Local Public Health Governance in North Carolina— Past, Present, and Future

Karl Johnson, PhD

Health Directors' Legal Conference April 16-17, 2025

Disclaimer

I am *not* a…

- lawyer
- health director
- historian
- county commissioner
- board of health member

I *am* a…

- Public health researcher
- LHD staff member (Granville-Vance Public Health)
- Board member for the Association of North Carolina Boards of Health
- Contract recipient for the National Association of Local Boards of Health

Agenda

- **What I *AM* going to discuss**
  - History of major laws impacting local public health governance
  - Current governance models—legality and reality
  - Topics for future governance discussions
- **What I'm *NOT* going to discuss**
  - *State* or *federal* public health governance
  - *Voluntary* governance associations (e.g., informal information/resource sharing, i.e., through regional partnerships)

ANCIENT HISTORY

(1877-1970)

VERY DISTANT PAST (1877-1970)

- **1877**: North Carolina State Board of Health created by the North Carolina Legislature
- **1911:**
  - First LHDs were established (all county LHD models with independent BOHs)
  - Restructuring of county auxiliary boards into 5-member BOHs
- **1927**: "County-manager" form of government established, gradual uptake of county-manager form throughout 20th century
- **1949**: The last remaining county establishes a full-time health department

POP QUIZ

Which was the first and last county to form a local health department in North Carolina?

POP QUIZ

Who was required to be on the first Boards of Heath (1911)?

PUBLIC LAWS AND RESOLUTIONS

OF THE

STATE OF NORTH CAROLINA

PASSED BY THE

GENERAL ASSEMBLY

AT ITS

SESSION OF 1911,

BEGUN AND HELD IN THE CITY OF RALEIGH

ON

WEDNESDAY, THE FOURTH DAY OF JANUARY, A. D. 1911.

PUBLISHED BY AUTHORITY.

RALEIGH:
E. M. UZZELL & CO., STATE PRINTERS AND BINDERS.
1911.

SEC. 9. *County board of health, who constitutes; election county superintendents of health.*

Members of county board of health.

The chairman of the board of county commissioners, the mayor of the county town, and in county towns where there is no mayor the clerk of the Superior Court, and the county superintendent of schools shall meet together on the first Monday in April, one thousand nine hundred and eleven, and thereafter on the first Monday of January in the odd years of the calendar, and elect from the regularly registered physicians of the county, two physicians, who, with themselves, shall constitute the county board of health.

Organization.

The chairman of the board of county commissioners shall be the chairman of the county board of health, and the presence of three members at any regular or called meeting shall constitute a quorum.

Quorum.

Term of office.

The term of office of members of the county board of health shall terminate on the first Monday in January in the odd years of the calendar, and while on duty they shall receive four dollars *per diem*, to be paid by the county.

Pay.

Health interests of county.

The county board of health shall have the immediate care and responsibility of the health interests of their county.

Annual meetings.

They shall meet annually in the county town, and three members of the board are authorized to call a meeting of the board whenever in their opinion the public-health interest of the county requires it.

Called meetings.

Powers.

They shall make such rules and regulations, pay such fees and salary, and impose such penalties as in their judgment may be necessary to protect and advance the public health: *Provided*, that all expenditures shall be approved by the board of county commissioners before being paid.

Proviso: expenditures approved by county commissioners.

County superintendent of health.

At their first annual meeting on the second Monday of May, one thousand nine hundred and eleven, and thereafter on the second Monday of January in the odd years of the calendar, they shall elect the county superintendent of health, who shall serve thereafter until the second Monday in January of the odd years of the calendar: *Provided*, that if the county board of health of any county shall fail to elect a county superintendent of health within two calendar months of the time set in this section, the Secretary of the State Board of Health shall appoint a registered physician of good standing in the said county, who shall serve the remainder of the two years, and shall fix his compensation, to be paid by the said county, in proportion to the salaries paid by other counties for the same service, having in view the amount of taxes collected by said county.

Term of office.

Proviso: appointment on failure of county board to elect.

Compensation.

