Introduction to Local Public Health Services in North Carolina

Jill D. Moore, JD, MPH

July 2013

This is an updated excerpt from *Article 41: Public Health*, in COUNTY AND MUNICIPAL GOVERNMENT IN NORTH CAROLINA (David M. Lawrence ed., UNC School of Government 2007). The full 2007 article is available at http://sogpubs.unc.edu/cmg/. An updated version of the complete article will be published in 2014.

Public Health at the Local Level

Local Health Departments

Each county in North Carolina is required by law to provide public health services (G.S. 130A-34). A county may satisfy this duty by operating a county health department, participating in a multi-county district health department, forming or joining a public health authority, establishing a consolidated human services agency that includes public health, or contracting with the state to provide public health services. Each type of agency is captured in the generic term "local health department."[1] Each type of agency has a governing board, which may be called a board of health, a public health authority board, or a consolidated human services board. For purposes of this article, the term "board of health" is used to refer to all of those.[2] A board of health may be an independent board appointed by the county commissioners, or the commissioners may elect to serve as the board of health themselves by adopting a resolution abolishing the board and conferring its powers and duties upon the board of commissioners.[3]

In June 2012, significant new legislation began to change the landscape for local public health agencies in North Carolina. Before that date, the law that provided the option of providing public health services through a consolidated human services agency was limited to counties with populations of 425,000 or more. The option for county commissioners to assume the powers and duties of a local board of health was subject to the same population threshold. By 2012, only three North Carolina counties had populations that large--Guilford, Mecklenburg, and Wake--and only two had exercised the options.[4] The new legislation removed the population threshold and extended the option of creating a

---

[1] G.S. 130A-2(5) (defining "local health department" as "a district health department or a public health authority or a county health department); 130A-43 (giving consolidated human services agencies the responsibility to carry out the duties of a local health department); 153A-77(b) (authorizing boards of county commissioners to create consolidated human services agencies that include public health). Cabarrus county provides public health services pursuant to an uncodified state law that authorizes a hospital authority to provide local public health services. S.L. 1997-502, sec. 12. The Cabarrus Health Alliance exercises the legal powers and duties of a local health department.

[2] G.S. 130A-2(4) (defining "local board of health" as "a district board of health or a public health authority board or a county board of health"); 153A-77(d) (providing that a consolidated human services board acquires the powers and duties of a local board of health).

[3] G.S. 153A-77(a) authorizes commissioners to directly assume the powers and duties of a county board of health or a consolidated human services board. It requires the board of commissioners to give 30 days' notice of a public hearing and hold the public hearing before adopting a resolution to abolish the appointed board.

[4] Wake county has provided public health services through a consolidated human services agency governed by a consolidated human services board since the mid-1990s. Mecklenburg county was the first in the state to abolish its local board

consolidated human services agency to any county with a county-manager form of government. It also extended the option of abolishing the local board of health and transferring its powers and duties to the board of commissioners to all counties. S.L. 2012-126 (H 438). As of July 10 2013, thirteen North Carolina counties had used their new authority under the law to change their local health department, their local board of health, or both.[5] Several other counties were in the process of considering or planning for changes. An up-to-date map of local health departments in North Carolina is maintained on the School of Government's website at http://www.sog.unc.edu/node/1035, under the sub-heading "Public Health Agencies."

County health departments. A county health department is a single-county agency that provides local public health services. It is created by the county commissioners and typically is governed by a board of health appointed by the commissioners (G.S. 130A-35). The board of health appoints a local health director after consultation with the county commissioners (G.S. 130A-40). The county health director must meet minimum education and experience requirements and has a number of legal powers and duties, which are described in greater detail in the section on local health directors later in this article.

District health departments. A district health department (sometimes called a regional health department) is a multi-county agency that provides local public health services for all the counties in the district. A district health department may be formed upon agreement of the boards of county commissioners and the boards of health of two or more counties (G.S. 130A-36). A county may join an existing district health department upon a similar agreement entered by each affected county. A district health department may have health department offices in each component county, but it is governed by one board of health and administered by one health director.

The governing board is called a district board of health. Each county in the district appoints one county commissioner to serve on the board, then those commissioners appoint the remaining members (G.S. 130A-37). If a county joins or withdraws from an existing district health department, the district board of health is dissolved and a new board appointed. After consultation with the boards of commissioners of each county in the district, the board of health appoints a district health director (G.S. 130A-40). The district health director must meet the same minimum education and experience requirements as a county health director and has the same legal powers and duties.

Any county may withdraw from a district health department when a majority of its county commissioners determines that the district is not operating in the best interests of health in that county. The district may be dissolved upon a similar decision by the boards of commissioners of all the counties in the district. Withdrawal or dissolution may take place only after written notice is given to the North Carolina Department of Health and Human Services (DHHS) and only at the end of the fiscal year. A

---

of health and transfer the board's powers and duties to the county commissioners. In 2008 Mecklenburg created a consolidated human services agency but did not appoint a consolidated board, choosing instead to maintain direct governance by the commissioners. The process of consolidating the functions of the agencies that make up Mecklenburg county's consolidated human services agency is still underway. Once it reached the population threshold imposed under prior law, Guilford county studied its options and elected to continue to operate a county health department governed by an appointed board of health.

[5] This number reflects counties that made changes after the 2012 law was enacted. Counting the two counties that made changes prior to that date (Wake and Mecklenburg), a total of fifteen North Carolina counties had agencies or boards operating pursuant to G.S. 153A-77 as of July 10 2013.

certified public accountant or an auditor certified by the Local Government Commission distributes surplus funds to the counties according to the percentage each of them contributed. When an entire district dissolves or when a county withdraws, any rules adopted by the district board of health remain in effect in the county or counties involved until amended or repealed by the new board or boards governing the affected counties (G.S. 130A-38).

