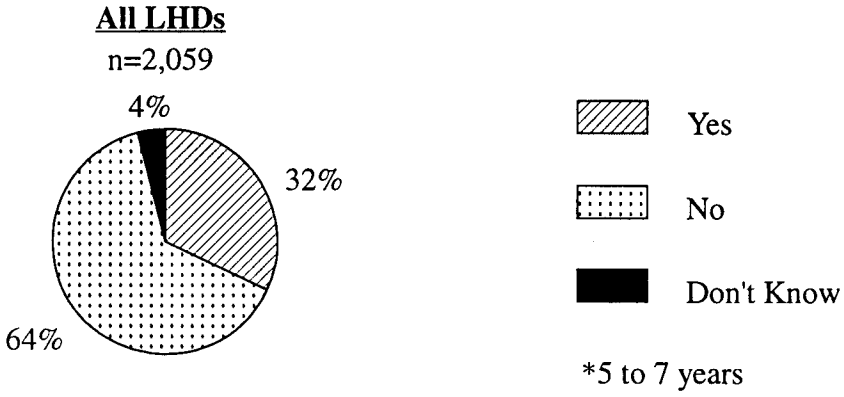


By Population of Jurisdiction

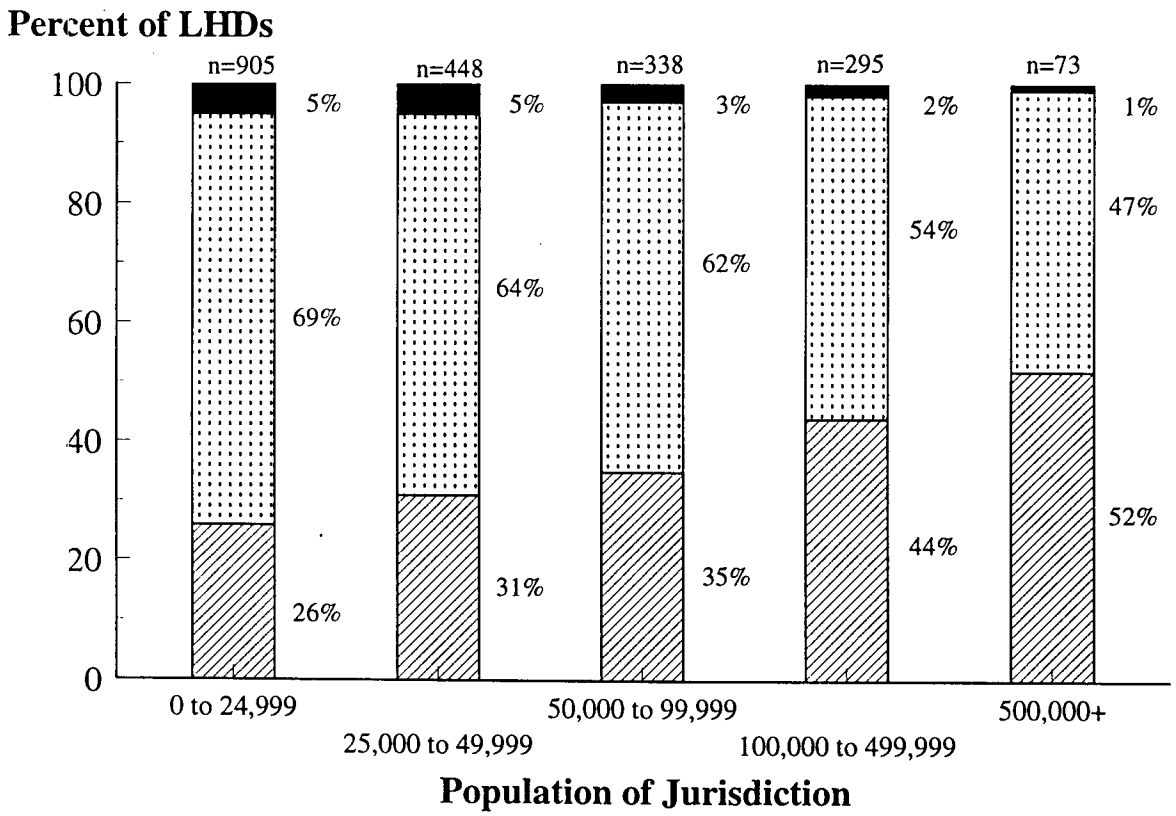


n= number of respondents

Figure 26
U.S. Local Health Departments with a Long-Term Plan* Setting Health Priorities
1992-1993



By Population of Jurisdiction

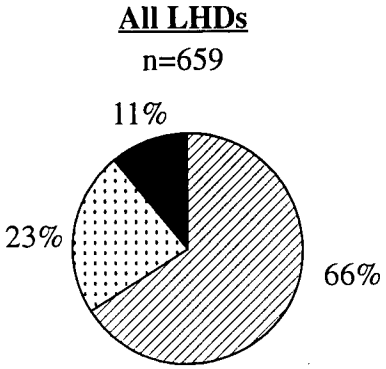


n= number of respondents

Figure 27

U.S. Local Health Departments with a Long-Term Plan* Setting Health Priorities That Used a Planning Model**

1992-1993

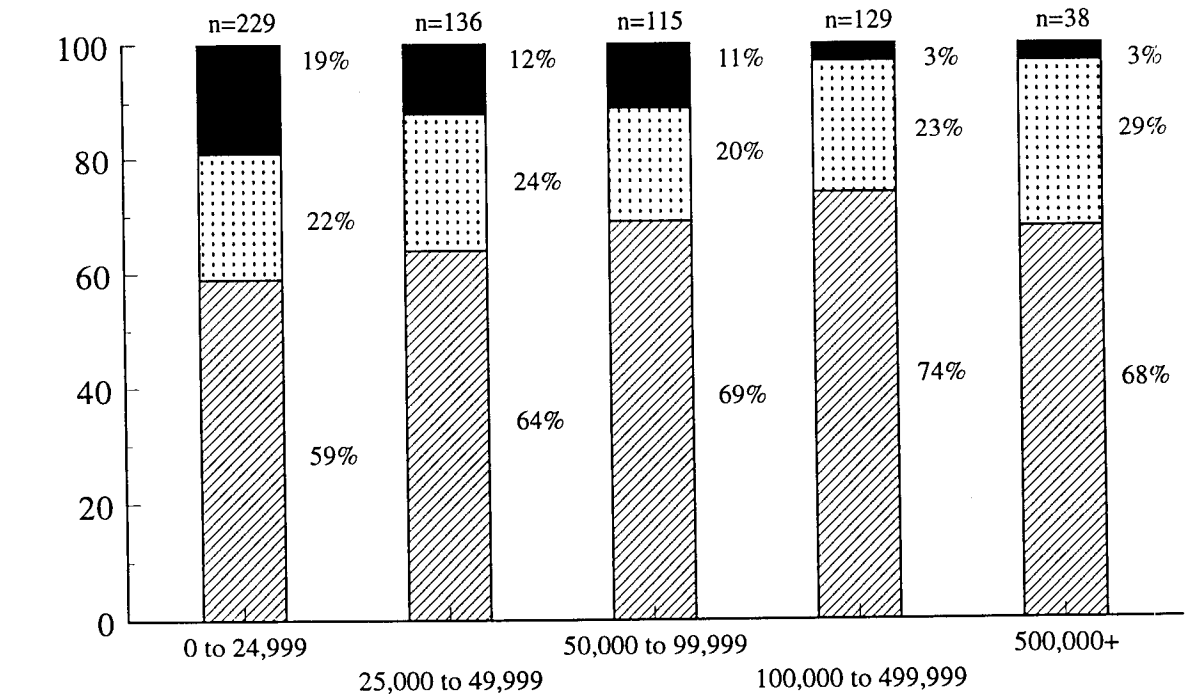


Yes
No
Don't Know

*5 to 7 years

**Models
Healthy People 2000
Healthy Communities 2000: Model Standards
PATCH
APEX*PH*

By Population of Jurisdiction

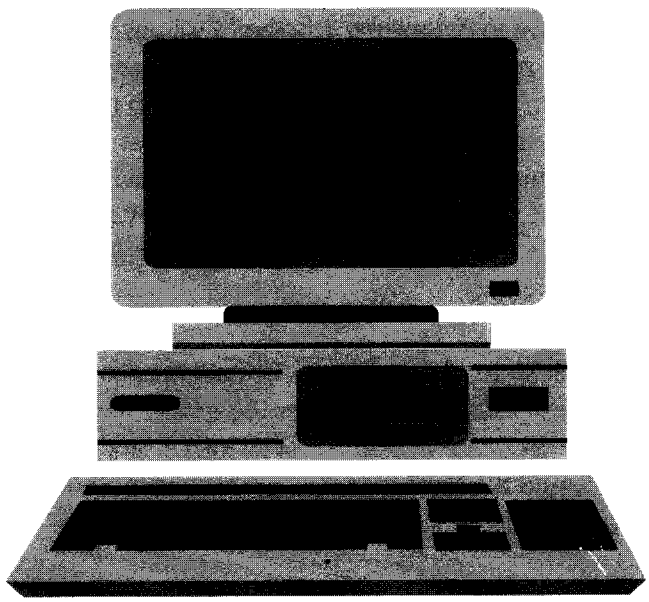


n= number of respondents

DATA COLLECTION

Fast Facts

- 57% of LHDs have responsibility to collect and maintain vital statistics for their jurisdiction.
- 82% of LHDs maintain communicable diseases surveillance data.
- 57% of LHDs evaluate the availability of and need for clinical preventive services. Of these LHDs, 83% provide programs to fill the identified gaps.
- 45% of LHDs collect data to document the number of providers of clinical preventive services.
- 76% of LHDs assess the extent to which screening, immunization, and counseling services are provided by other providers in the jurisdiction.



Data Collection

Vital Records

Fifty-seven percent (57%) of the LHDs indicated they have responsibility to collect and maintain vital statistics for their jurisdiction.

Surveillance Data by Selected Category

Of the respondents, 82% reported maintaining communicable disease surveillance data (Figure 28). In LHDs serving 500,000 or more, 5% of LHDs did not report maintaining communicable disease surveillance data. These were verified by telephone. In each of these cases the LHD representative stated that although it does not maintain communicable disease data, these data are collected and forwarded to the state health department where it is compiled and made available to LHDs. It is possible this situation applies to other size LHDs and other categories of surveillance data.

Fewer than 50% of all respondents reported maintaining surveillance activities in other selected data surveillance categories: drinking water, 49%; chronic disease, 42%; recreational water, 30%; behavioral risk factors, 20%; injury, 19%; and air quality, 14% (Figure 28). For each of the selected categories, LHDs with jurisdictions with larger populations tend to maintain surveillance data more often than smaller jurisdictions.

Clinical Preventive Services

Figure 29 indicates that almost half (45%) of responding LHDs document the number of providers of clinical preventive services (e.g., private providers, publicly funded clinics, hospital outpatient centers).

