

N.C. Public Health System: Legal Framework

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Section 1: Responsibility for Public Health Services in North Carolina

I. Public health services in North Carolina are the joint effort and responsibility of the state and county governments.

A. State responsibilities:

1. Rule-making:

a. The N.C. Commission for Health Services makes statewide public health rules. GS 130A-29.

b. The N.C. Environmental Management Commission makes statewide rules regarding water sources, including rules for wells.¹ GS 143B-282(a); GS 87-87; 15A NCAC 2C.

2. Oversight, administration, and enforcement: N.C. law gives the responsibility of administering and enforcing the public health laws to the Secretaries of the Department of Health & Human Services (DHHS) and the Department of Environment and Natural Resources (DENR). GS 130A-4. In practice, those duties are carried out principally by a State Health Director,² DHHS's Division of Public Health (DPH), and DENR's Division of Environmental Health (DEH). The state agencies also provide technical assistance and training to local public health officials and employees.

3. Allocation of funds: DPH and DEH allocate federal and state money to local health departments.

B. County responsibilities: Counties are legally required to provide public health services within the county. To meet this legal duty, a county may operate a local public health agency or contract with the state to furnish public health services. GS 130A-34. The county has several options for organizing and governing its local public health agency, which are described in the Section 2 of this outline.

C. Regional responsibilities: North Carolina law does not contain a formal regional structure

¹ GS 87-96(b) provides that Commission for Health Services rules regarding public health, wells, or groundwater prevail over well rules adopted by the Environmental Management Commission. GS 87-96(c) authorizes local boards of health to adopt EMC rules by reference, and to adopt more stringent rules when necessary to protect the public health.

² The State Health Director is appointed by the Secretary of Health and Human Services and performs duties and exercises authority assigned by the Secretary. GS 130A-3.

for public health services. However, in practice, there are several regional entities that carry out either state or local public health responsibilities.

1. The state public health agencies hire employees who are assigned to serve local health departments in designated regions.
2. There are seven public health regional surveillance teams (PHRST teams). Each team is based in a local health department but serves all the departments within its designated region.³
3. In 1997, several local health departments in the northeastern part of the state formed a voluntary collaborative, called the Northeastern North Carolina Partnership for Public Health, to improve public health services in their region. Their partnership served as a model for what are now called “public health incubators”— voluntary collaborations designed to “hatch” new ideas and practices to improve public health. The Northeastern Partnership was funded by the participating departments and grant funds. In 2004, the NC General Assembly provided non-recurring funding for four public health incubators, including the Northeastern Partnership.⁴ Participation in incubators is voluntary and the incubators themselves do not have specific duties or authorities under North Carolina’s public health laws (although the local health departments that participate in the incubators do).

Section 2: Organization and Governance of Local Public Health Services

I. County options for providing public health services

- A. All North Carolina counties may elect to provide local public health services in one of four ways:
 1. By operating a county health department governed by a county board of health.
 2. By participating in a multi-county district health department governed by a district board of health.
 3. By forming a single-county or multi-county public health authority governed by a public health authority board.

³ For more information about the PHRST teams, including a map showing the counties served by each, see <http://www.epi.state.nc.us/epi/phpr/regions.html>.

⁴ The 2004 Appropriations Act, SL 2004-124. The Act appropriated \$1 million to the NC Institute for Public Health to establish the incubator program. The NC Institute for Public Health then allocated funds to four incubators: the Northeastern North Carolina Partnership for Public Health (composed of 10 local health departments serving 19 counties: Bertie, Beaufort, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Halifax, Hertford, Hyde, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Tyrrell, Warren, and Washington); the South Central Incubator (composed of 8 local health departments serving 8 counties: Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Rowan, Stanly, and Union); the Western Incubator (composed of 13 local health departments serving 17 counties: Avery, Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey); and the Region III Northwest Incubator (composed of 8 local health departments serving 10 counties: Alleghany, Ashe, Davidson, Davie, Forsyth, Stokes, Surry, Watauga, Wilkes, and Yadkin).

