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Marion Public Health:

Investing in a Healthy Community

“Presentation in Brief”

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Introduction

Earlier this year, officials in Marion County expressed interest in receiving research assistance on several questions. The questions they raised relate to the spectrum of local tax support for public health services provided by Local Health Departments (LHDs), city-county shares of local public health financing contributions from recently consolidated Ohio LHDs, and appropriate practices for managing carryover fund balances at the end of each fiscal year. Officials in Marion County also sought external recommendations regarding appropriate splits for city and county shares of funds for local public health services in Marion County and next steps for managing carryover balances in the Marion Combined General Local Health District.

This “Brief Report” is a part of our effort to respond to this request. The three pages that follow include summaries of the data compiled to answer the three questions above. The last page summarizes recommendations made to inform discussions within Marion County regarding financing local public health services. More information about this project can be obtained by contacting Mr. Thomas Quade, Health Commissioner at Marion Public Health (MPH). We at the Center for Public Policy and Health at Kent State University are also happy to respond to questions as needed and upon request.

Question 1

Where does Marion Public Health (MPH) fall within the spectrum of tax support per capita per annum across Ohio or other comparable situations nationally?

Data

To estimate local shares of local health department expenditures in Marion County and elsewhere, we used financial and population data from the National Association of County and City Health Officials' (NACCHO) national Local Health Department Profile Survey, Annual Financial Report (AFR) data from the Ohio Department of Health (ODH), and information provided by accredited local health departments in Ohio and Wisconsin.

Findings

The data we compiled from the sources described above suggest that MPH is neither a “big spender”, nor is it “at the bottom of the barrel” in terms of its local government contributions for public health services. Rather, the data presented in the tables below suggest that local contributions for public health services in Marion County generally lie close to the average amounts of local contribution provided by other communities for local public health services in Ohio and around the nation.

Question 1: Where does MPH fall within the spectrum of tax support per capita per annum across Ohio or other comparable situations nationally?

(2013) Per Capita Revenue across U.S. Comparable* Local Health Districts



*Local Health Districts that are: 1) locally governed; 2) not providing primary care, behavioral health, or home health services, and; 3) serve between 50,000 and 99,999 persons. n= 147

(2012) Per Capita Revenue across Ohio Local Health Districts



n= 125

(2012) Per Capita Revenue across Ohio Local Health Districts Consolidated since 1999



n=14, including Marion Public Health

(2012) Per Capita Revenue across Nationally Accredited Local Health Districts



n=4

Question 2

How does the city to county ratio of tax support for Marion Public Health (MPH) compare with the funding ratios in similar city/county health districts in Ohio?

Data

To ascertain city-county funding shares, we reviewed fifteen consolidation contracts between cities and counties that have consolidated since 2001. We also conducted a survey of recently consolidated Local Health Departments (LHDs) in Ohio (1999-2012) and accessed Annual Financial Reporting (AFR) data from the Ohio Department of Health (ODH) to help us understand city-county shares.

Findings

We identified three major contractual mechanisms for determining city shares of public health services:

- Established proportions of assessed property valuations within the jurisdictions;
- Per capita payment shares, based on population, and;
- Negotiated fixed dollar amounts (“negotiated contract amounts”).

In general, we found that the jurisdictions where city shares were determined directly by assessed property valuations within the cities involved, or by population, were characterized by relatively low city shares.

We also found that most (9 out of 11) of the recently consolidated county LHDs in our sample are characterized by the consolidation of a relatively small city into a larger County Health District. In all 9 of these cases, the cities contribute 10% or less of the population served by the recently combined LHDs.

The two remaining cases of consolidation in our sample– Lucas County-Toledo and Summit County-Akron – are ones in which the city-county share is determined by a negotiated contract amount. They are also cases where the consolidating cities represent large proportions of the populations served by the newly consolidated LHD, 40% or more in both cases. In both of these cases, we also find that the cities pay 50% of local shares of revenue or more. The data in the table below summarize these findings and compare them to the city-county shares in Marion County.