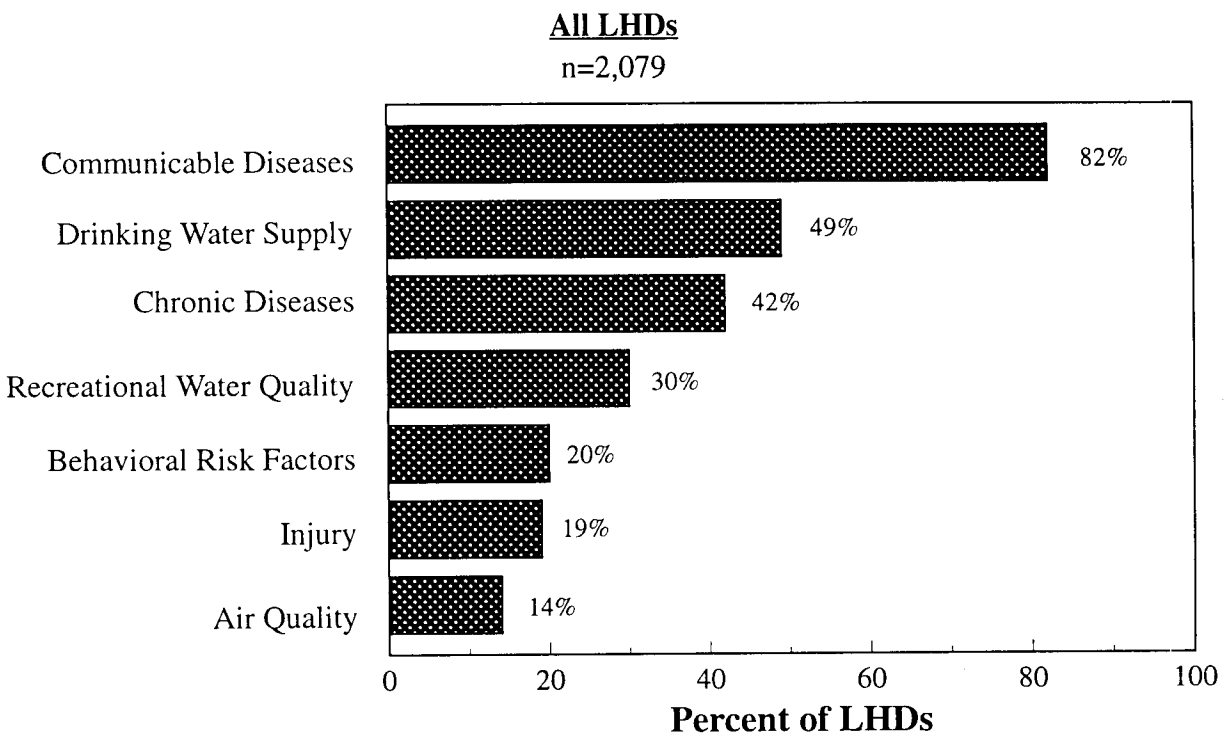
Overall, 57% of LHDs evaluate to determine whether a gap exists between availability of and need for clinical preventive services in their jurisdictions (Figure 30). Again, as the population of the jurisdiction increases, LHDs are more likely to perform this assessment.

Those 57% of LHDs that evaluate to determine whether a gap exists between available clinical preventive services and a need for those services were asked whether they provide clinical preventive service programs to fill the gaps they identify. Figure 30 indicates 83% provide programs to fill the identified gaps.

Screening, Immunization, and Counseling Services

Overall, 76% of the respondents stated they assess the extent to which screening, immunization, and counseling services (components of clinical preventive services) are provided to the local population (Figure 31). Population subgroupings are also provided. These data indicate little variation across the population categories.

Figure 28
U.S. Local Health Departments That Maintain Surveillance Data by Selected Category
1992-1993



By Population of Jurisdiction

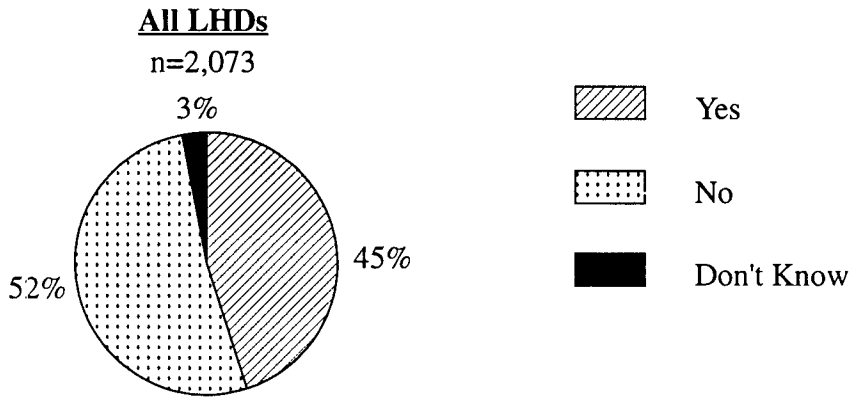
	0 to 24,999 n=915	25,000 to 49,999 n=453	50,000 to 99,999 n=296	100,000 to 499,999 n=296	500,000+ n=73
Communicable Diseases	76%	84%	85%	90%	95%
Drinking Water Supply	44%	48%	53%	58%	67%
Chronic Diseases	36%	45%	46%	46%	60%
Recreational Water Quality	24%	30%	33%	38%	60%
Behavioral Risk Factors	15%	21%	24%	25%	37%
Injury	15%	18%	21%	21%	47%
Air Quality	10%	11%	13%	21%	45%

n= number of respondents

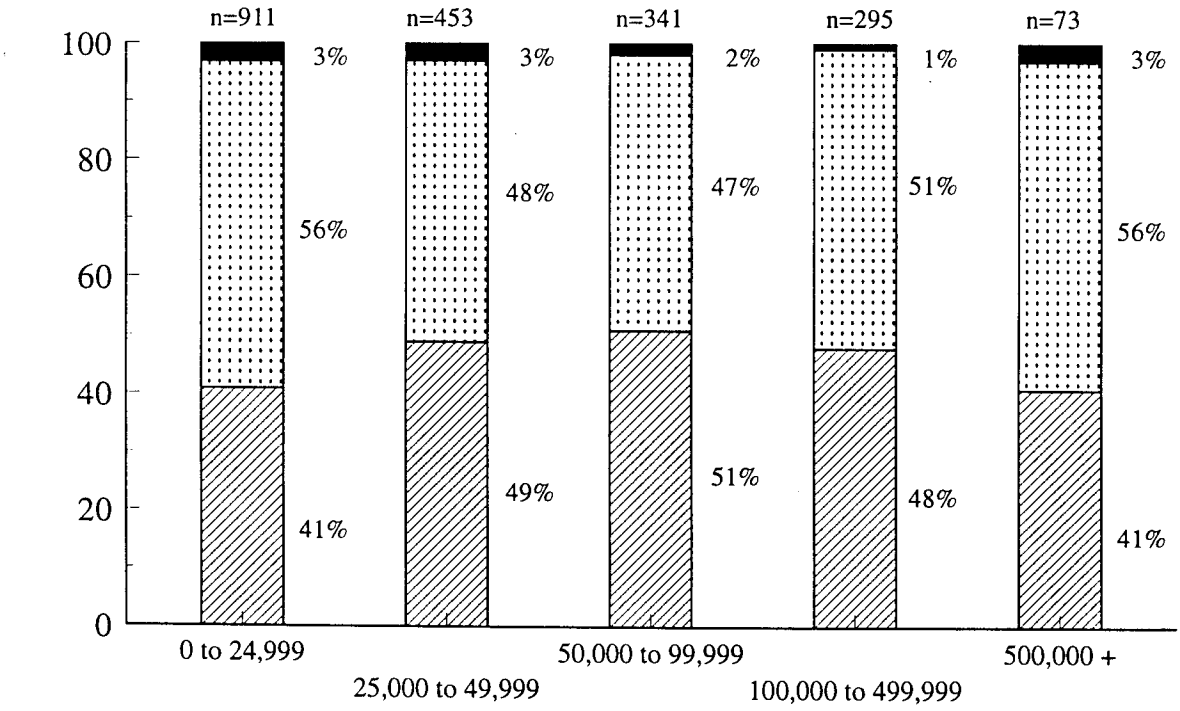
Figure 29

U.S. Local Health Departments That Collect Data on the Number of Providers of Clinical Preventive Services

1992-1993



By Population of Jurisdiction

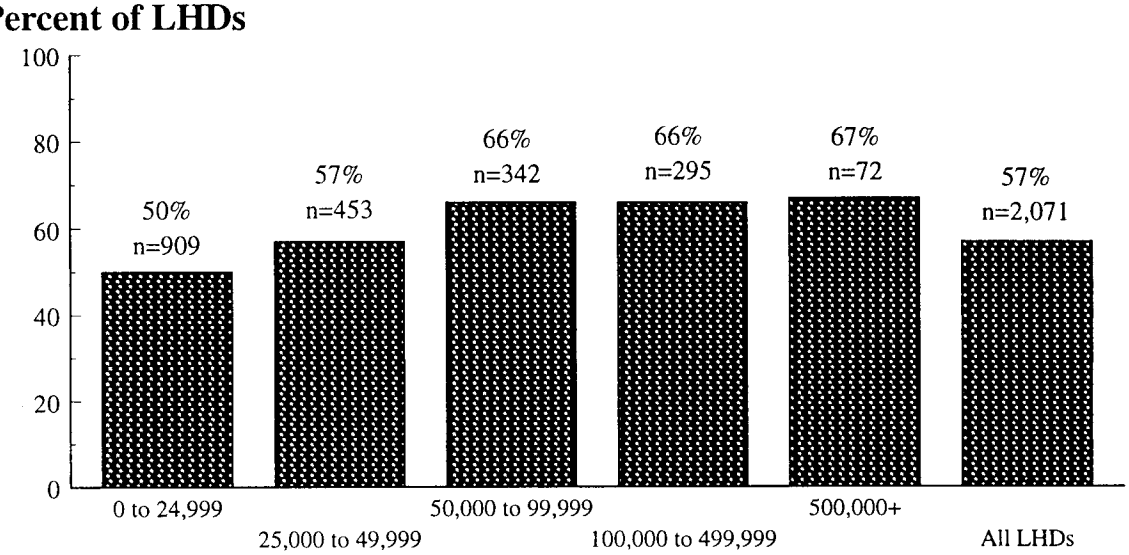


n= number of respondents

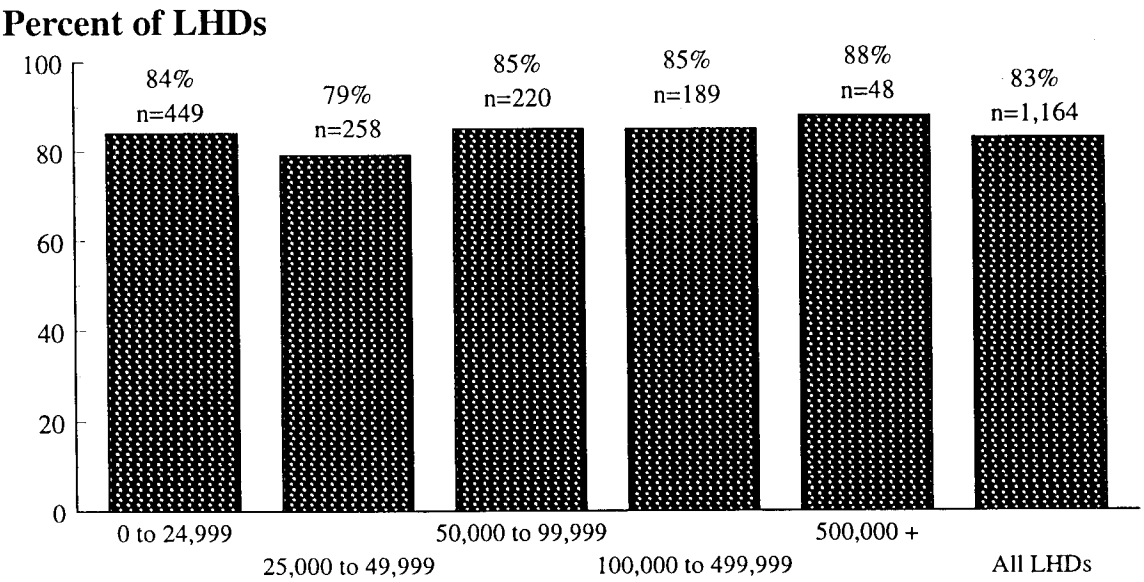
Figure 30

U.S. Local Health Departments That Evaluate to Identify Gaps Between Availability of and Need for Clinical Preventive Services All LHDs and by Population of Jurisdiction

