Moving Toward Public Health Equity in Connecticut

Appendices

Presented by the
Governor's Council for
Local Public Health Regionalization

Submitted to Governor Rell and the General Assembly
January 2010

Prepared by the Department of Public Health

APPENDIX A

STATE OF CONNECTICUT
BY HER EXCELLENCY
M. JODI RELL
GOVERNOR
EXECUTIVE ORDER NO. 26

WHEREAS, the people of Connecticut deserve a public health system capable of expertly monitoring and protecting the health and well-being of the communities it serves; and
WHEREAS, local health departments and our State Department of Public Health must effectively network in providing advocacy, training and certification, technical assistance and consultation, with regard to public health issues; and
WHEREAS, during these difficult economic times it is imperative that a comprehensive and thoughtful planning process occur relative to the future infrastructure of public health in Connecticut; and
WHEREAS, as Governor of Connecticut, it is my duty to take whatever steps are needed to ensure cooperation, communication and informed decision-making on all public health issues.
NOW, THEREFORE, I, M. Jodi Rell, Governor of the State of Connecticut, acting by virtue of the authority vested in me by the Constitution and by the statutes of this state, do hereby ORDER and DIRECT:

1. That there is hereby created a Governor's Council for Local Public Health Regionalization (hereinafter "Council"), that will advise the Governor and provide recommendations
2. That the council, through regular meetings and briefings, will devise a plan to communicate a practical regional approach for defining our local public health infrastructure with the goal of public health regionalization
3. That the Council submit a public health infrastructure regionalization plan to me within six months of the Council's first meeting.
4. That the Council shall be chaired by the Commissioner of Public Health
5. That additional members shall be as follows:
    a. Two Department of Health staff members,
    b. Three local health directors recommended by Connecticut Association of Directors of Health (CADH)
    c. One member from CADH
    d. One member from the Connecticut Conference of Municipalities
    e. One member of the Council of Small Towns
    f. Two members from local Boards of Health appointed by Commissioner of Public Health
    g. One member from the Office of Policy & Management
6. That this order shall take effect immediately.

Dated in Hartford, Connecticut, this 12th day of May 2009.

APPENDIX B

Governor's Council for Local Public Health Regionalization

Commissioner J. Robert Galvin, Chair
Connecticut Department of Public Health

Karen Buckley-Bates, Facilitator	Department of Public Health
William H. Blitz (Alternate)	Representing Local Directors of Health
Robert Dakers	Representing the Office of Policy and Management
Ralph Eno	Representing Connecticut Council of Small Towns
William W. Fritz, Jr.	Representing Local Boards of Health
Matt Hart	Representing CT Conference of Municipalities
Jennifer Kertanis	Representing CT Assoc. of Directors of Health
Pamela Kilbey-Fox	Representing Department of Public Health
Richard H. Matheny, Jr.	Representing Local Directors of Health
Mary Pettigrew	Representing Department of Public Health
Barton Russell (Alternate)	Representing Connecticut Council of Small Towns
Baker Salsbury	Representing Local Directors of Health
Karen N. Spargo	Representing Local Directors of Health
Carolyn Wysocki	Representing Local Boards of Health

APPENDIX C

Connecticut General Statutes sections 19a-2a

Sec. 19a-2a. Powers and duties. The Commissioner of Public Health shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of the Department of Public Health and the Public Health Code. He shall have responsibility for the overall operation and administration of the Department of Public Health. The commissioner shall have the power and duty to: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as are necessary to carry out the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department as established by statute; (5) contract for facilities, services and programs to implement the purposes of the department as established by statute; (6) designate a deputy commissioner or other employee of the department to sign any license, certificate or permit issued by said department; (7) conduct a hearing, issue subpoenas, administer oaths, compel testimony and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Department of Public Health; (8) with the health authorities of this and other states, secure information and data concerning the prevention and control of epidemics and conditions affecting or endangering the public health, and compile such information and statistics and shall disseminate among health authorities and the people of the state such information as may be of value to them; (9) annually issue a list of reportable diseases and reportable laboratory findings and amend such list as he deems necessary and distribute such list as well as any necessary forms to each licensed physician and clinical laboratory in this state. He shall prepare printed forms for reports and returns, with such instructions as may be necessary, for the use of directors of health, boards of health and registrars of vital statistics; (10) specify uniform methods of keeping statistical information by public and private agencies, organizations and individuals, including a client identifier system, and collect and make available relevant statistical information, including the number of persons treated, frequency of admission and readmission, and frequency and duration of treatment. The client identifier system shall be subject to the confidentiality requirements set forth in section 17a-688 and regulations adopted thereunder. The commissioner may designate any person to perform any of the duties listed in subdivision (7) of this section. He shall have authority over directors of health and may, for cause, remove any such director; but any person claiming to be aggrieved by such removal may appeal to the Superior Court which may affirm or reverse the action of the commissioner as the public interest requires. He shall assist and advise local directors of health in the performance of their duties, and may require the enforcement of any law, regulation or ordinance relating to public health. When requested by local directors of health, he shall consult with them and investigate and advise concerning any condition affecting public health within their jurisdiction. He shall investigate nuisances and conditions affecting, or that he has reason to suspect may affect, the security of life and health in any locality and, for that purpose, he, or any person authorized by him so to do, may enter and examine any ground, vehicle, apartment, building or place, and any person designated by him shall have the authority conferred by law upon constables. Whenever he determines that any provision of the general statutes or regulation of the Public Health Code is not being enforced effectively by a local health department, he shall