Public health authorities. A county may meet its obligation to provide public health services by creating a public health authority. A public health authority may be formed by a single county or by two or more counties jointly. To form a single-county public health authority, the board of commissioners and the county board of health must jointly adopt a resolution finding that it is in the interest of the public health and welfare in the county to create a public health authority and provide public health services through it. In the case of a multicounty authority, the resolution must be adopted jointly by the boards of commissioners and boards of health governing each affected county. A county may join an existing public health authority upon joint resolution of the boards of commissioners and boards of health of each county involved. Before adopting any such resolution, the county commissioners must give notice to the public and hold a public hearing (G.S. 130A-45.02).

After the resolution has been adopted, a public health authority board is appointed. The board of a single-county public health authority is appointed by the county commissioners of the county. For a multi-county public health authority, the chairs of the boards of commissioners of each participating county appoint one county commissioner (or designee) to the board, and those members appoint the remaining members (G.S. 130A-45.1). The board replaces the prior local board of health and becomes the rule-making, policy-making, and adjudicatory body for the authority. The public health authority board appoints a public health authority director after consultation with the appropriate county commissioners (G.S. 130A-45.5). The public health authority director must meet the same minimum education and experience requirements as a county health director and has similar legal powers and duties.

Once created, a public health authority operates more independently of the board (or boards) of county commissioners than a traditional county health department. For example, a public health authority is not required to submit its budget to the county commissioners. While it may request funding from county commissioners, the authority acts on its own to develop its budget in accordance with state financial management laws. It may also acquire or sell real property without going through the county commissioners.[6]

A board of county commissioners may dissolve a public health authority (or withdraw from a multicounty authority) upon a finding that the authority is not operating in the best health interests of the county. Dissolution may occur only after written notification to DHHS and only at the end of a fiscal year. If the authority was a multicounty authority, a certified public accountant or an auditor certified by the Local Government Commission distributes surplus funds to the counties according to the percentage each of them contributed. All rules adopted by the authority board continue in effect until amended or repealed by the new authority board or local board of health (G.S. 130A-45.2).

Consolidated human services agencies. A board of commissioners in a county with a county manager

[6] Other ways in which a public health authority differs from conventional county or district health departments are explored in more detail at http://www.sog.unc.edu/node/2358.

appointed under G.S. 153A-81 may elect to establish a consolidated human services agency (CHSA). G.S. 153A-77(b) authorizes such counties to create a CHSA to "carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to the authority of the board of county commissioners." It specifies that a CHSA may include public health, but it does not require public health to be included.[7]

A consolidated human services agency typically is governed by a consolidated human services board. If the CHSA includes public health, the consolidated human services board acquires the powers and duties of a local board of health, with one exception: the board is not authorized to appoint the agency's director. Instead, the director is appointed by the county manager with the advice and consent of the board. The consolidated board also has its own powers and duties set forth in the CHSA statute [G.S. 153A-77(d)].

A consolidated human services agency is administered by a consolidated human services director. If the CHSA includes public health, the director must appoint a person who meets the education and experience requirements for a local health director set out in G.S. 130A-40.[8] The consolidated human services director acquires most of the legal powers and duties of a local health director, with two provisos: (1) the director may serve as the CHSA's executive officer only to the extent and in the manner authorized by the county manager, and (2) the director may appoint CHSA staff only with the approval of the county manager [G.S. 130A-43(c)]. The director may exercise those powers and duties directly or delegate them to the appointee with local health director qualifications or other appropriate persons.[9]

Governance: Local Boards of Health

Each local public health agency in North Carolina has a governing board that is responsible for public health within its jurisdiction. What the board is called varies by agency: a county health department has a county board of health, a district health department has a district board of health, a public health authority has a public health authority board, and a consolidated human services agency has a consolidated human services board. The generic term "local board of health" embraces all of these types of boards when they are carrying out public health duties.[10] A board of health may be an independent

---

[7] The state law governing CHSAs was changed significantly by legislation enacted in June 2012. S.L. 2012-126 (amending G.S. 153A-77). Under prior law, the only counties that could create CHSAs were those with populations exceeding 425,000. Further, CHSAs were required to include public health, social services, and mental health, developmental disabilities, and substance abuse services. The 2012 legislation removed the population threshold and amended the language describing a CHSA, with the result that counties have a great deal of flexibility in determining which services will be provided. On March 1 2013, there were nine CHSAs in North Carolina and all of them provided public health services, but it is possible that at a later date the state may have counties with CHSAs that do not provide public health services.

There are some limitations to what may be included in a CHSA. Among other things, G.S. 153A-76 prohibits county commissioners from including a public health authority in a CHSA. However, a separate law permits commissioners to dissolve or withdraw from a public health authority at the end of a fiscal year. A county that is part of a public health authority could therefore create a CHSA including public health, but the commissioners would have the additional step of dissolving or withdrawing from the authority first. Similarly, a county that is presently part of a multi-county district health department could not include public health in a CHSA without first withdrawing from the district at the end of a fiscal year.

[8] G.S. 153A-77(e)(9). The county manager must approve the appointment. If the CHSA director meets the statutory requirements for a local health director, there is no need for a separate individual to be appointed.

[9] G.S. 130A-6 authorizes an official with authority granted by Chapter 130A to delegate that authority to another person.