1992-1993



LHDs Providing Programs to Fill Identified Gaps

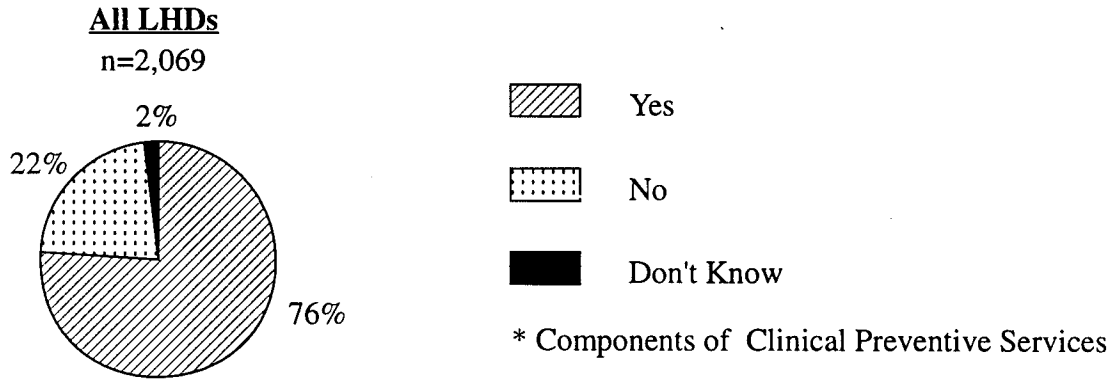


n= number of respondents

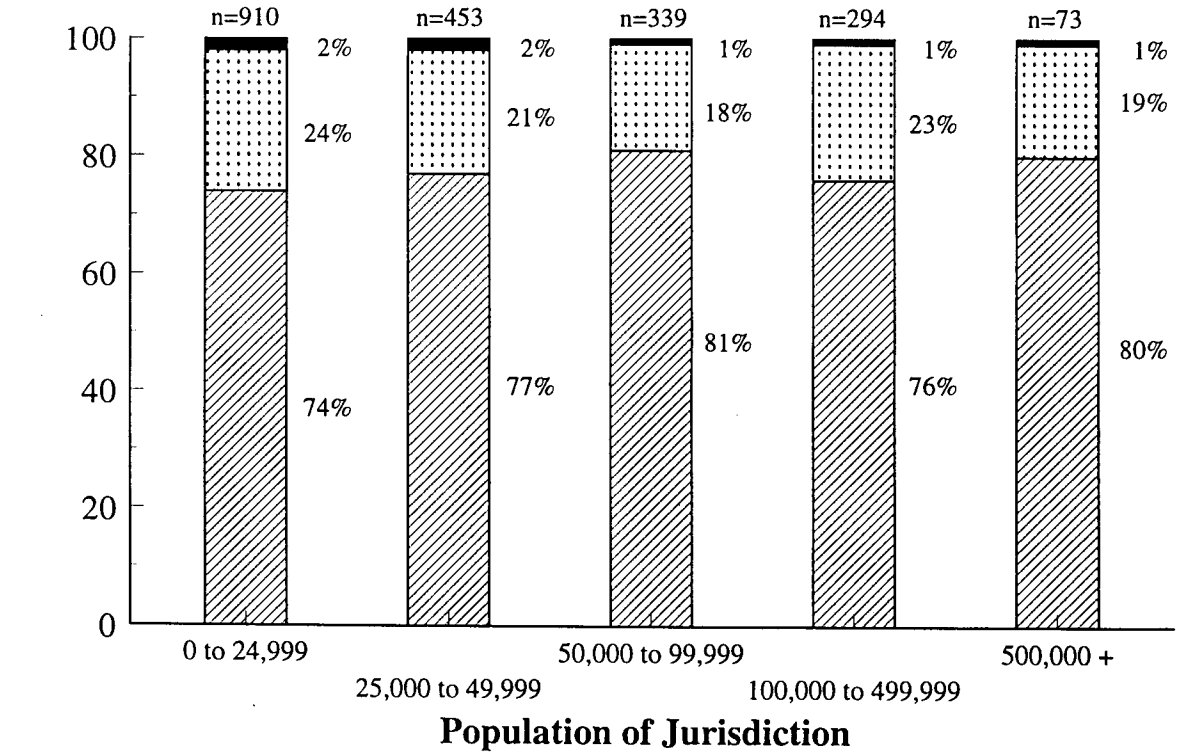
Figure 31

U.S. Local Health Departments That Assess the Extent to Which Screening, Immunization, and Counseling Services* Are Provided

1992-1993



By Population of Jurisdiction



n= number of respondents

AGENCY SERVICES

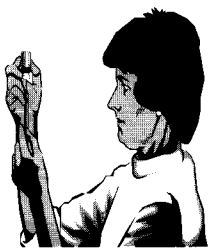
Fast Facts

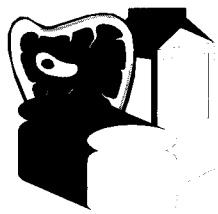
Personal Health

- 96% of LHDs directly provide or contract to provide immunizations.
- 86% of LHDs directly provide or contract to provide tuberculosis services.
- 79% of LHDs directly provide or contract to provide well child clinic services.
- 68% of LHDs directly provide or contract to provide HIV/AIDS testing and counseling, and 33% of all LHDs directly provide or contract to provide HIV/AIDS treatment.
- 91% of LHDs offered adult immunizations for influenza in the 12 months preceding the survey.

Environmental Health

- 75% of LHDs directly provide or contract to provide sewage disposal systems service.
- 74% of LHDs directly provide or contract to provide private water supply safety services.
- 52% of LHDs directly provide or contract to provide public water supply safety services.
- 58% of LHDs directly provide or contract to provide groundwater pollution control services.
- 80% of LHDs provide restaurant inspections and/or licensing.
- 56% of LHDs provide food and milk control inspections and/or licensing.





Agency Services

As part of the process of conducting a comprehensive study of LHDs, their activities and services must be separated into components that appear to be discrete activities. It is important to remember these individual components work together to form an integrated, prevention-oriented local public health system that links with the state and federal governmental levels, as well as other community health services and activities.

The data collected on service activity indicate that LHDs directly provide or contract to provide a broad range of services. In general, the percentage of LHDs reporting activity in specific services increased in relation to the size of population served by the LHD. No comparisons are made with the 1989 dataset because of variations in terminology of the questions.

Selected Personal Health Services

For each area of personal health services, LHDs were asked if they directly provide service, contract to provide service, or have no activity. Figure 32 presents the percentage of LHDs that directly provide or contract to provide selected personal health services. Of all responding LHDs, 96% directly provide or contract to provide immunizations, and 86% provide tuberculosis services. In the well child clinic category, 79% of all LHDs directly provide or contract to provide these services. Furthermore, whereas 68% of all LHDs directly provide or contract to provide HIV/AIDS testing and counseling, about one-third (33%) directly provide or contract to provide HIV/AIDS treatment.

Respondents were queried regarding adult immunizations. As shown in Figure 33, 91% of responding LHDs offered adult immunizations for influenza in the 12 months before completing the questionnaire. Furthermore, all LHDs serving populations of 500,000 or more offered adult immunizations for influenza. The population subgroupings on adult immunizations indicate that as the population increases, the likelihood of offering tetanus and diphtheria immunizations also increases.

Figures 34-39 provide information on a wide variety of personal health services by all LHDs and population subgroupings.

Selected Environmental Health Services

LHDs also reported on activities in selected environmental health service areas. For each area, LHDs were asked if they directly provide service, contract to provide service, or have no activity in the service area. Three-fourths (75%) of responding LHDs directly provide or contract to provide sewage disposal systems services (Figure 40). Furthermore, when queried whether the LHD directly provides or contracts to provide private water supply safety, 74% responded "Yes;" public water supply safety, 52%; groundwater pollution control, 58%.

Figure 41 demonstrates the percentage of LHDs that provide inspections and/or licensing for selected facilities. In the "Food" category, 80% of the respondents reported inspections and/or licensing for restaurants and 56% food and milk control. In the "Water" category, 68% reported inspections and/or licensing for swimming pools; 64% offered private water supply safety; and 45% inspect public water systems. Health facilities are inspected and/or licensed by 33% of responding LHDs and recreational facilities by 55%.

As shown in Figure 42, the majority of all LHDs reported activity in the traditional sanitation-related services, such as water protection, sewage disposal, and vector control. In addition, a sizeable percentage noted directly providing or contracting to provide services related to hazardous substances, such as environmental emergency response (57%) and hazardous waste management (42%). In addition, as the size of the jurisdiction served by the LHD increases so does the reporting of emergency response services, hazardous waste management, and indoor air quality (Figures 43-47). The reporting of occupational safety and health services does not seem to be influenced by the size of the jurisdiction.

Other Selected Services

Figure 48 depicts the percentage of LHDs reporting provision of services, either directly or through contractual arrangement, in other selected service areas. In the community outreach and education category, 86% of LHDs directly provide or contract to provide services; health education, 84%; and laboratory services, 60%.