forthwith take such measures, including the performance of any act required of the local health department, to ensure enforcement of such statute or regulation and shall inform the local health department of such measures. In September of each year he shall certify to the Secretary of the Office of Policy and Management the population of each municipality. The commissioner may solicit and accept for use any gift of money or property made by will or otherwise, and any grant of or contract for money, services or property from the federal government, the state or any political subdivision thereof or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant or contract. The commissioner may establish state-wide and regional advisory councils.

(P.A. 93-381, S. 2, 39; P.A. 94-174, S. 10, 12; P.A. 95-257, S. 12, 21, 24, 58; P.A. 03-252, S. 1.)

History: P.A. 93-381 effective July 1, 1993; P.A. 94-174 required commissioner to certify the population of each municipality to the secretary of the office of policy and management in September of each year, effective June 6, 1994; P.A. 95-257 replaced Commissioner of Public Health and Addiction Services with Commissioner and Department of Public Health, deleted responsibilities for coordination of alcohol and drug abuse problems, replaced "complete" with "compel" in Subdiv. (7), deleted duties re alcohol and drug facilities in Subdiv. (10) and added designation authority in Subdiv. (11), effective July 1, 1995; P.A. 03-252 deleted former Subdiv. (11) re requirement that commissioner make annual inspection of hospitals, asylums, prisons, schools and other institutions.

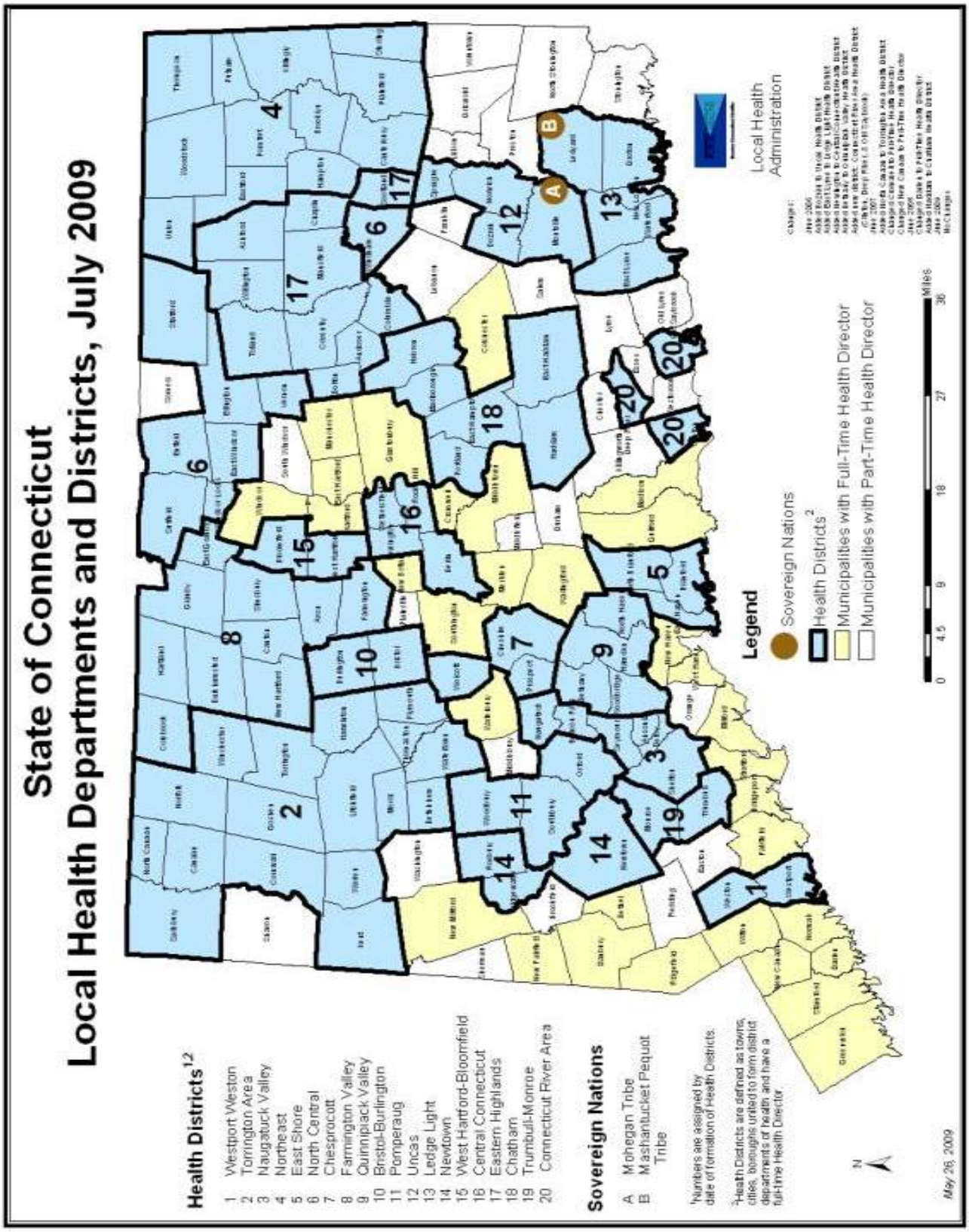
See Sec. 4b-31a re commissioner's role in development of plan for colocation of family resource centers and school-based health clinics.

