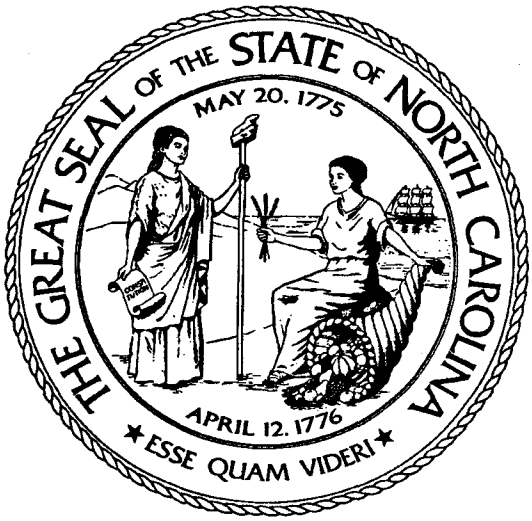
PUBLIC HEALTH STUDY COMMISSION



REPORT TO THE
1991 GENERAL ASSEMBLY
OF NORTH CAROLINA

TABLE OF CONTENTS

		Page
LETTER OF TRANSMITTAL		i
EXECUTIVE SUMMARY		1
INTRODUCTION		5
HISTORY OF PUBLIC HEALTH IN NORTH CAROLINA		8
PROCEEDINGS		14
RECOMMENDATIONS		24
APPENDICES		38
A.	1989 Session Laws, Chapter 802, Sections 4.1-4.9	A-1
B.	Public Health Study Commission Membership List	B-1
C.	North Carolina Public Health Budget	C-1
D.	A Summary of the Institute of Medicine Report and Summary Topical Outines of First Three Meetings	D-1
E.	1990 AHEC Public Health Department Personnel Survey-Summary Table	E-1
F.	Proposed Mission and Essential Services for the N. C. Public Health System	F-1
G.	AN ACT TO ESTABLISH THE MISSION AND ESSENTIAL SERVICES OF THE PUBLIC HEALTH SYSTEM.	G-1
H.	AN ACT TO ESTABLISH THE PUBLIC HEALTH STUDY COMMISSION	H-1
I.	AN ACT TO REQUIRE THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES TO CONDUCT VARIOUS HEALTH RELATED PROJECTS	I-1
J.	AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES FOR ALLOCATION TO ELIGIBLE COUNTIES TO INCREASE SALARY RANGES OF CERTAIN PUBLIC HEALTH WORKERS	J-1

K. AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES FOR ALLOCATION TO COUNTIES TO ASSIST WITH ENVIRONMENTAL SPECIALIST SALARY EXPENSES K-1

L. AN ACT TO ESTABLISH THE QUALIFICATIONS FOR THE POSITION OF LOCAL HEALTH DIRECTOR, AND TO ESTABLISH A HEALTH DIRECTOR' QUALIFICATION REVIEW COMMITTEE L-1

M. AN ACT TO ESTABLISH A HEALTH DIRECTOR ORIENTATION PROGRAM WITHIN THE DEPARTMENT OF ENVIRONMENT, HEALTH AND NATURAL RESOURCES..... M-1

N. AN ACT TO ESTABLISH THE HEALTH DIRECTOR INTERN PROGRAM..... N-1

North Carolina
Study Commission on Public Health

COCHAIRS

SEN. OLLIE HARRIS
KINGS MOUNTAIN
LEGISLATIVE BUILDING
ROOM 2113
RALEIGH, N. C. 27611
(919) 733-5880

REP. BETTY WISER
RALEIGH
LEGISLATIVE BUILDING
ROOM 1213
RALEIGH, N. C. 27611
(919) 733-5852

COMMISSION MEMBERS:

REP. HOWARD C. BARNHILL
CHARLOTTE

REP. CHARLES CROMER
THOMASVILLE

MR. WILLIAM T. DRAKE
HENDERSONVILLE

MR. CARL DURHAM
WILMINGTON

REP. THERESA ESPOSITO
WINSTON-SALEM

SEN. JAMES EZZELL, JR.
ROCKY MOUNT

JAMES S. FULGHUM, III, M.D.
RALEIGH

MS. VIRGINIA S. GAVIN
ASHEBORO

JAMES P. GREEN, SR., M.D.
HENDERSON

MS. MAE GURLEY
GOLDSBORO

RICHARD HOUSE, PH.D.
CHAPEL HILL

PERCY E. JONES, M.D.
GREENSBORO

MR. JEFFREY C. LONG
FAYETTEVILLE

CHRIS MANSFIELD, PH.D.
GREENVILLE

MR. GEORGE H. RUDY
RALEIGH

CHARLES SAWYER, M.D.
AHOSKIE

J. DALE SIMMONS, M.D.
MT. AIRY

SEN. PAUL S. SMITH
SALISBURY

SEN. RUSSELL G. WALKER
ASHEBORO

MR. JOHN YOUNG
MS. GANN WATSON
COMMISSION STAFF
LEGISLATIVE OFFICE BUILDING
SUITE 545
300 N. SALISBURY STREET
RALEIGH, N. C. 27611
(919) 733-2578

January 30, 1991

TO: President of the Senate James C. Gardner
Speaker of the House Josephus L. Mavretic
Members of the 1991 General Assembly
Governor James G. Martin

The CoChairs Senator Ollie Harris and Representative Betty H. Wiser submit to you the attached Report of the Public Health Study Commission. The Commission was established pursuant to the 1989 Session Laws, Chapter 802, sections 4.1 through 4.9, which reads: "The Commission shall submit a final written report of the findings and recommendations to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate before or upon the convening of the 1991 Session of the General Assembly."

The Public Health Study Commission presents to you recommendations based on extensive study and public hearings. The Commission has held twelve (12) meetings, including one public hearing. Proposed legislation is contained within this Report.

For the Commission,

Ollie Harris

Senator Ollie Harris, CoChair

Public Health Study Commission

DEDICATION

The 1989-91 Public Health Study Commission dedicates this report to the memory of one of its members, Mr. Carl T. Durham, who died in December, 1990. Mr. Durham was appointed to the Commission by Senator Henson P. Barnes, President Pro Tempore of the North Carolina Senate. In addition to his service on the Commission, Mr. Durham served for seven years on the New Hanover County Board of Health, two years of which he served as Chairman. Mr. Durham helped found the Association of North Carolina Boards of Health, and served as its first Chairman. Mr. Durham was also a newly elected County Commissioner for New Hanover County.

EXECUTIVE SUMMARY

The Public Health Study Commission met twelve times during the 1989-91 biennium, two days of which were dedicated to the issue of AIDS. Two Commission subcommittees met several times to address the need for a public health mission statement, and to make recommendations regarding the governance and organizational structure of the public health system. The Commission adopted twenty recommendations and approved eight legislative proposals to implement the recommendations.

SUMMARY OF RECOMMENDATIONS

(1) That the 1991 General Assembly establish the Public Health Study Commission as a permanent Commission and appropriate sufficient funds to hire staff and analyze information necessary to develop a long-range plan to improve and fund the public health system.