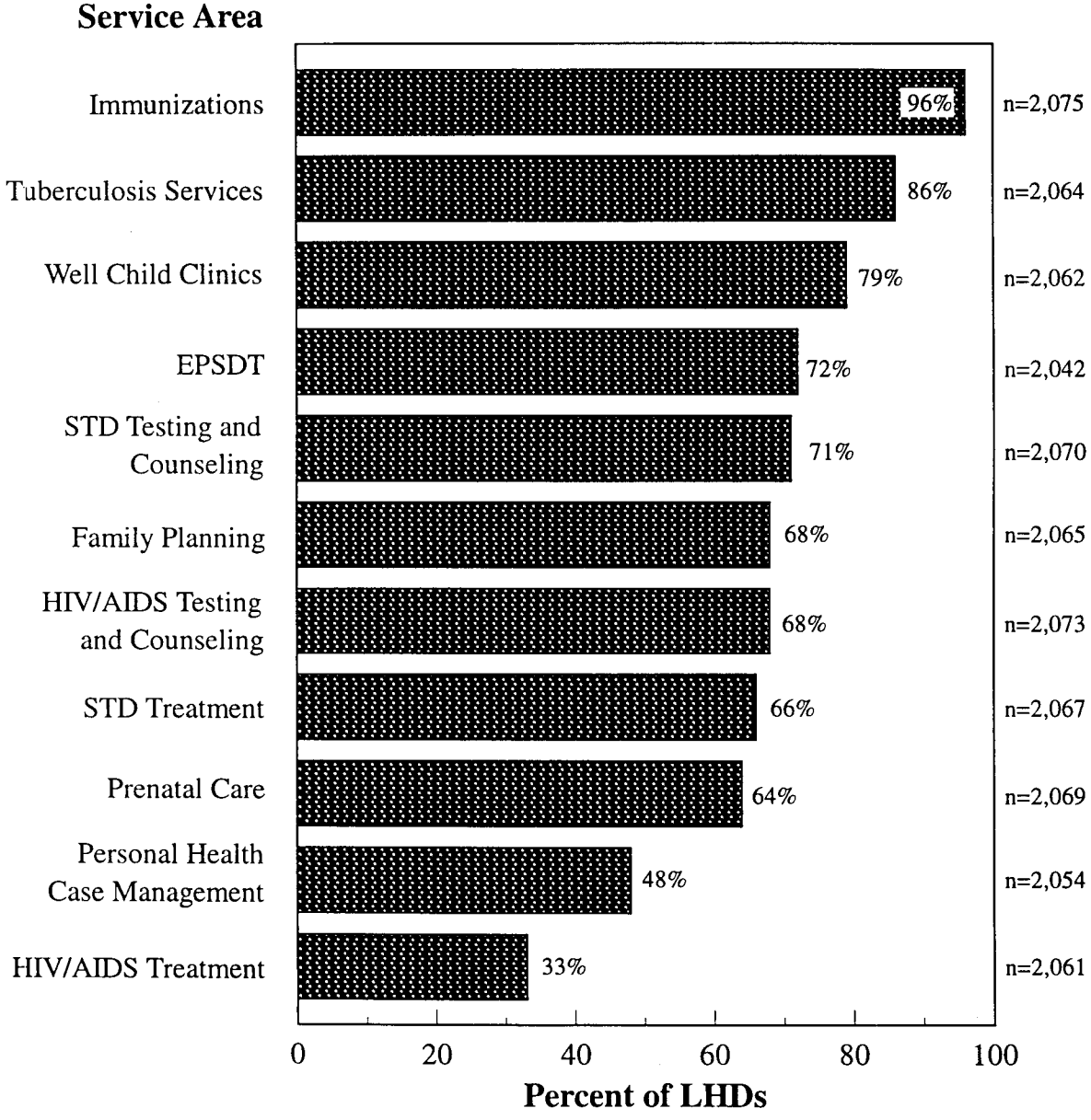
Public Health/Clinical Laboratory Services

LHDs were questioned on the provision of a broad range of laboratory services. Overall, as the size of a population increases, the activity in each laboratory service also increases (Figure 49). However, there are no services in which a majority of LHDs are active. The highest level of activity for all LHDs (40%) was reported in the urinalysis category. Over three-fourths (77%) of LHDs serving populations of 500,000 or more are active in immunology/serology and bacteriology. It is important to note, however, that although an LHD may not offer a particular laboratory service, the service may still be available to them through other means (e.g., state laboratory services).

Figure 32

U.S. Local Health Departments Reporting Activity* in Selected Personal Health Service Areas

1992-1993



EPSDT - Early and Periodic Screening, Diagnosis, and Treatment
STD - Sexually Transmitted Diseases
HIV/AIDS - Human Immunodeficiency Virus / Acquired Imuune Deficiency Syndrome

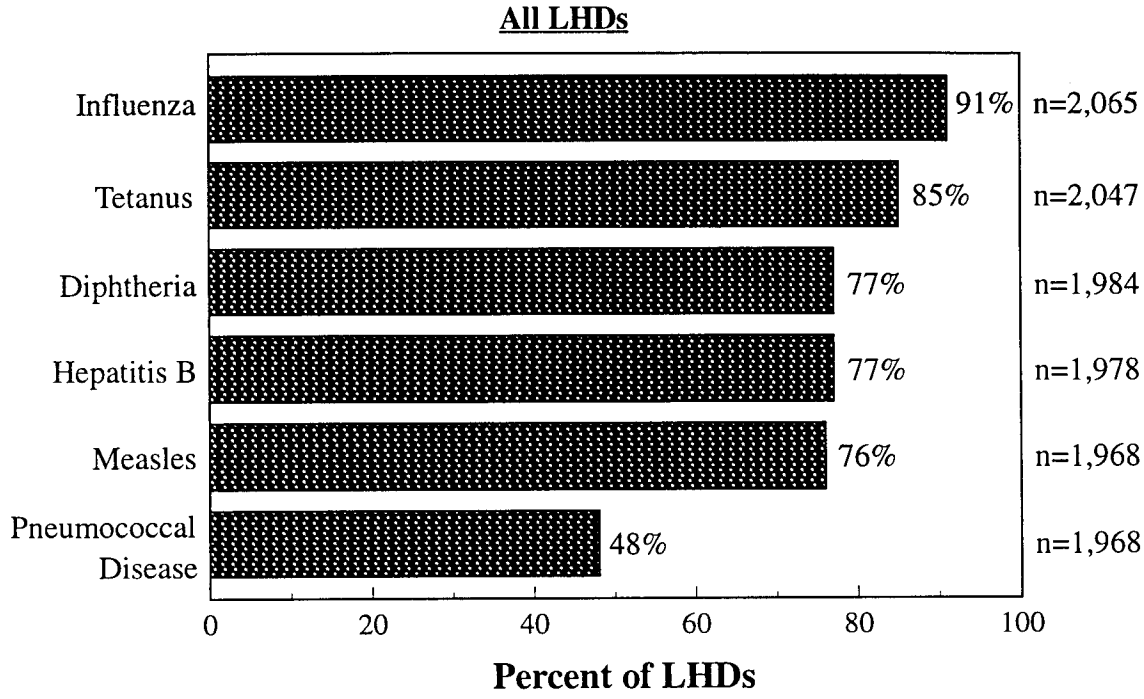
*Provision of service directly or through contractual arrangement

n= number of respondents

Figure 33

U.S. Local Health Departments That Have Recently* Offered Adult Immunizations for Selected Diseases

1992-1993



By Population of Jurisdiction

	0 to 24,999		25,000 to 49,999		50,000 to 99,999		100,000 to 499,999		500,000 +	
	n=	Percent	n=	Percent	n=	Percent	n=	Percent	n=	Percent
Influenza	907	86%	451	92%	339	96%	295	98%	73	100%
Tetanus	861	40%	432	44%	320	54%	284	66%	71	69%
Diphtheria	850	68%	433	80%	330	84%	292	85%	73	89%
Hepatitis B	898	83%	450	84%	337	89%	290	84%	72	89%
Measles	862	74%	435	78%	328	78%	287	77%	72	90%
Pneumococcal Disease	854	74%	431	75%	328	79%	285	78%	70	89%

* Within 12 months prior to completing survey.

n= number of respondents

Figure 34
U.S. Local Health Departments Reporting Activity in Selected Service Areas
All LHDs
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Child Health				
Child Abuse Risk Reduction	2,058	37%	5%	58%
Child Sick Care	2,056	29%	10%	61%
Children with Special Health Care Needs	2,064	51%	14%	35%
EPSDT	2,042	67%	5%	28%
Well Child Clinic	2,062	72%	7%	21%
WIC	2,062	67%	11%	22%
Chronic Disease				
Cancer	2,062	47%	6%	47%
Cardiovascular Disease	2,060	53%	5%	42%
Diabetes	2,063	55%	5%	40%
High Blood Pressure	2,071	79%	6%	15%
Glaucoma	2,049	15%	6%	79%
Other Services				
Community Outreach and Education	2,057	82%	4%	14%
Dental Health	2,057	35%	10%	55%
EMS (Ambulance Services)	2,058	8%	7%	85%
Family Planning	2,065	60%	8%	32%
Geriatric Care	2,053	33%	5%	62%
Health Education/Risk Reduction	2,069	80%	4%	16%

n= number of respondents

Figure 34 - *Continued*
U.S. Local Health Departments Reporting Activity in Selected Service Areas
All LHDs
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
HIV/AIDS Testing and Counseling	2,073	62%	6%	32%
HIV/AIDS Treatment	2,061	24%	9%	67%
Home Health Care	2,062	45%	9%	46%
Hospitals	2,054	2%	4%	94%
Immunizations	2,075	92%	4%	4%
Injury Control	2,047	38%	3%	59%
Laboratory Services	2,062	46%	14%	40%
Long-Term Care Facilities	2,060	2%	3%	95%
Mental Health Facilities and Services	2,060	6%	5%	89%
Multiculturally Sensitive Health Programs	2,049	20%	1%	79%
Obstetrical Care	2,057	23%	10%	67%
Personal Health Case Management	2,054	44%	4%	52%
Prenatal Care	2,069	54%	10%	36%
Primary Care	2,054	25%	5%	70%
School Based Clinics	2,055	20%	5%	75%
School Health	2,056	55%	5%	40%
STD Testing and Counseling	2,070	64%	7%	29%
STD Treatment	2,067	59%	7%	34%
Substance Abuse	2,057	13%	8%	79%
Tobacco Use Control	2,061	42%	3%	55%
Tuberculosis Services	2,064	81%	5%	14%

n= number of respondents

Figure 35
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 0 to 24,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Child Health				
Child Abuse Risk Reduction	908	30%	6%	64%
Child Sick Care	905	26%	11%	63%
Children with Special Health Care Needs	908	46%	15%	39%
EPSDT	896	61%	4%	35%
Well Child Clinic	905	65%	8%	27%
WIC	904	61%	12%	27%
Chronic Disease				
Cancer	907	44%	7%	49%
Cardiovascular Disease	907	50%	6%	44%
Diabetes	908	56%	7%	37%
High Blood Pressure	911	78%	8%	14%
Glaucoma	903	14%	7%	79%
Other Services				
Community Outreach and Education	902	73%	6%	21%
Dental Health	855	21%	76%	3%
EMS (Ambulance Services)	905	9%	7%	84%
Family Planning	907	55%	7%	38%
Geriatric Care	901	31%	6%	63%
Health Education/Risk Reduction	910	73%	5%	22%

n= number of respondents

Figure 35 - *Continued*
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction
0 to 24,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
HIV/AIDS Testing and Counseling	910	49%	6%	45%
HIV/AIDS Treatment	903	21%	8%	71%
Home Health Care	908	47%	11%	42%
Hospitals	902	1%	3%	96%
Immunizations	912	86%	7%	7%
Injury Control	903	32%	2%	66%
Laboratory Services	907	41%	11%	48%
Long-Term Care Facilities	905	1%	2%	97%
Mental Health Facilities and Services	907	5%	5%	90%
Multiculturally Sensitive Health Programs	899	11%	1%	88%
Obstetrical Care	906	17%	8%	75%
Personal Health Case Management	903	36%	3%	61%
Prenatal Care	910	46%	8%	46%
Primary Care	905	17%	4%	79%
School Based Clinics	904	20%	4%	76%
School Health	906	52%	7%	41%
STD Testing and Counseling	908	53%	6%	41%
STD Treatment	907	47%	6%	47%
Substance Abuse	904	9%	7%	84%
Tobacco Use Control	906	30%	3%	67%
Tuberculosis Services	908	73%	5%	22%