See Sec. 17b-277a re duty to establish informational program for applicants to Healthy Start Program.

See Sec. 22a-1i re environmental risk assessment duties.

Legislature has vested commissioner of public health with expansive powers with respect to enacting and enforcing public health law, as well as overseeing implementation and coordination of state and municipal health regulations. 263 C. 558.

APPENDIX D


State of Connecticut
Local Health Departments and Districts, July 2009
Health Districts[1,2]
1 Westport Weston
2 Torrington Area
3 Naugatuck Valley
4 Northeast
5 East Shore
6 North Central
7 Chesprocott
8 Farmington Valley
9 Quinnipiack Valley
10 Bristol-Burlington
11 Pomperaug
12 Uncas
13 Ledge Light
14 Newtown
15 West Hartford-Bloomfield
16 Central Connecticut
17 Eastern Highlands
18 Chatham
19 Trumbull-Monroe
20 Connecticut River Area
Sovereign Nations
A Mohegan Tribe
B Mashantucket Pequot Tribe
[1]Numbers are assigned by date of formation of Health Districts.
[2]Health Districts are defined as towns, cities, boroughs united to form district departments of health and have a full-time Health Director.
Legend
Sovereign Nations
Health Districts[2]
Municipalities with Full-Time Health Director
Municipalities with Part-Time Health Director
Local Health Administration
Miles
0 4.5 9 18 27 36
N
May 28, 2009

APPENDIX E
Boards of Health in Connecticut

According to a recent survey of State Statues by the National Association of Local Boards of Health (NALBOH) 44 of 51 States address local boards of health whether they are a district, county or city/town. There is both variation and commonality of roles, responsibilities and authority among the states.

In Connecticut, local boards of health and health departments originated in home rule municipal government. They preceded the State Board of Health, and its eventual State Department of Health, which were established in 1878. The first board of health was established 5 years earlier in 1873 in New Haven, Connecticut.

This was followed by local boards of health, and subsequently local health departments, in cities and towns throughout the state. These early municipal boards were governing as well as policy-making. They hired the director of health for the city or town, developed local public health ordinances, and determined the services and programs that the local health department would provide. The municipal boards were eventually codified in local municipal charters, where many remain today. In 1978 the State Legislature provided per capita funding for the first time to the large municipal health departments.

The interest of the State's towns to provide public health services on a regional basis was sparked in 1963. That year legislation was passed that gave towns the authority to form health districts, or regional health departments. The health districts were to be governed by a board whose members were appointed by the member towns. This gave the towns control over the new public health entities. The new law also provided the first funding for local public health based on the population of member towns in the districts.

The first local health district was the Aspetuck Valley Health District established in 1966 (now the Westport-Weston Health District). Over the years 104 cities and towns, representing nearly half the State's population, have formed or joined one of the 20 health districts throughout Connecticut.

