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Public Health

by Jill D. Moore

History

In 1988, the Institute of Medicine defined public health as "what we as a society do collectively to ensure the conditions in which people can be healthy."[1] The emphasis this definition places on collective action and the conditions that promote good health reflects a distinction between public health and medicine: public health is concerned with the health of populations, not just the health status or condition of particular individuals.

1. Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988).

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The oldest and most traditional concerns of public health systems—sanitation and disease control—reflect this focus. Practices such as isolation of the ill and proper food handling are described in the Old Testament book of Leviticus, a book that is viewed by public health scholars as the first written public health code. The focus on collective action and population-based activities is also the reason public health has long been a function of government.

In North Carolina, public health has been recognized as a proper concern of government since colonial times. The first public health legislation applicable to the territory that is now North Carolina was a maritime quarantine law, enacted in 1712. Throughout the colonial and antebellum eras, epidemics of typhoid fever, dysentery, malaria, and other illnesses produced demands for governmental action. Most public health efforts in those early years were undertaken by local governments, both municipal and county. Local public health initiatives were sporadic, however, and statewide legislation addressing public health concerns was rare. By the beginning of the Civil War, only three or four pages of the state statutes addressed public health, and no governmental agency had the authority to enforce public health laws.[2]

A state system for creating and enforcing public health policy began to emerge in 1877, when the General Assembly enacted a law that designated the entire membership of the North Carolina Medical Society as a state board of health with an annual state appropriation of $100. Two years later the legislature replaced that statute with another that created a nine-member state board of health. An 1893 statute defined the board's powers to include assuring safe drinking water sources, advising managers of institutions and towns with respect to their water supply and sewage disposal systems, inspecting the sanitation of public institutions, and regulating the transportation of corpses.

Local mechanisms for assuring public health began to develop in the late nineteenth century, when the General Assembly authorized counties to form boards of health. These boards were responsible for vaccinating citizens, isolating citizens with dangerous diseases, gathering vital statistics, and performing postmortem medical examinations.

By the early twentieth century, North Carolina had a fledgling public health system. A 1911 statute expanded county boards' authority and membership, and the first county health departments were formed shortly thereafter. Guilford County was an early leader in this area, establishing what may have been the first local health department in the nation. By 1915, seven counties were operating full-time health departments. The state board of health's range of activities had expanded as well. By 1915, the board employed a full-time state health director and supervised a variety of activities: education and engineering, vital statistics, quarantine, school inspection, tuberculosis, and a laboratory of hygiene. It was during this time that the state's role as a provider of funding and assistance to local public health activities began to emerge. In addition to providing some services directly to citizens, the state contributed public health expertise, enabling legislation, and some funding to local governments that undertook organized public health efforts.

The growth of North Carolina's public health system faltered during the Great Depression, when state and local appropriations for public health decreased drastically. By fiscal year 1932–33 the amount spent by the state was less than half that spent during 1929–30. In the mid-1930s, however, for the first time federal funding became available for local public health efforts. The Social Security Act of 1935 appropriated $8 million annually to assist states and their political subdivisions in providing public health services. By 1935 the state had recovered sufficiently for both the General Assembly and local governments again to appropriate funds for public health services. By 1949, the services of a full-time local health department were available in every county in the state.

As the public health service delivery structure grew, so did the legal framework authorizing public health services. Between 1911 and 1957, the General Assembly enacted a wide range of public health statutes. In 1957 and again in 1983, it completely rewrote these laws, clarifying and organizing them. Today, most of the state's public health laws are contained in G.S. Chapter 130A. Among other things, those laws provide for the state's present public health infrastructure, in which primary responsibility for providing public health services is given to counties.

In recent years, there has been a significant expansion in public health legal authority and infrastructure in North Carolina, prompted by a series of events that, while unrelated, all drew attention to the need for a public health system capable of rapidly detecting and responding to a variety of threats. The anthrax letter attacks of October 2001, the introduction of diseases such as the West Nile virus into the United States, the emergence of new illnesses such as severe acute respiratory syndrome (SARS), and the threat of pandemic flu have led to an increased focus on public health preparedness. In 2002, seven public health regional surveillance teams (PHRSTs) were formed and charged with planning for the rapid detection of, and response to, public health threats. Federal funding for bioterrorism preparedness allowed

2. Roddey M. Ligon Jr., *Public Health in North Carolina* (Chapel Hill, N.C.: Institute of Government, University of North Carolina at Chapel Hill, 1960), 2.

the state's public health laboratory system to be renovated and expanded. New legislation in 2002 and 2004 gave the public health system new powers and duties in responding to bioterrorism and communicable disease. In 2004, a task force created by the state's secretary of health and human services developed and published the "North Carolina Public Health Improvement Plan." Among other things, the plan called for the accreditation of local health departments and the formation of collaborative relationships between public health agencies and other governmental entities to address public health concerns.