S.L. 1911-62, sec. 9

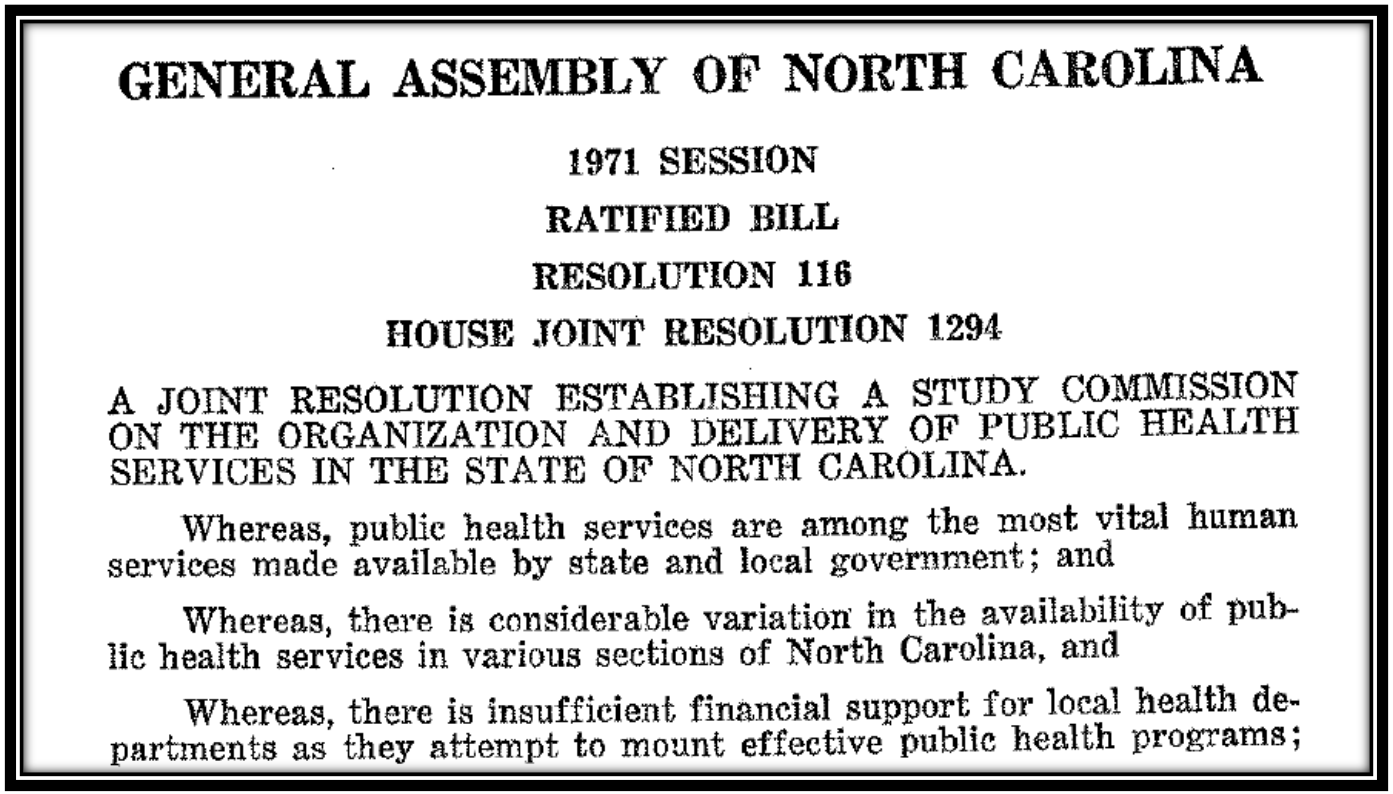
DISTANT PAST

(1971-2012)

DISTANT PAST (1971-2012)

- **1971:** Study Commission on the Organization and Delivery of Public Health Services (Resolution 116, House Joint Resolution 1294)
- **1973: First paragraph of G.S. 153A-77** ("Authority of boards of commissioners over commissions, boards, agencies)
  - Counties with > 300,000 can allow BOCC to assume the powers, duties, and responsibilities of other county boards, including human services boards
  - Population threshold increased to 400,000 in 1985 and then to 425,000 in 1987
- **1973**: Mecklenburg County BOCC assumes powers of BOH and DSS board
- **1974**: Funding for District Health Departments through general assembly

Formation of District Health Departments



GENERAL ASSEMBLY OF NORTH CAROLINA

1971 SESSION

RATIFIED BILL

RESOLUTION 116

HOUSE JOINT RESOLUTION 1294

A JOINT RESOLUTION ESTABLISHING A STUDY COMMISSION ON THE ORGANIZATION AND DELIVERY OF PUBLIC HEALTH SERVICES IN THE STATE OF NORTH CAROLINA.

Whereas, public health services are among the most vital human services made available by state and local government; and

Whereas, there is considerable variation in the availability of public health services in various sections of North Carolina, and

Whereas, there is insufficient financial support for local health departments as they attempt to mount effective public health programs;

<u>Recommendation 11:</u>
"Legislation should be enacted empowering the State Board of Health to require local health departments to combine into districts when a department serves a population less than 75,000."

Formation of District Health Departments

"**If we are to assure an acceptable minimum standard of public health services to citizens throughout the state, we must find a means to bring our smaller counties together in multi-county District Health Departments to the end that no local health department serve less than a specified population size**. Such an arrangement would increase the Department's ability to employ a qualified local health director as well as a full complement of staff and would ultimately enhance its ability to provide a full spectrum of services to its community."

Testimony given by Dr. Ronald H. Levine (former North Carolina State Health Director) before a legislative study commission on the organization and delivery of public health services, June 1972

Formation of District Health Departments

Timeline of District Health Department formation

- App Healthcare (3 counties): 1933 (first just Watauga and Avery)
- Albermarle Regional Health Services (8 counties): 1943 (Perquimans County joined with Pasquotank County, then Chowan in 1949, Currituck in 1999, Bertie in 2002, Gates in 2004, and Hertford in 2018)
- **Foothills Health District (2 counties): 1974 (first just Polk and Rutherford County)**
- **Granville Vance (2 counties): 1974**
- **Martin-Tyrell-Washington (3 counties): 1974**
- Toe River Health District (2 counties): 1980

DISTANT PAST (1971-2012)