4. By contracting with the state to provide public health services within the county. GS 130A-34(b); 130A-45.02.

B. North Carolina counties with populations greater than 425,000 have two additional ways they may elect to offer public health services:

1. They may form a consolidated human services agency, combining public health, social services, and mental health, developmental disabilities, and substance abuse services. A consolidated human services agency is governed by a consolidated human services board.
2. They may operate a county health department, but instead of having a board of health to govern it, they may abolish the board of health and give its powers and duties to the board of county commissioners.

GS 153A-77.

II. County health departments

A. A county health department is formed and operated by a single county. It is governed by a county board of health and administered by a local health director. Seventy-five counties in North Carolina provide public health services through a county health department governed by a county board of health.⁵

B. County board of health members—GS 130A-35(b) through (g)

1. A county board of health is composed of 11 members appointed by the county commissioners. Members must be residents of the county. The membership must include a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, a professional engineer, a county commissioner, and three members of the general public.
 - a. If no county resident is qualified and available to serve in a position representing a profession, a member of the general public may be appointed to that position. However, the member of the general public must step down as soon as a person who qualifies for the position becomes available. If there is only one county resident who is qualified and available to serve in a position representing a profession, the commissioners have the option to appoint either that person or a member of the general public.
2. Members serve three-year staggered terms and are generally limited to three consecutive three-year terms. However, if a member is the only person in the county who represents one of the named professions, that person may be appointed to additional consecutive terms. The commissioner-member's position is ex officio; the commissioner must step down from the board if his or her term

⁵ One county, Mecklenburg, has a county health department governed by the county commissioners pursuant to GS 153A-77. See section 2, part VI of this outline.

as a commissioner ends before the health board term expires.

3. The county commissioners may remove a board member from office for any of the following reasons:
 - a. Commission of a felony or a crime involving moral turpitude;
 - b. Violation of state conflict-of-interest laws;
 - c. Violation of a written policy adopted by the county commissioners;
 - d. Habitual failure to attend meetings;
 - e. Conduct that tends to bring the office into disrepute; or
 - f. Failure to maintain the qualifications for appointment to the board (e.g., if the person is required to be a licensed professional, failure to maintain licensure).

Before it acts to remove the member, the board of commissioners must give the board of health member written notice of the basis for removal and an opportunity to respond.

C. Role of the board of health—GS 130A-35(a)

The board of health is the policy-making, rule-making, and adjudicatory body for public health in the county.

D. Powers and duties of the board of health

1. Rule-making⁶: The board of health has the duty to protect and promote the public health and the authority to adopt rules necessary to that purpose. GS 130A-39(a). There are several limitations to the board's rule-making authority:
 - a. A board may not adopt rules concerning the issuing of grades and permits to food and lodging facilities, or the operation of those facilities. GS 130A-39(b).
 - b. A board may issue its own regulations regarding wastewater management only with the approval of the state Department of Environment and Natural Resources, 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.⁷ GS 130A-39(b).
 - c. A board may adopt a rule that is more stringent than the state rules adopted by the Commission for Health Services or the Environmental Management Commission if a more stringent rule is required to protect the public health. However, a board may not adopt a rule that is *less* stringent than a state rule on the same issue. GS 130A-39(b). A board that adopts a more

⁶ For more detailed information about this subject, see Aimee N. Wall, The Rulemaking Authority of North Carolina Local Boards of Health, Health Law Bulletin No. 81 (November 2003).