(2) That the 1991 General Assembly charge the permanent Public Health Study Commission with the following responsibilities:

- (a) Establish a standing committee on public health finance;
- (b) Determine if additional local fees should be authorized and designated for public health services;
- (c) Review the organizational structure of the public health system;
- (d) Determine if there is a need to organize local public health services into district health departments;
- (e) Monitor public and private efforts to provide orientation and training to local boards of health; and
- (f) Review status and needs of local health departments relative to facilities.

(3) That the 1991 General Assembly incorporate into the State's public health statutes the mission statement and list of essential public health services developed by the 1989-91 Public Health Study Commission.

(4) That the 1991 General Assembly direct the Department of Environment, Health, and Natural Resources to do the following:

(a) Implement a plan to increase its capability and the capability of local health departments to secure private sector financial resources to supplement public health activities and services mandated by the State;

(b) Establish a statewide program to coordinate and strengthen orientation programs for local health directors;

(c) Establish a statewide system for assessing health status and health needs in every county;

(d) Develop a computerized statewide data collection and retrieval system to permit valid comparisons of State and local health data with those of the nation and other states and localities; and

(e) Implement statewide health outcome objective and delivery standards adopted by the Commission for Health Services.

(5) That the 1991 General Assembly appropriate special incentive funds to enable certain local health departments to bring the salaries for public health directors, public health nurses, health educators, and environmental health specialists to competitive levels.

(6) That the 1991 General Assembly appropriate sufficient funds to pay the annual salary of one environmental health specialist in every county.

(7) That the 1991 General Assembly establish more specific qualifications for the position of local health director.

(8) That the 1991 General Assembly appropriate special incentive funds to establish public health director internship programs in selected local health departments.

INTRODUCTION

The Public Health Study Commission is an independent commission created by the Study Commissions and Committees Act of 1989, Chapter 802, Sections 4.1-4.9 (See Appendix A). The Commission was charged with studying public health services in North Carolina and recommending improvements that will assure cost-effective, uniform, and consistently administered public health services. Beyond the general charge the Commission was assigned more specific duties. The legislation requires that the Commission--"examine the need for improvement in the statewide public health system through local communities and the need for additional legislation to deal with Acquired Immune Deficiency Syndrome, AIDS, within this State, and shall develop legislation to address those needs". The Commission will submit its report to the Governor and the General Assembly on or before the convening of the 1991 Session.

The Commission membership consisted of 21 members as follows:

1. Seven members appointed by the Speaker, at least four of whom are members of the House of Representatives;
2. Seven members appointed by the President Pro Tempore, at least four of whom are members of the Senate; and
3. Seven non-legislative members appointed by the Governor, one of whom is a recipient of public health services, one of whom is a public health director, one of whom is a county commissioner, one of whom is an advocate for low income people and is familiar with public health services in North Carolina, one of whom is the Secretary of the Department of Environment, Health, and Natural Resources or a designee thereof, one of whom is a physician licensed to practice medicine under Chapter 90 of the General Statutes, and one of

whom is an individual involved in the administration or funding of public health services.

The Legislative Services Commission assigned Mr. John Young of the General Assembly's General Research Division, and Ms. Gann Watson of the General Assembly's Legislative Drafting Division, to staff this study. A list of the current membership of the Commission is attached as Appendix B.

HISTORY OF PUBLIC HEALTH IN NORTH CAROLINA

From the Outer Banks to the Great Smokies, North Carolina is a land of contrast; these contrasts are manifest in all aspects of the State's life including its health problems. The State, because of its rural nature, has some of the country's most difficult dilemmas and some of the most exciting solutions. In order to understand the progress made in public health, an understanding of history may be necessary.

The first substantial piece of health legislation was a quarantine law enacted in 1712 by the General Assembly of the Province of Carolina which included the states of North and South Carolina, Alabama, Tennessee, Kentucky, Georgia, Florida and ten other states. From this rather small beginning, the State has made tremendous strides in providing health services to its citizens.

In 1877, following severe yellow fever and smallpox epidemics, the State Board of Health was established. It had an annual appropriation of $100 and all of North Carolina's 150 doctors were members of the Board. In 1879, the annual appropriations were increased to $200 per year and a governing board of nine members with terms of six years was created. Provisions were also made for health boards in the 94 counties, and for the first time in North Carolina failure to comply with health regulations was a misdemeanor subject to fine ($25.00) or imprisonment. At this time the State Board examined water, gave some vaccinations, quarantined people with communicable diseases, gathered and registered vital statistics and distributed educational materials.

In 1885, annual appropriations jumped to $2,000 and by 1892 the Board had been authorized to inspect water and sewage facilities and inspect public institutions. The Board now had sections on epidemics, hygienics in public schools, climatology, adulteration of food and medicine, and sanitary conditions of State institutions.

In 1899, an epidemic of smallpox occurred in Wilson County and 1500-2000 people were stricken. This led to the 1905 law by Hyde County which ordered vaccinations in schools in their county and led Washington County to order compulsory vaccination and stipulated that if both pupils and teachers were not vaccinated, the schools would be closed. Several years later the State ordered smallpox vaccinations to become mandatory. In 1909, a full-time state health office was created and the total appropriations had increased to $10,500. By 1949 all counties in North Carolina had a local health department.

From its rather shaky start in the Colony of Carolina, this State has made tremendous strides in improving the health of the people of North Carolina. There has been the decline and practical elimination of malaria, polio, typhoid fever, endemic typhus, diphtheria, pellagra and whooping cough. There has been a marked decrease in tuberculosis, and in maternal and infant death rates.

Over the years there have been a number of administrative changes in public health in North Carolina. As a continual response to change, the 1973 General Assembly, directed the long and difficult process of consolidating most of the State's health functions into the Department of Human Resources. This department was placed under the direction of a Secretary who reported to the Governor. In 1989 the public health functions were removed from the Department of Human Resources and placed within a new Department of Environment, Health, and Natural Resources.

The delivery of public health services in North Carolina has become a complex process with the major emphasis placed on local health departments to deliver patient and community services. The public health system in North Carolina reflects the strong local government philosophy in North Carolina. The State and regional staff serve as a

catalyst to the local departments to develop new programs and improve existing programs. The State establishes and verifies compliance with standards of care, acts as an administrator for federal and State funds, and provides technical support to the local health department. The relationship between State and local health departments is predominantly a cooperative effort. In many instances, the local health department staff will act as agents of the State to carry out State requirements.

There are approximately 7,000 people providing delivery of public health services in this State with approximately 1,000 of them in State and regional offices and 6,000 in district and local health department settings. Appendix C indicates funding sources.

Public health services are provided locally by counties, either through a county health department, in combination with other counties through a district health department, or through contract with the State. Staffing and budgeting of local health departments are ultimately under the control of the county commissioners. The county and district boards of health are appointed by the county commissioners and all of their recommendations are subject to budgetary control by the commissioners.