- **1983 (S.L. 1983-891)**: **Re-write of state's public health code.** Formalized the structure and authority of local boards of health (5 --> 11 members, more diversity), among many other changes
- **1996**: **Statute G.S. 153A-77 amended** (sections B-G) to allow counties with > 425,000 to consolidate social services, public health, and MH/DD/SA into CHSA.
- **1996**: Wake County adopts a resolution creating a CHSA
- **1998**: Formation of the Cabarrus Public Health Authority (AKA Cabarrus Health Alliance)
- **1998**: Creation of the UNC Health Care System and 10 health regions
- **2008**: Mecklenburg County adopts a resolution creating a CHSA

Agency Consolidation among Metropolitan Health Agencies

- Prior to 2012, only counties with a population of at least 425,000 could create a CHSA.
  - Wake County created a CHSA in 1996
  - Mecklenburg County adopted a resolution creating a CHSA in 2008
  - Guilford County *could* have pursued CHSA, but did not (until 2014)
- **More Humans (+ $$) → More Human Services → More Human Service Personnel → More desire for county management to oversee personnel**

RECENT PAST

(2012-2023)

Passage of Session Law 126-2012

AN ACT TO PROMOTE EFFICIENCY AND EFFECTIVENESS IN THE ADMINISTRATION OF HUMAN SERVICES AND TO STRENGTHEN THE LOCAL PUBLIC HEALTH INFRASTRUCTURE BY ESTABLISHING A PUBLIC HEALTH IMPROVEMENT INCENTIVE PROGRAM AND ENSURING THE PROVISION OF THE TEN ESSENTIAL PUBLIC HEALTH SERVICES.

- **Major changes:**
  - Removed population threshold for CHSA formation and BOCC to assume DSS/BOH responsibilities
  - Allowed counties to keep employees of a CHSA agency under the State Personnel Act.
- **Minor changes:**
  - Removed mental health area authorities from the “consolidated human services” mix, allows CHSAs to include a mix of human service agencies
  - Modified the *composition* requirements of a consolidated human services (CHS) board (reduced number of MH/DD/SA consumers on the board).
  - Modified the *duties* of a CHS board (eliminated mental health services planning).
  - *Provided financial incentive for the creation and expansion of multicounty local health departments serving a population

In their own words

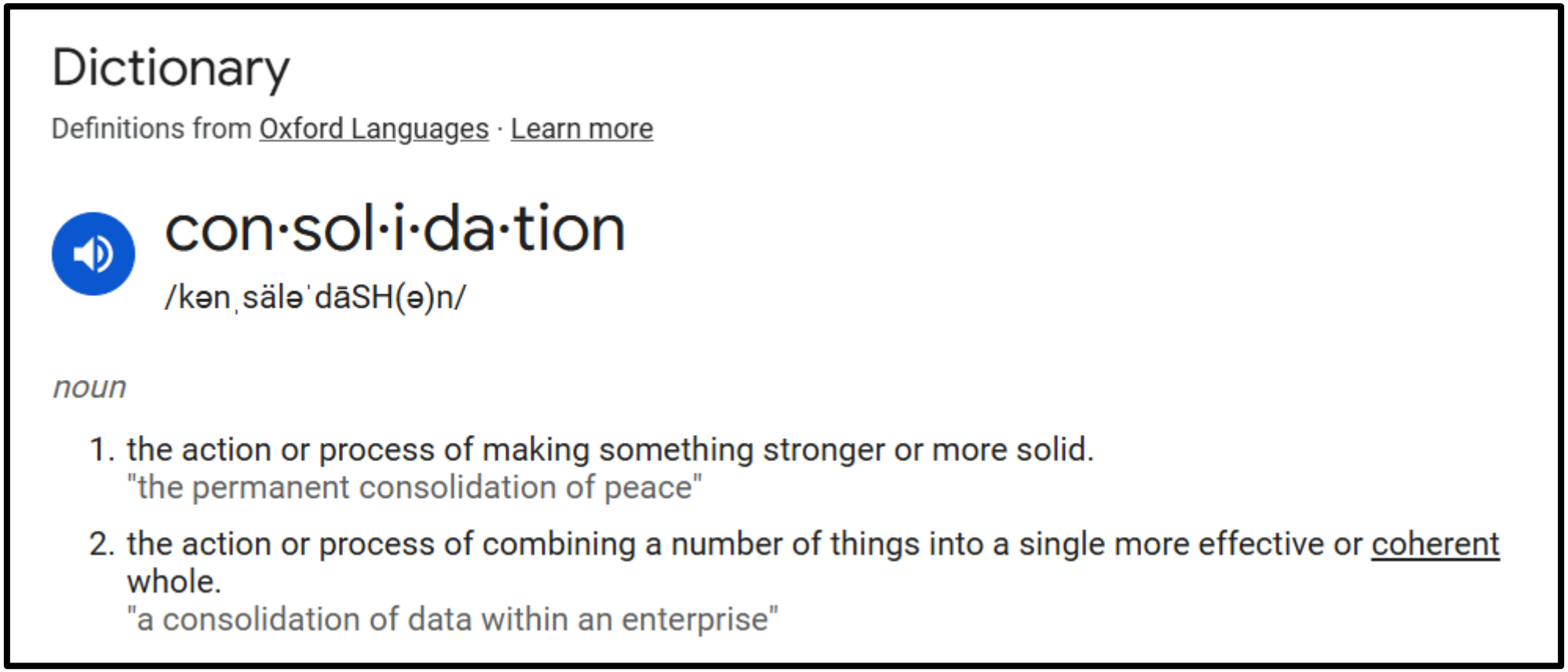
"**Commissioners in other counties want to see** if [consolidation is] something that would benefit their communities"

"…if something is looking good in a couple of counties, it ought to be available in all counties. **We're not looking to mandate it**. we're just trying to get that authority for any county that wants it."

