

**Local Boards of Health in North Carolina:  
Overview of Membership Requirements and Legal Authorities**

Jill D. Moore, UNC School of Government

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**I. Introduction**

Each local public health agency in North Carolina has a governing board that 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. What the board is called varies by agency:

- a county health department has a county board of health
- a district health department has a district board of health
- a public health authority has a public health authority board
- a consolidated human services agency has a consolidated human services board, which has responsibility for public health if the agency provides public health services.<sup>1</sup>

The generic term "local board of health" embraces all of these types of boards when they are carrying out public health duties.<sup>2</sup>

In some counties, the board of county commissioners serves as the board of health. If a county provides public health services through a county health department or a consolidated human services agency, the board of county commissioners may adopt a resolution directly assuming the powers, responsibilities, and duties of the county board of health or consolidated human services board – an action that has the effect of abolishing the appointed board.<sup>3</sup> A board of

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<sup>1</sup> A consolidated human services agency (CHSA) may be composed of "any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to the authority of the county commissioners." G.S. 153A-77(b)(3). The law specifies that a CHSA may include public health, but it is not required to include public health.

<sup>2</sup> This is consistent with statutory definitions and usage. G.S. 130A-2(4) defines "local board of health" to mean "a district board of health or a public health authority board or a county board of health." G.S. 153A-77(d) gives consolidated human services boards the powers and duties of local boards of health, except when the statutes specifically provide otherwise.

<sup>3</sup> G.S. 153A-77(a). A board of county commissioners that wishes to assume the powers and duties of a local board must hold a public hearing after providing 30 days' notice of the hearing and intended action, and then adopt a resolution formally assuming the powers and duties of the board. A board of commissioners may not assume the powers and duties of a district board of health or a public health authority board.

county commissioners that takes this action must appoint an advisory committee on health that includes the same membership as a county board of health.<sup>4</sup>

The composition of the different types of boards varies, but in general members represent county commissioners, professionals with expertise in health care or public health, and the general public. County commissioners play a role in the appointment of each type of board, but the specifics of the commissioners' role varies by type of board.

## **II. Board of Health Membership**

### **A. Composition**

The composition of a local board's membership varies depending on the type of local public health agency (see Table 1). In general, board members represent county commissioners, professionals with expertise in health care or public health, and the general public. A consolidated human services board also includes members who are consumers of human services, and a public health authority board includes a hospital administrator. Depending on the type of board, the number of board members may be as few as seven or as many as 25.

If the board of county commissioners has assumed the powers and duties of the local board of health, the commissioners do not have to meet the membership composition requirements in the statutes. However, they must appoint an advisory committee that has the same membership as a county board of health.

### **B. Method of Appointment**

How board of health members are appointed varies by type of board, but in all cases, county commissioners are involved. The board of county commissioners appoints the members of a county board of health or a single-county public health authority board.<sup>5</sup> For a district board,

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<sup>4</sup> G.S. 153A-77(a). The requirement for an advisory committee on health applies only to counties that abolish their health boards after January 1, 2012. This amounts to an exception for Mecklenburg county, which abolished its boards (a county board of health, and subsequently a consolidated human services board) before that date.

<sup>5</sup> G.S. 130A-35(b) (county boards of health), 130A-45.1(b) (public health authority board).

**Table 1. Board of Health Membership Requirements by Type of Board**

	<b>County Board of Health</b>	<b>District Board of Health</b>	<b>Single-County Public Health Authority Board</b>	<b>Multi-County Public Health Authority Board</b>	<b>Consolidated Human Services Board</b>
Number of members	11	15 to 18	7 to 9	7 to 11	Up to 25
Members of the public or consumers	3	✓	✓	✓	4 or more <sup>c</sup>
County commissioner	✓	✓ <sup>a</sup>	✓	✓ <sup>b</sup>	✓
Physician	✓	✓	✓	✓	✓ <sup>d</sup>
Psychiatrist					✓
Psychologist					✓
Social worker					✓
Hospital administrator			✓	✓	
Dentist	✓	✓	✓	✓	✓
Optometrist	✓	✓	✓	✓	✓
Veterinarian	✓	✓	✓	✓	✓
Registered nurse	✓	✓	✓	✓	✓
Pharmacist	✓	✓	✓	✓	✓
Engineer	✓	✓	✓	✓	✓
Accountant			✓	✓	