There are over 90 different health programs provided to the citizens of North Carolina, however, not all of these services are provided in every county. The programs most familiar to the public are:

1. Maternal and child care which includes maternity clinics, child health clinics, developmental disabilities clinics, WIC, and family planning;
2. Environmental health programs which include public water supply regulation, sanitation including inspection of food, lodging and on-site sewage disposal, and pest management;

3. Epidemiology which includes vital records, injury prevention and control, occupational health, communicable disease control including tuberculosis, AIDS and other sexually transmitted diseases, occupational health, and environmental epidemiology;
4. Dental health including preventive dental services, dental screening, and dental care of the elderly;
5. Adult health services which include health promotion and disease prevention, migrant health programs, home health care services, and cancer, diabetes and hypertension screening and control;
6. Chief medical examiner's office which includes investigation of deaths by injury, obscure causes and violence, and forensic toxicology services; and
7. Public health laboratories which include diagnostic and confirmatory laboratory testing.

North Carolina's health services have come tremendously far from the simple Moravian hospital in the Revolutionary War to the sophisticated facilities we enjoy today. The people have demanded services and its leaders have responded. North Carolina has been among the leaders in public health in this country and the world and was one of the first states to establish a state and local health departments. In 1940 North Carolina founded the first state-supported school of public health. In the late 40's there arose the "Good Health Movement" during which time Kay Kaiser wrote the song Better Health for North Carolina which led to better training facilities. Also during this time Duke University developed the first hospital administration program in the country. The 70's saw the development of rural health clinics and physician's assistants and the extensive system of Area Health Education Centers.

Many of the major improvements in the health of North Carolinians have been accomplished through public health measures. Control of epidemic diseases, safe water and food, and maternal and child health services are only a few of public health's achievements. Public health is the unsung hero of the 19th and 20th centuries and suffers from its own great success. The public has come to take the success of public health for granted.

This situation is not only true for North Carolina but applies to the nation as a whole. The Institute of Medicine as part of the National Academy of Sciences advises the U.S. Congress on health policy matters. In 1985 the IOM established a committee to look at the current state of public health in America and to outline recommendations for future directions. In an extensive two-year study, the committee reviewed the public health system in detail. The committee found that despite valiant efforts of many people and programs, the public health system is currently in disarray. A brief summary of the IOM Report prepared by the staff of the UNC School of Public Health can be found in Appendix D.

Public health personnel in North Carolina are concerned about the sense of malaise that hangs over public health in North Carolina. This malaise prevents attention to the need to maintain current preventive efforts and to sustain the capacity to meet future threats to the public's health. There is an even greater need now than at any other time in our history to mount an organized and sustained effort by the public sector to protect the nation's and the State's health. This study was created out of the desire of public health officials to bring the difficulties of public health to the attention of the State in order to mobilize action to strengthen public health.

PROCEEDINGS

The Public Health Study Commission created by the General Assembly at the request of public health interests in the State is a recognition by both the General Assembly and public health professionals that the health problems now facing the public are complex and diverse and, at the same time, that these problems are not fully understood and may be inadequately addressed. To investigate these and other public health issues, the General Assembly established this independent Commission with specific charges set forth in the Study Commission and Committees Act of 1989. To this end the Commission met 12 times as a full commission and many more times in the subcommittee format; one of these full Commission meetings was a public hearing on the topic of AIDS. The Commission met on the following dates: December 18, 1989, January 31, 1990, February 28, 1990, April 4, 1990, May 9, 1990, August 20, 1990, August 21, 1990, September 26, 1990, October 25, 1990, November 15, 1990, November, 16, 1990 and January 23, 1991.

The first three meetings were dedicated to organizational functions and Commission education regarding:

1. the definition of public health;
2. the history of public health;
3. the delivery of public health services in North Carolina; and
4. public health issues.

A topical summary outline of these three initial meetings is included in Appendix D-6 through D-21. Also included in Appendix D is Key Issues or Needs in Public Health in North Carolina and Priority Issues for Study Commission Consideration.

As testimony was presented to the Commission, it became evident that even a definition of public health was difficult to grasp. Presenters tended to mix observations

about what health departments do with global concerns about what society ought to do. As the Future of Public Health states--"some emphasize a community focus in contrast to individual patient care. Others concentrate on ideas of government response to market failure. Still others list the contents of practice, such as control of environmental hazards--". It became clear that there was a differentiation between organizational expressions and mission or subject matter. The Future of Public Health defines the substance of public health as--"organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology".

It was suggested to the Commission that public health in North Carolina has an identity problem. There is a lack of knowledge and information about the mission and goals of public health, and who its many and various players are. There is a need to recognize the many partnerships and alliances across the State that accommodate different roles and contributions from both public and private providers in addressing community health needs and meeting common goals.

Related to this identity problem is another concern, manpower. The lack of an adequate supply and the continuing maldistribution of many trained health professionals will reduce access, hinder the continuity of care, and lower the quality of care that is being provided by placing an undue burden on our existing public health practitioners.

A second problem is the system's inability to coordinate and cooperate among and between various elements within the system. What may be needed is leadership and planning.

A third problem is funding, though not necessarily the lack of, but rather the need for focus and priorities. It may be time to hold accountable the array of public health programs by measuring just what it is they do for the health status of the population.

Some of the public health issues brought to the attention of the Commission during the first three meetings were:

1. Inability to attract and retain qualified public health professionals;
2. Inadequate financial resources;
3. Inadequate facilities;
4. Environmental health concerns;
5. Health promotion;
6. Infant mortality;
7. Medical care coverage of the indigent;
8. AIDS;
9. Cost of liability insurance;
10. State Health Insurance pool;
11. Women's health;
12. Injury control; and
13. Pharmaceutical cooperative programs.

Local health departments are the critical components of the public health system that directly deliver public health services to citizens. Therefore the Commission devoted a number of meetings and requested testimony concerning local public health personnel issues. A number of speakers testified that local public health is in a crisis related to salary, recruitment, and retention of staff. Public agencies in particular have a difficult time recruiting and retaining staff because they often cannot compete with

the salaries offered by hospitals, nursing homes,and privately-operated home health agencies. Public health providers are often restrained from offering creative salary or benefit packages.

A representative of the North Carolina County Commissioner's Association spoke to the Commission on a year-long study done by the Association on local public health personnel issues. The full report of this study is contained in the files of the Commission. The study discerned two important factors:

1. The private sector offered higher salaries; and
2. The stress factor was the main reason many employees leave to work in the private sector.

Many counties had no expertise in dealing with personnel matters and, in fact, 49 counties had no personnel manager at all.

Findings also reflected a heavy federal involvement by local officials. Counties made heavy financial commitments to public health, in some instances providing 68% of their budgets.

During the spring of 1990, the public health coordinators of the North Carolina Area Health Education Centers (AHEC) Program undertook a survey of public health departments to assess personnel supply, shortages, and turnover. The survey was intended to provide a current manpower status report to the Commission. The survey was also intended to assess manpower status relative to the adequate delivery of public health services, and to serve as an update of the County Commissioner's report.

Surveys were sent to each of the 87 county health departments or districts. These requested information for 20 categories of personnel regarding (1) numbers of budgeted Full Time Equivalents (FTE's), (2) numbers of vacancies, (3) numbers of additional

FTE's needed to meet service demand and (4) the numbers of resignations during the previous 12 months. A final question on the survey asked what public health services are threatened by current staffing levels. The response rate to the survey was 95%.