⁷ If a local board of health adopts local rules governing wastewater collection, treatment, and disposal, then it is required to also adopt rules for imposing administrative penalties when the local wastewater rules are violated. GS 130A-22(h).

stringent rule must provide a rationale or basis for setting 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.⁸

- d. In addition to meeting the above requirements, state courts have adopted a five-part test that a local board of health rule must satisfy to be valid. The rule must:
 - (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.⁹
- e. Finally, the North Carolina Supreme Court has held that a local rule is preempted by state law if the state has already provided a complete and integrated regulatory scheme in the area addressed by the local rule.¹⁰

2. Imposing fees: The board of health may impose a fee for most services rendered by the health department. GS 130A-39(g). The fees must be based on a plan proposed by the local health director. Fees adopted by the board must be approved by the county commissioners. There are several limitations to the board's fee-setting authority:

- a. A board may not charge fees when the health department employee is acting as an agent of the state. This covers most environmental health programs.
 - i. There are three statutory exceptions to this rule—fees may be charged for services provided under the on-site sewage treatment and disposal program, the public swimming pools program, and the tattooing regulation program.
- b. Regulatory fees must be reasonable—that is, they generally should cover no more than the actual costs of the regulatory program.¹¹
- c. State law specifically prohibits charging health department clients for the following services:
 - i. testing and counseling for sickle cell syndrome (GS 130A-130)
 - ii. examination for and treatment of tuberculosis and sexually transmitted diseases (GS 130A-144(e))
 - iii. testing and counseling for HIV (10A NCAC 41A.0202(9))

⁸ *Craig v. County of Chatham*, 356 N.C. 40 (2002).

⁹ *City of Roanoke Rapids v. Peedin*, 124 N.C. App. 578 (1996). In this case, the Court of Appeals articulated and adopted the five-part test, then used it to invalidate the Halifax County Board of Health's smoking control regulations. The court held that the rules violated part (5) of the test because they established different rules for different public places based on consideration of non-health related factors, such as economic hardship and difficulty of enforcement.

¹⁰ *Craig v. County of Chatham*, 356 N.C. 40 (2002).

¹¹ *Homebuilders Ass'n of Charlotte v. City of Charlotte*, 336 N.C. 37 (1994).

- iv. immunizations that are required by law and supplied by the state (GS 130A-153)(a))
 - d. Fees collected by the local health department must be used for public health purposes and usually must be returned to the specific program that generated them.¹²
- 3. Administration and policy-making
 - a. The board appoints the local health director after consultation with the county commissioners. GS 130A-40. The statute does not require the board to obtain the approval of the county commissioners before making its appointment, but the board must consult with them.
 - b. The board makes policy for the local health department. GS 130A-35.
 - c. Although no law requires it to do so, the board usually reviews and approves the health department's proposed budget before it is submitted to the county commissioners.
- 4. Adjudication—GS 130A-24(b), (c), & (d)
 - a. A person who is aggrieved by the health department's interpretation or enforcement of the board's rules may appeal to the board. The board must then hold a hearing in which it makes findings of fact and reaches a conclusion about the merits of the appeal. The board's ruling must be in writing and must set forth the factual findings upon which it is based. A person dissatisfied with the board's ruling may appeal to the district court.

III. District health departments

- A. A multi-county district health department may be formed upon agreement of the county commissioners and the boards of health of two or more counties. A county may join an existing district health department upon a similar agreement entered by all affected counties. GS 130A-36. A district health department may have health department offices in each component county, but it will be governed by one local board of health and administered by one local health director. GS 130A-37. Twenty-one counties in North Carolina are members of district health departments. There are six district health departments in the state.
- B. District board of health members—GS 130A-37
 - 1. A district board of health is composed of 15 to 18 members. Each county in the district appoints one county commissioner to the board. Those commissioners then appoint the other members. Members must be residents of the district. In addition to the commissioner members, the board's membership must include a licensed physician, a licensed dentist, a licensed optometrist, a licensed

¹² This requirement is imposed by the "Consolidated Agreement," a contract between local health departments and the state public health agencies that governs the use of funds disseminated by or through the state.

veterinarian, a registered nurse, a licensed pharmacist, and a professional engineer.