n= number of respondents

Figure 36
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 25,000 to 49,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Child Health				
Child Abuse Risk Reduction	449	37%	4%	59%
Child Sick Care	451	24%	9%	67%
Children with Special Health Care Needs	452	50%	12%	38%
EPSDT	444	65%	5%	30%
Well Child Clinic	450	69%	9%	22%
WIC	452	66%	10%	24%
Chronic Disease				
Cancer	452	51%	5%	44%
Cardiovascular Disease	450	56%	4%	40%
Diabetes	449	58%	4%	38%
High Blood Pressure	452	82%	4%	14%
Glaucoma	451	16%	5%	79%
Other Services				
Community Outreach and Education	450	81%	5%	14%
Dental Health	449	33%	8%	59%
EMS (Ambulance Services)	452	5%	5%	90%
Family Planning	452	58%	11%	31%
Geriatric Care	449	31%	4%	65%
Health Education/Risk Reduction	391	91%	5%	4%

n= number of respondents

Figure 36 - *Continued*
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 25,000 to 49,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
HIV/AIDS Testing and Counseling	453	59%	6%	35%
HIV/AIDS Treatment	451	21%	7%	72%
Home Health Care	451	45%	7%	48%
Hospitals	451	1%	3%	96%
Immunizations	453	94%	3%	3%
Injury Control	446	41%	3%	56%
Laboratory Services	450	40%	15%	45%
Long-Term Care Facilities	451	1%	2%	97%
Mental Health Facilities and Services	451	5%	4%	91%
Multiculturally Sensitive Health Programs	450	18%	1%	81%
Obstetrical Care	447	20%	7%	73%
Personal Health Case Management	452	41%	5%	54%
Prenatal Care	451	54%	10%	36%
Primary Care	445	24%	2%	74%
School Based Clinics	449	19%	4%	77%
School Health	449	57%	4%	39%
STD Testing and Counseling	452	59%	10%	31%
STD Treatment	451	53%	9%	38%
Substance Abuse	451	12%	5%	83%
Tobacco Use Control	451	43%	3%	54%
Tuberculosis Services	450	84%	5%	11%

n= number of respondents

Figure 37
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 50,000 to 99,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Child Health				
Child Abuse Risk Reduction	340	43%	5%	52%
Child Sick Care	338	31%	8%	61%
Children with Special Health Care Needs	341	54%	15%	31%
EPSDT	336	71%	4%	25%
Well Child Clinic	340	80%	5%	15%
WIC	339	71%	12%	17%
Chronic Disease				
Cancer	336	48%	6%	46%
Cardiovascular Disease	338	50%	4%	46%
Diabetes	341	50%	6%	44%
High Blood Pressure	341	80%	3%	17%
Glaucoma	337	15%	7%	78%
Other Services				
Community Outreach and Education	340	91%	2%	7%
Dental Health	338	37%	10%	53%
EMS (Ambulance Services)	341	6%	7%	87%
Family Planning	341	60%	9%	31%
Geriatric Care	341	31%	5%	64%
Health Education/Risk Reduction	341	89%	2%	9%

n= number of respondents

Figure 37 - *Continued*
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 50,000 to 99,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
HIV/AIDS Testing and Counseling	342	72%	7%	21%
HIV/AIDS Treatment	340	20%	11%	69%
Home Health Care	341	46%	8%	46%
Hospitals	336	2%	4%	94%
Immunizations	342	98%	2%	0%
Injury Control	340	43%	4%	53%
Laboratory Services	341	47%	19%	34%
Long-Term Care Facilities	342	4%	4%	92%
Mental Health Facilities and Services	341	5%	6%	89%
Multiculturally Sensitive Health Programs	340	19%	1%	80%
Obstetrical Care	338	24%	11%	65%
Personal Health Case Management	336	48%	4%	48%
Prenatal Care	340	61%	9%	30%
Primary Care	340	30%	5%	65%
School Based Clinics	339	16%	4%	80%
School Health	338	57%	3%	40%
STD Testing and Counseling	342	75%	7%	18%
STD Treatment	341	66%	8%	26%
Substance Abuse	340	14%	8%	78%
Tobacco Use Control	338	51%	5%	44%
Tuberculosis Services	339	87%	5%	8%

n= number of respondents

Figure 38
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 100,000 to 499,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Child Health				
Child Abuse Risk Reduction	290	46%	5%	49%
Child Sick Care	289	37%	8%	55%
Children with Special Health Care Needs	293	62%	12%	26%
EPSDT	288	82%	3%	15%
Well Child Clinic	294	88%	4%	8%
WIC	294	80%	8%	12%
Chronic Disease				
Cancer	294	48%	6%	46%
Cardiovascular Disease	292	55%	7%	38%
Diabetes	290	52%	5%	43%
High Blood Pressure	294	78%	3%	19%
Glaucoma	286	14%	7%	79%
Other Services				
Community Outreach and Education	292	92%	3%	5%
Dental Health	294	52%	10%	38%
EMS (Ambulance Services)	290	9%	8%	83%
Family Planning	292	71%	8%	21%
Geriatric Care	291	36%	6%	58%
Health Education/Risk Reduction	294	93%	2%	5%

n= number of respondents

Figure 38 - *Continued*
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 100,000 to 499,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
HIV/AIDS Testing and Counseling	295	90%	3%	7%
HIV/AIDS Treatment	294	31%	13%	56%
Home Health Care	291	37%	7%	56%
Hospitals	293	1%	9%	90%
Immunizations	295	98%	1%	1%
Injury Control	288	45%	2%	53%
Laboratory Services	291	62%	19%	19%
Long-Term Care Facilities	290	5%	3%	92%
Mental Health Facilities and Services	291	8%	7%	85%
Multiculturally Sensitive Health Programs	289	37%	2%	61%
Obstetrical Care	294	35%	20%	45%
Personal Health Case Management	290	57%	4%	39%
Prenatal Care	295	67%	13%	20%
Primary Care	291	36%	12%	52%
School Based Clinics	292	20%	7%	73%
School Health	291	53%	4%	43%
STD Testing and Counseling	295	89%	4%	7%
STD Treatment	295	86%	6%	8%
Substance Abuse	290	23%	10%	67%
Tobacco Use Control	293	59%	3%	38%
Tuberculosis Services	294	91%	3%	6%

n= number of respondents

Figure 39
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction 500,000 +
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Child Health				
Child Abuse Risk Reduction	71	69%	6%	25%
Child Sick Care	73	64%	8%	28%
Children with Special Health Care Needs	70	67%	9%	24%
EPSDT	71	89%	3%	8%
Well Child Clinic	73	93%	1%	6%
WIC	73	89%	4%	7%
Chronic Disease				
Cancer	73	53%	10%	37%
Cardiovascular Disease	73	66%	3%	31%
Diabetes	73	66%	1%	33%
High Blood Pressure	73	77%	5%	18%
Glaucoma	72	28%	1%	71%
Other Services				
Community Outreach and Education	73	96%	3%	1%
Dental Health	72	81%	7%	12%
EMS (Ambulance Services)	70	17%	13%	70%
Family Planning	73	87%	5%	8%
Geriatric Care	71	58%	3%	39%
Health Education/Risk Reduction	73	99%	1%	0%

n= number of respondents

Figure 39 - *Continued*
U.S. Local Health Departments Reporting Activity in Selected Service Areas by Population of Jurisdiction
500,000 +
1992-1993

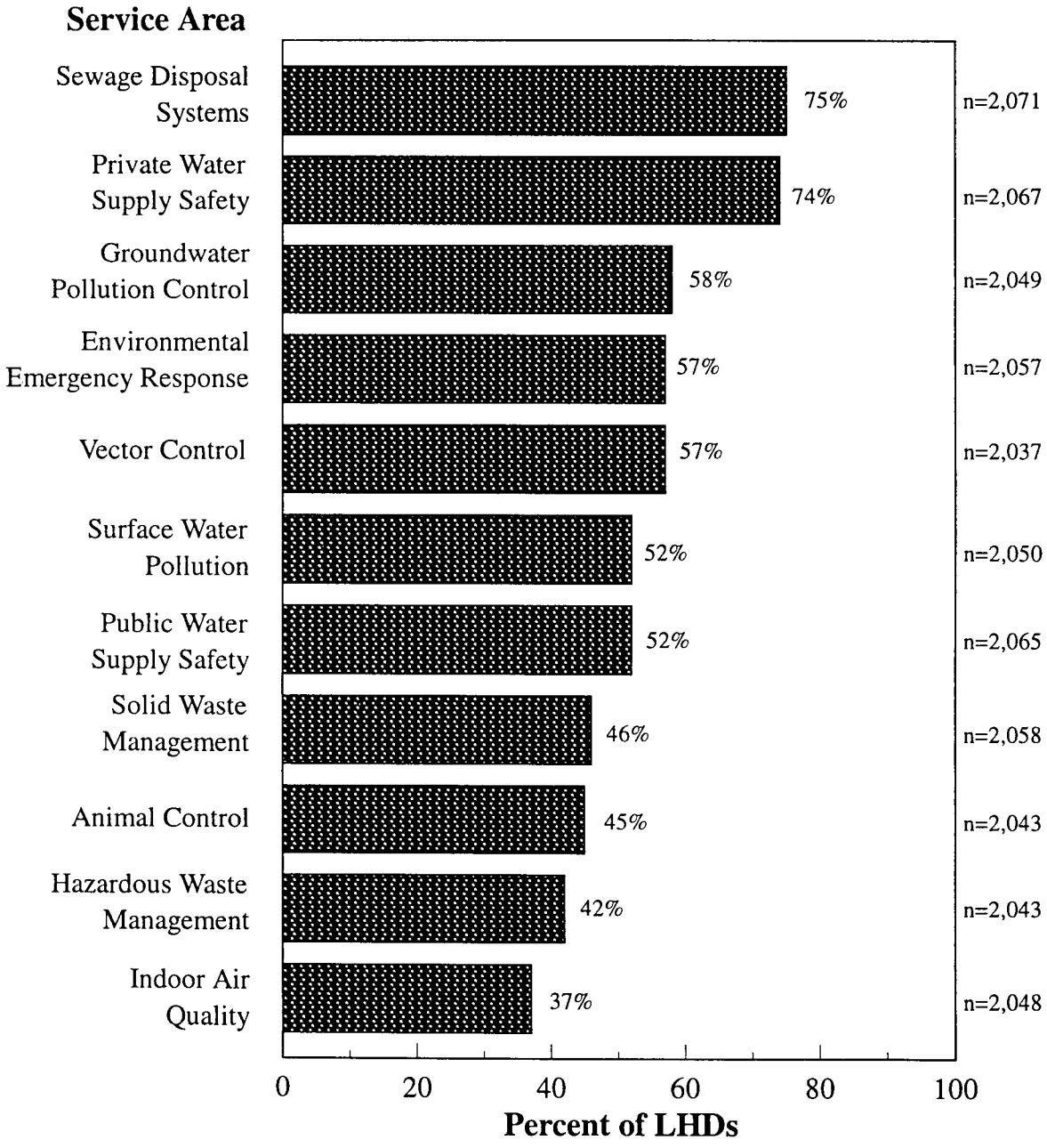
Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
HIV/AIDS Testing and Counseling	73	93%	3%	4%
HIV/AIDS Treatment	73	57%	11%	32%
Home Health Care	71	34%	13%	53%
Hospitals	72	6%	11%	83%
Immunizations	73	99%	1%	0%
Injury Control	70	57%	3%	40%
Laboratory Services	73	82%	14%	4%
Long-Term Care Facilities	72	11%	4%	85%
Mental Health Facilities and Services	72	28%	6%	66%
Multiculturally Sensitive Health Programs	71	73%	6%	21%
Obstetrical Care	72	53%	15%	32%
Personal Health Case Management	73	78%	3%	19%
Prenatal Care	73	82%	10%	8%
Primary Care	73	64%	7%	29%
School Based Clinics	71	48%	3%	49%
School Health	72	70%	1%	29%
STD Testing and Counseling	73	96%	2%	2%
STD Treatment	73	93%	3%	4%
Substance Abuse	72	39%	15%	46%
Tobacco Use Control	73	64%	5%	31%
Tuberculosis Services	73	93%	4%	3%

n= number of respondents

Figure 40

U.S. Local Health Departments Reporting Activity* in Selected Environmental Service Areas