The study documented the following conclusions:

1. Health departments report that approximately 200 additional positions in nursing and environmental health are needed to deliver public health services. (Nurses comprise 49% of the public health work force; environmental health specialists, 18%)
2. Because there is no consensus on "essential public health services" that should be offered in every county, services vary widely across the State. Thus, it is likely that FTE's needed are underestimated as far as being adequate for providing services the Commission might define as "essential".
3. Of the currently budgeted nursing positions in the State, 144.7 vacancies exist. Environmental health specialist positions represent the second highest number of vacancies in the State. The nursing numbers represent 48% of all public health department vacancies.
4. Nurses and environmental health specialists lead in the numbers of resignations. Percentages of resignations, however, are also critical among physicians, health educators, and nutritionists.
5. Twelve health director resignations are documented out of 83 health departments/districts.
6. Turnover rates in double digits are costly. (One health director from a small district reported expenditures of $19,447 for training costs from the onset of

employment of an environmental health specialist until certification was earned two years later.)

A summary table is attached as Appendix E. The complete study is on file with the Commission.

In eighteenth and nineteenth century America, people knew what public health's mission was--to respond to particular epidemic crises. In the current century, public health has moved in response to a number of broader issues. These changing values over both time and place have allowed a variety of public health programs across the State but have left the mission and services of public health open to some interpretation.

Therefore, to establish a current definition of mission and essential public health services that could be the basis of future State public health decisions, the Commission requested that the State Health Director select a panel of experts in the field of public health to comprise a subcommittee. The purpose of the subcommittee would be to suggest to the full Commission a mission statement and essential public health services for North Carolina. The report of this subcommittee is attached as Appendix F. After discussion at a number of meetings, the mission statement and essential public health services were adopted by the Commission and are reflected in the "Recommendations" section of this report.

One of the charges to the Commission was that it "examine the need for improvement in the statewide public health delivery system". Therefore the Commission spent a number of meetings on issues related to governance.

Localities are clearly creatures of the State in legal terms, yet politically they are a significant force in the development of policy and the allocation of resources. The

previous section gives some explanation of how North Carolina's public health system functions. It may be categorized by shared organizational control. This is the case when local health departments are under the authority of the State health agency as well as local government and a board of health.

From a report presented to the Commission entitled Characteristics of State and Local Health Agencies it was learned that there are three other categories of state-local health agency governing patterns besides the shared organizational control as represented by North Carolina. These are:

1. Centralized organization--local health departments that function directly under the state's authority and are operated by a state health agency or a state board of health;
2. Decentralized organization--local government directly operates a health department with or without the intervening authority of a local board of health;
3. Mixed--local health services in a state may be provided by the state health agency in some jurisdictions and by local governmental units, boards of health, or health departments in other jurisdictions.

The neighboring state of South Carolina represents centralized organization. Representatives from South Carolina's Department of Health and Environmental Control were requested to make a presentation to the Commission about their public health system. This information is on file with the Commission.

Another model of public health governance is represented by Tennessee's Department of Health and Environment. Their structure is classified as mixed

governance. Representatives of this department appeared before the Commission. Their presentation and supporting documents are on file with the Commission.

AIDS is also part of the Commission's charge assigned by the 1989 General Assembly and two meetings were devoted to this topic. Since AIDS is a relatively new topic in which new scientific and behavioral information is being generated almost daily, the Commission, by necessity, spent one full meeting educating itself about AIDS which will be used as background for analysis. The following topics and speakers were heard by the Commission on November 15, 1990:

- °AIDS: Laws, Policies, and Future Directions
  - John Bartlett, M.D., Clinical Research Director, Duke University AIDS Clinical Trials Group
  - Maureen Byrnes, Executive Director, National Commission on AIDS
  - Rebecca A. Meriwether, M.D., Div. of Epidemiology, Department of Environment, Health, and Natural Resources
  - Thad Wester, M.D., Deputy State Health Director
- °Impact of AIDS on Institutions
  - Catherine Wilfert, M.D., Professor of Pediatrics, Duke Medical Center
  - Susan Cohn, M.D.,UNC Health Services Research Center
  - Pete Hunt, HIV/Health Education Consultant, N.C. Department of Public Instruction
  - Parker Eales, Chief of Health Services, Division of Prisons, N.C. Department of Correction
- °Impact of AIDS on Communities

- Robert Wooten, Public Health Clinic Manager, Forsyth County Health Department
- John Connelly, Executive Director, Metrolina AIDS Project
- Alan McKenzie, North Carolina Medical Society Staff

°AIDS Policy Issues

- Bert Coffer, M.D., Americans for Sound AIDS Policy
- Brenda Youngblood, Executive Director, AIDS Service Coalition
- Nat Blevins, Person with AIDS

On November 16, 1990, the Commission held a public hearing on AIDS. This Public hearing was advertised in the media across the State. This event was intended as an open forum for anyone who wished to address the Commission. The Commission records contain the testimony of the 20 persons who appeared before the Commission on this date.

The following section contains a distillation of the information presented to the Commission filtered through numerous hours of discussion and debate among the Commission. The Commission believes that the following recommendations to the 1991 General Assembly and the Governor reflect an urgent message to the people of this State. Public health is a vital governmental effort but restoring an effective public health system cannot be achieved by public health professionals alone. The recommendations suggest the first step toward a renewed effort in this State in an organized community effort to prevent disease and promote health.

RECOMMENDATIONS

RECOMMENDATION ONE: The General Assembly should enact legislation making the Public Health Study Commission a permanent Commission with sufficient funds to hire staff and collect and analyze the information necessary to develop a long-range plan to improve and fund the public health system. (See Appendix G)

The Public Health Study Commission was established by the 1989-91 General Assembly to "examine the need for improvement in the statewide public health delivery system through local communities" and to "develop legislation to meet those needs." 1989 S.L., Ch. 802, Sec. 4.4. As part of its charge, the Commission has adopted a mission statement for the public health system, and a list of essential public health services that the State ought to assure are available to all its citizens. Having determined the overall mission and essential services of the State public health system, the Commission then set about to examine how the present system is organized and governed and whether the current structure and governance is the most efficient and effective for accomplishing the public health mission. Discussions about governance have revealed a number of issues that require more in-depth study than the Commission has the time or resources to expend prior to its final report and expiration. The Commission has concluded that the present system needs improvement, and such improvement will require a substantial commitment of State and local resources.

RECOMMENDATION TWO: The General Assembly should incorporate into the State's public health statutes the mission statement and list of essential public health services adopted by the Public Health Study Commission. The Commission for Health Services should be expressly charged with determining the individual types of

programs and services that are incorporated within each broad category of the essential health services. (See Appendix H)

Critical to the development and implementation of an effective statewide public health system is the understanding of the system's overall mission and the essential public health services that need to be assured for every citizen in order to accomplish that mission.

RECOMMENDATION THREE: **Legislation enacting the establishment of a permanent Public Health Study Commission should provide for the Commission to have a standing committee on public health finance. Membership on the committee should be representative of groups that have a specific interest in financing issues.** (See Appendix G)

The availability of State, local, federal, and private financial resources for public health services is decreasing, while the demand for these services is increasing. A long-range plan for funding the public health system, including review and evaluation of current financing, is needed to ensure the availability of adequate resources for the public health system in North Carolina.