In 2006, the public health system continues to carry out the traditional functions of ensuring sanitation and controlling infectious diseases, but its focus has expanded to include other duties and embrace other roles. Among other things, the public health system today systematically monitors the health status of the state's residents, serves as a provider of health care services, and engages in a number of community-based activities designed to promote health and prevent chronic disease or injury. At the same time, there is clearly an increased focus on developing the infrastructure and workforce that will be required to face twenty-first-century public health challenges.

Responsibility for Public Health Services in North Carolina

The state and county governments share legal responsibility for assuring that public health services are available to all of North Carolina's residents (G.S. 130A-1.1; 130A-34). However, most public health service delivery occurs at the local level, through various forms of local health departments.[3]

Public Health at the State Level

The state agencies with chief responsibility for public health in North Carolina are the Division of Public Health, within the Department of Health and Human Services (DHHS); the Division of Environmental Health, within the Department of Environment and Natural Resources (DENR); and the Commission for Health Services. These agencies are responsible for administering and monitoring state public health programs, making and enforcing statewide public health rules, and allocating funds to local public health agencies. In addition, they maintain some direct services and provide a connection to other federal and state agencies.

In 2005, the General Assembly created a new agency with statewide public health responsibilities—the Local Health Department Accreditation Board. The Accreditation Board is located administratively in the North Carolina Institute for Public Health, a unit of the University of North Carolina School of Public Health.

Rule Making

The Commission for Health Services is the primary rule-making body for public health in North Carolina. It also has the authority to create metropolitan water districts, sanitary districts, and mosquito control districts.

The commission has thirteen members, four of whom are elected by the North Carolina Medical Society. The remaining nine are appointed by the governor and must include a pharmacist, a soil scientist or engineer experienced in sanitary engineering, a veterinarian, an optometrist, a dentist, and a registered nurse. The members serve four-year staggered terms.

The commission is responsible for adopting rules governing the operation of the state's public health programs. It also has general rule-making authority for the protection of the public health, and may adopt rules necessary to enable the state public health agencies to administer and enforce public health statutes. In addition, several state statutes direct the commission to adopt rules regarding specific public health issues, such as communicable disease control and the sanitation of institutions. The commission's rules are codified in Title 10A of the North Carolina Administrative Code.

The N.C. Environmental Management Commission also has some rule-making authority in the area of public health. It makes statewide rules regarding water sources, including rules governing local health departments' inspection and permitting of private drinking water wells.[4]

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3. The term *local health department* encompasses county health departments, district health departments, public health authorities, and the public health components of consolidated human services agencies. *See* G.S. 130A-2(5); 130A-43.

4. The Commission for Health Services also adopts rules governing the sampling and testing of drinking water from wells.

Oversight, Administration, and Enforcement

North Carolina statutes give the responsibility of administering and enforcing the public health laws to the secretaries of DHHS and DENR. In practice, those duties are carried out principally by the state health director, DHHS's Division of Public Health,[5] and DENR's Division of Environmental Health. The state health director is appointed by the state secretary of health and human services (G.S. 130A-3). The statute states simply that the director performs duties and exercises authorities assigned by the secretary, but it is customary for the secretary to delegate all administrative responsibility for public health programs to the state health director. In addition, a few state statutes give powers and duties directly to the state health director. For example, the communicable disease laws give the director the power to issue temporary orders requiring health care providers to report certain health conditions (G.S. 130A-141.1), the authority to inspect medical records in an outbreak [G.S. 130A-144(b)], and the authority to impose isolation or quarantine (G.S. 130A-145). The state health director shares those powers and duties with local health directors. In contrast, the public health bioterrorism laws give certain powers and duties to the state health director alone. These powers and duties apply only during a suspected terrorist event, and include the power to close property, the authority to require individuals to submit to examinations and tests, and the authority to access information (G.S. Ch. 130A, Art. 22).

The Division of Public Health (DPH) is divided into sections and offices that are responsible for a wide variety of public health services and programs, including chronic disease prevention and control, injury prevention, communicable disease control, the Women, Infants, and Children's supplemental nutrition program (WIC), and the childhood immunization program. The Division of Environmental Health (DEH) also has sections and offices responsible for public health programs, including on-site wastewater programs, institutional sanitation, recreational water quality protection, and food protection. DPH and DEH staff members assist local health departments by providing training and technical assistance. They also conduct quality assurance activities, such as periodic reviews of local health department services.

The directors and employees of local health departments enforce public health laws and rules. State agencies monitor these local enforcement activities. For example, DPH assures that communicable disease information is collected by the local agency and reported to the state, while DEH oversees enforcement of the on-site waste water (septic tank) permitting program.