1992-1993



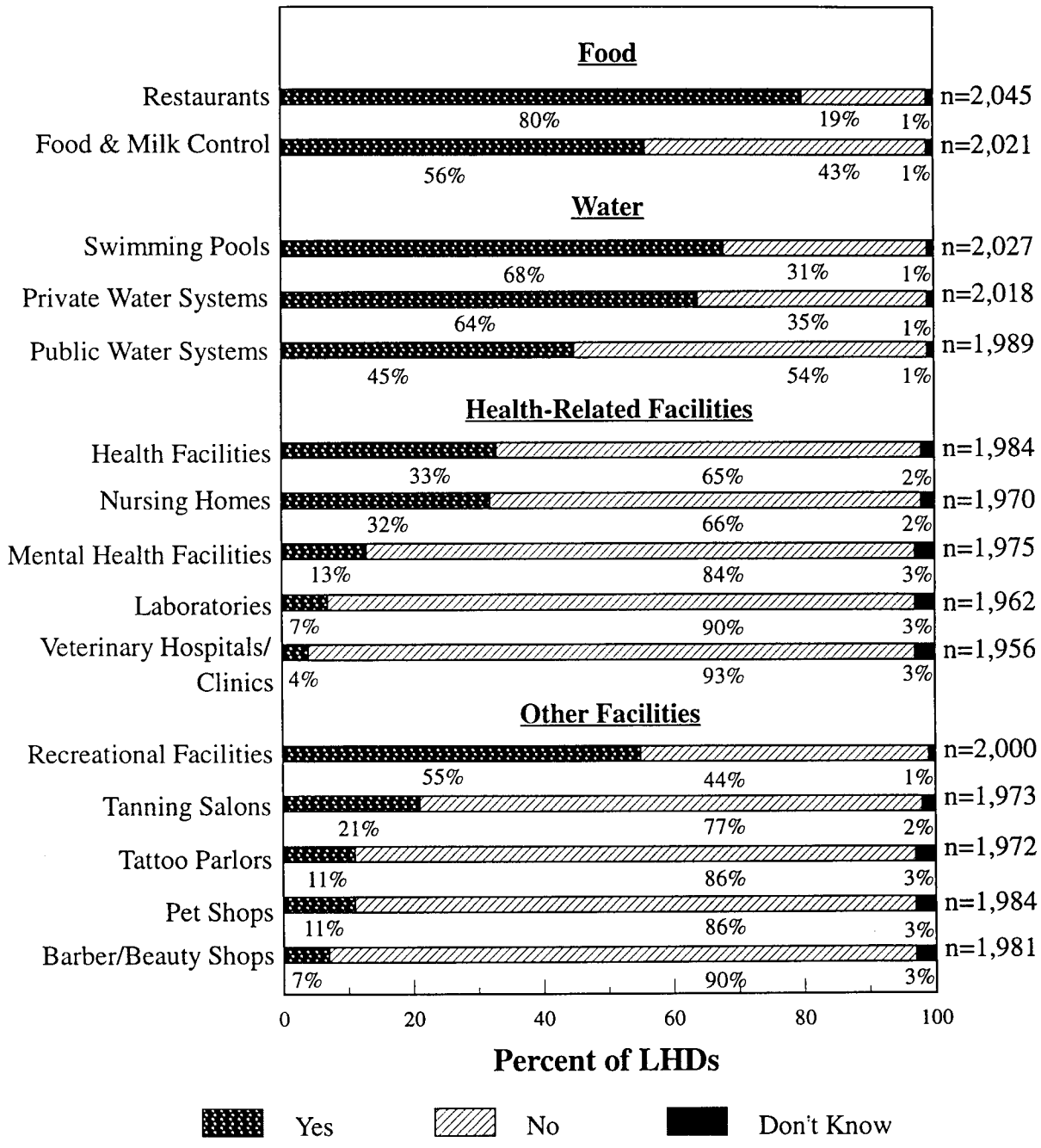
*Provision of service directly or through contractual arrangement

n= number of respondents

Figure 41

U.S. Local Health Departments That Provide Inspections and/or Licensing of Selected Facilities

1992-1993



n= number of respondents

Figure 42
U.S. Local Health Departments Reporting Activity in Selected Environmental Service Areas
All LHDs
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Animal Control	2,043	36%	9%	55%
Environmental Emergency Response	2,057	52%	5%	43%
Groundwater Pollution Control	2,049	54%	4%	42%
Hazardous Waste Management	2,043	35%	7%	58%
Indoor Air Quality	2,048	32%	5%	63%
Noise Pollution	2,041	17%	4%	79%
Occupational Safety and Health	2,044	20%	4%	76%
Private Water Supply Safety	2,067	70%	4%	26%
Public Water Supply Safety	2,065	45%	7%	48%
Radiation Control	2,058	15%	5%	80%
Sewage Disposal Systems	2,071	72%	3%	25%
Solid Waste Management	2,058	41%	5%	54%
Surface Water Pollution	2,050	49%	3%	48%
Vector Control	2,037	53%	4%	43%

n= number of respondents

Figure 43
U.S. Local Health Departments Reporting Activity in Selected Environmental Service Areas by Population of Jurisdiction 0 to 24,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Animal Control	896	33%	9%	58%
Environmental Emergency Response	902	43%	5%	52%
Groundwater Pollution Control	897	46%	5%	49%
Hazardous Waste Management	895	32%	7%	61%
Indoor Air Quality	892	24%	5%	71%
Noise Pollution	892	13%	4%	83%
Occupational Safety and Health	895	19%	4%	77%
Private Water Supply Safety	911	63%	6%	31%
Public Water Supply Safety	909	39%	8%	53%
Radiation Control	906	11%	6%	83%
Sewage Disposal Systems	910	64%	5%	31%
Solid Waste Management	905	35%	6%	59%
Surface Water Pollution	897	45%	4%	51%
Vector Control	888	42%	5%	53%

n= number of respondents

Figure 44
U.S. Local Health Departments Reporting Activity in Selected Environmental Service Areas by Population of Jurisdiction 25,000 to 49,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Animal Control	447	40%	6%	54%
Environmental Emergency Response	452	52%	4%	44%
Groundwater Pollution Control	449	56%	3%	41%
Hazardous Waste Management	443	34%	6%	60%
Indoor Air Quality	450	34%	3%	63%
Noise Pollution	450	20%	3%	77%
Occupational Safety and Health	445	20%	3%	77%
Private Water Supply Safety	452	71%	3%	26%
Public Water Supply Safety	449	43%	5%	52%
Radiation Control	449	13%	4%	83%
Sewage Disposal Systems	453	74%	1%	25%
Solid Waste Management	450	45%	5%	50%
Surface Water Pollution	450	50%	2%	48%
Vector Control	449	59%	4%	37%

n= number of respondents

Figure 45
U.S. Local Health Departments Reporting Activity in Selected Environmental Service Areas by Population of Jurisdiction 50,000 to 99,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Animal Control	339	37%	9%	54%
Environmental Emergency Response	340	58%	7%	35%
Groundwater Pollution Control	339	56%	6%	38%
Hazardous Waste Management	339	33%	8%	59%
Indoor Air Quality	341	36%	5%	59%
Noise Pollution	339	18%	5%	77%
Occupational Safety and Health	339	15%	6%	79%
Private Water Supply Safety	336	77%	3%	20%
Public Water Supply Safety	339	49%	6%	45%
Radiation Control	339	15%	6%	79%
Sewage Disposal Systems	341	78%	1%	21%
Solid Waste Management	339	41%	5%	54%
Surface Water Pollution	338	51%	4%	45%
Vector Control	334	62%	3%	35%

n= number of respondents

Figure 46
U.S. Local Health Departments Reporting Activity in Selected Environmental Service Areas by Population of Jurisdiction 100,000 to 499,999
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Animal Control	289	36%	10%	54%
Environmental Emergency Response	292	65%	6%	29%
Groundwater Pollution Control	293	67%	2%	31%
Hazardous Waste Management	290	46%	5%	49%
Indoor Air Quality	292	45%	5%	50%
Noise Pollution	289	22%	3%	75%
Occupational Safety and Health	292	23%	3%	74%
Private Water Supply Safety	295	80%	1%	19%
Public Water Supply Safety	295	56%	5%	39%
Radiation Control	291	22%	5%	73%
Sewage Disposal Systems	295	85%	1%	14%
Solid Waste Management	292	50%	5%	45%
Surface Water Pollution	292	57%	4%	39%
Vector Control	293	65%	2%	33%