RECOMMENDATION FOUR: **The Department of Environment, Health, and Natural Resources should implement a plan to increase its capability and the capability of local health departments to secure private sector financial resources to supplement public health activities and services mandated by the State.** (See Appendix I)

Demands on financial resources to support State and local public services have increased dramatically and are likely to continue to increase in the foreseeable future. Strategies for financial resource development at the State and local levels are critical to ensuring that essential public health services are available and accessible to all citizens.

RECOMMENDATION FIVE: **The on-going Public Health Study Commission's committee on public health finance should consider the feasibility of recommending that the General Assembly authorize fees currently unauthorized. Receipts from newly authorized fees should be designated for public health services.**

Demands on local health department services have exceeded State and local resources to support these services. State and local designated fees may be a source of funding for local health departments.

RECOMMENDATION SIX: **The present organizational structure reflecting the historical State and local partnership should be maintained for the time being; however, the organizational structure of the present system should be scrutinized and evaluated by the ongoing Public Health Study Commission to determine if it is promoting and supporting maximum efficiency and effectiveness in the administration and delivery of public health services to all citizens.**

Recent data on the health of North Carolina's citizens suggest that the State public health system is not operating at maximum efficiency or effectiveness. One component of the system that may need strengthening is its organizational structure. The present structure is one of decentralization with State and local government sharing responsibility for providing essential public health services. An alternative structure is

the centralized system wherein the State assumes greater responsibility for the funding and administration of these services. Moving from our present structure to a centralized one would necessitate a substantial commitment of State resources, as well as the willingness of local governments to yield authority and autonomy in the management and operation of local health departments.

RECOMMENDATION SEVEN: **The ongoing Public Health Study Commission should monitor and further evaluate whether the current organization of the public health system at the State level is effective in meeting citizens' public health needs, and the likelihood that such organizational structure will be able to achieve the State's public health mandate in the future. The Commission should report the findings and recommendations of this evaluation to the 1993 General Assembly upon its convening.**

The Division of Health Services, formerly under the Department of Human Resources, was recently merged into a new Department of Environment, Health, and Natural Resources. Certain public health related organizations and advocates have expressed concern to the Commission that the new merger has diminished the visibility of the State health agency and the authority of the State Health Director. In 1988, the Institute of Medicine Report on "The Future of Public Health" made some recommendations relative to the placement of public health within the State executive structure which the ongoing Public Health Study Commission may wish to consider in its deliberations regarding organizational structure of the public health system. In light of these concerns the ongoing Public Health Study Commission should review the

ability of the State's organizational structure to effectively and efficiently assure the delivery of public health services to all citizens of the State.

RECOMMENDATION EIGHT: **The organization of public health services into district health departments, as authorized under G.S. 130A-36, et seq., should be seriously considered by the ongoing Public Health Study Commission's committee on public health finance.**

The desirability of having public health services in counties with sparse populations, scarce resources, or other unique characteristics, organized and administered through district health departments, requires consideration of at least two questions: one is whether individual counties now have and can expect to have in the future the financial resources to maintain their own public health departments that are capable of meeting county health needs and State health mandates; the other is whether individual counties are willing to sacrifice their present level of autonomy over public health services, and what the State should do, if anything, to encourage formation of district health departments.

RECOMMENDATION NINE: **The ongoing Public Health Study Commission should encourage the continuation of local public and private efforts to provide orientation and training to local boards of health. The Commission should investigate whether, after expiration of the Kellogg Grant, there will be a need for the State to initiate, coordinate, or fund such programs for local boards of health.**

Local boards of health represent a vital part of the public health system in North Carolina, and steps should be taken to strengthen their effectiveness. Orientation and

training for members of local boards of health are important parts of strengthening the public health system. The Association of North Carolina Boards of Health has recently received a $300,000 grant from the Kellogg Foundation to provide orientation and training services to local boards of health. The grant is for a three-year period.

RECOMMENDATION TEN: **The General Assembly should appropriate special incentive funds for counties whose current salary scales for public health directors, public health nurses, environmental health specialists, and health educators are more than 10% below the State recommended salary scale as of July 1, 1990. Incentive funds should be used to encourage counties to raise their pay scales for these positions to a minimum of 90% of the State recommended pay scale. Upon reaching the 90% salary level, counties should be required to maintain the minimum pay level of 90% of the State recommended salary scale. In order to minimize the financial impact of the pay scale increase, special incentive funds for salary adjustments could be phased-in over a two-year period.** (See Appendix J)

RECOMMENDATION ELEVEN: **State recommended salary scales for public health personnel should be established at levels competitive with the private sector and the scales should be reviewed for competitiveness at least every two years and, if necessary, adjusted to maintain competitiveness. The State health director should request the Office of State Personnel to study salary scales for all public health disciplines. The Office of State Personnel should report its findings to the ongoing Public Health Study Commission in 1991 and every two years thereafter.**

Local public health departments are experiencing substantial difficulties in recruiting and retaining qualified public health personnel, especially public health nurses, environmental health specialists, health directors, and health educators. This situation has eroded the capability of local health departments to deliver State-mandated public health services to the community.

RECOMMENDATION TWELVE: **The State should appropriate sufficient funds in its continuing operations budget to pay the annual salary of one environmental health specialist in every county.** (See Appendix K)

Local health departments have an increasingly difficult time in meeting State health inspection requirements primarily because the number of qualified local inspectors has not kept pace with the rapid increase in the number of local establishments that need to be inspected. If the State is committed to providing essential health services in the area of environmental health, then local health departments will need financial assistance to ensure that there are sufficient personnel to carry out inspections required by law.

RECOMMENDATION THIRTEEN: **Effective January 1, 1992, all persons being considered for employment as local health director on or after that date must possess the following minimum education and experience requirements for that position: a medical doctorate or a Master's degree in Public Health Administration, and at least one year of experience managing health programs or services. Candidates who do not have a Master's degree in Public Health Administration should have a Master's degree in another public health discipline or in a related**

field, and should have at least three years of experience in managing health programs or services. (See Appendix L)

RECOMMENDATION FOURTEEN: The State should establish a health director qualification review panel, which shall review the qualifications of Master's degree level health director candidates who do not possess a medical doctorate, a Master's degree in Public Health Administration, or a Master's degree in a public health discipline other than public health administration, to determine if their Master's degree field is directly related to public health and administration. The panel shall review Masters degrees in related fields within 90 days of enactment of legislation establishing the panel to determine whether the related degrees substantially meet appropriate educational requirements. The panel shall consist of the State Health Director, the Dean of the School of Public Health of the University of North Carolina at Chapel Hill, and the President of the North Carolina Association of Local Health Directors, or their designees. The Office of State Personnel shall provide staff assistance to the panel, as necessary, and shall schedule meetings of the panel within 30 days of receipt of an application for review. The panel shall act upon all applications under its jurisdiction within 45 days of receipt of the application. Actions taken shall be by majority vote of the panel. Applications not acted upon by the panel within 45 days of receipt shall be deemed approved. (See Appendix L)

Current State law provides that qualifications for employment as a local health director be established by the State Personnel Commission in consultation with the Commission for Health Services, and that such qualifications give equal emphasis to

education and experience. State law further provides that such qualifications cannot require that a public health director be a physician (G.S. 130A-40). Authority to hire a local public health director rests exclusively with the local board of health. If the local board fails to appoint a health director within 60 days of when a vacancy in the position occurs, the State health director may appoint a local health director to serve in the position until the local board makes a permanent appointment.