"We're not looking to usurp existing rules and guidelines…**The hope is that it could help counties save some money** that could go back into services for citizens."'

- Todd McGee. Spokesperson for North Carolina Association of County Commissioners (2012)

A note on word choice…



Dictionary

Definitions from Oxford Languages · Learn more

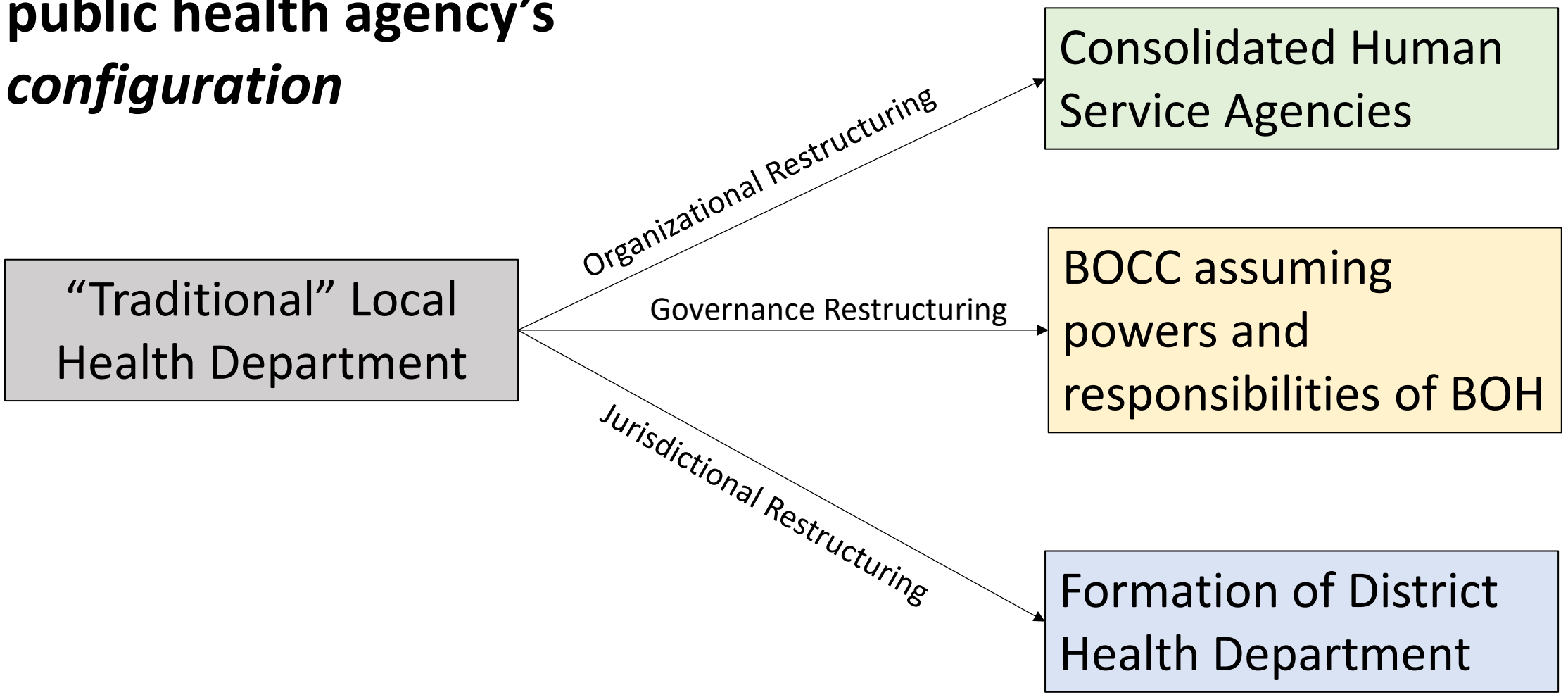
con·sol·i·da·tion

/kənˌsäləˈdāSH(ə)n/

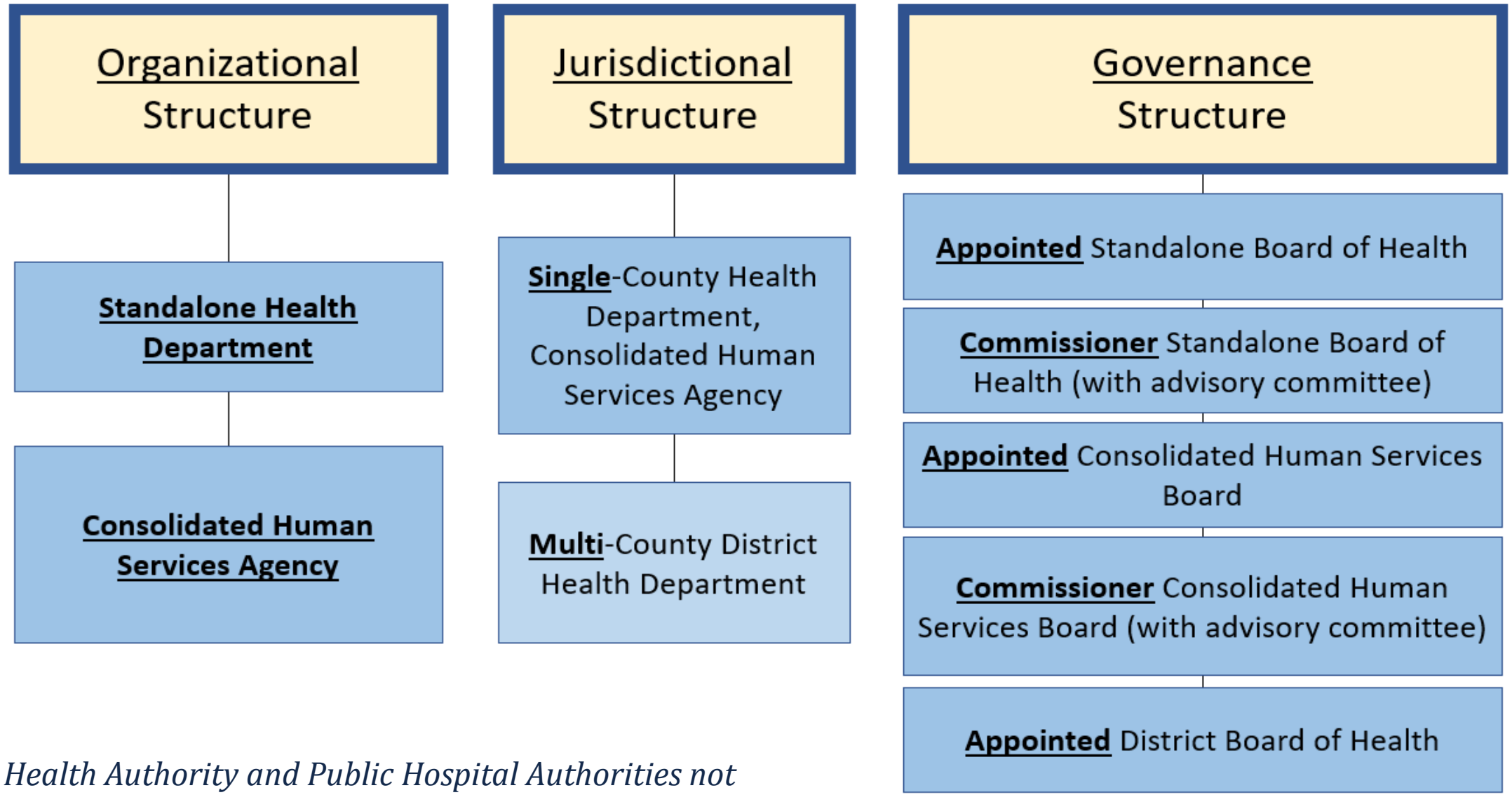
noun

1. the action or process of making something stronger or more solid.
   "the permanent consolidation of peace"
2. the action or process of combining a number of things into a single more effective or coherent whole.
   "a consolidation of data within an enterprise"

Three forms of *restructuring* a public health agency's *configuration*



Major Local Health Department Configurations across North Carolina



**Public Health Authority and Public Hospital Authorities not included due to limited representation*

Trends in Public Health Governance Configurations across North Carolina			
LHD Configuration	July 1, 2012	April 1, 2013	Dec 2024
CHD, Commissioner BOH	0	0	5
CHD, Appointed BOH	75	68	42
CHSA, Commissioner BOH	1	5	16
CHSA, Appointed Board	1	4	16
District Health Department, District BOH	6	6	6