[10] This is consistent with statutory definitions and usage. G.S. 130A-2(4) defines "local board of health" to mean "a district board of health or a public health authority or a county board of health." G.S. 153A-77(d) gives consolidated human services

board appointed by the county commissioners, or the commissioners may elect to serve as the board of health themselves by adopting a resolution abolishing the board and conferring its powers and duties upon the board of commissioners.[11]

The composition of the different types of boards varies, as illustrated in Table 1. In general, board members represent county commissioners, professionals with expertise in health care or public health (including physicians, pharmacists, veterinarians, and professional engineers, among others), and the general public. The powers and duties of each type of board also vary somewhat, but each is charged with protecting and promoting the public health, and with serving as the policy-making, rule-making, and adjudicatory body for public health in the county or counties in its jurisdiction. Each board has limited authority to set fees for public health services. Each board also influences the day-to-day administration of the local health department, public health authority, or consolidated human services agency.

---

boards the powers and duties of local boards of health, except when the statutes specifically provide otherwise.

[11] G.S. 153A-77(a) authorizes commissioners to directly assume the powers and duties of a county board of health or a consolidated human services board. It requires the board of commissioners to give 30 days' notice of a public hearing and hold the public hearing before adopting a resolution to abolish the appointed board.

Table 1. Board Membership Requirements By Type of LPHA Board*

Board type	Number of	Members of the public	County	Physician	Psychiatrist	Psychologist	Social	Hospital	Dentist	Optometrist	Veterinarian	Registered	Pharmacist	Engineer	Accountant
County board of health	11	3	✓	✓					✓	✓	✓	✓	✓	✓	
District board of health	15 to 18	✓	✓[a]	✓					✓	✓	✓	✓	✓	✓	
Single county public health authority board	7 to 9	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓
Multi-county public health authority board	7 to 11	✓	✓[b]	✓				✓	✓	✓	✓	✓	✓	✓	✓
Consolidated human services board	Up to 25	4 or more [c]	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	

Shaded area: Two professionals representing the following fields must serve on the board: optometry, veterinary science, nursing, pharmacy, engineering, or accounting. In other words, not *all* of these professions will necessarily be represented.

* These requirements do not apply if the county commissioners serve as the board for a county health department or a consolidated human services agency including public health.

[a]One commissioner from each county.

[b]One commissioner or commissioner's designee from each county.

[c]A consolidated human services board must have 4 members who are consumers of human services and may have additional members to represent the general public.

Board membership qualifications and terms. The statutes authorizing county boards of health, district boards of health, and consolidated human services boards all require that board members be residents of the county or district. For county and district boards, if there is no resident available to serve in one of the licensed professional positions, a member of the general public must be appointed instead. [12] There is no similar provision for consolidated human services boards, suggesting that a licensed professional position on such a board would simply remain vacant if there were no resident available to serve. Members of public health authority boards are not required to be residents of the county or multi-county area served by the authority.

County and district board of health members are appointed to three-year terms and may serve a maximum of three consecutive three-year terms. There are a couple of exceptions to this general rule. First, if the member is the only county or district resident who is a member of one of the licensed professions that must be represented on the board, the member may serve more than three consecutive three-year terms.[13] Second, if a member of a district board of health is serving in his or her capacity as a county commissioner, the NC Attorney General has advised that the member may serve for as long as he or she remains a commissioner, even if that time exceeds three consecutive three-year terms.[14] Consolidated human services board members are appointed to four-year terms and may serve a maximum of two consecutive four-year terms. There is no exception for a situation in which a member is the only county resident who is a member of a licensed profession that must be represented on the board.[15] The county commissioner member of the board may serve only as long as he or she remains a county commissioner. Public health authority board members are appointed to three-year terms and there is no limit on the number of terms they may serve.[16] If the county commissioners are serving as the board of health, a person's service as a board of health member ends when his or her service as a county commissioner ends.

An appointed board of health member may be removed from office if there is cause for removal under state law. The laws for county and district boards of health, consolidated human services boards, and public health authority boards all state that a member may be removed for any of the following reasons:[17]

- Commission of a felony or other crime involving moral turpitude
- Violation of a state law governing conflict of interest
- Violation of a written policy adopted by the county commissioners (or all of the applicable boards of commissioners, if it is a multi-county board)
- Habitual failure to attend meetings

---

[12] There is an exception for the member of a *county* board of health who serves in the licensed optometrist spot. G.S. 130A-35(b). If a licensed optometrist who is a county resident is not available for appointment, the county commissioners may fill the position with either: (1) a licensed optometrist who resides in another county, or (2) a member of the general public who is a county resident. This provision does not apply to a *district* board of health.

[13] G.S. 130A-35(c) (county board of health); 130A-37(c) (district board of health).

[14] Attorney General Advisory Opinion to Hal G. Harrison, Mitchell County Attorney, 1998 WL 856356 (Oct. 8, 1998).

[15] G.S. 153A-77(c).

[16] G.S. 130A-45.1.

[17] G.S. 130A-35(g) (county board of health); 130A-37(h) (district board of health); 130A-45.1(j) (public health authority board); 153A-77(c) (consolidated human services board). If the board of commissioners is serving as the board of health, these sections do not apply.

- Conduct that tends to bring the office into disrepute
- Failure to maintain qualifications for appointment (e.g., maintaining licensure in a profession, being a county resident, etc.)