**City-County Proportions of Local Public Health Funding Shares:
Recently Consolidated Local Health Departments in Ohio**

Jurisdictions	Description	City Share of LHD Local Public Health Revenue
9 small Ohio cities (for example, Indian Hill, Ravenna, Campbell, Struthers, etc.)	Small cities in larger counties, where the city population is < 10% of the county population.	< 10% (all cases)
Toledo (Lucas County) and Akron (Summit County)	A large city in proportion to the size of the county. City populations constitute at least 40% of the county population.	>50%. In both cases, the city pays their population-based proportionate share or more.
Marion (Marion County)	The City of Marion, where the city comprises about 53% of the County’s population	68%, based on current contract.

Question 3

What is an appropriate range of end-of-year cash balance to assure no disruption of services results from an insufficient end of year cash balance?

Data

To address this question, we researched best practices from national health and public finance organizations, surveyed recently consolidated Local Health Departments on their carryover management practices, accessed relevant data from the Ohio Department of Health, and reviewed carryover reports with MPH officials.

Findings

The Government Finance Officers Association (GFOA) “recommends that governments establish a formal policy on the level of unrestricted fund balance that should be maintained in in the general fund.” It also recommends that general purpose governments, regardless of size, “maintain an unrestricted fund balance in their general fund of no less than two months of regular general fund operating revenues or regular general fund operating expenditures.” In addition, GFOA also makes it clear that this “two month” recommendation is a minimum, and suggests that a government’s situation often may require a level of unrestricted fund balance in excess of this recommendation – particularly if revenues are unpredictable, as is the case with health departments in Ohio that depend on externally provided revenues.

Our survey of recently consolidated LHDs regarding their carryover practices also revealed a range of insights. While formal written policies regarding carryover balances were not reported, the responding health departments did reveal a range of ongoing practices, including for example:

- Estimating and budgeting for future liabilities annually;
- Budgeting carryover balances as a part of severance, public health emergency, community health assessment, and other planning ...;
- Maintaining carryover balances of at least 25% of annual expenditures, and;
- Carrying over funds to cover potential payouts, plus enough to cover operating costs for the department for the first quarter of each year.

Our investigation revealed no reason to believe that MPH is carrying over excessive amounts of unrestricted revenue. However, given the findings above regarding GFOA recommendations and the practices of other LHDs in Ohio, our investigation does suggest that MPH may benefit from a more self-conscious approach to dealing with future liabilities and unexpected situations that may require additional revenue (public health emergencies, for example). In addition, it is appropriate to note that further research would be helpful to improve our understanding of MPH’s carryover levels and those of other Ohio LHDs because of what appear to be variable reporting practices in this area.

Recommendations for Consideration in Marion County

While policies regarding city and county shares of local public health revenues should be established by local authorities and carryover management practices are typically determined by local Boards of Health in Ohio, it can be helpful to have recommendations made by external parties to help guide decision-making processes in these areas. Based on our investigations, we offer recommendations below to inform discussions and to support the ongoing improvement of public health in Marion County.

City-County Share Recommendations for Consideration in Marion County:

1. Marion County should define a new method of determining the city and county shares of locally provided LHD revenues that is based on population shares within Marion County. This kind of population indicator reflects both health needs and the benefits likely to be received from health related services.
2. MPH should separate out the services provided exclusively to the City of Marion and not to the rest of the county. The full costs of these “city only” services should be paid by the City of Marion.
3. The transition to a population-based calculation of the city/county shares should take place over the period of two or three years to ease impacts on individual jurisdictions.
4. MPH officials should convene a group of respected citizens who, as a collectivity, have equal ties to the city and the outlying areas of the county to review the funding source changes made two years after they are fully implemented (e.g., within five years of initial implementation).

Carryover/reserve fund Recommendations for Consideration in Marion County:

1. The MPH should establish a written policy for managing its General Fund balances.
2. The MPH should join other LHDs in Ohio in drawing useful guidance from the GFOA’s 2009 “Best Practices” document.
 - a. Establishing unrestricted cash balances of “at least 25%” of annual expenditures would be an appropriate starting point for discussions in this area. The actual determination of an appropriate minimum fund balance is a policy judgment that is appropriately made by governing officials with the Marion Board of Health.
3. The MPH may also want to consider a staged process of policy responses to differing fund balances as is done in the City of Tallmadge, Ohio. Decisions on policy responses may also affect judgments on threshold fund balances incorporated into the written policy referenced in 1 and 2 above.