Allocation of Funds

DHHS allocates federal and state money for public health projects to local public health agencies. To receive certain funds, the local health department must enter into a contract with DHHS, called the consolidated agreement.[6] The consolidated agreement requires local public health agencies to comply with all public health laws and rules and it specifies how funds must be managed. This contract has a significant effect on how local public health agencies operate since noncompliance with its terms can result in loss of state and federal funds. It is renewed annually.

Direct Service Provision and Coordination with Other Agencies

Some public health services are provided directly by the state. These include purchase-of-care programs, which help individuals obtain medications or health care services; the vital records program, which records all births and deaths in North Carolina; and the State Center for Health Statistics, which compiles information about health conditions in the state's population and conducts public health research. The Division of Public Health also operates the state public health laboratory and the post-mortem investigation (medical examiner) program.

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5. There are other divisions within DHHS that are relevant to the provision of public health services in North Carolina. These include the office of Minority and Health Disparities, which collects data on health disparities and works to eliminate them through direct services and advocacy; the Division of Medical Assistance, which administers the Medicaid program; the Division of Facility Services, which is responsible for licensure and certification of health care facilities; and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The mental health, developmental disabilities, and substance abuse services system is described in Article 44.

6. The contract is signed by the local health director, the finance director, and, in county health departments, the chair of the board of county commissioners. The chair's signature is required by DHHS because, although the health director has authority to enter contracts on behalf of the department, that contracting authority may not be construed to abrogate the authority of the county commissioners [G.S. 130A-41(13)]. In district health departments and public health authorities, only the health director and finance director sign the contract.

The division maintains relationships and coordinates its work with federal public health agencies, including the Centers for Disease Control and Prevention, and with other state agencies that have responsibilities relating to public health. These include the Department of Agriculture, which has responsibility for food safety and for diseases in animals, including some that could spread to humans; the Department of Labor, which is responsible for occupational health and safety; and the Department of Crime Control and Public Safety, which leads the state's emergency management operations.

Local Health Department Accreditation

In 2005, the General Assembly enacted G.S. 130A-34.1, which requires every local health department in North Carolina to obtain and maintain accreditation. The law provided for initial accreditation of health departments to occur over a period of eight years, beginning January 1, 2006. It created a new agency, the Local Health Department Accreditation Board, which is responsible for reviewing accreditation applications and assigning an accreditation status to each local department.

The accreditation board is located administratively within the North Carolina Institute for Public Health, a unit of the University of North Carolina School of Public Health. The board is composed of seventeen members appointed by the secretary of health and human services. The membership includes representatives of boards of county commissioners, local boards of health, local health directors, and staff members of the state divisions of public and environmental health. The board is responsible for developing a schedule by which local health departments must apply for accreditation, reviewing each department's application for accreditation, and assigning an accreditation status as follows:

- "Accredited" means the department has satisfied the standards for accreditation. Accreditation expires after four years and the department must apply for re-accreditation.
- "Conditionally accredited" means the department has failed to meet one or more of the standards for accreditation and has been granted short-term accreditation status that is subject to conditions set by the board. This status is good for two years. By the end of that time, the department must have satisfied the board's conditions and met the criteria for accreditation, or it will become unaccredited.
- "Unaccredited" means the department has continued to fail to meet one or more of the standards after a period of conditional accreditation.[7]

The Commission for Health Services is responsible for adopting rules and standards for the accreditation process. The rules must provide for local health department self-assessments, site visits by the accreditation board, and informal review of board decisions.[8]

Public Health at the Regional Level

North Carolina law does not contain a formal regional structure for public health services. However, in practice, there are several regional entities that carry out either state or local public health responsibilities.

The state public health agencies hire employees, usually called consultants, who are assigned to serve local health departments in designated regions. Consultants work in different disciplines or service areas. For example, there are administrative consultants, nurse consultants working in areas such as child health or school health, and regional environmental health specialists.

There are seven public health regional surveillance teams, known as PHRSTs. Each team is based in a local health department but serves all the local health departments within its region.[9] Each team's membership includes an epidemiologist, a nurse consultant, an industrial hygienist, and an administrative specialist. These teams monitor

7. Because a department that fails to become fully accredited will have the two-year period of conditional accreditation to cure its deficiencies, DHHS does not expect local health departments to become unaccredited. However, if the "unaccredited" status is assigned to a local health department, DHHS may withhold state and federal funds from the department until it satisfies the standards.

8. Temporary rules were approved by the Commission for Health Services in December 2005 and became effective January 1, 2006. The rules will be codified as Chapter 48 of Title 10A of the North Carolina Administrative Code.

9. The local health departments that host the PHRSTs are Buncombe, Mecklenburg, Guilford, Durham, Cumberland, Pitt, and New Hanover. A map showing the location of each PHRST and the regions they serve is available on the Internet at http://www.epi.state.nc.us/epi/phpr/regions.html.

public health conditions in the regions they serve. They are also responsible for a number of public health preparedness activities, including training the public health workforce and developing public health emergency response plans in collaboration with local and regional entities that work with emergency response or disaster management.