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

- a. One commissioner from each county involved.
- b. One commissioner from each county involved. The commissioners may designate someone other than a commissioner to serve in this position.
- c. At least 4 members must be consumers of human services.
- d. Two licensed physicians must serve on the board, one of whom must be a psychiatrist.

the board of commissioners for each county in the district appoints a county commissioner to the board, then those commissioners appoint the remaining members.<sup>6</sup> Multi-county public health authorities are managed similarly, but each board of commissioners may appoint either

<sup>6</sup> G.S. 130A-37(b).

a commissioner or a commissioner’s designee.<sup>7</sup> Although no law requires it, it is a common practice for the boards of all of these agency types to recommend appointees to the commissioners.

For a consolidated human services board, the board of county commissioners appoints members from a slate of nominees. When the board is initially created, the nominees are identified by a nominating committee composed of members of the pre-consolidation boards of health, social services, and mental health, developmental disabilities, and substance abuse services. Subsequent members are appointed by the commissioners from nominees selected by the consolidated human services board.<sup>8</sup>

**Table 2. Appointment of local board of health members**

Type of board	Method of appointment	Statute
County board of health 11 members	County commissioners appoint all members.	G.S. 130A-35
District board of health 15-18 members	Each county in the district appoints one commissioner to serve on the board. Those commissioners appoint the remaining members.	G.S. 130A-37
Public health authority board (single-county) 7-9 members*	County commissioners appoint all members.	G.S. 130A-45.1
Public health authority board (multi-county) 8-11 members*	Each county in the authority appoints one commissioner or designee to serve on the board. Those individuals appoint the remaining members.	G.S. 130A-45.1
Consolidated human services board Up to 25 members	County commissioners appoint all members from nominees presented by a nominating committee (initial appointments) or the consolidated board (subsequent appointments).	G.S. 153A-77

\* In some instances, a public health authority may want to apply to the federal government to become a community health center so that it may be eligible for additional funding from specific federal programs. The federal law governing community health centers has strict requirements related to board membership. Therefore, state law allows a public health authority interested in applying for that status to have up to 25 board members.

<sup>7</sup> G.S. 130A-45.1(b).

<sup>8</sup> G.S. 153A-77(c). The statute specifies that the area mental health board must be represented on the initial nominating committee, even though changes in the mental health system mean that mental health cannot be part of a consolidated human services agency.

### C. Residency

In most cases, members of county boards of health, district boards of health, and consolidated human services boards must be residents of the county or multi-county district.<sup>9</sup> Public health authority boards are different: except for the county commissioner members, members of those boards are not required to be residents of the county or multi-county area served by the authority.<sup>10</sup>

There is an exception to the residency requirement for the *county* board of health member who serves in the licensed optometrist position.<sup>11</sup> If a licensed optometrist who is a county resident is not available for appointment, the county commissioners may fill the position with either a licensed optometrist who resides in another county, or a member of the general public who is a county resident. Note that this provision does not apply to a *district* board of health, or to a consolidated human services board.

Each type of board requires some members who are licensed professionals. Sometimes there is no resident in the local public health agency's jurisdiction who qualifies for one of the licensed professional positions. How this situation is managed varies for the different types of boards.

- *County board of health or district board of health:* If there is no one available to serve in one of the licensed professional positions, a member of the general public must be appointed instead. Also, if there is only one member of a licensed profession available to serve in the jurisdiction, the commissioners have the option of appointing either that person or another member of the general public.<sup>12</sup>
- *Consolidated human services board:* There is no provision for substituting a member of the general public for a licensed professional.<sup>13</sup> If no county resident is available to serve in a licensed professional position, that seat likely must remain vacant.
- *Public health authority board:* These boards are different in two ways that may make this issue less of a concern for them. First, the only licensed professional positions that must be represented on a public health authority board are one physician and one dentist. The commissioners are permitted to choose two to four additional members from a list of licensed professionals—optometrist, veterinarian, registered nurse, pharmacist, professional engineer, accountant—but the board is not required to have all of them. Second, public health authority board members are not required to be

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<sup>9</sup> G.S. 130A-35(b); 130A-37(b); 153A-77(c).