Rule making. A local board of health has the duty to protect and promote the public health and the authority to adopt rules necessary to those purposes (G.S. 130A-39). A board of health rule is valid throughout the county or counties in the board's jurisdiction, including within any municipalities served by the board.[18]

There are several limitations to the board's rule-making authority that are set out in statutes:

- A board may not adopt rules concerning the issuing of grades and permits to food and lodging facilities or the operation of those facilities [G.S. 130A-39(b)].
- A board may issue its own regulations regarding on-site wastewater management only with the approval of DHHS, which must find that the proposed rules are at least as stringent as state rules and are necessary and sufficient to safeguard the public health [G.S. 130A-39(b); 130A-335(c)].[19]
- A board of health rule regulating smoking in public places must abide by statutory restrictions on this authority and must be approved by the applicable board(s) of county commissioners (G.S. 130A-498).

Additional limitations to the rule-making authority have been imposed by state courts. The North Carolina Supreme Court has held that a local board of health rule may be preempted by state law if the state has already provided a complete and integrated regulatory scheme in the area addressed by the local rule. However, state law expressly permits a board to adopt a more stringent local rule even in the presence of statewide rules on the same issue, if a more stringent rule is required to protect the public health [G.S. 130A-39(b)]. The supreme court has interpreted this to mean that a board adopting a more stringent rule must provide a rationale for local standards that exceed the statewide standards. To do this, the board likely needs to be able to demonstrate that conditions in the board's jurisdiction are different from the rest of the state in a way that warrants higher standards.[20]

In addition, the North Carolina Court of Appeals has enunciated a five-part test that a local board of health rule must satisfy to be valid. The rule must:

---

[18] G.S. 130A-39(c) ("The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.")

[19] If a local board of health adopts rules governing wastewater collection, treatment, and disposal, then it must also adopt rules for imposing administrative penalties when the local wastewater rules are violated [G.S. 130A-22(h)].

[20] *See* Craig v. County of Chatham, 356 N.C. 40 (2002). The *Craig* court considered two local actions regulating swine farms: an ordinance adopted by the Chatham County Board of Commissioners, and a rule adopted by the Chatham County Board of Health. The court held that both the ordinance and the rule were preempted by state statutes that amounted to a complete and integrated regulatory scheme for swine farms. *Id*. at 50. However, the court acknowledged that local boards of health may regulate an area already subject to a comprehensive statewide regulatory scheme in some circumstances. G.S. 130A-39 specifically authorizes local boards of health to adopt more stringent rules in areas that are already subject to statewide regulation by the Commission for Health Services or Environmental Management Commission, but only when a more stringent local rule is necessary to protect the public health. The court concluded that this statute does not authorize a local board of health to "superimpose additional regulations without specific reasons clearly applicable to a local health need." *Id*. at 51–52. The court noted that the board of health had not provided "any rationale or basis for making the restrictions in Chatham County more rigorous than those applicable to and followed by the rest of the state and invalidated the rule on that basis. *Id*. at 52.

1. be related to the promotion or protection of health,
2. be reasonable in light of the health risk addressed,
3. not violate any law or constitutional provision,
4. not be discriminatory, and
5. not make distinctions based upon policy concerns traditionally reserved for legislative bodies.[21]

Before adopting, amending, or repealing any local rule, the board of health must give the public notice of its intent and offer the public an opportunity to inspect its proposed action. Ten days before the proposed action is to occur, notice of the proposal must be published in a local newspaper with general circulation. The notice must contain a statement of the substance of the proposed rule or a description of the subjects and issues involved, the proposed effective date, and a statement that copies of the proposed rule are available at the local health department. At the same time, the board must make the text of the proposed rule, amendment, or rule to be repealed available for inspection by placing it in the office of each county clerk within the board's jurisdiction.

Imposing fees. A local board of health may impose a fee for many services rendered by the health department [G.S. 130A-39(g); 130A-45.3(a)(5); 153A-77(d)(1)]. County and district boards of health and consolidated human services boards must base their fees on a plan proposed by the local health director, and any fees adopted by the board must be approved by the county commissioners (in the case of a district health department, all applicable boards of county commissioners). Public health authority boards may establish fee schedules and are not required to obtain commissioner approval.

There are some limitations to a board's fee-setting authority. First, a board may not charge fees for services rendered by a health department employee acting as an agent of the state. This covers most environmental health programs, but there are exceptions: fees may be charged for services provided under the on-site wastewater treatment program, the public swimming pools program, the tattooing regulation program, and the local program for inspecting and permitting drinking water wells. Second, the fees must be reasonable. That is, they generally should be set at a level designed to recover the actual costs of the program associated with the fee.

Third, local health departments charge fees for some of their clinical services as well, but the local board of health has limited discretion in determining the amount of the fee. Fees may reflect Medicaid reimbursement rates established by the state Division of Medical Assistance, or fees set by a state or federal program that provides funds for a particular service. Also, local health departments are specifically prohibited by state law from charging health department clients for some services:[22]

- testing and counseling for sickle cell syndrome[23]
- examination for and treatment of tuberculosis[24]
- examination for and treatment of certain sexually transmitted diseases[25]
- testing and counseling for HIV[26]

---

[21] City of Roanoke Rapids v. Peedin, 124 N.C. App. 578 (1996).

[22] Sometimes a third-party payer such as Medicaid provides reimbursement for one of the listed services. A local health department may bill a third-party payer for the services but it may not bill the client.

[23] G.S. 130A-130.

[24] G.S. 130A-144(e).

[25] G.S. 130A-144(e).

[26] 10A NCAC 41A.0202(9).