Finally, most local health departments participate voluntarily in regional partnerships. 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 initially funded by the participating departments and grant funds. In 2004, the General Assembly provided one-time funding for four public health incubators, including the Northeastern Partnership. In 2005, the General Assembly appropriated $1 million in recurring funds to support the original four and two additional public health incubators.[10] Participation in incubators is voluntary and the incubators themselves do not have specific duties or authorities under North Carolina's public health laws.

Public Health at the Local Level

Local Health Departments

Every county is required by statute to provide public health services (G.S. 130A-34). Counties have several options for how they choose to carry out these duties. Any county may:

- operate a county health department, governed by a county board of health,
- join with one or more other counties to operate a district health department, governed by a district board of health, or
- form a single-county or multicounty public health authority, governed by a public health authority board.

Counties with populations of 425,000 have additional options: they may establish a consolidated human services agency that offers public health, social services, and mental health, developmental disabilities and substance abuse services, and is governed by a consolidated human services board. Counties that reach this population threshold may also operate a county health department that is governed directly by the board of county commissioners instead of a board of health (G.S. 153A-77).[11]

County health departments. 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 (G.S. 130A-35; 130A-40; 130A-41). On July 1, 2005, seventy-five North Carolina counties met their obligation to provide public health services by operating a county health department.

A county board of health is composed of eleven members appointed by the county commissioners. 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. All board members must be county residents, and the membership must reasonably reflect the population make-up of the county.

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10. In fiscal year 2005–6, there were sixty-three local health departments (representing seventy-seven counties) participating in six public health incubators: Central Partnership for Public Health (Alamance, Caswell, Chatham, Durham, Guilford, Orange, Person, Rockingham, and Wake counties); Northeastern North Carolina Partnership for Public Health (Albemarle district health department [Bertie, Camden, Chowan, Currituck, Gates, Pasquotank, and Perquimans counties], Martin-Tyrrell-Washington district health department, and Beaufort, Dare, Edgecombe, Halifax, Hertford, Hyde, Northampton, Pamlico, and Warren counties); the Northwest Partnership for Public Health (Appalachian district health department [Alleghany, Ashe, and Watauga counties], Davidson, Davie, Forsyth, Stokes, Surry, Wilkes, and Yadkin counties); South Central North Carolina Partnership for Public Health (Anson, Bladen, Cumberland, Harnett, Lee, Montgomery, Moore, Randolph, Richmond, Robeson, and Scotland counties); Southern Piedmont Partnership for Public Health (Alexander, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties); and the Western North Carolina Partnership for Public Health (Rutherford-Polk-McDowell district health department, Toe River district health department [Avery, Mitchell, and Yancey counties], Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, and Transylvania counties).

11. In 2005, only two North Carolina counties met the 425,000 population threshold: Wake and Mecklenburg. Wake County operates a consolidated human services agency. Mecklenburg County has abolished its local board of health and given its powers and duties to the board of county commissioners.

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, but 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.

Board 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 as a commissioner ends before the health board term expires.

The county commissioners may remove a board member from office for any of the following reasons: commission of a felony or a crime involving moral turpitude, violation of state conflict-of-interest laws, violation of a written policy adopted by the county commissioners, habitual failure to attend meetings, conduct that tends to bring the office into disrepute, or failure to maintain the qualifications for appointment to the board. 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 provide the member an opportunity to respond.

The board of health appoints a local health director after consultation with the county commissioners. The health director is the administrative head of the health department and also serves as secretary to the board of health.

District health departments. A multicounty 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 each affected county. A district health department may have health department offices in each component county, but it will be governed by one board of health and administered by one health director (G.S. 130A-36 through 130A-38; 130A-40; 130A-41). On July 1, 2005, twenty-one counties were members of six district health departments.[12]

A district board of health is composed of fifteen to eighteen members. Each county in the district appoints one county commissioner to the board. Those commissioners then appoint the remaining members, which must include a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, and a professional engineer. After each of the counties in the district is represented by a commissioner, and all the member positions representing professions are filled, any remaining positions may represent the general public. Members must be residents of the district. As with county boards, if no person from one of the named professions is qualified and available to serve, a member of the general public may be appointed to serve until a member of the named profession 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. The membership must provide for districtwide representation and reflect the population of the district. Whenever a county joins or withdraws from an existing district health department, the district board of health is dissolved and a new board appointed.

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, the person may be appointed to additional consecutive terms. The terms of the commissioner-members are concurrent with their tenure as county commissioners.

The district board of health may remove one of its member from office for any of the following reasons: commission of a felony or a crime involving moral turpitude, violation of state conflict-of-interest laws, violation of a written policy adopted by the boards of commissioners of each county in the district, habitual failure to attend meetings, conduct that tends to bring the office into disrepute, or failure to maintain the qualifications for appointment to the board. Before it acts to remove the member, the board must give the member written notice of the basis for removal and provide the member an opportunity to respond.