<sup>10</sup> G.S. 130A-45.1.

<sup>11</sup> G.S. 130A-35(b).

<sup>12</sup> G.S. 130A-35(b) (county board of health); 130A-37(b) (district board of health.)

<sup>13</sup> See G.S. 153A-77(c).

residents of the authority's jurisdiction, so the commissioners could choose a non-resident to represent one of the professions.<sup>14</sup>

#### D. Terms and Term Limits

The number of terms a board of health member may serve and the length of each term varies by type of board. In each case, when boards are first appointed, members may be appointed to terms of different lengths in order to establish a staggered term structure.

County and district board of health members are appointed to three-year terms and may serve a maximum of three consecutive three-year terms. There are a couple of exceptions to this general rule. First, if the member is the only county or district resident who is a member of one of the licensed professions that must be represented on the board, the member may serve more than three consecutive three-year terms.<sup>15</sup> Second, if a member of a district board of health is serving in his or her capacity as a county commissioner, the NC Attorney General has advised that the member may serve for as long as he or she remains a commissioner, even if that time exceeds three consecutive three-year terms.<sup>16</sup>

Consolidated human services board members are appointed to four-year terms and may serve a maximum of two consecutive four-year terms. There is no exception for a situation in which a member is the only county resident who is a member of a licensed profession that must be represented on the board.<sup>17</sup> The county commissioner member of the board may serve only as long as he or she remains a county commissioner.

Public health authority board members are appointed to three-year terms. There is no limit to the number of terms they may serve.<sup>18</sup>

If the county commissioners have assumed the powers and duties of the board of health, a person's service in that role ends when his or her service as a county commissioner ends. In this

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<sup>14</sup> G.S. 130A-45.1(c).

<sup>15</sup> G.S. 130A-35(c) (county board of health); 130A-37(c) (district board of health).

<sup>16</sup> Attorney General Advisory Opinion to Hal G. Harrison, Mitchell County Attorney, 1998 WL 856356 (Oct. 8, 1998).

<sup>17</sup> G.S. 153A-77(c). Before 2012, state law allowed only counties with populations exceeding 425,000 to form consolidated human services board. See S.L. 2012-126, sec. 1 (repealing the population threshold requirement). This could explain why there is no provision for a term to be extended if an individual is the only person in the county available to represent one of the professions that is required on the board, as it is less likely that a highly-populated county would encounter that circumstance.

<sup>18</sup> G.S. 130A-45.1.

situation, there must be an advisory committee on health. The law that requires the advisory committee does not establish terms or term limits for advisory committee members.<sup>19</sup>

**Table 3. Local board of health terms and term limits**

Local board of health	Term Length	Term Limit	Statute
County board of health	3 years	3 consecutive 3-year terms	G.S. 130A-35
District board of health	3 years	3 consecutive 3-year terms	G.S. 130A-37
Public health authority board (single and multi-county)	3 years	None	G.S. 130A-45.1
Consolidated human services board	4 years	2 consecutive 4-year terms	G.S. 153A-77
Board of county commissioners assume board of health powers & duties	Coincides with time in office	None	
• Advisory committee on health	Not specified	Not specified	G.S. 153A-77

#### E. Removal of a Board of Health Member

A board of health member may be removed from office before his or her term is up only if there is cause for removal under state law. The laws for county and district boards of health, consolidated human services boards, and public health authority boards state that a member may be removed for any of the following reasons:<sup>20</sup>

- Commission of a felony or other crime involving moral turpitude
- Violation of a state law governing conflict of interest
- Violation of a written policy adopted by the county commissioners (or all of the applicable boards of commissioners, if it is a multi-county board)
- Habitual failure to attend meetings
- Conduct that tends to bring the office into disrepute
- Failure to maintain qualifications for appointment (such as maintaining residency in the county or licensure in a profession)

<sup>19</sup> G.S. 153A-77(a). The advisory committee requirement does not apply to Mecklenburg county, as explained in footnote 4.