Public Hospital Authority, Public Health Authority Board	1	1	1
Single County Public Health Authority, Single-County Public Health Authority Board	1	1	0
Multi-County Public Health Authority, Multi-County Public Health Authority Board	0	0	0

	Total Counties	Population Totals (2023)	Percentage of State Population
TOTAL		10,846,274	100%
All Governance Models			
CHD, Appointed BOH	42	3,923,865	36%
CHD, Commissioner BOH	5	257,214	2%
CHSA, Appointed BOH	16	3,249,729	30%
CHSA, Commissioner BOH	16	2,642,852	24%
DHD	20	3,614,667	33%
PHA	1	242,880	2%
Across Governance Structure			
Appointed BOH/CHS	79	7,690,050	71%
Commissioner BOH/CHS	21	3,156,224	29%
Across Organizational Structure			
CHSA	32	5,892,581	54%
CHD	47	4,181,079	39%
DHD	20	3,614,667	33%
PHA	1	242,880	2%

*Population sizes for each county were derived from the 2023 Certified County Population Estimates: https://www.osbm.nc.gov/facts-figures/population-demographics/state-demographer/county-population-estimates/certified-county-population-estimates

Present
(2024-2025)

Recent Decisions (2024)

- BOCC assumes governance over *separate* public health and social services boards:
  - **Burke County**
- CHSA formation, BOCC assumes governance of CHS Board
  - **Duplin County**
  - **Jones County**
  - **Robeson County**

What's the Stated Motivation?