The local public health districts are one example in successful regionalization in Connecticut. They demonstrate that regionalization of a critical municipal service is possible in this solidly home rule state. Among the key elements in the current health district statutes that make regionalization of public health services in Connecticut work include:

- Participation by towns in a health district is voluntary
- Communities are allowed to cluster in ways that will meet their needs and local relationships.
- The health districts acknowledge and respect historical relationships between and among towns that join the health district

- The health districts recognize the existing legal authority of local town health departments (town ordinance, codes, etc. and their municipalities and accommodate this in their planning and function. Sometimes it remains with the town, other times it is transferred to the district by mutual consent.
- Because of their voluntary nature health districts are able to design their services to support and accommodate local existing structures and existing arrangements for delivering regional public health services, such as emergency preparedness and vaccine mass dispensing.
- The health district legislation and regulations provide a legal base and standards for organization and function, while allowing for different models of regional structures and operations.
- Participating cities and towns had incentives to join, particularly state funding, and, most importantly, the ability to get more and better local public health services for less than it would cost any one town to provide.
- Because of their voluntary nature, member towns have the option to leave a health district after two years, if the model is not working.

A major key to the voluntary formation, and subsequent function, of these districts is their governing boards of health made up of representatives appointed to three year terms by the member towns. In this way the town's needs and perspective is maintained.

All district boards of health are governing bodies empowered pursuant Chapter 368f of the Connecticut General Statutes. They develop and implement strategic goals and objectives that support desired public health outcomes and establish public health policy for the Health District.

By state statute the responsibilities of district boards include, but not be limited to:

- Appointment and periodic performance evaluation of a Director of Health
- Oversight of the financial activities of the Health District; monitoring of its fiscal status; and the development and approval of an annual
- Development and implementation of strategic goals and objectives that support desired public health outcomes in the Health District and monitoring their achievement.
- Enforcement of applicable state and municipal laws
- Promulgation and enforcement of public health regulations for the prevention of disease and injury and the promotion of health in the Member Towns.
- Approval of admission of other towns to the Health District

Many of the enabling statutes go back decades. They have provided a sound legal foundation and model governance structure for many years. However, revisions are needed in both statutes and regulations. Proposed changes should support regionalization and address statutory issues raised by the current district and municipal boards. Boards of Health are an integral part of any Regionalization Plan in Connecticut.

APPENDIX F

Connecticut Public Health Code 19a-76-2

19a-76-2. Basic local health program

(a) Except as provided in subsection (c) of this section, to be eligible for state grants under section 19a-202 or section 19a-245 of the Connecticut General Statutes or section 19a-202a of the Connecticut General Statutes health departments shall ensure the provision of a basic public health program in accordance with subsection (b) below. The health department may ensure the provision of a program by directly providing the service, contracting with another health department or community agency or coordinating public health services with other community or regional resources providing specialized services. Nothing in these regulations shall prohibit any health department from providing health services in addition to the basic services described in subsection (b) below.

(b) The basic health program to be provided shall include the following services that prevent disease or reduce conditions that have an adverse effect on health:

- (1) Public health statistics. There shall be participation in a mechanism for the collection, tabulation, analysis and reporting of public health statistics for the health jurisdiction served;
- (2) Health education. There shall be public and professional information and education with emphasis on prevention and individual responsibility for health status, community organization and outreach;
- (3) Nutritional services. There shall be a nutrition program including appropriate activities in education and consultation for the promotion of positive health, the prevention of ill health, and the dietary control of disease;
- (4) Maternal and child health. There shall be a comprehensive plan for maternal and child health services to include but not necessarily be limited to:
  - (A) Prenatal, childbearing, and reproductive care;
  - (B) Family planning;
  - (C) Child and adolescent health including school health;
  - (D) Child abuse;
  - (E) Genetic disease control;
- (5) Communicable and chronic disease control
  - (A) There shall be preventive services including immunization, screening, consultation, diagnostic services, epidemiological investigation, and community education;
  - (B) The qualifying health department shall identify resources and provide referral for treatment and rehabilitation of persons with communicable, chronic, and handicapping conditions including, but not necessarily limited to, tuberculosis, venereal disease, cancer, hypertension, and cardiovascular disease;
  - (C) There shall be a plan for the prevention and control of vision, hearing, and dental problems;

(6) Environmental services. These shall include activities relating to water, food, air, wastes, vectors, housing, bathing places, safety, noise, toxic hazards, and nuisances in the community and work place;

(7) Community nursing services. There shall be provision for community nursing need to implement programs for which the qualifying health department is responsible;

(8) Emergency medical services. There shall be provision for the development and implementation of an emergency medical service system to include: identification of primary services, written mutual aid and mass casualty plans, and participation in regional planning.

(c) A municipality that has designated itself as having a part-time health department may ensure the provision of a basic public health program as described in subsection (b) of this section by directly providing the service, contracting with another health department or community agency or coordinating public health services with other community or regional resources providing specialized services.