<sup>20</sup> G.S. 130A-35(g) (county board of health); 130A-37(h) (district board of health); 130A-45.1(j) (public health authority board); 153A-77(c) (consolidated human services board).

These provisions do not apply to boards of county commissioners that have assumed the powers and duties of a board of health.

Who has the authority to remove a board member? The answer varies by type of board. For county boards of health and consolidated human services boards, the county commissioners have this authority.<sup>21</sup> A county board of health or consolidated human services board may recommend removal of a member to the commissioners if it wishes, but it lacks authority to carry out the removal. For district boards of health and public health authority boards, the board itself may remove a member.<sup>22</sup>

### **III. Board of Health Powers and Duties**

A local board of health is the policy-making, rule-making, and adjudicatory body for public health in the county or counties in its jurisdiction.<sup>23</sup> State statutes give boards of health specific powers and duties.<sup>24</sup> Every type of local board may make local public health rules that apply throughout the board's 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 public health agency.

Public health authority boards have expanded powers and duties compared to county and district boards of health. Consolidated human services boards have all of the powers of county and district boards of health, except a consolidated human services board may not appoint the agency director (who is appointed instead by the county manager, with the advice and consent of the board). A consolidated human services board also plays a more active role in the development of the agency's budget,<sup>25</sup> and has additional powers and duties related to its oversight of other human services programs.

Table 4 compares the powers and duties of the different types of boards in more detail.

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<sup>21</sup> G.S. 130A-35(g) (county board of health); 153A-77(c) (consolidated human services agency).

<sup>22</sup> G.S. 130A-37(h) (district board of health); 130A-45.1(j) (public health authority board).

<sup>23</sup> G.S. 130A-35(a) (county board of health); 130A-37 (district board of health); 130A-45.1 (public health authority board); 153A-77(d)(4) (consolidated human services board).

<sup>24</sup> G.S. 130A-39 (county and district boards of health); 130A-45.3 (public health authority board); 130A-43(b) and 153A-77(d) (consolidated human services board).

<sup>25</sup> G.S. 153A-77(d)(7) (a consolidated human services board is authorized to plan and recommend a consolidated human services budget). Although it may plan and recommend the agency budget, the consolidated human services board may not present or transmit the budget for local health programs. G.S. 130A-43(b)(2).



**Table 4. Comparison of Powers and Duties by Type of Board**

	<b>County Board of Health</b>	<b>District Board of Health</b>	<b>Public Health Authority Board</b>	<b>Consolidated Human Services Board</b>
Adopt local public health rules	Yes	Yes	Yes	Yes
Make policy for the local agency	Yes	Yes	Yes	Yes
Adjudicate appeals related to local rules or fines imposed by the local health director	Yes	Yes	Yes	Yes
Appoint local health director after consultation with board (or boards) of county commissioners	Yes	Yes	Yes	No, county manager appoints human services director with consent of the board
Impose fees for services	Yes, subject to approval of BOCC <sup>a</sup>	Yes, subject to approval of all BOCCs <sup>a</sup>	Yes	Yes, subject to approval of BOCC <sup>a</sup>
Prepare and recommend the agency budget	Informal role <sup>b</sup>	Yes	Yes	Yes <sup>c</sup>
Approve local public health agency budget	No	Yes	Yes	No
Enter contracts <sup>d</sup>	No	No	Yes	No
Set salaries of employees and professional reimbursement policies	No	Yes, with approval of Office of State Human Resources <sup>e</sup>	Yes	No
Employ legal counsel and staff	No	Yes	Yes	No
Construct or otherwise acquire property for use as public health facilities	No	No	Yes	No
Sell surplus buildings, land, and equipment	No	No	Yes	No
Establish and operate health care networks and contract for the provision of public health services	No	No	Yes	No

- a. Fees imposed by a county, district, or consolidated board must be based on a plan recommended by the health director and approved by the board of county commissioners (BOCC).
- b. It is customary for a county board of health to develop a proposed budget for the county health department.
- c. Consolidated human services agency boards plan and recommend the agency's budget (G.S. 153A-77(d)(7)) but are prohibited from transmitting or presenting the budget for local health programs (G.S. 130A-43(b)(2)) and do not approve the final budget.
- d. County, district, and consolidated boards do not have the authority to enter contracts. A separate statute authorizes local health directors to enter contracts on behalf of the local health department; however, the director's authority may not be construed to abrogate the authority of the county commissioners.
- e. The salaries of district health department employees are based on a plan that the district board of health adopts, but the plan must be approved by the Office of State Human Resources.

