Variations in Public Health Governance

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Background

While some studies of local health departments (LHDs) suggest that local boards of health (LBOHs) make an important contribution to higher performance by LHDs, other studies find LBOHs have no significant impact on LHD performance or community health. To assess LBOHs’ significance, the study uses a binary dummy variable capturing if a LHD has or does not have a LBOH. However, analyses based on measures/variables capturing powers and authorities of LBOHs can provide further insights into significance and complexities of LBOHs’ functions.

Data on LBOH powers drawn from the 2011 National Association of Local Boards of Health (NALBOH) Profile reveal insights into significance and complexities of LBOHs’ functions. Capturing powers and authorities of LBOHs can provide better use a binary dummy variable capturing if a LHD has or does not have a LBOH. To assess LBOHs’ significance, the studies that local boards of health (LBOH) make an important contribution to public health. To analyze and map variations in Public Health Governance, the data for regional and national patterns.

Methods

Using national profile sample data from the National Association of Local Boards of Health (NALBOH), we categorized LBOHs using 33 variables based on four domains: (1) community health priorities, (2) public health responsibilities, (3) budgetary authorities, (4) human resource authorities. Results summarize the data for regional and national patterns.

Results

Budgetary Authorities: LBOHs with budgetary authorities (11.3% of all LBOHs) are more likely to be elected (p=0.001) and to have board chairs with longer tenures (p=0.007). Most (87.5%) LBOHs with such powers have used them in the past 3 years and are thus considered active LBOHs in regards to budgetary authorities. Active LBOHs differ from other LBOHs with budgetary powers in that they are more likely to have members designated by statute to a non-elected position (p=0.001).

Human Resources Authorities: Eighty-four percent (84.5%) of LBOHs report having human resources authorities, and these LBOHs do not differ from other LHDs in any significant way in terms of board composition or demographics. Most (73.6%) LBOHs with such powers have used them in the past 3 years. These active LBOHs are more likely to have provided training to their chairs (p=0.004).

Regulatory Authorities: Ninety-six percent of LBOHs report having regulatory authorities, and these LBOHs are more likely to have a chair who has worked in public health (p<0.001) and more likely to serve a city or multi-county jurisdiction (p<0.001). Most (89.6%) LBOHs with such powers have used them in the past 3 years. These active LBOHs are more likely to have provided training to their chairs (p<0.001), have more female board members (p<0.001), and are more likely to be the elected board (p<0.001).

Enforcement Authorities: Seventy-seven percent (76.5%) of LBOHs report having enforcement authorities and are less likely to have female board members (p<0.005), Native American members (p<0.005) and fewer Native Hawaiian and Pacific Islander members (p<0.015). Most (78.8%) LBOHs with such powers have used them in the past 3 years and are thus considered active LBOHs in regards to enforcement authorities.

Discussion

Do LBOHs matter? LBOHs are the predominant governance structure for local health departments in general and in rural and low-income areas in particular. The diversity of authorities and their uses found in this study suggest a need for a deeper analysis that takes into account more than whether a local health department has or does not have a LBOH. In Idaho, for example, every LBOH reported being an active one in all four domains. In Wyoming, every reporting LBOH categorizes itself as having no authorities.

Future research from this project includes developing a deeper typology of LBOHs as well as investigating whether variations within a state reflect allowances granted under local control or errors in knowledge and perceptions of authority by the self-reporting LBOHs.