- a. The composition of the board must reasonably reflect the population make-up of the district and provide equitable district-wide representation.
 - b. If no resident of the district is qualified and available to serve in a position representing a profession, a member of the general public may be appointed to that position. However, the member of the general public must step down as soon as a person who qualifies for the position becomes available. If there is only one district resident who is qualified and available to serve in a position representing a profession, the commissioners have the option to appoint either that person or a member of the general public.
2. Members serve three-year staggered terms and are limited to three consecutive three-year terms. However, if a member is the only person in the district who represents one of the named professions, that person may be appointed to additional consecutive terms. The commissioner-members' positions are ex officio; commissioners must step down from the board if their terms as commissioners end before their health board terms expire.
3. The board may remove one of its members from office for any of the following reasons:
- a. Commission of a felony or a crime involving moral turpitude;
 - b. Violation of state conflict-of-interest laws;
 - c. Violation of a written policy adopted by the boards of county commissioners of each county in the district;
 - d. Habitual failure to attend meetings;
 - e. Conduct that tends to bring the office into disrepute; or
 - f. Failure to maintain the qualifications for appointment to the board (e.g., if the person is required to be a licensed professional, failure to maintain licensure).

Before it acts to remove the member, the board must give the member written notice of the basis for removal and an opportunity to respond.

C. Role of the board of health

The board of health is the policy-making, rule-making, and adjudicatory body for public health in the county. GS 130A-37(a).

D. Powers and duties of the board of health

The powers and duties of a district board of health are the same as the powers and duties of a county board of health, described in Sec. 2, Part II.E. of this outline.

IV. Public health authorities

- A. Counties may meet their obligation to provide public health services by forming public health authorities. GS 130A-45. A public health authority may be formed by a single county or by two or more counties jointly. GS 130A-45.02. A public health authority is governed by a public health authority board and administered by a public health authority director. GS 130A-45.02(e); 130A-45.4. At present, one county (Hertford) has a single-county public health authority that was formed under the public health authority statutes.
1. In addition, Cabarrus County has a unique situation that is similar to the public health authority model. Cabarrus provides public health services through the Cabarrus Health Alliance, an organization established and operated as a public hospital authority.¹³ As a public hospital authority, the Cabarrus Health Alliance has more autonomy and its board has more powers than a public health authority would.
- B. Public health authority board members—GS 130A-45.1
1. Single-county public health authority boards must be composed of 7 to 9 members appointed by the county commissioners. Multi-county boards must have 8 to 11 members. In multi-county authorities, the chairs of the boards of commissioners each appoint one commissioner to the board, and those commissioners appoint the remaining board members.
 2. Members must be residents of the county or counties making up the public health authority and must include a licensed physician, a licensed dentist, a county commissioner (or commissioner's designee) from each county in the authority, an administrator from a hospital serving the authority's service area, at least one member of the general public, and at least two licensed or registered professionals from any of the following professions: optometry, veterinary science, nursing, pharmacy, engineering, or accounting.
 3. Members serve three-year terms. The commissioner-members' positions are ex officio; commissioners must step down from the board if their terms as commissioners end before their board terms expire.
 4. The board may remove any of its members from office for any of the following reasons:
 - a. Commission of a felony or a crime involving moral turpitude;
 - b. Violation of state conflict-of-interest laws;
 - c. Violation of a written policy adopted by the boards of county commissioners of each county in the authority;

¹³ S.L. 1997-502, s. 12, authorized this arrangement in Cabarrus County. This portion of the law is uncodified, meaning it does not appear in the General Statutes. It can be found in bound copies of the 1997-98 N.C. Session Laws, or on the Internet at <http://www.ncleg.net/html1997/bills/CurrentVersion/ratified/Senate/Sbil0636.full.html>.

- d. Habitual failure to attend meetings;
- e. Conduct that tends to bring the office into disrepute; or
- f. Failure to maintain the qualifications for appointment to the board (e.g., if the person is required to be a licensed professional, failure to maintain licensure).

Before it acts to remove the member, the board must give the member written notice of the basis for removal and an opportunity to respond.

C. Role of the public health authority board—GS 130A-45.1(a): The public health authority board is the policy-making, rule-making, and adjudicatory body for public health in the county (or counties) it serves.