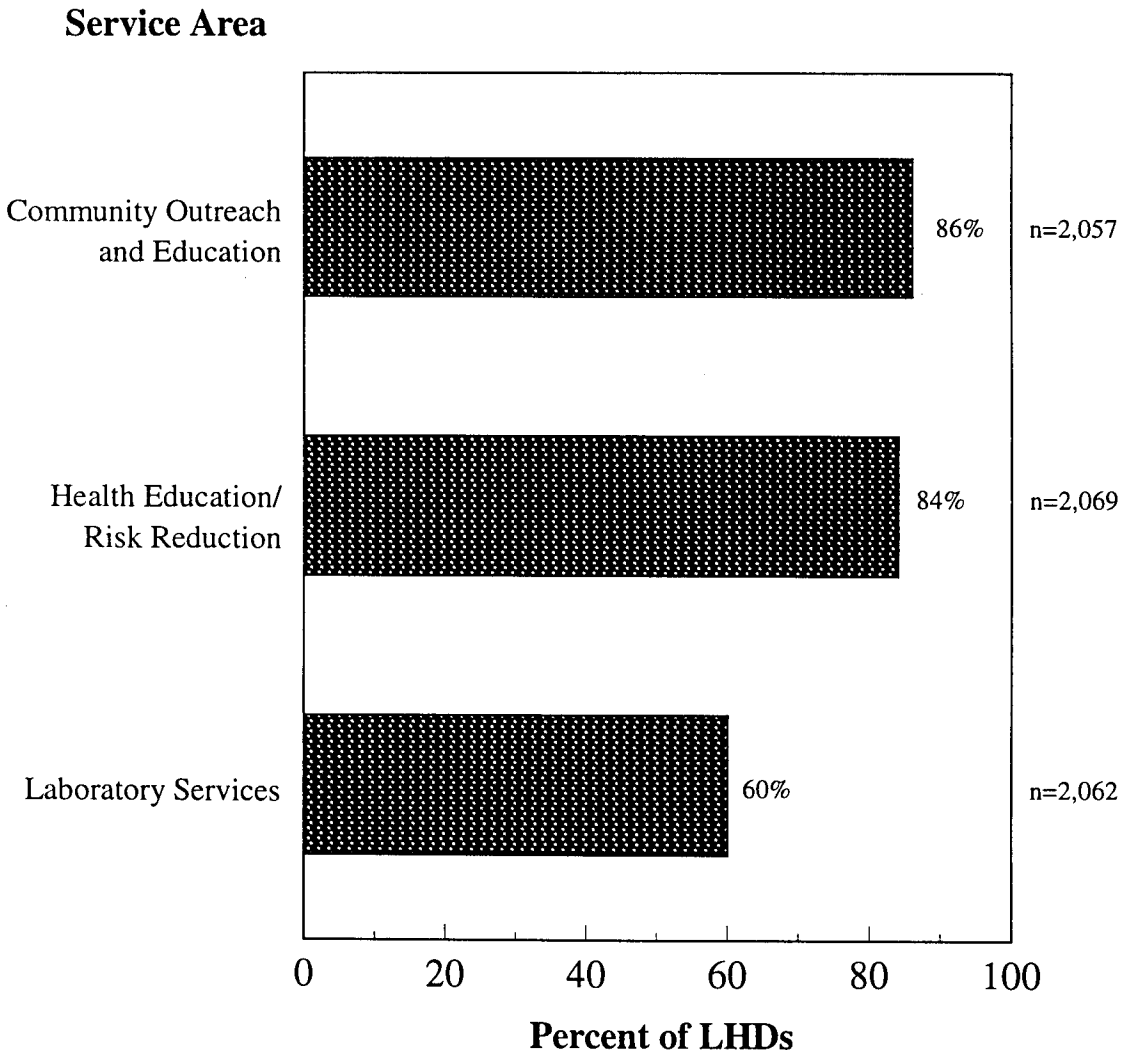
n= number of respondents

Figure 47
U.S. Local Health Departments Reporting Activity in Selected Environmental Service Areas by Population of Jurisdiction
500,000 +
1992-1993

Service	n=	Directly Provides Service	Contracts to Provide Service	No Activity
Animal Control	72	54%	11%	35%
Environmental Emergency Response	71	75%	4%	21%
Groundwater Pollution Control	71	69%	4%	27%
Hazardous Waste Management	71	61%	7%	32%
Indoor Air Quality	73	63%	3%	34%
Noise Pollution	71	31%	4%	65%
Occupational Safety and Health	73	40%	7%	53%
Private Water Supply Safety	73	75%	3%	22%
Public Water Supply Safety	73	67%	3%	30%
Radiation Control	73	40%	5%	55%
Sewage Disposal Systems	72	78%	3%	19%
Solid Waste Management	72	57%	3%	40%
Surface Water Pollution	73	59%	3%	38%
Vector Control	73	73%	3%	24%

n= number of respondents

Figure 48
U.S. Local Health Departments Reporting Activity* in Selected Service Areas
1992-1993



*Provision of service directly or through contractual arrangement

n= number of respondents

Figure 49
Public Health /Clinical Laboratory Services Offered by U.S. Local Health Departments All LHDs and by Population of Jurisdiction
1992-1993

Laboratory Services	0 to 24,999		25,000 to 49,999		50,000 to 99,999		100,000 to 499,999		500,000 +		All LHDs	
	n	%	n	%	n	%	n	%	n	%	n	%
Microbiology												
Bacteriology	904	19%	446	24%	337	34%	294	54%	73	81%	2,054	30%
Mycobacteriology	901	16%	445	18%	332	21%	290	29%	72	54%	2,040	20%
Mycology	900	11%	442	13%	333	14%	286	22%	73	42%	2,034	14%
Parasitology	906	22%	446	21%	337	24%	293	32%	73	58%	2,055	25%
Virology	901	18%	444	15%	334	19%	288	25%	73	45%	2,040	19%
Immunology/Serology	897	23%	446	20%	334	29%	293	45%	73	77%	2,043	29%
Other Microbiology	853	15%	429	15%	322	20%	260	28%	66	52%	1,930	19%
Chemistry												
Clinical Chemistry	897	16%	445	16%	335	22%	289	29%	73	62%	2,039	21%
Inborn Errors of Metabolism	903	17%	445	14%	334	17%	291	14%	73	23%	2,046	16%
Multiphasis Screening	892	8%	444	9%	331	13%	284	13%	72	31%	2,023	10%
Urinalysis	902	32%	446	34%	337	44%	294	59%	73	75%	2,052	40%
Other	800	18%	399	19%	282	16%	233	17%	59	37%	1,773	18%

n= number of respondents

Figure 49 - *Continued*
Public Health /Clinical Laboratory Services Offered by U.S. Local Health Departments All LHDs and by Population of Jurisdiction
1992-1993

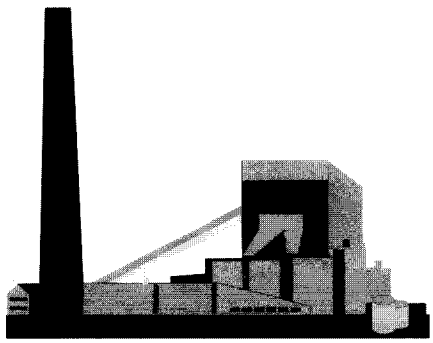
Laboratory Services	0 to 24,999		25,000 to 49,999		50,000 to 99,999		100,000 to 499,999		500,000 +		All LHDs	
	n	%	n	%	n	%	n	%	n	%	n	%
Hematology												
Immunohematology	892	10%	436	10%	330	10%	288	17%	72	33%	2,018	12%
Hemoglobinopathy	906	29%	440	27%	336	28%	293	29%	73	42%	2,048	29%
Other	806	17%	398	18%	291	19%	249	22%	62	44%	1,806	19%
Pathology												
Cytology	901	16%	441	15%	332	18%	290	19%	72	32%	2,036	17%
Other Pathology	863	3%	436	5%	311	7%	268	8%	67	16%	1,945	5%
Environmental												
Chemistry	894	14%	444	17%	330	21%	289	30%	72	61%	2,029	20%
Microbiology	890	17%	446	20%	333	28%	290	43%	72	72%	2,031	25%
Occupational Safety and Health	895	7%	441	7%	330	8%	285	11%	71	32%	2,022	9%
Toxicology	891	6%	443	9%	329	9%	286	15%	72	25%	2,021	9%
Laboratory Improvement/Training	889	17%	441	17%	327	20%	282	28%	70	46%	2,009	20%
Research and Development	875	2%	431	1%	322	2%	276	6%	70	24%	1,974	3%

n= number of respondents

OCCUPATIONAL SAFETY AND HEALTH

Fast Facts

- 61% of responding LHDs received OSH complaints or requests for assistance in the previous 12 months.
- 81% of LHDs refer to other agencies as a method to address OSH complaints or requests for assistance.
- 12% of LHDs cited they provide the NIOSH technical information phone number as a method to address OSH complaints or requests for assistance.
- 59% of those LHDs receiving complaints or requests for assistance in the previous 12 months concerning OSH functions/problems reported inquiries relating to indoor air quality.
- 15% of those LHDs receiving complaints or requests for assistance in the previous 12 months concerning OSH functions/problems reported inquiries relating to occupational injuries/death.



Occupational Safety and Health

The *1992-1993 National Profile of Local Health Departments* study included a section of questions funded by the National Institute of Occupational Safety and Health (NIOSH). Comprehensive results from this important section will be distributed in a separate publication in Fall 1995; however, Figures 50-52 provide a preview of these data.

Complaints or Requests for Assistance

Overall, 61% of all responding LHDs indicated they had received complaints or requests for assistance concerning occupational safety and health (OSH) functions/problems in the previous 12 months (Figure 50).

Methods Used to Address Complaints or Requests for Assistance

Of the choices provided to address OSH complaints or requests for assistance, the most commonly reported method (81%) was "refer to other agencies" (Figure 51). About half of the respondents also reported "provide consultation by phone" (53%), "conduct on-site investigation" (47%), and/or "send information/publications materials" (46%). A small percentage (12%) reported they "provide the NIOSH technical information phone line." Please note that this question was not restricted to the previous 12 months, and therefore is not a subset of complaints or requests for assistance displayed in Figure 50.

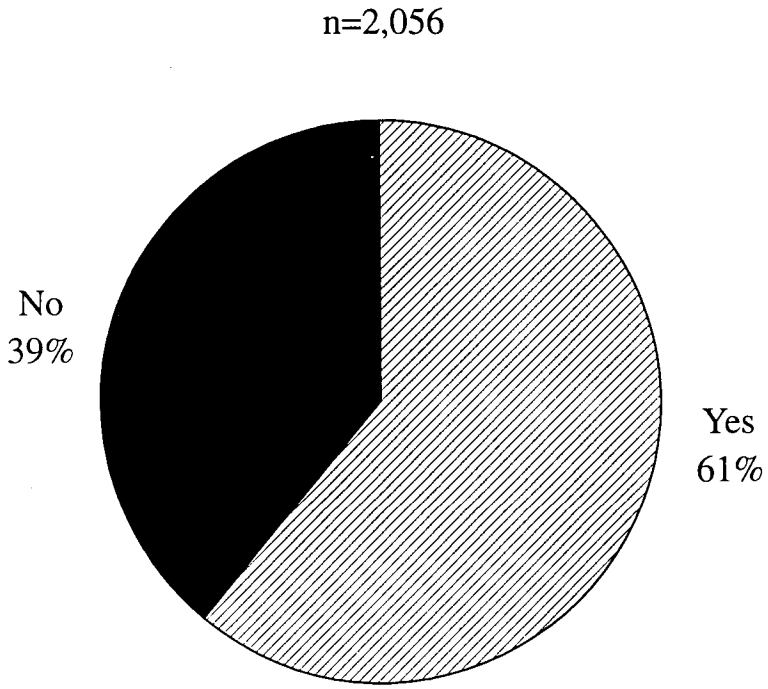
Selected Types of Complaints or Requests for Assistance

Figure 52 displays the various types of OSH complaints or requests for assistance received by those LHDs that have received complaints/requests in the previous 12 months. Of the respondents, 59% reported requests for assistance or complaints about indoor air quality. About half of the respondents cited exposure/illness (52%) and hazardous or unsafe workplace conditions (50%), compared with requests for assistance or complaints for occupational injuries/death by 15% of the respondents and engineering controls by 7%.