After consultation with the boards of commissioners of each county in the district, the board of health appoints a district health director. The director serves as administrative head of the department and as secretary to the board.

12. The districts were Albemarle Regional Health Services (Bertie, Camden, Chowan, Currituck, Gates, Pasquotank, and Perquimans counties), Appalachian District Health Department (Alleghany, Ashe, and Watauga counties), Granville-Vance District Health Department, Martin-Tyrrell-Washington District Health Department, Rutherford-Polk-McDowell District Health Department, and Toe River District Health Department (Avery, Mitchell, and Yancey counties).

Any county may withdraw from a district department when the majority of its 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 DHHS and only at the end of the fiscal year. 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. 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.

Public health authorities. A county may meet its obligation to provide public health services by forming a public health authority (G.S. Ch. 130A, Art. 2, Pt. 1A). A public health authority may be formed by a single county or by two or more counties jointly. On July 1, 2005, one North Carolina county (Hertford) was operating as a single-county public health authority under G.S. Chapter 130A. In addition, since July 1, 1997, Cabarrus County has been providing public health services through the Cabarrus Health Alliance, an organization established and operated as a hospital authority under G.S. Chapter 131E, Article 2, Part B.[13] The Cabarrus Health Alliance operates very similarly to a public health authority.

To form a single-county public health authority, the board of commissioners and the county board of health must jointly issue 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 the required 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.

After the resolution has been adopted, the county commissioners of a single-county authority or the chairs of the boards of commissioners forming a multicounty authority appoint a public health authority board. The board replaces the local board of health and becomes the rule-making, policy-making, and adjudicatory body for the authority. Ordinarily, a single-county board is composed of seven to nine members and a multicounty board is composed of eight to eleven members. However, a 2005 law provides that a public health authority that plans to seek federally qualified health center status (or look-alike status) may have between nine and twenty-five members. The board's membership must include a licensed physician, a licensed dentist, a commissioner or commissioner's designee from each county in the authority, an administrator from a hospital serving the authority's service area, a 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. Whenever a county joins or withdraws from an existing public health authority, the board is dissolved and a new board appointed.

Board members serve three-year staggered terms. County commissioner members are *ex officio* and serve only during their terms as county commissioners. The public health authority board may remove one of its members for any of the following reasons: commission of a felony or a crime involving moral turpitude, violation of state conflict-of-interest laws, violation of a written policy adopted by the boards of county commissioners of each county in the authority, habitual failure to attend meetings, conduct that tends to bring the office into disrepute, or failure to maintain the qualifications for appointment to the board. Before it acts to remove a member, the board must give the member written notice of the basis for removal and an opportunity to respond.

The public health authority board appoints an authority director after consultation with the appropriate county commissioners. The authority director serves as the administrative head of the authority and as secretary to the board.

Public health authorities operate more independently of boards of commissioners than traditional local health departments. Moreover, the public health authority board has powers and flexibility that local boards of health—both county and district—do not. For example, public health authorities are exempt from the state personnel act, may set

13. Cabarrus County was granted the authority to provide public health services through a hospital authority in an uncodified portion of the Public Health Authorities Act, SL 1997-502. Section 12 of that act authorized counties that meet certain narrow, prescribed conditions and obtain the approval of the state health director to provide public health services through a hospital authority.

employee salaries, and may acquire and sell property. Public health authority boards also have contracting authority. In traditional local health departments, local health directors have contracting authority, but it is subordinate to the authority of the county commissioners.

Despite the expanded powers of the public health authority board, county commissioners retain ultimate control. They appoint the members of the authority board and they may dissolve the 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.

Consolidated human services agencies. A board of commissioners in a county with a population that exceeds 425,000 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 agencies [G.S. 153A-77(b)-(e)]. A consolidated human services agency is a single-county agency. The statute does not authorize multicounty consolidated human services agency. On July 1, 2005, one county (Wake) provided public health services through a consolidated human services agency.

A consolidated human services agency is governed by a consolidated human service board, which may have no more than twenty-five 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 composed of the members of the preconsolidation boards of health, social services, and mental health, developmental disabilities, and substance abuse services. Subsequent appointments are made by the commissioners from nominees presented by the human services board.

Board members must be residents of the county and the board's composition must reasonably reflect the population makeup of the county. The membership must include:

- eight 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
- eight professionals, including one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse
- two licensed physicians, one of whom must be a psychiatrist
- one county commissioner
- 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.

Board members serve staggered four-year terms and are limited to two consecutive four-year terms. The county commissioner-member may serve in that position for only as long as he or she remains a county commissioner.