Why form CHSAs?

- Cost savings
- Cost savings
- Cost savings
- Streamlined, integrated services
- Align county personnel policies (get out of SHRA)

Why form commissioner BOHs?

- "Vertical integration"
- Aligns with other county departments (libraries, parks and rec, etc.)
- Oversight over public health decision-making
- Rule-making authority of BOH has been rendered unnecessary

In their own words

“[CHSAs] makes the personnel issues much smoother…anytime you have a personnel issue, the county is contacted and then they must turn around and contact these boards. And these boards are made up of public community people, people that have jobs nine to five that volunteer to be on these boards...” - County Commissioner, Jones County

“For years, employees under DSS and health department fell under SHRA, so a different set of rules for grieves and disciplinary action to them. From a human resources perceptive, it has not always been as efficient having to look into which set of rules apply to which employees.” – County Attorney, Jones County

In their own words

“nothing will change if the board takes control of the boards. Commissioners will simply have the final authority.” – County Manager Robeson County

“I think it’s a good business move to take it over and manage it ourselves…The county can manage the departments more efficiently.” -- County Commissioner, Robeson County

In their own words

“Substantial equivalency gives more local input into how positions are developed. “

“Supervision of department head becomes to the BOCC through the county manager, like any other department of local government.”

“Rule-making authority has been rendered unnecessary given we now have the EPA (1970) and DEQ (1977)…for local board to have rule-making authority it has to be more stringent than state boards…less often now.”

“the only reason we have independent human services boards is because they emerged before the council-manager form for counties really took off.”

- Burke County, County Manager

In their own words

“it presents an opportunity to create a more comprehensive care model and streamline processes, which could ultimately enhance services for residents.”

“No one is losing their jobs. Any reduction enforced will be through attrition, retirement, resignation.”

“This is not an attempt to gain the authority to terminate the employment of either the health director or the DSS director”

“no other programs or areas within these departments are subject to termination due to the consolidation.”

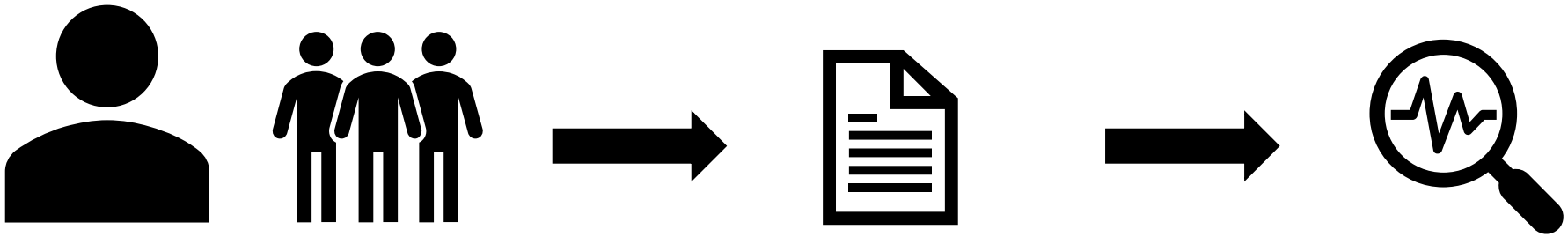
“This is also an opportunity to bring all employees under one personnel policy and an opportunity to gain better financial internal controls over the organization as a whole”

- Duplin County, County Manager

https://ncmedicaljournal.com/article/121368-assessing-local-public-health-governance-in-north-carolina-across-organizational-and-governance-configurations

Data Collection and Analysis

INTERVIEW **TRANSCRIBE** **ANALYZE**



19 LHD Directors ***16 BOH Members***

Tradeoffs across each LHD configuration

- District Health Departments
  - **Core strengths:**
    - Pooling economic resources
    - Semi independence from county management, esp. around external funding
  - **Core weaknesses:**
    - Limited levels of county funding
    - Perceived challenge of managing across multiple BOCCs
    - Threats to local autonomy when forming districts

Tradeoffs across each LHD configuration

- District Health Departments
- Consolidated Human Service Agencies
  - **Core strengths:**
    - Better integration of human services (“one-stop shop” to address SDOHs)
      - Some claim integration can be achieved without organizational restructuring
    - Broader perspective on public health decision-making
  - **Core weakness:**
    - Board meetings can be dominated by the concerns of other human services
    - Challenge to practically integrated services

Tradeoffs across each LHD configuration

- District Health Departments
- Consolidated Human Service Agencies
- Commissioner BOHs
  - **Core strengths:**
    - Efficient access to the funding and policymaking authority of the BOCC (esp. important for SDOH-related work)
    - BOCC has additional accountability for LHD
    - BOCC may better connect LHD to other departments of local government (“birds eye view”)
  - **Core weaknesses:**
    - Risks of LHD decision-making becoming influenced by local politics.
    - Overemphasis on funding constraints
    - Limited medical/public health backgrounds