(Effective December 15, 1983; Amended April 29, 1999).

APPENDIX G

TEN ESSENTIAL PUBLIC HEALTH SERVICES
including examples of performance standards

ESSENTIAL SERVICE #1: **MONITOR HEALTH OF THE COMMUNITY**
• Conduct community health assessment to identify public health risks and inform public health planning • Review available health data to determine most prevalent health problem afflicting community • Identify groups of people who might have a greater change of becoming ill because of where they live or work, because of social economic situations, or because they have behaviors that can cause health problems • Develop community health profile to educate community and community leaders about public health promotion • Establish website to provide community information about persistent health problems within community and how to prevent these problems
ESSENTIAL SERVICE #2: **DIAGNOSE & INVESTIGATE HEALTH COMMUNITY PROBLEMS**
• Investigate foodborne outbreaks • Communicate serious health threats to community in timely manner • Develop emergency response plans for public health emergencies • Respond to public health emergencies including disease outbreaks or terrorism • Ensure access to laboratory with capacity for sampling
ESSENTIAL SERVICE #3: **INFORM, EDUCATE & EMPOWER**
• Provide health information that is easy for people to get and understand • Develop and provide community with information on seasonal and ongoing public health issues including influenza and West Nile Virus prevention, cancer and obesity prevention, and bioterrorism preparedness • Provide health promotion activities like cholesterol screening, blood pressure screening, and flu clinics • Support legislation that will improve the community's health, such as clean indoor air legislation
ESSENTIAL SERVICE #4: **MOBILIZE COMMUNITY PARTNERSHIPS**
• Convene other health organizations (e.g., hospital) within community to develop community-wide health improvement plan • Coordinate agreements between other community health organizations to determine specific roles and responsibilities toward improving community's health

ESSENTIAL SERVICE #5 **POLICY DEVELOPMENT**
• Advocate for policies that will improve public health, such as clean indoor air law • Testify at public hearings in support of legislation that will improve public health
ESSENTIAL SERVICE #6: **ENFORCE LAWS AND REGULATIONS**
• Enforce public health code • Protect drinking water supplies • Conduct timely inspections (i.e., restaurants, tattoo parlors, campgrounds, daycare) • Conduct timely environmental inspections (i.e., septic systems, pools, lead abatement) • Follow up on hazardous environmental exposures and preventable injuries • Serve quarantine/isolation order to individual infected with infectious diseases such as tuberculosis, SARS, or Smallpox • Assist in revising outdated public health laws and development of proposed public health legislation
ESSENTIAL SERVICE #7: **LINK PEOPLE TO HEALTH SERVICES**
• Establish and maintain referral network for provision of personal health services to ensure that people who cannot afford health care get the care they need • Distribute mass quantities of antibiotics or vaccines in event of widespread disease outbreak (e.g., pandemic flu) or bioterro-related attack (i.e., smallpox or anthrax) • Identify and locate underserved populations such as low-income families, minorities, and the uninsured • Provide culturally and language appropriate materials so that special groups of people can be linked with preventive services
ESSENTIAL SERVICE #8: **ASSURE A COMPETENT WORKFORCE**
• Fund professional development opportunities for staff • Test emergency response plan during mock event to evaluate performance
ESSENTIAL SERVICE #9: **EVALUATE QUALITY**
• Monitor trends in disease rated to assess effectiveness of disease prevention activities • Monitor trends in risk factors (i.e., unprotected sex, drinking-and-driving, smoking) to assess effectiveness of health promotion activities • Evaluate effectiveness of public health programs and services
ESSENTIAL SERVICE #10 **RESEARCH FOR NEW INSIGHTS**
• Monitor rapidly changing disease prevention research and health promotion research • Revise practices to remain current with recommended practices from evidenced-based research

APPENDIX H

Sources Of Funding For Full And Part Time Municipal Health Departments And Health Districts: Fiscal Year 2007-08

Background Regarding Revenue Data for Local Health Departments and Districts

As part of the State Fiscal Year 2008 Annual Report completed by the Local Health Administration Branch of the State Department of Public Health, local health departments and districts submitted information regarding the sources of funding for their operations. Along with the total amount of revenues received in fiscal year 2007-08, departments and districts were also asked to provide the amounts received in the following categories: Federal Funds; State Funds; Local Funds and Department Revenues. The definitions of these revenue sources, which are shown on a Per Capita basis in Tables 1, 2 and 3 are as follows:

- **Federal:** Federal Funds largely involve grant funds of a categorical nature to fund specific services.
- **State:** State Funds involve grant funds, some of which are categorical to fund specific services, while others, like the State per capita grant provided to eligible departments and districts, are for general use in funding district and department operations and services.
- **Local:** Local funds generally are appropriations from municipal general funds and tax dollars (including payments from member municipalities in the case of health districts).
- **Department:** Department revenues typically involve charges and fees charged to individuals and entities for a service or permit. One example would be a fee related to restaurant license issued by a local health department or district.