Carrying out the powers and duties mandated by State law for local health directors (G.S. 130A-41), and meeting the demands for services and resources made upon local public health departments, requires well-trained, experienced administrators who have also practiced as public health professionals. Current qualification requirements for local health director positions need to be strengthened and a mechanism established to ensure that job qualifications are met before appointment by the local board is upheld.

RECOMMENDATION FIFTEEN: **The Department of Environment, Health, and Natural Resources, in collaboration with the U.N.C. School of Public Health, the Institute of Government, the Area Health Education Centers, and other appropriate agencies, should establish a statewide program to coordinate and strengthen orientation programs currently offered for local health directors. The General Assembly should appropriate funds to hire staff in the Department to implement the statewide effort. The counties should not be responsible for tuition, travel, or other program costs. All local health directors with less than two years experience as a local health director in North Carolina, should be required to attend a minimum number of orientation hours, established by the State Health Director, during the first two years of employment as health director.** (See Appendix M)

Programs to assist newly hired local health directors in their orientation to the duties of public health administrator are currently offered from several different sources. These sources include the Institute of Government, the UNC School of Public Health, and various State agencies. However, time and tuition costs to attend these programs are often not available to new health directors, and the frequency and subject matter of the programs may not meet local needs in a systematic manner. Nevertheless, such programs are a valuable resource to local directors as they struggle to serve the department and the community as efficiently and effectively as possible.

RECOMMENDATION SIXTEEN: The General Assembly should appropriate special incentive funds to establish public health director internship programs in selected counties that volunteer to participate. The program should initially consist of five training sites, one to be located in each of five local health departments. Interns should serve as assistant to the health director at the training site for a period of two years. The State should pay half the salary expense for each intern for the full internship period.

The General Assembly should establish a committee to oversee the operation of the internship program. Membership on the committee should include: the State Health Director, the President of the Local Health Directors Association, the President of the North Carolina Public Health Association, and a representative of the County Commissioners Association. The committee should be responsible for: soliciting applications from local government to participate as training sites in the program; selection of training sites; establishing qualifications for interns which

should be consistent with qualifications required for local health directors; and other responsibilities designated by the General Assembly.

The program should be reviewed by the General Assembly after five years to determine if it is serving the purposes for which it was designed and to determine if the personnel trained are remaining in North Carolina. (See Appendix N)

Problems related to the recruitment and orientation of local health directors strongly suggest the need for a training ground for these positions in local health departments. Such training would provide a pool of qualified candidates for local health director positions around the State. The most effective means for implementing such a training program would be through a joint effort by State and local government.

RECOMMENDATION SEVENTEEN: **The Department of Environment, Health, and Natural Resources should establish a statewide system for assessing health status and health needs in every county. The system should include input from private providers, community groups and agencies, the general public, and policy makers in determining community health needs.** (See Appendix I)

The effective delivery of public health services depends in large part upon a system-wide assessment of health status and health needs, and the efficient use of State, local, and federal financial resources to address these needs.

RECOMMENDATION EIGHTEEN: **The Department of Environment, Health, and Natural Resources should develop a computerized statewide data collection and retrieval system that will permit valid comparisons of State and local health data with those of the nation and of other states and localities. The system should be**

standardized with respect to local reporting of health status and needs, health services delivered, funds expended, and outcomes achieved, and should be adaptable to systems currently used by local health departments. The State should substantially assist counties with the financial burden of initial integration into the statewide system and with costs incurred to make local information systems in place compatible with the statewide system. Every county that has information processing capability should be required to provide all information requested by the State health agency. Counties that refuse to comply with health agency requirements for this information should be informed that repeated refusal will result in reductions in State funds for health services in those counties. (See Appendix I)

Documentation of health needs, services provided, outcomes achieved, and accountability for expenditures can best be achieved by a well integrated, standardized data collection and retrieval system that is available to every local health department in the State. The absence of this data collection and retrieval capability has forced some local health departments to purchase data collection systems designed to suit their special needs, which may not be adaptable for integration with one another or with the State's system. Most local health departments do not have the local resources to purchase sophisticated information gathering systems and thus do not have access to data that would help them assess local needs and be more accountable for the use of their public health funds.

RECOMMENDATION NINETEEN: The General Assembly should direct the Commission for Health Services to establish and the Department of Environment, Health, and Natural Resources to implement statewide health outcome objectives

and delivery standards. The establishment of these objectives and standards should take into account funds available to address them. The Department should implement a monitoring and evaluation program to measure local health department progress in applying standards and achieving objectives. Monitoring and evaluation should take place on a regularly scheduled basis and assistance should be provided to local health departments that are having difficulty meeting State requirements. (See Appendix I)

In order to assure the availability and accessibility of essential public health services to all citizens, the State must first ascertain the status of health needs and service delivery, and then set standards and objectives for improving that status. The absence of long range goals and standardized procedures for the public health delivery system ultimately impedes the effectiveness of local health department operations and diminishes efficiency in the expenditure of scarce public health resources.

RECOMMENDATION TWENTY: **One of the major areas of study of the on-going Public Health Study Commission should be a review of the status and needs of local health departments relative to facilities, and the development of minimum standards governing the provision and maintenance of these facilities.**

One of the most important elements of providing public health services in an efficient and effective manner is the suitability of local facilities designated for these services. Other State and local agencies that provide human services are subject to minimum standards for their facilities, whereas facilities used for the administration and delivery of public health services are not subject to such standards.

APPENDICES

APPENDIX A

PART IV.-----PUBLIC HEALTH STUDY COMMISSION

Sec. 4.1. There is established the Public Health Study Commission, an independent commission, to study public health services in North Carolina and to recommend improvements that will assure that North Carolina has cost-effective, uniform and consistently administered public health services.

Sec. 4.2. The Commission shall consist of 21 members. The Speaker of the House of Representatives shall appoint seven members, a minimum of four of whom shall be members of the House of Representatives. The President Pro Tempore of the Senate shall appoint seven members, a minimum of four of whom shall be members of the Senate. The Governor shall appoint seven non-legislative members, as follows: one of whom shall be a recipient of public health services, one of whom shall be a public health director, one of whom shall be a county commissioner, one of whom shall be an advocate for low-income people who is familiar with public health services in North Carolina, one of whom shall be the Secretary of the Department of Environment, Health, and Natural Resources or a designee thereof, one of whom shall be a physician licensed to practice medicine under Chapter 90 of the General Statutes, and one of whom shall be an individual involved in the administration or funding of public health services.

Initial appointments shall be made within 30 days following adjournment of the 1989 Session of the General Assembly. Vacancies shall be filled by the official who made the initial appointment using the same criteria as provided by this section.