The board of commissioners may remove a consolidated human services board member from office for any of the following reasons: commission of a felony or a crime involving moral turpitude, violation of state conflict-of-interest laws, violation of a written policy adopted by the board of county commissioners, habitual failure to attend meetings, conduct that tends to bring the office into disrepute, or failure to maintain the qualifications for appointment to the board. Before it acts to remove a member, the board of commissioners must give the member notice of the basis for removal and an opportunity to respond.

In general, consolidated human services boards assume the duties and responsibilities of a local board of health, with one exception: they do not appoint the agency's director. Otherwise, the board serves in the same rule-making, fee-setting, and adjudicatory roles as traditional boards of health. The board is also responsible for planning and recommending a consolidated human services budget to the county commissioners.

A consolidated human services agency is administered by a consolidated human services director, who is appointed by the county manager with the advice and consent of the consolidated human services board. The consolidated human services director may hire a person to administer the agency's public health functions and delegate to that person the powers and duties of a local health director.

Assumption by county commissioners of direct responsibility for services. A second option that is available only to counties with populations of more than 425,000 is for the board of county commissioners to assume direct control of several county services, including public health services [G.S. 153A-77(a)]. A county that chooses this option may abolish its board of health, board of social services, and 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. Instead, the commissioners are the policy-making, rule-making, and adjudicatory body for public health in Mecklenburg County. The commissioners also appoint the local health director.

Contracting for services to be provided by the state. A final way for a county to meet its obligation to provide public health services is for the county to contract with the state to provide public health services in the county (G.S. 130A-34). On July 1, 2005, no county in the state was operating under this type of arrangement.

Governance: Local Boards of Health

The previous section describes several types of boards that have responsibility for local public health activities: local (either county or district) boards of health, public health authority boards, consolidated human services boards, and in some cases, the board of county commissioners. Each of these boards 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.

All of the different types of boards have the powers and duties that are described in this section, but public health authority boards and consolidated human services boards have additional powers and duties, as described previously.

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). There are several limitations to the board's rule-making authority. A board may not adopt rules concerning the issuing of grades and permits to food and lodging facilities, or the operation of those facilities. A board may issue its own regulations regarding on-site wastewater management only with the approval of DENR, 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.[14]

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, a board may adopt a rule that is more stringent than the statewide rules of the Commission for Health Services or the Environmental Management Commission on the same issue, if a more stringent rule is required to protect the public health. The supreme court has interpreted this to mean a board that adopts a more stringent rule must provide a rationale 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.[15]

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14. If a local board of health adopts 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 [G.S. 130A-22(h)].

15. *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. For a more

In addition to meeting the above requirements, North Carolina's 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.[16]

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)]. Fees must be based 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).

There are some limitations to the board's fee-setting authority. First, 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, but there are four statutory 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, regulatory fees must be reasonable. That is, they generally should be set at a level designed simply to recoup the actual costs of the regulatory program.[17]

Local health departments charge fees for some of their clinical services, but these are not set by the local board of health. Instead, fees charged to patients with third-party insurance generally reflect Medicaid reimbursement rates established by the state Division of Medical Assistance. Patients who are classified "self-pay" because they lack third-party insurance often are charged fees according to sliding scales that may be linked to federal or state categorical funding. For example, sliding scales for family planning services are governed by regulations attached to federal funding.

Moreover, local health departments are specifically prohibited by state law from charging health department clients for some clinical services:

- testing and counseling for sickle cell syndrome (G.S. 130A-130)
- examination for and treatment of tuberculosis [G.S. 130A-144(e)]

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detailed analysis of *Craig* and a complete treatment of this issue, see Aimee N. Wall, "The Rulemaking Authority of North Carolina Boards of Health," *Health Law Bulletin* 81 (November 2003).

16. 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 rules. 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. The court stated,

> [T]he statutes cannot be held to permit the [local board of health] to consider factors other than health in promulgating its rules. While a legislative body arguably may direct that distinctions be based on factors other than public health when authorizing the promulgation of rules by health boards, such factors may not be considered *sua sponte* [i.e., of the local boards' own initiative].

The implication of this decision for the rule-making authority of local boards of health is troublesome. Public health traditionally concerns itself with a number of social, economic, and other factors that may contribute to a particular public health problem without being part of a specific disease process. Whether such concerns will be recognized by future courts as being sufficiently health related to be properly within a local board's rule-making authority remains to be seen.