Consistent challenges with CHSAs and Commissioner BOHs

<u>On CHSAs:</u> *"I think that sometimes* ***public health can get buried under the social services piece.*** *At the end of the day, [social services] are protecting vulnerable people, and they're having to do some really difficult things.* ***That can overshadow the preventative work and programming that public health needs to do in the community****." (Director, CHD, Appointed Board)*

<u>On Commissioner BOHs:</u> *"****As soon as its politically unfavorable, public health suffers*** *because a politician is going to do what's politically motivated, not what's publicly health minded. At the end of the day, it's all about the number of votes they get." (Director, CHD, Commissioner BOH)*

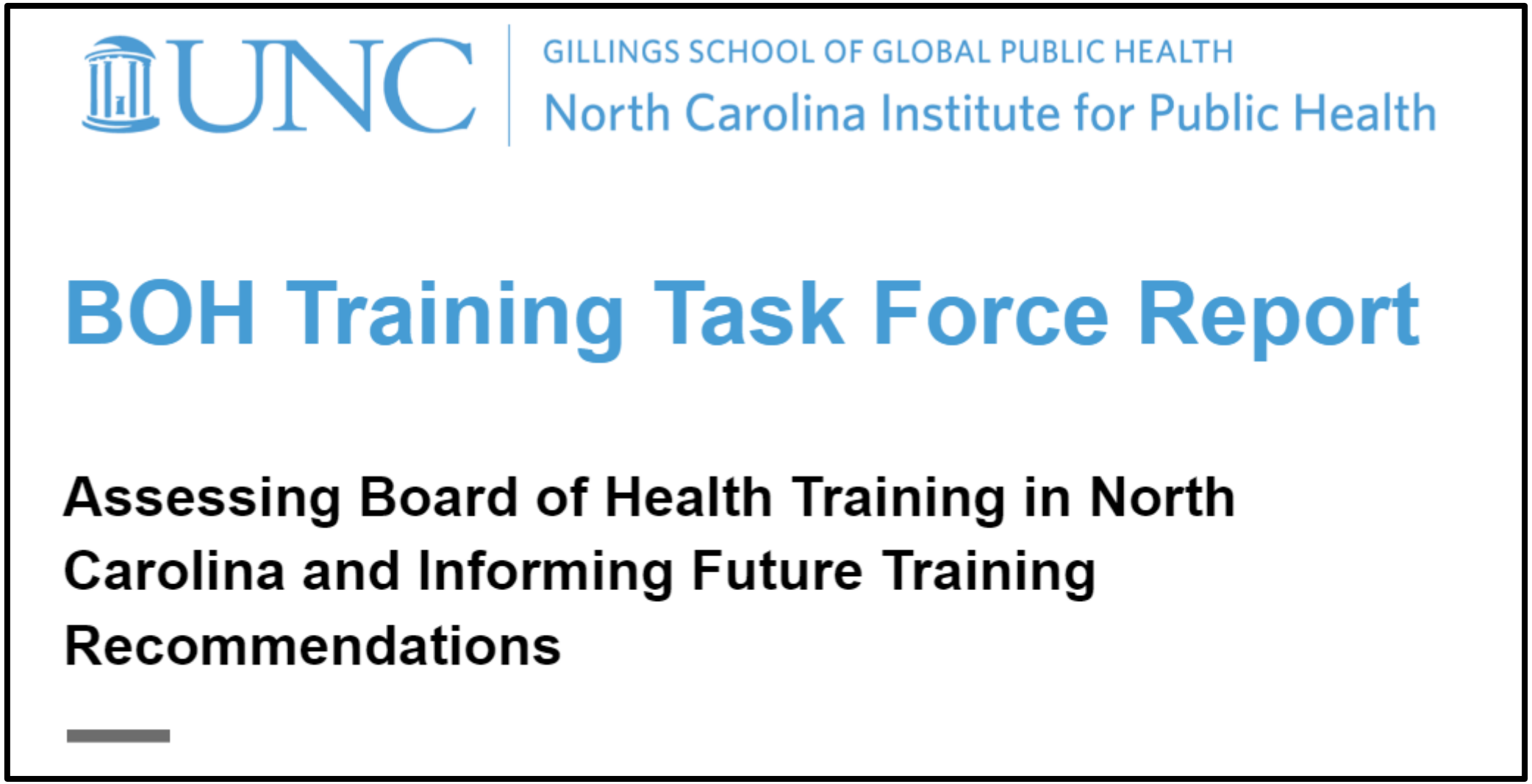
Perceived Origins of SL-2012-126

1. Desire to terminate DSS or LHD director
2. Economic efficiency
3. Shifts in personnel policies

"The early days of consolidation were typically done for two reasons. ***It was either done to prove 'I'm shrinking government,' or it was an opportunity to get rid of the health director or social services director****." (Director, CHSA, Appointed Board)*

"Some counties have elected to shift the Board of Health to the Board of Commissioners because ***they wanted to retain that ability to make…the personnel related to decisions****. Our board of commissioners oftentimes is* ***not interested in making any of the other [decisions]****…They'd rather the advisory board…do all the obligations related to accreditation.* ***However, the way it's outlined currently, that's not a possibility. It's either all or nothing****." (Director, CHD, Elected Board)*

What has happened since…



FUTURE

Preparing for the Future

- **Be *individually* informed—resources:**
  - School of Government:
    - NC public health law microsite
    - NC human services hub
    - Coates' Canons blog posts on public health
  - LHD Directors / BOH members who have experienced governance changes
- **Be *collectively* prepared**
  - What kinds of tools/resources can NCALHD produce to increase awareness and advocacy?
  - What conversations should NCALHD have with NCACC/NCCCMA?