## A. Board of Health 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. A local board of health rule can be enforced using one or more of several methods set forth in the public health laws, potentially including a criminal charge, a civil action, or, in limited cases, the imposition of administrative penalties (fines). The rule is valid only within the local board's jurisdiction (that is, the county or counties it serves), including within the boundaries of any municipalities in the counties served by the board.<sup>26</sup>

### *1. Limitations to Board of Health Rule-Making Authority*

It is important to recognize that a board of health may not adopt a rule on any matter it deems important. As an administrative rule-making body, the board has only the authority that has been delegated to it by the state legislature, which has specified that the board may make rules only as necessary to protect and promote the public health. This statutory requirement was interpreted by the North Carolina Court of Appeals in a 1996 case, *City of Roanoke Rapids v. Peedin*.<sup>27</sup> The *Peedin* decision enunciated a five-part test that a board of health rule must satisfy in order 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 any distinctions based on policy concerns traditionally reserved for legislative bodies.<sup>28</sup>

State statutes impose additional limitations to board of health rule-making authority:

1. A board of health may not adopt rules concerning the issuing of grades and permits to food and lodging facilities.<sup>29</sup>
2. A board may issue its own regulations regarding on-site wastewater management only with the approval of the NC Department of Health and Human Services, 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.<sup>30</sup>

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<sup>26</sup> G.S. 130A-39(c) ("The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.").

<sup>27</sup> 124 N.C. App. 578 (1996).

<sup>28</sup> *Id.* at 587.

<sup>29</sup> G.S. 130A-39(b).

<sup>30</sup> G.S. 130A-39(b); 130A-335(c).

3. A board of health rule regulating smoking in public places must abide by statutory restrictions on this authority and must be approved by the applicable board(s) of county commissioners.<sup>31</sup>

Finally, if a board of health adopts a rule that addresses an issue that is already addressed by a state law, it is possible that the board of health rule will be preempted (overridden) by the state law. 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.<sup>32</sup> However, the state law that gives boards of health their rule-making authority specifically allows a local board of health to adopt rules that are more stringent than state rules if the local board determines that a more stringent rule is necessary to protect the public health.<sup>33</sup> The Supreme Court’s decision does not preclude this, but it means that a board of health that wishes to adopt a local rule that exceeds statewide standards must provide a rationale for doing so. 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 the higher standards.

## 2. *Board of Health Rule vs. Local Ordinance*

Boards of county commissioners and municipal governing boards both have ordinance-making authority, including the authority to adopt ordinances addressing public health. When deciding whether to pursue a public health goal via board of health rule versus local ordinance, it is important to understand the differences between these two types of local laws.

**Body that makes the law.** The first and most obvious difference is in who makes the local law. A local public health rule is adopted by the board of health, while a local ordinance is enacted by the governing body of a local government, either a county or a municipality.

**Territorial jurisdiction.** A major difference between local public health rules and local ordinances is their territorial jurisdiction. Typically, county ordinances apply only in the unincorporated areas of the county, not inside the municipalities (unless the municipalities consent to be governed by the county ordinance).<sup>34</sup> Similarly, municipal ordinances typically

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<sup>31</sup> G.S. 130A-498.

<sup>32</sup> *Craig v. County of Chatham*, 356 N.C. 40 (2002). This limitation is sometimes referred to as “implied preemption,” or preemption that is based on the existence of a comprehensive higher law. In comparison, the limitation imposed by the statute prohibiting local boards of health from adopting rules regarding the operation or permitting of restaurants is an example of “express preemption.”

<sup>33</sup> G.S. 130A-39(b).