Sec. 4.3. The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each appoint a cochair of the Commission from their appointees. The cochairs shall call the first meeting and preside at alternate meetings.

Sec. 4.4. The Public Health Study Commission shall examine the need for improvement in the statewide public health delivery system through local communities and the need for additional legislation to deal with Acquired Immune Deficiency Syndrome -- AIDS within this State, and shall develop legislation to address those needs. If legislation is enacted directing the Department of Environment, Health and Natural Resources to develop a Public Health Services Plan, the Department may provide status reports on the development of the Plan to the Commission. Upon completion of the Plan, the Department shall submit the Plan to the Commission for the Commission's review.

Sec. 4.5. Commission members shall receive subsistence and travel expenses as provided in G.S. 120-3.1, 138-5, and 138-6, as applicable.

Sec. 4.6. The Commission may solicit, employ, or contract for professional, technical, or clerical assistance, and may purchase or contract for the materials and services it needs. Subject to the approval of the Legislative Services Commission, the professional and clerical staff of the Legislative Services Office shall be available to the Commission, and the Commission may meet in the Legislative Building or the Legislative Office Building. With the consent of the Secretary of the Department of Environment, Health, and Natural Resources, staff employed by the Department or any of its divisions may be assigned permanently or temporarily to assist the Commission or its staff.

Sec. 4.7. Upon request of the Commission or its staff, all State departments and agencies and all local government agencies shall furnish the Commission or its staff with any information in their possession or available to them.

Sec. 4.8. The Commission shall submit a final written report of its findings and recommendations to the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate before or upon the convening of the 1991 Session of the General Assembly. The Commission shall terminate upon the filing of the report.

Sec. 4.9. There is allocated from the funds appropriated to the General Assembly $25,000 for fiscal year 1989-90 and $25,000 for the 1990-91 fiscal year to fund the work of the Commission created by this Part.

APPENDIX B

PUBLIC HEALTH STUDY COMMISSION MEMBERSHIP LIST

President Pro Tempore's Appointments

Sen. Ollie Harris, Co-Chair
Kings Mountain, NC 28086

Mr. Carl Durham
Wilmington, NC 28405

Sen. James E. Ezzell, Jr.
Rocky Mount, NC 27804-1225

Mrs. Maye Gurley Myers
Goldsboro, NC 27530

Richard M. House, PHD
Chapel Hill, NC 27599-7400

Sen. Paul S. Smith
Salisbury, NC 28145

Sen. Russell G. Walker
Asheboro, NC 27203

Speaker's Appointments

Rep. Betty H. Wiser, Co-Chair
Raleigh, NC 27607

Rep. Howard C. Barnhill
Charlotte, NC 28216

Rep. W. W. (Dub) Dickson, DVM
Gastonia, NC 28054

Rep. James P. Green,Sr., MD
Henderson, NC 27536

Rep. Theresa H. Esposito
Winston-Salem, NC 27104

Chris Mansfield, PHD
Greenville, NC 27858

Lois K. Selhorst, MA
Cary, NC 27511

Rep. Charles L. Cromer
(Resigned 8/17/90)

Charles Sawyer, MD
(Resigned 4/90)

Governor's Appointments

Mr. William T. Drake
Hendersonville, NC 28739

James S. Fulghum, III, MD
Raleigh, NC 27608

Mrs. Virginia S. Gavin
Asheboro, NC 27203

Percy E. Jones, MD
Greensboro, NC 27403

Mr. Jeffrey C. Long
Fayetteville, NC 28304

Mr. George H. Rudy
Raleigh, NC 27604

J. Dale Simmons, MD
Dobson, NC 27017

APPENDIX C

N. C. PUBLIC HEALTH BUDGET
(In Millions)

Source of Funds	1986	1987	1988	1989
State Approp.	77.9 (29.1%)	79.5	77.9	79.1 (22.3%)
Federal	76.8 (28.7%)	77.7	84.5	89.1 (25.2)
Local	85.4 (31.9%)	90.3	102.2	134.6 (38.0)
Earned	27.6 (10.3%)	30.8	34.8	51.2 (14.5)
	267.7	278.3	299.4	354.0

EMPLOYEES

State and Regional - 1100

Local - 5900

THE FUTURE OF PUBLIC HEALTH

A Summary of the Institute of Medicine Report

The Institute of Medicine (IOM) is a part of the National Academy of Sciences, which advises the U.S. Congress on health policy matters. In 1985 the IOM established a committee to look at the current state of public health in America and to outline recommendations for future directions.

In an extensive two-year study, the committee reviewed the public health system in detail--through visits to local agencies in six states, interviews with over 350 people, and the examination of demographic and epidemiologic statistics, agency programs and budgets, and the statutes and regulations that set public health policy. They also heard expert testimony, held public hearings and solicited papers on critical issues.

The committee found that, despite valiant efforts of many people and programs, the public health system is currently in disarray. To provide a guide for future directions for public health, the committee developed a set of recommendations dealing with the mission of public health, the government's role in fulfilling this mission, the unique responsibilities of each level of government, and specific guides for accomplishing public health objectives.

The Public Health Mission

The mission of public health is "fulfilling society's interest in assuring conditions in which people can be healthy." Public health is distinguished from health care by its focus on community-wide concerns--the public interest--rather than the health interests of particular individuals or groups. Its aim is to generate organized community effort to address the public interest in health by applying scientific and technical knowledge. The mission is addressed not only by government but by everybody who takes positive action for health, including private organizations, individuals and public agencies.

Governmental Role in Public Health

The unique function of government is to see that vital elements are in place and that the mission is adequately addressed. The committee outlines three core functions of public health agencies at all levels of government:

- **Assessment**--information on community health status and needs should regularly and systematically be collected, analyzed and made available for health planning and decision-making

- **Policy Development**--public health agencies should provide leadership in developing comprehensive public health policies based on scientific knowledge and community needs.

• **Assurance**–public health agencies have the responsibility to ensure that necessary services are provided, either by encouraging actions of other entities (public or private), by requiring action through regulation, or by providing services directly.

Responsibilities of Government at Each Level

The functions of assessment, policy development and assurance of services are common to all levels; however, each level also has unique responsibilities.

• States must be the central force in public health, with primary public sector responsibility for health. Duties of the state include: assessment of health needs based on statewide data collection; a statutory base for state health activities; statewide health objectives; guarantee of essential health services; and support for local government services when necessary.

• Federal duties are to: establish nationwide health objectives; provide technical assistance to help states/localities determine their own objectives; provide funds to states to strengthen their service capacity and to achieve national objectives; and carry out actions of national public interest such as control of AIDS and other communicable diseases, interstate environmental actions, and food and drug inspection.

• Local governments are extremely diverse, therefore, generalizations are made with caution. No citizen from any community, however, should be without access to public health protection through a local delivery system.

Duties of localities include: assessment and monitoring of local health problems; policy development emphasizing local needs; ensuring that services are available to all people; assurance that the community receives its share of federal, state and local resources for public health; and informing the community about available public health services.

FULFILLING THE GOVERNMENT ROLE: IMPLEMENTING RECOMMENDATIONS

The committee recommends specific steps that should be taken in order for public health agencies to fulfill the functions outlined above.