One caution with respect to this revenue information is that this is self-reported information and it is not standardized across all departments and districts. This can lead to the information not being directly comparable or completely accurate in all cases. One example of this is that district revenues are likely to cover all the costs, including employee benefits and other overhead costs, while this is not the case for many full and part-time municipal departments. Nonetheless, the revenue information reported should give a good sense of how local health departments and districts are funded. In addition, it appears that the amount of revenues correlates fairly strongly, but not perfectly, to the level of expenditures for departments and districts.

FY 2007-08 Revenues, Full-Time Municipal Health Departments

Generally, it is small to mid-size suburban communities and larger urbanized communities that operate their own health departments with a full-time director. As a group, as indicated in Table 1, departments with full-time directors get over half of their revenues come from municipal appropriations and departmental fees and charges. The remaining portion of the funding for full-time municipal health departments comes from State and Federal Sources, which provide about 45 percent of the total for these departments. This 45 percent amount is higher than the comparable percentages of less than three percent for Part-Time Departments and almost 30 percent for health districts.

Table1: Revenues, Full-Time Health Departments FY 2007-08

Municipality	Department Total: All Funds	7/1/2007 Population	Per Capita Federal	Per Capita State	Per Capita Local	Per Capita Department	Per Capita Total
Bethel	$349,509	18,514		$4.61	$13.33	$0.94	$18.88
Bridgeport							
Colchester	$211,027	15,495		$4.49	$7.88	$1.25	$13.62
Cromwell	$181,500	13,552		$1.18	$10.74	$1.48	$13.39
Danbury	$2,499,159	79,226	$0.17	$15.11	$14.30	$1.95	$31.54
Darien (FY08)	*$305,185*	20,246		*$0.50*	*$9.46*	*$5.12*	*$15.07*
East Hartford	$2,318,223	48,697		$19.59	$26.58	$1.44	$47.61
Fairfield	$3,247,754	57,548		$2.89	$49.52	$4.02	$56.44
Glastonbury	$420,656	33,169		$1.39	$8.96	$2.34	$12.68
Greenwich	$2,590,028	61,871	$0.16	$2.53	$32.98	$6.20	$41.86
Guilford	$275,697	22,373		$3.46	$7.46	$1.40	$12.32
Hartford	$22,730,234	124,563	$82.26	$24.93	$63.27	$12.02	$182.48
Madison	$212,018	18,793	$1.51	$1.20	$8.44	$0.13	$11.28
Manchester	$951,483	55,857		$3.17	$12.61	$1.25	$17.03
Meriden	$ 3,132,100	59,225		$14.61	$36.37	$1.90	$52.88
Middletown	$480,585	47,778		$6.75	$	$3.31	$10.06
Milford	$1,421,143	55,445		$8.38	$15.98	$1.27	$25.63
New Britain	$1,153,232	70,664		$5.67	$9.23	$1.42	$16.32
New Canaan	$458,761	19,890		$2.45	$15.13	$5.48	$23.06
New Fairfield	$299,030	14,100		$4.67	$14.95	$1.59	$21.21
New Haven	$12,010,000	123,932	$40.34	$24.21	$25.61	$6.75	$96.91
New Milford	$363,751	28,439		$4.22	$5.72	$2.85	$12.79
Norwalk	$ 3,468,327	83,456		$7.54	$ 26.04	$7.99	$41.56
Ridgefield	$403,054	23,872		$5.35	$11.53		$16.88
Southington	$653,824	42,142	$1.99	$1.35	$11.18	$0.99	$15.51
Stamford	$2,569,537	118,475	$9.50	$1.97		$10.22	$21.69
Stratford	$998,537	49,015		$4.28	$11.14	$4.96	$20.37
Wallingford	$408,341	44,679		$1.35	$7.46	$0.32	$9.14
Waterbury	$7,244,877	107,174	$9.33	$23.45	$33.34	$1.48	$67.60
West Haven	$582,230	52,676		$3.54	$6.67	$0.85	$11.05
Wilton	$344,965	17,715		$4.12	$12.29	$3.06	$19.47
Windsor	$607,620	28,754		$4.97	$ 14.63	$1.54	$21.13
	$72,892,387	1,557,335	$11.24	$10.02	$21.28	$4.27	$46.81
	Average	50,237					
	Minimum	13,552					
	Maximum	124,563					
Excluding Selected Cities/Towns*		**34,420**	**$.16**	**$3.89**	**$11.79**	**$2.26**	**$18.11**

***Danbury, East Hartford, Fairfield, Hartford, Meriden, New Haven, Norwalk, Stamford and Waterbury**

Note: Hartford's revenues reflect some non-public health activities (e.g., Parks and Recreation); Hartford and New Haven provide some AIDS-related services to other municipalities in their regions.