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

- examination for and treatment of certain sexually transmitted diseases[18] [G.S. 130A-144(e)]
- testing and counseling for human immunodeficiency virus (HIV) [10A N.C.A.C. 41A.0202(9)]
- immunizations that are required by law and supplied by the state [G.S. 130A-153(a)]

A local health department may charge third-party payers (such as Medicaid) for the above services, but it may not charge the client. 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. Similarly, the federal HIPAA medical privacy rule limits the fees that may be charged for copies of medical records.[19]

Adjudication (G.S. 130A-24). A person who is aggrieved by a local health department's interpretation or enforcement of local rules may appeal to the board. A person who wishes to appeal must provide notice of appeal to the local health director within thirty days of the action being appealed. The notice must contain the name and address of the aggrieved party, describe the action being appealed, and state the reasons the health department's action was incorrect. The health director must transmit the notice of appeal to the board of health within five working days. The board must then hold a hearing within fifteen days, after giving the aggrieved person a minimum of ten days' notice of the time, date, and place of the hearing.

After the hearing, the board of health makes findings of fact and reaches a conclusion about the merits of the appeal. 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. A person who is dissatisfied with the board's ruling may appeal to the district court within thirty days of receiving notice of the board's decision.

Administration. Local boards of health have an important, though indirect, role in the administration of the local health department. First, the board appoints—and may elect to replace—the local health director, who is responsible for the day-to-day administration of the department. Second, the board makes policy decisions governing the department. Finally, although no law requires it to do so, the board typically reviews and approves the health department's proposed budget before it is submitted to the county commissioners.

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 handling 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 health department. In addition, the director has powers and duties that are prescribed by law.

The director of a county or district health department 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). If the county commissioners have abolished the board of health and assumed direct control of the health department pursuant to G.S. 153A-77, 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.

A public health authority board is not required to consult the county commissioners before appointing the health director (G.S. 130A-45.3). In a county that operates a consolidated human services agency, the agency director is appointed by the county manager with the advice and consent of the consolidated human services board (GS 153A-77).

All local health directors, public health authority directors, and consolidated human services directors have the following powers and duties [G.S. 130A-41; 153A-77(e); 130A-45.5(c)]:

- investigating the causes of diseases
- quarantining or isolating individuals when the public health requires it

18. This requirement applies only to syphilis, gonorrhea, chlamydia, nongonnococcal urethritis, mucopurulent cervicitis, lymphogranuloma venereum, and granuloma inguinale [10A N.C.A.C. 41A.0204(a)].

19. 45 C.F.R. 164.524(c)(4).

- disseminating public health information and promoting good health
- advising local health officials about public health matters
- investigating individual cases of communicable diseases
- abating public health nuisances and imminent hazards
- employing and dismissing health department employees

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 there is a limitation to this authority. G.S. 130A-41(13) states 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 the health department to submit contracts to the manager for approval.) Directors of public health authorities do not have the authority to enter contracts on behalf of the public health authority without the approval of the authority's board, which is granted contracting authority by statute [G.S. 130A-45(3)(a)(12)].

Local health department personnel. All local health departments must have at least a health director, a nurse, an environmental health specialist, and a secretary [10A N.C.A.C. 46.0301(a)]. There are no other requirements in law for specific numbers or types of staff, but local health departments need sufficient personnel to provide all services required by the state (described in detail below). Many departments employ or contract with physicians, physicians' assistants, nurse practitioners, nursing assistants, health educators, and nutritionists. Additional categories of staff may include social workers, medical records specialists, epidemiologists or statisticians, and administrative staff.

The qualifications, salary, and terms of employment of personnel in most health departments are governed by the State Personnel Commission. However, counties may propose their own personnel regulations, which the commission may approve if it finds them to be substantially equivalent to the state regulations. Public health authorities have specific authority to establish salary plans for their employees and are exempt from the State Personnel Act (G.S. 130A-45.3; 130A-45.12).

Financing of 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 varies by locality, but on average, local sources of funding—including income from local health department fees as well as county appropriations—accounted for almost 80 percent of local health department budgets in fiscal year 2002–3. That same year, about 18 percent of local health department funding statewide came from federal sources. State and private grant funds made up the rest.[20]

Federal Funds

Local health departments receive federal funds both directly and indirectly. The major source of direct federal support is reimbursement under the Medicaid program for services rendered by the department. 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, the WIC program, and several other services and programs.

State Funds

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. Categorical support is typically given out according to formulas that include a base amount that is the same for each county and an additional amount that varies according to population, need, and performance. 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, local health departments must sign a contract with the state. Currently, the funds are distributed under a single "consolidated agreement," although no law prohibits the state from requiring a separate contract for each funding program. The contract contains a number of general provisions governing how local health

20. Leah Devlin, "North Carolina Public Health: Priming the Pump of Improved Health for All," *Popular Government* 71 (Fall 2005): 2–15.

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 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. It is common practice for a local board of health to approve the health department's budget before it is submitted to the county manager and the commissioners, but no statute requires it. 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. If one of these agencies were to seek county appropriations, however, the county commissioners would of course have to approve the expenditure.

The General Assembly has set no minimum level of local funding that county commissioners must provide for public health. The basic requirement is that funding must be sufficient to support the mandated services set forth in the Commission for Health Services' rules (described later in this article). The amount set aside for mandated services varies widely from county to county, however.