Empower Local Public Health Governance

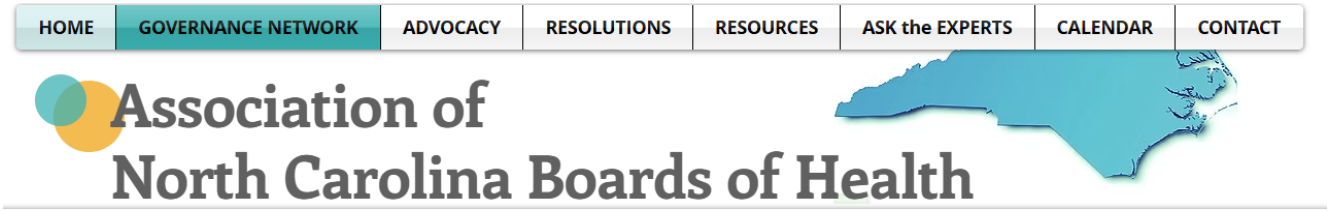
- If you believe in (and still have) an independent BOH—show it, empower it
- Opportunities for BOH Improvement (from dissertation research):
  - **Educate BOH on LHD programs** and the scope of their legal mandates.
  - **Additional training and guidance on how LHDs can best "assemble" their BOH**
  - **Expansion of BOH composition**: mental health professionals, emergency management leaders, nutritionists, non-allopathic health professionals, and more community participants.

ANCBH's "Governance Network"

Mission: To identify and address training needs, enable sharing information, identify best practices, learn stories of success/growth, and build relationships among board members per ANCBH's mission

Past Presentations:

- February 10, 2025: "A State of Affairs: Dental Public Health in NC" -- Rhonda Stephens, DDS, MPH
- November 18, 2024: "What Health Board Members Need to Know About PH Preparedness" --Raul Gomez, Disaster Preparedness Manager, Guilford County Dept of Public Health.
- September 23, 2024: "Results of the NCIPH's BOH Training Task Force" -- Karl Johnson, PhD.
- July 22, 2024: Dr. Elizabeth Tilson, NC State Health Director/Chief Medical Officer NC DHHS, discussed the critical role of local Boards of Health in North Carolina's decentralized public health system.
- May 28, 2024: "The Role of Local BOHs as a Critical Public Health Institution" by Vaughn Upshaw, DrPH, MPH, EdD, Chair, Department of Public Health Leadership and Practice at UNC Chapel Hill and founding member of ANCBH.



The Future of Districts (?)

- 1974 funding inspired the creation of several DHDs (all still in existence)
- Since 1980, *no new district health departments have formed* in North Carolina
- Since their formation, only two counties have *left* a district health department (Polk, Yancey)
- SL-126-2012 originally proposed funding to incentivize district formation, but no funding was allocated
- 2019: Law adopted to form regional social services agencies (which function like DHDs), though no county has opted for this model yet

Agency Structure and Personnel Policies

- One of the main perceived drivers of the 2012 Law—the desire to remove LHD employees from the SHRA—has largely been confirmed: *nearly every county that has formed a CHSA in the last decade has removed employees from the coverage of the SHRA*.
- ***Alternative policy solution:*** Allow DSS and health department employees to be exempt from the SHRA akin to what is available within CHSAs, without having to become CHSAs.
    - Currently, pursuing "substantial equivalency" outside of SHRA is a burdensome, piecemeal process (only 11 counties have pursued this route, and often not in full)
    - "substantial equivalency" exempts certain aspects of the county's personnel management system from compliance with the SHRA but does not necessarily exempt social services or public health employees from the SHRA in its entirety (as a county could do when creating a CHSA).

Current Unknowns

- Does agency or governance restructuring *actually* lead to…

  - More efficient services
  - Cost savings
  - Policymaking behavior
  - Changes in board (advisory or governing) engagement
  - Personnel changes / turnover
  - Agency performance
  - Improved community health

Current Study: The Impact of Session Law 2012-126—Examining the Downstream Consequence of Changes in Public Health Governance Configurations in North Carolina

Three study objectives:

1. **Quantify Changes in Public Health Outcomes**: Assess variations in key public health indicators before and after the implementation of different governance configurations;
2. **Evaluate Resource Allocation and Efficiency**: Analyze how governance structures impact funding distribution, staffing levels, and service delivery efficiency within LHDs;
3. **Assess BOH Engagement and Effectiveness**: Measure the level of BOH involvement in policy-making, advocacy, and community engagement across different governance models.

Timeline: May 1, 2025 – April 30, 2026

Study funded by the North Carolina Alliance of Public Health Agencies

What Else?