In addition to the $1.18 from the State per capita grant received by eligible full-time departments in fiscal year 2007-08, most full-time departments received, in many cases, significant amounts of categorical grants from the State and Federal Governments to fund particular services or programs. These included programs related to AIDS prevention and treatment, immunizations, childhood lead poisoning and prevention, preventive health programs, STD prevention and other programs.

In terms of the breakdown of revenues between federal and state sources, a number of municipalities may, in providing this revenue information, list Federal funds passed through the State Department of Health and other State agencies as State Funds, while others will include them in the Federal Funds column. For many municipalities, therefore, it makes sense to combine these columns when looking for the sources of non-local revenues. This is less true in the cases of Hartford and New Haven, for example, which have both received large and direct federal grants related to AIDS and HIV prevention and treatment services.

At the bottom of Table 1, when the revenue figures for more urbanized municipalities (along with Fairfield which includes school nurses in its budget) are excluded, the per capita amounts for the remaining, largely suburban towns look more similar in nature to the per capita amounts found in Table 3 for health districts.

FY 2007-08 Revenues, Part-Time Municipal Health Departments (Table 2)

As indicated in Table 2, almost all of the revenues for municipal health departments having part-time directors is comprised of local municipal appropriations or local charges and fees. There are no reported Federal Funds for these departments, with the State Funds appearing to only involve the State $.49 per capita grant provided to eligible departments.

Among the 25 towns providing revenue information, more than one-half reported total revenues of less than $3.50 per capita, which means that a small or modest amount of resources are provided for local health department activities. Meanwhile, nine towns had per capita revenues of $10 or more. It should be noted however, that many smaller towns may not charge for services or may not account for fees by department, which could lead to understating the local public health services provided by these communities.

Table 2: Revenues, Part-Time Health Department FY2007-08

Municipality	Department Total	7/1/2007 Population	Per Capita State	Per Capita Local	Per Capita Department	Per Capita Total
Brookfield	$199,611	16,413	$0.49	$9.42	$2.25	$12.16
Chester	$1,600	3,834			$0.42	$0.42
Durham	$4,045	7,397			$0.55	$0.55
Easton	$84,746	7,366	$0.50	$8.12	$2.89	$11.51
Essex	$123,707	6,753		$16.91	$1.41	$18.32
Franklin	$3,000	1,891			$1.59	$1.59
Griswold	$6,121	11,390			$0.54	$0.54
Killingworth						
Lebanon	$24,000	7,354		$2.60	$0.66	$3.26
Lisbon	$1,190	4,205			$0.28	$0.28
Lyme						
Middlebury	$61,387	7,252	$0.47	$6.74	$1.26	$8.46
Middlefield	$84,133	4,248	$0.49	$18.71	$0.60	$19.81
North Stonington	$43,980	5,212		$8.44		$8.44
Old Lyme	$171,604	7,384		$22.40	$0.84	$23.24
Orange	$710,990	13,813	$0.50	$16.44	$34.54	$51.47
Plainville	$180,307	17,193	$0.50	$9.45	$0.54	$10.49
Preston	$800	4,902			$0.16	$0.16
Redding	$15,895	8,840	$0.49		$1.30	$1.80
Salem	$4,535	4,102		$0.11	$1.00	$1.11
Sharon	$26,691	3,022		$8.21	$0.62	$8.83
Sherman	$13,780	4,110			$3.35	$3.35
Somers	$25,475	10,850	$0.49		$1.86	$2.35
South Windsor						
Stonington	$22,676	18,343	$0.46		$0.77	$1.24
Voluntown	$1,200	2,612			$0.46	$0.46
Washington	$36,861	3,671		$8.46	$1.58	$10.04
Westbrook	$74,634	6,618	$0.49	$8.28	$2.51	$11.28
	$1,922,968	188,775	$0.29	$6.28	$3.62	$10.19
	Average	7,551				
	Minimum	1,891				
	Maximum	18,343				

FY 2007-08 Revenues, Health Districts (Table 3)

The total revenues per capita for all of the health districts, as indicated in Table 3, was $15.20 in fiscal year 2007-08, with between $2.08 to $2.43 coming from the State per capita grant, between $2.25 and $2.50 per capita in state and federal categorical or block grants, $7.07 per capita from participating municipalities and $3.60 per capita in department fees and charges. The State and Federal grants were for services or programs such as bioterrorism preparation, prevention programs, obesity prevention, AIDS and others.