<sup>34</sup> G.S. 153A-122.

apply only within the municipality.<sup>35</sup> In contrast, a board of health rule applies throughout the board's territorial jurisdiction—the county or counties represented by the board of health and all the municipalities contained in them.<sup>36</sup>

**Scope of authority.** Another major difference is that boards of health are subject to some limitations on their authority that do not apply to elected boards of commissioners. These limitations were described briefly earlier in this document, but a couple of matters are worth further elaboration in this context.

First, boards of health may only adopt rules that are related to the protection and promotion of health.<sup>37</sup> Boards of county commissioners are allowed to adopt ordinances that address a wider range of issues and concerns.

The second and perhaps more significant limitation is that boards of health must not “make distinctions based upon policy concerns traditionally reserved for legislative bodies.”<sup>38</sup> This limitation was explained by the North Carolina Court of Appeals and is grounded in the board of health's status as an appointed body rather than a legislative (elected) body. By contrast, because the members of a board of county commissioners are elected, the commissioners may make distinctions based on policy concerns having nothing to do with health. So, for example, a board of county commissioners could enact an ordinance imposing certain requirements generally on businesses in the community, but exempting small businesses for whom the requirements might pose economic hardship. In contrast, a local board of health could not craft exceptions to a general public health rule that were based on businesses' economic concerns and had no health-based rationale.

**Enforcement:** A final significant difference between board of health rules and local ordinances is in how they may be enforced. Board of health rules are enforced using the specific methods set forth in the public health laws. The laws provide for the possibility of a criminal charge, a

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<sup>35</sup> A municipal ordinance may extend to property or rights-of-way outside the municipality if they are owned by the municipality. G.S. 160A-176.

<sup>36</sup> G.S. 130A-39(c). Whether this general principle extends to local board of health rules regulating smoking has been questioned by some municipalities. The state law that authorizes boards of health to adopt local smoking rules, G.S. 130A-498, also requires the board of county commissioners to approve the rules by ordinance. Some attorneys believe the commissioners' approval ordinance narrows the territorial jurisdiction of the rules. Others take the position that the approval ordinance is a procedural step that does not affect the jurisdiction of the board of health's rule. In an advisory letter, the North Carolina Attorney General concluded that a local board of health rule regulating smoking applies within municipalities. Advisory Letter, Robert Hargett and Mabel Bullock, Special Deputy Attorneys General, to Colleen Bridger, Orange County Health Director (Feb. 20, 2013), on file with author.

<sup>37</sup> G.S. 130A-39(g); *City of Roanoke Rapids v. Peedin*, 124 N.C. App. 578 (1996).

<sup>38</sup> *Peedin*, 124 N.C. App. at 587.

civil action, or, in limited cases, the imposition of administrative penalties (fines).<sup>39</sup> Ordinances may also be enforced using similar methods, but in general a board of county commissioners has broader authority to impose administrative fines or to make violation of an ordinance an infraction.<sup>40</sup>

## B. Board of Health Adjudications

In limited circumstances, a local board of health may act essentially as a court. When a person is aggrieved by the health department's interpretation or enforcement of a *local* board of health rule, or the *local* imposition of administrative penalties, the person may appeal the department's decision to the board of health.<sup>41</sup> The board then hears the case and issues a decision either upholding or overturning the department's action. If the person is not satisfied with the board of health's decision, he or she may appeal to district court.

The specific procedures a local board of health should follow for an adjudication are set out in G.S. 130A-24(b) through (d). The statute prescribes actions that must be taken and provides specific timeframes. ***It is essential to follow the steps and timeframes in the statute to the letter.*** A local health director who receives notice of appeal should consult the department's attorney promptly to ensure that proper procedures are followed. The following is a general depiction of the steps and timeframes, but it should not be used in lieu of the department's attorney's advice:

1. A person is aggrieved by one of the following:
  - a. The local health department interprets or enforces a *local* rule, or
  - b. The *local* health director imposes administrative penalties. At the time of this writing, a local health director's authority to impose administrative penalties is limited to two contexts: violation of public health smoking laws (state or local), or violation of *local* on-site wastewater rules (*not* state).<sup>42</sup>
2. If the aggrieved person wishes to appeal the action to the local board of health, he or she must give written notice of appeal to the local health director within *30 calendar days*. The notice must include the aggrieved person's name and address, a description

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<sup>39</sup> See G.S. 130A-25 (providing that violation of most local board of health rules is a misdemeanor); 130A-18 (authorizing local health directors to seek injunctive relief for violation of local board of health rules); 130A-22 (authorizing the imposition of administrative penalties for violations of public health smoking laws, or on-site wastewater rules adopted by a local board of health).