D. Powers and duties of the public health authority board—GS 130A-45.3. The public health authority board has all the powers and duties of a county board of health (see section 2, Part II.D. above), plus the following additional powers:

1. Powers related to contracting, management, and administration—the board is authorized to:
 - a. enter into contracts for necessary supplies, equipment, or services for the operation of its business
 - b. contract with public or private organizations, agencies, or corporations for the provision of public health services
 - c. establish a fee schedule for services (this includes authority to make services available regardless of ability to pay)
 - d. set the salaries of authority employees
 - e. adopt and enforce a professional reimbursement policy
2. Powers related to the acquisition and use of property—the board may:
 - a. construct, equip, operate, and maintain public health facilities
 - b. use property owned or controlled by the authority
 - c. acquire real or personal property
 - d. act as an agent for the federal, state, or local government in connection with the acquisition, construction, operation, or management of a public health facility
 - e. accept and take title to donations of money, personal property, or real estate for the benefit of the authority
 - f. lease a public health facility to a nonprofit association on terms and conditions consistent with the Public Health Authorities Act
 - g. lease a public health facility to any corporation on terms and conditions consistent with G.S. 160A-272
 - h. sell surplus buildings, land, or equipment to any corporation or other business entity operated for profit
3. The board may establish and operate health care networks, and engage in managed

care activities.

4. The board may employ its own legal counsel and staff; sue and be sued; insure its property or operations against risks; and insure itself, its board members, agents, or employees against liability.

V. Contracting with the state to provide services

A county may meet its legal duty to provide public health services by arranging for the state to furnish public health services within the county. GS 130A-34(b). No county in North Carolina has this type of arrangement.

VI. Consolidated human services agency—GS 153A-77(b)

- A. Boards of commissioners in counties with populations of 425,000 or more may elect to establish a consolidated human services agency with the authority to carry out the functions of the local health department, the county department of social services, the area mental health, developmental disabilities, and substance abuse authority, and other human services functions. The consolidated human services agency is governed by a consolidated human services board and administered by a consolidated human services director. One county (Wake) provides public health services through a consolidated human services agency.
 1. A consolidated human services agency is a single-county agency. GS 153A-77 does not authorize multi-county consolidated human services agencies.
- B. Membership of the consolidated human services board—GS 153A-77(c)
 1. A consolidated human services board is composed of up to 25 members appointed by the county commissioners. When a consolidated human services agency is initially formed, commissioners select board members from nominees presented by a nominating committee. Subsequent board members are selected from nominees presented by the consolidated human services board.
 2. Members must be residents of the county and must include:
 - a. 8 consumers of human services, public advocates, or family members of the agency's clients, including one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem, and two consumers of other human services.
 - b. 8 professionals, including one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.

- c. 2 licensed physicians, one of whom must be a psychiatrist.
- d. 1 county commissioner.
- e. Other persons, including members of the general public representing various occupations.

A person who has the qualifications or attributes of more than one membership category may be appointed to fulfill the membership requirement for more than one category.

- 3. Members serve four-year terms and are limited to two consecutive four-year terms. The commissioner-member's position is ex officio; the commissioner must step down from the board if his or her term as a commissioner ends before the board term expires.
- 4. The board of county commissioners may remove a consolidated human services board member from office for any of the following reasons:
 - a. Commission of a felony or a crime involving moral turpitude;
 - b. Violation of state conflict-of-interest laws;
 - c. Violation of a written policy adopted by the board of county commissioners;
 - d. Habitual failure to attend meetings;
 - e. Conduct that tends to bring the office into disrepute; or
 - f. Failure to maintain the qualifications for appointment to the board (e.g., if the person is required to be a licensed professional, failure to maintain licensure).

Before it acts to remove the member, the board of commissioners must give the member written notice of the basis for removal and an opportunity to respond.