Table 3: Revenues, Health Districts Fiscal Year 2007-08 Districts

District	Department Total	7/1/2007 Population	Per Capita Federal	Per Capita State	Per Capita Local	Per Capita Dept.	Per Capita Total
Westport Weston	$1,365,758	36,708		$4.97	$13.57	$18.67	$37.21
Chesprocott	$687,617	54,513		$3.68	$6.14	$2.79	$12.61
East Shore	$966,844	72,022	$0.16	$5.10	$5.74	$2.43	$13.42
Farmington Valley	$1,141,644	101,384		$4.01	$4.08	$3.18	$11.26
Naugatuck Valley	$1,598,103	124,936	$2.35	$2.46	$5.23	$2.76	$12.79
North Central	$1,505,727	162,733	$0.17	$2.68	$3.67	$2.73	$9.25
Northeast	$1,032,103	85,405	$1.90	$2.16	$3.71	$4.31	$12.08
Torrington Area	$1,697,354	127,354		$4.11	$4.71	$4.51	$13.33
Quinnipiack Valley	$1,135,646	96,467	$1.96	$2.29	$5.18	$2.34	$11.77
Bristol-Burlington	$2,887,957	70,054	$1.76	$2.53	$34.27	$2.67	$41.22
Pomperaug	$784,593	41,949		$3.41	$7.79	$7.50	$18.70
Uncas	$947,543	61,601	$0.08	$6.46	$6.43	$2.41	$15.38
Ledge Light	$2,502,711	120,809	$1.37	$5.94	$7.26	$6.15	$20.72
Newtown (FY 08)	*$595,995*	30,993		*$3.94*	*$12.36*	*$2.93*	*$19.23*
West Hrtfrd-Bloomfield	$1,510,505	81,179		$7.73	$8.76	$2.11	$18.61
Central Connecticut	$942,251	94,462		$3.32	$4.05	$2.60	$9.97
Eastern Highlands	$868,415	80,180		$4.46	$4.29	$2.09	$10.83
Chatham	$601,631	54,320		$2.59	$6.80	$1.68	$11.08
Trumbull-Monroe	619,411	54,154		$3.19	$6.20	$2.05	$11.44
CT River Area	$630,615	28,790	$0	$6.89	$10.75	$4.26	$21.90
	$24,022,423	1,580,013	$0.62	$3.92	$7.07	$3.60	$15.20
	Average	79,001					
	Minimum	28,790					
	Maximum	162,733					

In terms of "local effort" (i.e. Local Funds and Department Funds), the average amount for districts was $10.67 per capita. This is only slightly higher than the $9.90 average for the part-time departments as a whole, despite districts overall revenues being $5.00 more per capita than municipal departments with part-time directors.

When comparing districts to the per capita amounts for more suburban towns at the bottom of Table 1, overall revenues for those full-time departments was $18.11 per capita as opposed to the $15.20 per capita for districts. As indicated previously, however, district budgets to which these revenues correlate are likely more inclusive than most of the budgets for the full-time departments in the areas of employee benefits and other indirect costs. Part of the revenue difference between districts and these towns may also relate to the fact that the suburban full-time departments appear to be slightly higher (i.e. approximately $.50 to $.75 per capita) in terms of State and federal categorical grants than the amounts received by districts.

Potential Conclusions and Issues Re: Health Department and District Revenues

Revenues are the highest for municipal health departments with full-time directors, due in part to the significant levels of federal and state funds aimed at meeting the public health needs of Connecticut's larger, urbanized communities. In drilling down further, it can also be seen that full-time, more suburban health departments and health districts also have a greater eligibility for and potentially a greater capacity to obtain state and federal funding than do health departments with part-time directors.

The total revenues per capita are comparatively appear very low for a large number of departments with part-time directors, which suggests a lower level of resources being available to fund public health services in these towns. For part-time districts having higher levels of spending, the "local effort" needed to fund these services is higher than for departments or districts with comparable levels of spending. This implies that it may be more cost-effective for a town with a part-time health director that is seeking to expand the level of public health services provided to its citizens to do so by joining a district.

The level of revenues per capita for more suburban health departments and health districts overall were fairly close, particularly in light of the issue that district budgets are likely more inclusive of all costs than those for departments. In comparing the per capita revenues for full-time departments with that of adjoining districts, the differences imply the potential for savings for some municipal departments and not for others. Issues of the scope and quality of services provided, a closer analysis of costs and issues of governance would need to be explored in terms of weighing the costs and benefits of joining a district.