Figure 50

U.S. Local Health Departments Receiving OSH Complaints or Requests for Assistance in the Previous 12 Months

1992-1993

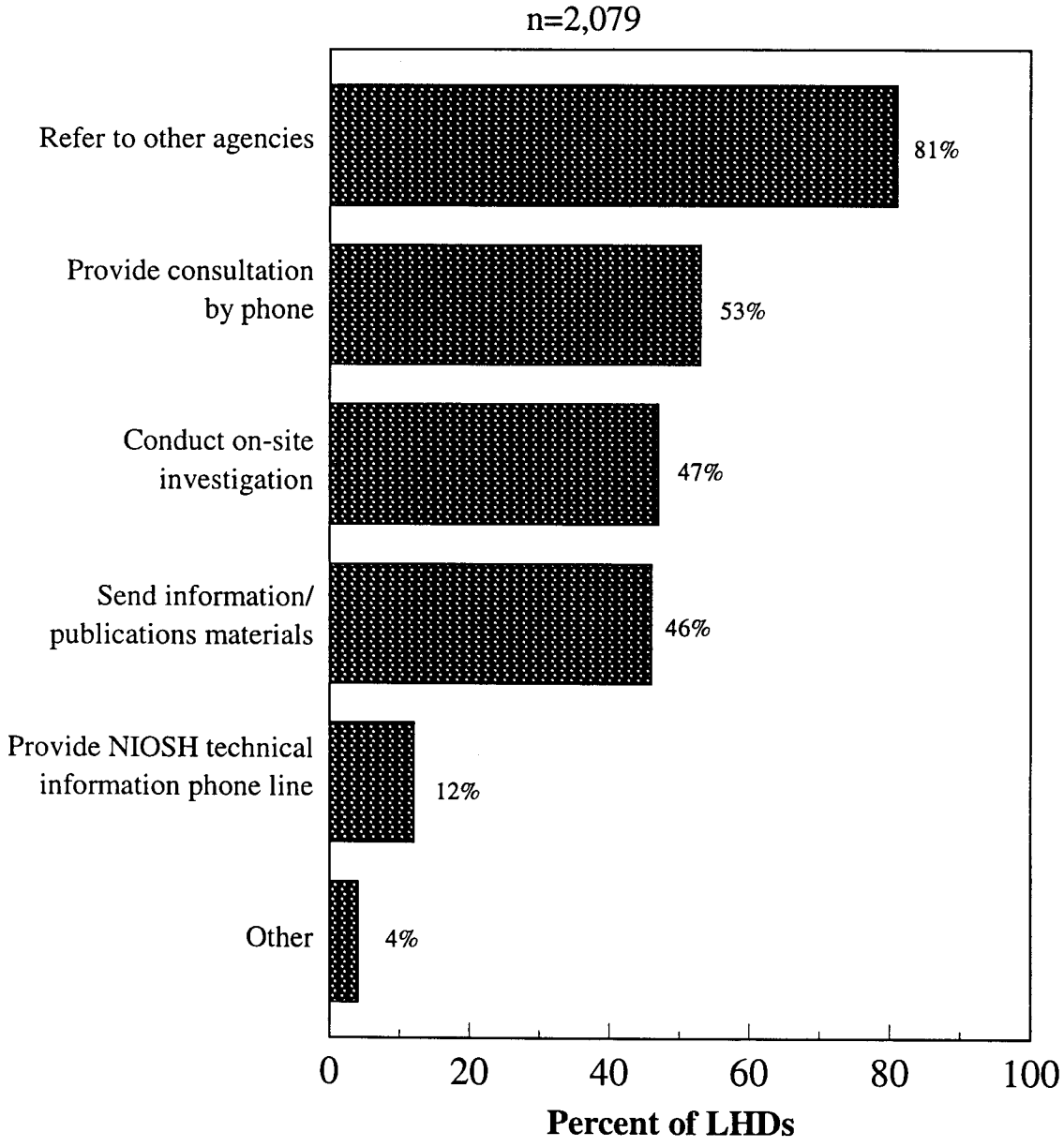


n= number of respondents

Figure 51

Methods U.S. Local Health Departments Use to Address OSH Complaints or Requests

1992-1993

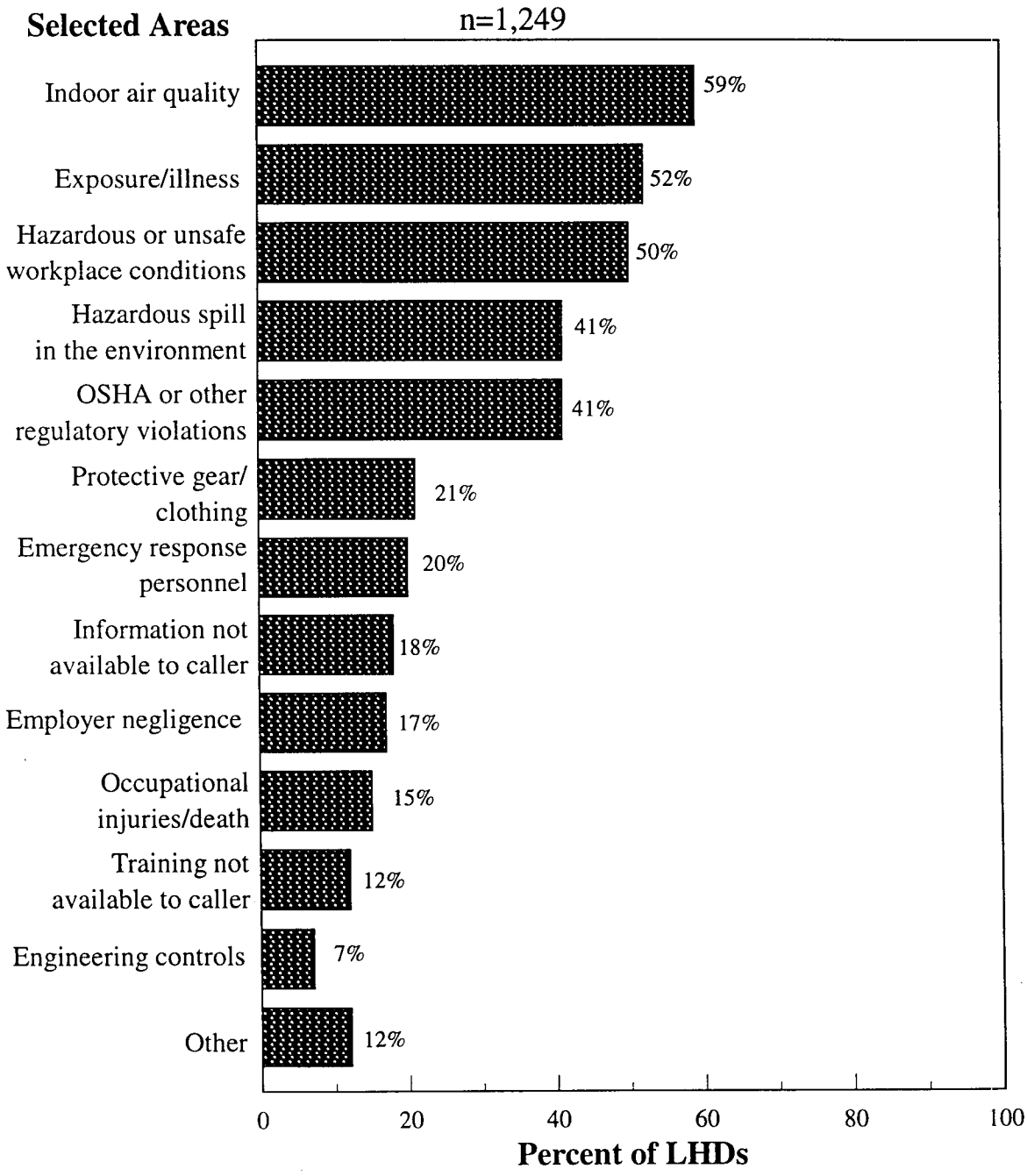


n= number of respondents

Figure 52

Requests for Assistance in Selected OSH Areas to U.S. Local Health Departments That Received Complaints or Requests for Assistance in the Previous 12 Months

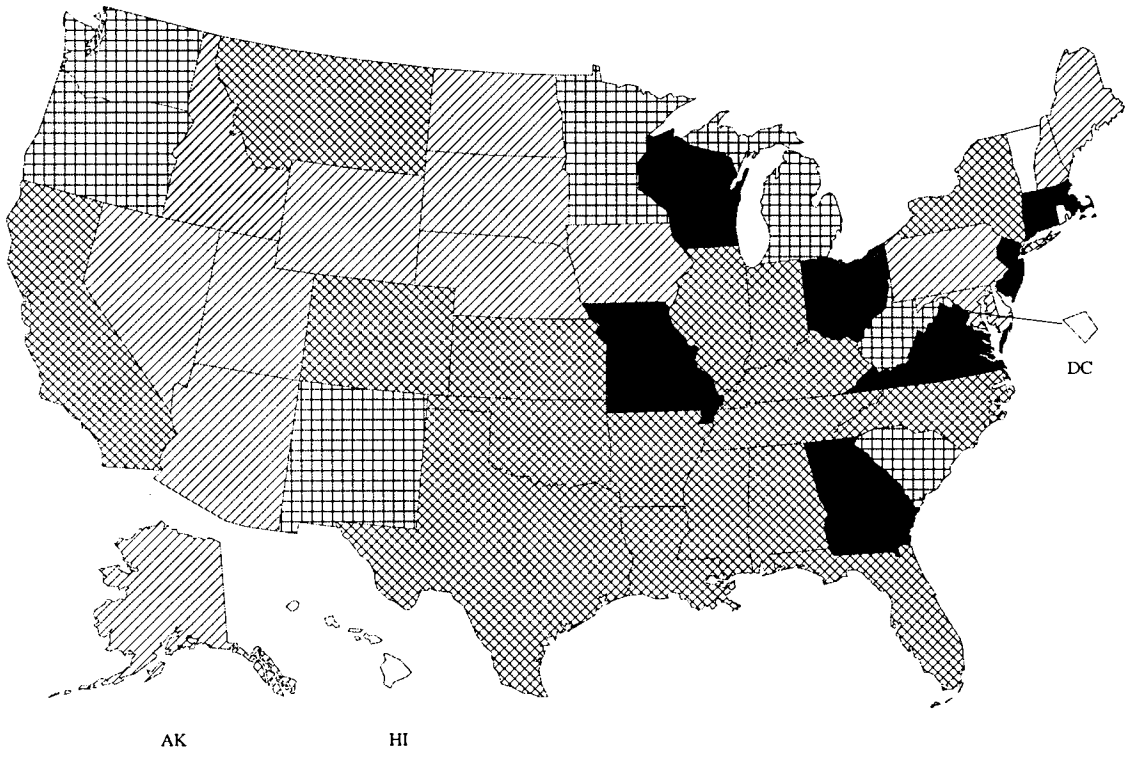
1992-1993



n= number of respondents

APPENDIXES

Appendix A
Number of U.S. Local Health Departments by State
1990



Number of Local Health Departments

n=2,932

None | 1 to 24 | 25 to 49 | 50 to 99 | 100 or more

Note: This map was recreated from information originally published in the *1990 National Profile of Local Health Departments.*

Appendix B

U. S. PUBLIC HEALTH SERVICE REGIONS

Region 1
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island*, Vermont

Region 2
New Jersey, New York, Puerto Rico**, Virgin Islands**

Region 3
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

Region 4
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

Region 5
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Region 6
Arkansas, Louisiana, New Mexico, Oklahoma, Texas

Region 7
Iowa, Kansas, Missouri, Nebraska

Region 8
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

Region 9
American Samoa**, Arizona, California, Guam**, Hawaii, Nevada, N. Mariana Islands**, Trust Territories**

Region 10
Alaska, Idaho, Oregon, Washington

*Rhode Island has no local health departments as defined in this report.

**The scope of this report is limited to the continental United States, Alaska, and Hawaii.

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