- immunizations that are required by law and supplied by the state must be provided at no cost to uninsured or underinsured patients with family incomes below 200 percent of the federal poverty level[27]

Finally, sometimes other federal laws affect a local health department's ability to set fees or charge clients for services. For example, Title VI of the federal Civil Rights Act of 1964 prohibits recipients of federal financial assistance from charging their limited-English proficient clients for interpretation services.[28] Similarly, the federal HIPAA medical privacy rule limits the fees that may be charged for copies of medical records.[29]

Adjudication (G.S. 130A-24). In some circumstances, a local board of health acts as an adjudicatory body. When a person is aggrieved by the local health department's interpretation or enforcement of a local board of health rule, or the local imposition of administrative penalties, the person may appeal the department's decision to the board of health. The board hears the case and issues a written decision either upholding or overturning the department's decision. The rules of evidence that are enforced in courtrooms do not apply at the board hearing, but the board's decision must be supported by adequate evidence. The board must put its decision in writing and state the factual findings upon which it is based. If the person is not satisfied with the board of health's decision, he or she may appeal to district court. The procedures and timeframes for actions are set out in G.S. 130A-24(b)-(d).

When a person is aggrieved by the local health department's enforcement of state rules, such as the food and lodging rules, the local board of health is not authorized to hear the appeal. Those cases go to the state Office of Administrative Hearings [G.S. 130A-24(a)].

Local Health Department Administration

The administrative functions within local health departments include managing operations and programs; providing in-service training for staff; preparing the budget; explaining the department's activities to the board of health, official agencies, and the public; informing the public of health laws and rules as well as enforcing them; suggesting new rules and services; and purchasing equipment and supplies. These duties generally are the local health director's responsibility, but the management of particular functions may differ from county to county.

Local health directors. The local health director is essentially the chief executive officer of the local public health agency—he or she administers the department and exercises specific powers and duties that are prescribed by law. The term "local health director" includes directors of county health departments, district health departments, and public health authorities, as well as the director of a consolidated human services agency or his or her designee.[30] A director of a county or district health

---

[27] G.S. 130A-153(a).

[28] *See* Voluntary Compliance Agreement between the Office for Civil Rights, U.S. Department of Health and Human Services, and N.C. Department of Health and Human Services (available at http://www.sog.unc.edu/sites/www.sog.unc.edu/files/2004DHHSTitle6VCA.pdf).

[29] 45 C.F.R. 164.524(c)(4).

[30] The term "local health director" is defined by statute to mean "the administrative head of a local health department appointed pursuant to this Chapter." The same statute defines "local health department" as "a district health department or a public health authority or a county health department." G.S. 130A-2. Although these definitions do not capture consolidated human services agencies and directors, a separate statute assigns local public health roles to the agency by: (1) giving the agency "the responsibility to carry out the duties of a local health department"; (2) providing that the consolidated human

department or a public health authority must meet minimum education and experience requirements [G.S. 130A-40(a); 130A-45.4]. In general, the director must have education and experience in medicine, public health, or public administration related to health.[31] A consolidated human services director is not required by statute to meet particular education or experience requirements. However, a consolidated human services director who does not satisfy the statutory qualifications for a local health director must appoint a person who does [G.S. 153A-77(e)]. In addition, North Carolina's standards for local public health agency accreditation specify that the agency's governing board must appoint a local health director who meets the requirements of the law that applies to county and district health directors.[32]

The appointment of the local health director varies by type of local public health agency. For a county or district health department, the local health director is appointed by the local board of health after consultation with all applicable boards of county commissioners. Although the board must consult with the commissioners, the commissioners are not required to approve the appointment (G.S. 130A-40). The same procedure is followed by a public health authority board when it appoints the public health authority director (G.S. 130A-45.4). A consolidated human services agency director is appointed by the county manager with the advice and consent of the consolidated human services board [G.S. 153A-77(e)]. If the county commissioners have abolished the board of health and assumed direct control of the health department pursuant to G.S. 153A-77(a), then the commissioners have all the powers and duties of the local board of health, including the power to appoint the local health director. This is the only circumstance in which the county commissioners may directly appoint the local health director.

All local health directors have powers and duties that come from multiple sources of law.[33] A local health director's powers and duties fall into five general categories:

- **Administration**: The local health director administers programs under the direction of the board of health. All types of local health directors have the authority to employ and dismiss health department staff, but the employment decisions of a director of a consolidated human services agency must be approved by the county manager. In addition, the director of a county health department, a district health department, or a consolidated human services agency may enter contracts on behalf of the department, but the law that gives local health directors this authority also states that it shall not "be construed to abrogate the authority of the county

---

services board "shall have all the powers and duties of a local board of health" except for appointing the director and transmitting or presenting the budget for local health services; and (3) stating that "a human services director shall have all the powers and duties of a local health director provided under G.S. 130A-41," except that the human services director's activities in managing the department are subject to the oversight of the county manager, and the human services director may appoint agency staff only with the county manager's approval.

[31] Another law provides for a limited pilot program (one county only) to allow a person with education and experience in public health nursing to serve as a local health director, as long as the appointment is approved by the NC Secretary of Health and Human Services. G.S. 130A-40.1. In fiscal year 2011-2012, Northampton County's health director was serving pursuant to this law.

[32] See 10A NCAC 48B .1304; see also 10A NCAC 48B .0901(b)(1) (requiring the agency to have, or be recruiting, a local health director who meets legal requirements for the position).

[33] The main statutes setting forth the powers and duties of local health directors are G.S. 130A-41 (county and district health directors); 153A-77(e) (consolidated human services directors); and 130A-45.5(c) (public health authority directors). However, other powers and duties appear in several other statutes in Chapter 130A. Except as otherwise noted, the powers and duties discussed in this section of the Article either originate in or are cross-referenced in G.S. 130A-41.

commissioners."[34] Thus, it is a common practice to have county managers involved in the approval or execution of health department contracts.