<sup>40</sup> G.S. 153A-123.

<sup>41</sup> G.S. 130A-24(b)-(d).

<sup>42</sup> G.S. 130A-22(h) & (h1).

of the challenged action, and a statement of the reasons the action is believed to be incorrect.

3. The local health director has *5 working days* to transmit the following information to the board of health: the notice of appeal, and the papers and materials upon which the challenged action was taken.
4. The local board of health must hold a hearing within *15 calendar days* of receipt of the notice of appeal. The aggrieved person must receive at least *10 calendar days'* notice of the date, time, and place of the hearing. To satisfy these time frames, the local health director likely needs to set the hearing date immediately upon receipt of the notice of appeal.
5. After hearing the appeal, the board of health may affirm, modify, or reverse the action that is the subject of the appeal. The board must issue a *written* decision that contains a concise statement of the reasons for its decision. There is no time frame in the statute for issuing the decision but it is generally prudent to act promptly.
6. The board of health's decision may be appealed to the district court. Notice to the district court must be given within *30 calendar days* after the board of health's decision is issued.

When a person is aggrieved by the local health department's enforcement of *state* rules, such as the food and lodging rules, the local board of health is not authorized to hear the appeal. Those cases go to the state Office of Administrative Hearings.<sup>43</sup>

### C. Setting Fees

All local boards of health are authorized to set fees, but the procedure for setting them varies by type of board. County and district boards of health and consolidated human services boards must base their fees on a plan proposed by the local health director, and any fees adopted by the board must be approved by the county commissioners (in the case of a district health department, all applicable boards of county commissioners).<sup>44</sup> Public health authority boards may establish fee schedules and are not required to obtain commissioner approval.<sup>45</sup>

There are several limitations to the fee-setting authority that apply to all the different types of boards of health. First, a board may not charge fees for activities carried out by a health department employee acting as an agent of the state. This covers most environmental health programs, but there are four exceptions: fees may be charged for services provided under the

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<sup>43</sup> G.S. 130A-24(a).

<sup>44</sup> G.S. 130A-39(g).

<sup>45</sup> G.S. 130A-45.3(a)(5).

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.<sup>46</sup>

Second, while local health departments may charge fees for some of their clinical services, the board of health has limited discretion in determining the amount of the fee. Fees may reflect Medicaid reimbursement rates, or sliding scales established by a state or federal program that provides funds for a particular service. Also, local health departments are specifically prohibited by state law from charging health department clients for some services:

- testing and counseling for sickle cell syndrome<sup>47</sup>
- examination for and treatment of tuberculosis<sup>48</sup>
- examination for and treatment of certain sexually transmitted diseases<sup>49</sup>
- testing and counseling for HIV<sup>50</sup>

Additionally, immunizations that are required by law and supplied by the state must be provided at no cost to uninsured or underinsured patients with family incomes below 200 percent of the federal poverty level.<sup>51</sup>

Finally, some federal laws affect whether or to what extent a local board may impose fees for particular 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.<sup>52</sup> Similarly, the federal HIPAA medical privacy rule limits the fees that may be charged for copies of medical records.<sup>53</sup>

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<sup>46</sup> G.S. 130A-39(g).

<sup>47</sup> G.S. 130A-130.

<sup>48</sup> G.S. 130A-144(e).

<sup>49</sup> G.S. 130A-144(e).

<sup>50</sup> 10A NCAC 41A.0202(9).

<sup>51</sup> G.S. 130A-153(a).

<sup>52</sup> Civil Rights Act of 1964, Title VI, Section 601 (42 U.S.C. § 2001d); see also Policy Guidance: Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, 65 Fed. Reg. 52,762 (August 30, 2000).

<sup>53</sup> 45 C.F.R. 164.524(c)(4).