- C. Role of the board with respect to public health—GS 130A-43(b): The consolidated human services board is the policy-making, rule-making, and adjudicatory body for public health in the county.
- D. Powers and duties of the board with respect to public health—GS 130A-43(b)

The consolidated human services board has the same powers and duties as a local board of health (described in Sec. 2, Part II.D. of this outline), except that the consolidated human services board does not appoint the consolidated human services director. Instead, the director is appointed by the county manager with the advice and consent of the consolidated human services board.

VII. Direct commissioner control of services—GS 153A-77(a)

- A. A second option available only to counties with populations of 425,000 or more is for the board of county commissioners to assume direct control of several county services, including public health services. A county that chooses this option may abolish its board

of health, board of social services, and area mental health, developmental disabilities, and substance abuse board, and transfer those boards' duties to the county commissioners. Mecklenburg County has exercised this option. It operates a county health department, but it is governed directly by the board of commissioners rather than by a board of health. An advisory committee advises the commissioners on health matters, but the committee does not have the powers and duties of a board of health.

- B. Role of the board of commissioners with respect to public health—When this model is adopted, the county commissioners abolish the local board of health and assume its role. Thus, the board of commissioners becomes the policy-making, rule-making, and adjudicatory body for public health in the county.
- C. Powers and duties of the board of commissioners with respect to public health—When this model is adopted, the county commissioners assume the powers and duties of the local board of health. The powers and duties of a local board of health are described in Sec. 2, Part II.D. of this outline.

Section 3: Administration of Local Public Health Services

I. Local health director

- A. The local health director is essentially the chief executive officer of the local public health agency.
- B. Appointment of the local health director
 - 1. The director of a county health department or a district health department is appointed by the local board of health after consultation with all appropriate boards of county commissioners. GS 130A-40(a).
 - a. If the county commissioners have abolished the board of health and assumed direct control of the health department pursuant to GS 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.
 - 2. The director of a public health authority is appointed by the public health authority board after consultation with all appropriate boards of county commissioners. 130A-45.4(a).
 - 3. The director of a consolidated human services agency is appointed by the county manager with the advice and consent of the consolidated human services board. GS 153A-77(e).
- C. Administrative Role: The local health director is the administrative head of the health department.

D. Powers and Duties—GS 130A-41; 130A-45.5; 130A-43(c).

1. General: All local health directors, public health authority directors, and consolidated human services directors have the following powers and duties:
 - a. investigating the causes of diseases
 - b. quarantining or isolating individuals when the public health requires it
 - c. disseminating public health information and promoting good health
 - d. advising local officials about public health matters
 - e. investigating individual cases of communicable diseases
 - f. abating public health nuisances and imminent hazards
 - g. employing and dismissing health department employees
2. Entering contracts on behalf of the department:
 - a. 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. GS 130A-41(13).
 - i. There is a limitation to this contracting authority. The statute provides that this authority shall not “be construed to abrogate the authority of the county commissioners.” Thus, it is a common practice to have county managers sign health department contracts. (In some counties, a county policy requires that county managers approve the contracts.)
 - b. Directors of public health authorities do not have the authority to enter contracts on behalf of the public health authority. Contracting authority is retained by the public health authority board. GS 130A-45.3(a)(12).

II. Local health department personnel

- A. The number and types of persons employed by local public health agencies varies greatly from county to county, depending upon the services the local department offers and the amount of resources available.
- B. Required personnel
 1. All local public health agencies must have at least a health director, a nurse, an environmental health specialist, and a secretary. 10A NCAC 46.0301(a). There are no other requirements in law for specific numbers or types of staff, but local public health agencies need sufficient personnel to provide all services required by the state (see Sec. 4 of this outline for a description of the required local public health services).
- C. Additional personnel
 1. Many public health agencies employ (or contract with) physicians, physicians’ assistants, nurse practitioners, nursing assistants, health educators, and

- 2. nutritionists.
 - 2. Additional categories of staff often found in health departments include medical records specialists, social workers, epidemiologists or statisticians, and administrative staff.
- D. Personnel governance
- 1. The qualifications, salary, and terms of employment of local health department personnel are governed by the State Personnel Commission. However, counties may propose their own health department personnel regulations, which the Commission may approve if it finds them to be substantially equivalent to the state regulations.
 - 2. Public health authorities have specific authority to establish salary plans for their employees and are exempt from the State Personnel Act. GS 130A-45.3(a)(7); 130A-45.12.