- **Remedies**: The local health director is responsible for enforcing public health laws within his or her jurisdiction and may employ a number of legal remedies when public health laws are violated. The remedies the director may exercise include:
    - Initiate civil or criminal proceedings against a public health law violator.[35]
    - Abate public health nuisances or imminent hazards[36]
    - Impose administrative penalties (fines) for violations of state or local laws regulating smoking in public places[37]
    - Embargo food or drink in some circumstances[38]
    - Impose administrative penalties for violations of local on-site wastewater rules, or conditions imposed on permits issued under such rules[39]

  The local health director may also play a role in actions taken by local public health employees to suspend or revoke permits, such as a permit to operate a restaurant.[40]
- **Communicable disease control**: The local health director must investigate cases and outbreaks of communicable diseases and ensure that communicable disease control measures are given.[41] The director may order isolation or quarantine if the legal conditions for exercising the isolation or quarantine authority are met.[42] The local health director also has the duty to enforce the North Carolina laws requiring the immunization of children.
- **Other disease control**: The local health director must examine, investigate and control rabies in accordance with state public health laws. The director must also investigate the causes of other diseases in the jurisdiction, whether or not they are communicable.

---

[34] G.S. 130A-41(b)(13). A public health authority director does not have the power to enter contracts. Instead, the public health authority board holds that power. The board could, however, delegate contracting authority to the director or another agent or employee. G.S. 130A-45.3(a)(9) (allowing the public health authority board to "delegate to its agents or employees any powers or duties as it may deem appropriate").

[35] G.S. 130A-18 authorizes the local health director to institute an action for injunctive relief in superior court. G.S. 130A-25 makes violation of most state and local public health laws or rules a class 1 misdemeanor (see also G.S. 14-3, providing for the classification of misdemeanors). However, violations of laws and rules pertaining to smoking in public places may not be prosecuted as misdemeanors. G.S. 130A-497(d). Further, in counties in which the county commissioners have assumed the role of the local board of health, the commissioners are authorized to enforce local rules through civil penalties--an option that is not available in counties with other forms of public health governance. G.S. 153A-77(a). However, if the commissioners exercise the option to impose a civil penalty, violation of the local rule subject to the penalty is *not* a misdemeanor unless the rule specifically states that it is.

[36] G.S. 130A-19 (public health nuisance); 130A-20 (imminent hazard).

[37] G.S. 130A-22(h1).

[38] G.S. 130A-21.

[39] G.S. 130A-22(h). Most North Carolina counties do not have local on-site wastewater rules. Rather, the state rules apply within the county and different remedies are available.

[40] *See* G.S. 130A-23, authorizing the Secretary of Health and Human Services to revoke or suspend permits upon finding a violation of state environmental health laws. Although the power to exercise this remedy is given to a state official, in practice violations are discovered and permit actions are taken by local environmental health specialists acting under the supervision of the local health director.

[41] G.S. 130A-144.

[42] G.S. 130A-145.

- **Educate and advise**: The local health director must disseminate public health information, promote the benefits of good health, and advise local officials about public health matters.

This list is not exhaustive. Local health directors are responsible for the overall operation of the local public health agency, which makes the director ultimately accountable for administrative activities associated with the agency's performance of local public health services and functions. A consolidated human services director also has duties that go beyond those of a traditional local health director, largely reflecting the consolidated human services director's role as the chief administrator for human services programs other than public health.

Most of the powers and duties of a local health director may be delegated to another person. However, the director's authority to embargo food and drink in some circumstances may not be delegated.[43]

Local health department personnel. In addition to a director, each type of local public health agency must have certain other staff members. A state regulation that addresses minimum staffing requires each local health department to employ a health director, a public health nurse, an environmental health specialist, and a secretary [10A N.C.A.C. 46.0301(a)]. In general these staff members must be full-time employees, but there is an exception that allows an agency to share a health director with another agency. The local health department accreditation rules also address staffing both directly and indirectly. One of the accreditation standards requires a local agency to employ or contract with one or more licensed physicians to serve as medical director [10A N.C.A.C. 48B.0901(b)(3)].[44] Portions of the accreditation rules refer to other categories of staff members or to specific expertise that the agency must possess or have access to, but they do not explicitly require the agency to have staff positions for those categories or expertise.[45]

There are no other requirements in law for specific numbers or types of staff, but local health departments need sufficient personnel to provide public health services and to perform all the activities and functions associated with other duties of the health department (such as assuring compliance with state and federal laws). Many departments employ or contract with a number of health care providers and environmental health specialists, as well as health educators, social workers, medical records specialists, epidemiologists or statisticians, and administrative staff.

The employees of county and district health departments ordinarily are subject to the North Carolina State Personnel Act (SPA) [G.S. 126-5(a)(2)].[46] Public health authorities are exempt from the SPA and establish their own personnel policies and salary plans [G.S. 130A-45.12; 130A-45.3(a)(7)]. The

[43] G.S. 130A-6; 130A-21(a).

[44] It is possible for an agency to be accredited without satisfying every standard. The accreditation rules establish benchmarks and specify how many benchmarks must be met in each of three areas: agency core functions and essential services, facilities and administrative services, and board of health. 10A N.C.A.C. 48B.0103. The medical director provision falls under agency core functions and essential services. An agency could skip the medical director provision and still be accredited if it met enough of the other benchmarks in that area.

[45] See, e.g., 10A N.C.A.C. 48B.0203 (directing agency to assure staff have expertise in data management); 48B.0301 (requiring access to and consultation with an epidemiologist); 48B.0701 (referring to unit directors for communicable disease, nursing, and environmental health).