Two "maintenance of effort" 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.

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, as described earlier in this article. Revenues from fees imposed by local boards of health 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

There are three sources of law that influence which services local health departments in North Carolina provide. G.S. 130A-1.1(b) identifies the *essential public health services* that should be available to all citizens in the state. Statewide rules identify the *mandated services* that each local health department must either provide or assure are otherwise available within the local health department's jurisdiction (10A N.C.A.C. 46.0201-46.0216). Finally, G.S. 130A-34.1 requires local health departments to be accredited, as described earlier in this article. To be accredited, a health department must meet certain requirements, including undertaking activities that pertain to the essential public health services. For example, the department must conduct regular community health assessments that meet specific standards (10A N.C.A.C. 48.0201). The remainder of this section explains the essential public health services statute and the mandated services rules, and describes the services that a typical North Carolina local health department might provide.

Essential Public Health Services

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 regulation 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.

The statute gives DHHS and DENR the responsibility for assuring that these services are available throughout the state. As a practical matter, however, many of the services must be provided at the local level. Thus the Commission for Health Services has adopted rules giving local health departments the responsibility of ensuring that services are available.

Mandated Services

Services that the local public health agency must guarantee are called, appropriately, "mandated services" (10A NCAC 46.0201). Mandated services fall into two categories. The first category consists of services that the local health department must itself provide directly, under the control of the local health director and the local board of health. These are environmental health services (inspection and regulation of individual, on-site water supply; sanitary sewage collection, treatment, and disposal; food, lodging, and institutional sanitation; and public swimming pools and spa safety and sanitation), communicable disease control, and vital records registration.

In the second category are services that the county may provide directly through the health department, provide by contracting with someone else to provide the services, or not provide at all, if it can certify to the state's satisfaction that the services are available in the county from other providers. These services include grade "A" milk certification, public health laboratory services, child health, maternal health, family planning, dental health, home health, and adult health.

Within each of these general categories of services there are specific services that must be provided or assured. For example, the specific services that must be provided for maternal health 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 (10A N.C.A.C. 46.0205).

Typical Services

Local health departments are permitted to provide additional services that are not mandated, and many do. The extent of health department services varies considerably across the state. Of the many factors that explain the variations, the most important are the availability of funds and the size of the department's staff. It is therefore impossible to describe the precise range and scope of services that will be provided by any given health department. However, a typical local health department is likely to offer the following programs and services:

- *Vital statistics and disease reporting.* Local health departments collect information about all births and deaths and all instances of certain diseases that occur within the areas the departments serve and then prepare records and reports on these events.
- *Sanitation and environmental health*. The Commission for Health Services has adopted statewide rules regarding the sanitation of restaurants, hotels, summer camps, migrant labor camps, residential-care facilities, jails, and other establishments. Registered environmental health specialists employed by local health departments enforce these rules. The normal procedure calls for periodic inspections, grading, and issuing of required permits. Environmental health specialists also inspect and permit septic systems.
- *Communicable disease control.* Local health departments are required to provide immunizations and to diagnose and treat tuberculosis and sexually transmitted diseases. Local health departments also receive reports of communicable diseases from health care providers, schools, and others; investigate outbreaks of diseases; and enforce individuals' compliance with communicable disease control laws.
- *Clinical services.* Local health departments offer the communities they serve a number of screening services and health care clinics. Most departments offer child health, prenatal care, and family planning clinics. Some local health departments also have chronic disease, adult health, or dental clinics.
- *Nutrition services*. Many local health departments administer the federal WIC (women, infants, and children) supplemental food program. They may also offer nutrition counseling and education.

- *Health education*. Local health departments work to educate citizens in healthy lifestyles, preventive health care, and management of chronic health problems. An agency's educational programs may be offered in its own facilities, in schools, and at public places.
- *School health services*. A local health department may conduct screenings in schools, teach special classes in the schools, and cooperate with school personnel in identifying and treating students' health problems. Some local health departments contract with the local education agency to provide school nurses, and some operate school-based health centers that provide a wide range of health care services to students.
- *Services coordination*. Many local health departments provide case management services to coordinate the care of women with high-risk pregnancies (maternity care coordination) and children with developmental delays, chronic health problems, or other special needs (child services coordination).

Additional Resources

Institute of Government, North Carolina Public Health Law website, www.ncphlaw.unc.edu.

Leah Devlin, "North Carolina Public Health: Priming the Pump of Improved Health for All," *Popular Government* 71 (Fall 2005): 2–15.

N.C. Department of Health and Human Services, North Carolina Public Health Improvement Plan: Final Report (January 15, 2005), available at http://www.ncpublichealth.com/taskforce/docs/FinalReport1.15.05.pdf.

Jill D. Moore is a School of Government faculty member who works in the area of public health law.