Section 4: Required Local Public Health Services

I. “Essential” and “mandated” public health services

The North Carolina General Assembly has identified the *essential public health services* that should be available to all citizens in the state. These are codified in the General Statutes (G.S. 130A-1.1(b)). The Commission for Health Services has identified the *mandated services* that every local health department in North Carolina must provide or assure are available in the local health department’s jurisdiction. These are codified in the North Carolina Administrative Code (10A N.C.A.C. 46.0201 through 46.0216 – formerly 15A N.C.A.C. 25.0201 through 25.0216).

What is the difference between the essential public health services and the mandated services? The laws themselves do not say. However, the essential public health services are part of a statute that describes the mission of the state public health system as promoting and contributing to the highest level of health possible for the people of N.C. In my view, the essential public health services represent a general statement of what should be done to meet that mission, while the list of mandated services is a specific list of the minimal services that must be available to all residents of the state in order for the public’s health to be preserved and promoted.

II. Essential public health services—GS 130A-1.1

- A. The North Carolina General Assembly has declared that the following three categories of “essential public health services” should be available to all citizens in the state:
 - 1. Health support services—assessment of health status, health needs, and environmental risks to health; patient and community health education; operation of a public health laboratory; and registration of vital events.
 - 2. Environmental health services—sanitation inspections and regulations of milk, restaurants, meat markets, hotels and motels, hospitals, schools, ambulances, local

detention facilities, agricultural labor camps, swimming pools, and other public places.

3. Personal health services—services for child health, chronic disease control, communicable disease control, dental health, family planning, health promotion and risk reduction, and maternal health.

- B. Responsibility for ensuring that essential public health services are available throughout the state is given to the North Carolina Department of Health and Human Services; however, the actual provision of most services occurs at the local level.

III. Mandated Services—10A NCAC 46.0201

- A. The Commission for Health Services requires local health departments to provide or ensure the provision of thirteen services.

1. Five of the mandated services must be provided by the agency directly and cannot be contracted out:
 - a. communicable disease control (see 10 N.C.A.C. 46.0214)
 - b. vital records registration (see 10 N.C.A.C. 46.0215)
 - c. food, lodging, and institutional sanitation (see 10 N.C.A.C. 46.0213)
 - d. individual on-site water supply (see 10 N.C.A.C. 46.0210)
 - e. sanitary sewage collection, treatment and disposal (see 10 N.C.A.C. 46.0211)
2. The remaining services may be provided directly through the local health department, or the department may contract with someone to provide the service, or the department may certify to the state's satisfaction that the services are available in the department's jurisdiction from other providers:
 - a. adult health (see 10 N.C.A.C. 46.0209)
 - b. home health (see 10 N.C.A.C. 46.0208)
 - c. dental public health (see 10 N.C.A.C. 46.0207)
 - d. grade "A" milk certification (see 10 N.C.A.C. 46.0212)
 - e. maternal health (see 10 N.C.A.C. 46.0205)
 - f. child health (see 10 N.C.A.C. 46.0204)
 - g. family planning (see 10 N.C.A.C. 46.0206)
 - h. public health laboratory support (see 10 N.C.A.C. 46.0216)
3. Within each of these general categories of services, there are specific services that must be provided or assured. Those are found in the Administrative Code sections cited in parentheses, above. For example, the specific services that must be provided or assured for maternal health are found in 10A N.C.A.C. 46.0205 and include: pregnancy testing, information, and referral; and prenatal care for women not otherwise served, through direct provision of care, referral to other providers, contracts with other providers, or a combination of those methods.