[46] Local health department employees may be removed from SPA coverage if the State Personnel Commission determines that the local personnel system is substantially equivalent to the SPA. G.S. 126-11(a).

employees of consolidated human services agencies are subject to county personnel policies or ordinances, unless the board of county commissioners elects to make the CHSA employees subject to the SPA [G.S. 153A-77(d)]. When the agency employees are covered by the SPA, their qualifications and terms of employment are governed by the rules of the State Personnel Commission.

The hiring authority for local health department employees varies by agency type. The director of a county or district health department is authorized to employ or dismiss department employees in accordance with the SPA [G.S. 130A-41(b)(12)]. The director of a public health authority is authorized to employ, discipline, and dismiss employees of the authority [G.S. 130A-45.5(c)(12)]. The director of a consolidated human services agency may appoint employees, but the appointments must be approved by the county manager [G.S. 153A-77(e)(1); 130A-43(c)(2)].

Financing of Local Public Health Services

Public health activities in North Carolina are financed at the state level through federal funds, state funds, private grants, and fees. The precise mix of funds to support local public health services varies by locality.

Federal and State Funds

Local health departments receive federal funds both directly and indirectly. Indirect federal support comes from federal funds that are paid to the state, and then channeled by the state to the local agencies. Federal categorical funds support maternal and child health services, family planning, the WIC program, and several other services and programs. The major source of direct support is the state Medicaid program, which in fiscal year 2010 was composed of about 75% federal funds and 25% state funds.[47] Medicaid provides direct reimbursement for services to Medicaid-eligible clients, as well as an annual cost settlement. Some local health departments also receive federal funds in the form of Medicare reimbursement for services such as home health or diabetes care.

The state provides general aid-to-county funds, which are distributed to local public health agencies by DHHS. Funds are allocated based on population and utilization of allocated funds (10A NCAC 46.0101). The state health director may allocate special needs funds to local health departments that demonstrate a critical public health need, unique to the department's service area, that cannot be met through other funding mechanisms (10A NCAC 46.0102). Additional support comes from categorical grants, which may include a combination of federal and state funds. The state also awards other grant or contract funds for special projects. Finally, the state reimburses some services on a fee-for-service basis.

To receive state funds and federal funds that the state distributes, local health departments must sign a contract with DHHS called the "consolidated agreement." The consolidated agreement contains a number of general provisions governing how local health departments must use and account for money flowing from the state, as well as provisions that set out special requirements for the use of certain funds. If a department fails to comply with the terms of the contract, the state may take steps to cut off state funding for the program that is out of compliance. The state would first notify the department that

[47] Source: Kaiser Family Foundation State Health Facts, North Carolina (available at http://www.statehealthfacts.org/profileind.jsp?sub=47&rgn=35&cat=4). The match rate varies from state to state and may vary from year to year.

it has sixty days to comply. If the problem were not corrected to the satisfaction of the state within that period, the state could temporarily suspend funding for the program that was out of compliance. If the deficiency remained uncorrected thirty days after the temporary suspension, program funds could be permanently suspended until the department provided evidence that the deficiencies were corrected. After all other reasonable administrative remedies have been exhausted, the state may cancel, terminate, or suspend the contract in whole or in part and the department may be declared ineligible for further state contracts or agreements. Alternatively, the state could enforce the contract by suing the county. Neither of these actions has ever been taken by the state against a county; nevertheless, the ability to withhold funds gives the state some leverage to require certain levels of service by the local public health agency.

Local Sources of Revenue

County appropriations. Local boards of health have no power to tax, so a board and its department must depend on other sources for funds. Boards of county commissioners are authorized to appropriate funds from property tax levies and to allocate other revenues whose use is not otherwise restricted by law for the local health department's use.

For county health departments, county commissioners approve the health department budget as a regular part of their responsibility for county finance. For consolidated human services agencies, the budget for public health is a part of the budget planned by the consolidated human services director, recommended by the consolidated human services board, and approved by the county commissioners. Public health authorities and district health departments prepare and approve their own budgets and need not obtain county commissioners' approval. These agencies seek county appropriations, however, and the county commissioners must approve those expenditures.

In the past, there was no minimum level of local funding that county commissioners were required to provide for public health. Local health departments worked with county governments to try to ensure that funding was sufficient to support the services and functions the health department performed, and the amount appropriated for public health services varied widely from county to county.[48] Legislation adopted in 2012 imposed a maintenance-of-effort requirement for local public health (S.L. 2012-126, sec. 3). Effective July 1, 2014, in order to receive state and federal funding for local public health, a county government must maintain its operating appropriations to its local health department from local ad valorem tax receipts at levels equal to amounts appropriated in state fiscal year 2010-2011 [(G.S. 130A-34.4(a)(2)]. Two additional "non-supplantation" provisions in the statutes prohibit reductions of county appropriations when state money increases in certain circumstances. G.S. 130A-4.2 requires the state DHHS to ensure that local health departments do not reduce county appropriations for health promotion services because of state appropriations. G.S. 130A-4.1 places the same requirement on maternal and child health services.

---

[48] A study conducted by the School of Government in 2012 examined funding for local health departments in greater detail and found wide variations in the proportion of local health department budgets that were from county appropriations versus other sources. See *Comparing North Carolina's Local Public Health Agencies: The Legal Landscape, the Perspectives, and the Numbers* (May 2012), at 39-45 (available at http://www.sog.unc.edu/sites/www.sog.unc.edu/files/REPORT%20Comparing%20North%20Carolina%20Local%20Public%20Health%20Agencies_0.pdf).

Grants. Local health departments may receive grants from government agencies or from private entities, such as foundations. These grants are essentially contracts between the local health department and the granting agency and usually are provided to enable the department to develop a particular project or provide a specific service.

Local fees. Public health agencies may charge and collect fees imposed by their boards, as described earlier in this article. Revenues from such fees must be used for public health purposes.

Management of Local Funds

All funds received or spent at the local level must be budgeted, disbursed, and accounted for in accordance with the Local Government Budget and Fiscal Control Act (G.S. Ch. 159, Art. 3). The budgeting, disbursing, and accounting for a county health department or consolidated human services agency is done by the county's budget officer and finance officer. District health departments and public health authorities (both single-county and multicounty) are responsible for performing these functions themselves.

Local Public Health Services

Local public health agencies provide services at both the community and individual levels. While there is no single law describing the minimum services that a local agency must provide, there are three primary state laws that affect the scope and range of local service provision.

The first of these is a law that describes the public health services that the General Assembly has determined are essential to promoting and contributing to the highest levels of health and that should be available to everyone in the state (G.S. 130A-1.1). This law incorporates the "ten essential public health services," a nationally recognized set of services that was adopted in 1994 by a national committee charged with providing a framework for effective public health systems,[49] and directs local health departments to ensure the services are available and accessible to the population served by the department. The ten essential public health services fall into three categories: assessment of community health status and health problems; policy development to educate the community about health, solve community health problems, support individual and community health, and protect health and ensure safety; and assurance of quality public health and public and private health care services within the community. Table 2 identifies the specific services in each category.

[49] See www.cdc.gov/nphpsp/essentialServices.html.

Table 2. Essential Public Health Services (G.S. 130A-1.1)

Category	**Services**
Assessment	Monitoring health status to identify community health problems
	Diagnosing and investigating health hazards in the community
Policy development	Informing, educating, and empowering people about health issues
	Mobilizing community partnerships to identify and solve health problems
	Developing policies and plans that support individual and community health efforts
Assurance of services	Enforcing laws and regulations that protect health and ensure safety
	Linking people to needed personal health care services and ensuring the provision of health care when otherwise unavailable
	Ensuring a competent public health workforce and personal health care workforce
	Evaluating effectiveness, accessibility, and quality of personal and population-based health services
	Conducting research

Another law requires each local public health agency in the state to be accredited by the North Carolina Local Health Department Accreditation Board (G.S. 130A-34.1). To be accredited, a local agency must satisfy accreditation standards that address the agency's capacity to provide the ten essential public health services, as well as several additional duties imposed by state law (10A N.C.A.C. Ch. 48). The accreditation standards are divided into three categories: agency core functions and essential services, facilities and administrative services, and local boards of health. The Accreditation Board assesses a local health department's performance of 148 specific activities. A health department must satisfy about 90 percent of the activities in order to obtain or maintain accreditation.[50]

A third statute authorizes the N.C. Commission for Public Health to establish standards for the nature and scope of local public health services (G.S. 130A-9). The commission has adopted rules, known as the mandated services rules, which specify some of the public health services that local public health agencies must guarantee (10A N.C.A.C. 46.0201–.0216). The mandated services rules address thirteen types of services that fall into one of two categories: (1) services that the local agency must provide under the direction of the local health director and supervision of the local board of health; or (2) services that a county may provide through the local agency, contract with another entity to provide, or not provide at all if the local agency can certify to the state's satisfaction that the services are available in the county from other providers. Each of the mandated services has its own rule that identifies more specifically which services must be provided or assured. Figure 1 identifies the mandated services.

[50] The accreditation rules specify the exact number of activities that must be satisfied in each category for the department to be accredited. 10A N.C.A.C. 48B.0103(a).

Figure 1. Mandated public health services in North Carolina (10A NCAC 46 .0201-.0216)

Local health department must provide

- Food, lodging, and institutional sanitation
- Individual on-site water supply
- Sanitary sewage collection, treatment, and disposal
- Communicable disease control
- Vital records registration

Local health department must provide, contract for, or certify available

- Adult health
- Home health
- Dental public health
- Grade-A milk certification*
- Maternal health
- Chiild health
- Family planning
- Public health laboratory

* In 2011, responsibility for milk sanitation at the state level was transferred from the former Division of Environmental Health, Department of Environment and Natural Resources, to the Food and Drug Protection Division of the Department of Agriculture and Community Services. S.L. 2011-145, sec. 13.3.(b).

These laws provide a starting point for understanding local public health services, but they do not paint the complete picture. Local public health agencies also must provide services or perform activities to comply with other laws. For example, in order to comply with the federal HIPAA medical privacy rule, local health departments must develop and maintain numerous forms, notices, and policies and procedures for keeping health information confidential and secure and honoring individuals' rights regarding their health information.[51]

The North Carolina Department of Health and Human Services (DHHS) conducts a biennial survey of services that are provided by local public health agencies in North Carolina, which provides additional insight into the range of local public health services that are provided by the state's local agencies. The services that are typically included in the survey cover a wide range of activities, from epidemic investigations, to school nursing services, to childhood lead poisoning prevention, to chronic disease control, to name just a few.[52]

[51] 45 C.F.R. Parts 160, 163, and 164.

[52] A list of the 127 specific services that were included in DHHS's survey for fiscal year 2011 is available at http://www.sog.unc.edu/sites/www.sog.unc.edu/files/Comparing%20North%20Carolina%20Local%20Public%20Health%20Agencies%20AppB_0.pdf.