State public health statutes should be reviewed and modified as needed to:

• clearly define the authority and responsibilities of state and local public health agencies and officials.

• support modern disease control measures related to health problems such as AIDS, cancer and heart disease.

States should examine their organizational structures to establish a clear focal point for public health responsibility. The committee recommends that each state have:

• a department of health that manages all primary health-related functions including health promotion and disease prevention, indigent health care programs,

mental health and substance abuse, environmental health, and health planning and regulation. The director of the department should be a cabinet level officer.

- a health council that reports on the health of the state's residents, makes policy recommendations to the governor and legislature, and reviews the work of the state health department.

- standards specifying minimum services for local public health functions, identifying who will provide them and how they will be financed. The "Model Standards for Community Preventive Health Services" should be used as a guide.

Localities--While local circumstances will determine the appropriate balance between state and local responsiblities, in general, delegation to the local level is recommended.

Federal--The federal government should clearly identify the specific officials and agencies with primary responsibility for the recommended public health functions. A task force should be established to determine the most effective ways to carry out these recommendations.

SPECIAL LINKAGES

Environmental Health--State and local public health agencies should have direct operational involvement in identifying and controlling environmental health hazards.

Mental Health--A study of the public health/mental health interface should be done to document how the lack of linkages with public health hampers the mental health mission.

Social Services--Public health should be separated organizationally from income maintenance, but public health agencies should maintain close and cooperative working relationships with social service agencies.

Care of the Indigent--Many public health agencies have become last-resort providers of personal medical care, draining vital resources away from population-wide services. Ultimate responsibility for assuring equitable access to health care for all, through a combination of public and private sector action, rests with the federal government. Until federal action is forthcoming, however, public health agencies must continue to serve the priority personal health needs of the uninsured, underinsured and Medicaid clients.

STRATEGIES FOR BUILDING CAPACITY OF PUBLIC AGENCIES

To equip public health agencies to fulfill their assessment, policy development and assurance functions, it is necessary to build agency competence in the following areas:

Technical--A uniform national data set should be established to permit valid comparison of local, state, and national health data.

Research should be conducted at all levels on population-based health problems; the federal government should not only conduct but also support research by states, localities, universities and the private sector.

Political--Public health leaders should develop relationships with and educate legislators and other public officials on community health needs and public health issues. Agencies should build citizen participation into program implementation.

Agencies should cultivate relationships with physicians and other private sector representatives, with other professional groups, and with groups concerned with improving social services, the environment or economic development.

Agencies should educate the public on community health needs and public health policy issues. They should train employees to treat clients and members of the public with cordiality and respect.

Managerial--Demonstrated management competence as well as technical and professional skills should be required for upper-level management posts.

Salaries and benefits for health department managers should be improved and systems instituted so that managers can carry retirement benefits with them when they move among different levels and jurisdictions of government.

Programmatic--Public health professionals should place more emphasis on factors that influence health-related behavior and develop strategies that take these factors into account.

Fiscal--Federal support of state-level health programs should help balance disparities in revenue-generating capacities.

State support of local health services should also balance local revenue-generating capacities.

EDUCATION FOR PUBLIC HEALTH

The most direct path to a career in public health is a degree from a school of public health. Many of the 25 schools of public health are located in research universities and thus have a dual responsibility to develop knowledge and to produce well-trained practitioners, two roles that are not always easy to balance. In some cases the result is that the training of professionals to work in public health agencies may not be given a sufficiently high value.

In addition, many public health workers have no formal training in public health at all, and their need for basic grounding may not be appropriately met by the degree programs designed to prepare people for middle- and upper-level positions.

To these ends the committee recommends that:

- Schools of public health establish firm practice links with state and local public health agencies.

- Recruitment of faculty and students should give weight to prior public health experience as well as academic qualifications.

- Schools of public health should be a resource to governments at all levels in developing public health policy.

- Students should be taught the entire scope of public health practice including environmental, educational and personal health problems, basic epidemiologic and biostatistical techniques, and political and management skills needed for leadership in public health.

- Research in schools of public health--basic, applied, and program evaluation and implementation--should include subjects of relevance to the solutions of real-life public health problems, tested in application to real-life settings.

- Since schools of public health cannot train all the vast numbers of personnel needed, they should assist other institutions to prepare qualified professionals for positions in the field.

- Continuing education should be offered to upgrade the competence of public health workers who do not have adequate preparation and to expand the knowledge of previously trained professionals.

- Educational programs for public health professionals should seek information about current employment opportunities and needs in the field.

CONCLUSION

The report summarized its findings by stating, "The specifications appropriate to strengthen public health will vary from area to area, and must blend professional knowledge with community values. The committee intends not to prescribe one best way of rescuing public health, but to urge that readers get involved in their own communities in order to address present dangers, now and for the sake of future generations."

Note: This summary was prepared by staff at the UNC School of Public Health. For further information, call Linda Parker, Associate Director for Community Service, at (919) 966-2248.

The IOM report can be ordered from the:
National Academy Press
2101 Constitution Avenue, N.W.
Washington, DC 20418 Tel: (202) 334-3313
Price: $19.95 per copy

SURVEY OF ISSUES PRESENTED BY SPEAKERS TO THE PUBLIC HEALTH STUDY COMMISSION ON DECEMBER 18, 1989

Dr. Ibrahim (Dean, School of Public Health - UNC)

I. State Public Health Policy
   A. establish basic level of public health services for every citizen
   B. State should provide financial support to county or district health departments on an adequate per capita basis
   C. require well-trained health professionals to manage and provide services
   D. State should establish minimum salaries for health professionals.

II. Emphasis on Health Outcomes
   A. Evaluation of public health programs
      1. how they contribute to improved health status
   B. provide funding for innovative projects
   C. funding to joint studies by the University and public health agencies to evaluate intervention programs

III. Ongoing Legislative Public Health Study Commission

Dr. Ron Levine (State Public Health Director)

I. Inability to attract and retain qualified public health professionals
   A. qualifications on local health personnel should be tighter
   B. make pay plan consistent statewide

II. Inadequate financial resources

III. Inadequate facilities.

Mr. Carl Tuttle (President- Health Directors' Association)

I. Environmental Health
   A. more help with state rules & regulations
      1. inadequate state funding
   B. increasing contamination of ground and surface water with little help from the State

II. Health Promotion
   A. educating public

III. Infant Mortality
   A. provide prenatal care to all pregnant women
      1. 24 counties - no physicians providing OB

services
B. liability insurance assistance
C. epidemiological studies
1. to study infant death

IV. Salary, Recruitment and Retention of Staff
A. Salaries for nurses
1. not competitive with private sector
2. inconsistent - vary from county to county

Polly J. Baker, RN MPH,(Association of Public Health Admin.)

I. Lack of funds
A. inability to access community to impart and collect information

II. Establish Comprehensive Programs
A. need highly qualified health professionals
1. increase salaries
2. provide educational opportunities for existing employees
B. need legislation changing medical care coverage for the indigent so as not to use funds needed for preventive services

Steve Shore (N. C. Primary Health Care Assoc.)

I. Identity problems
A. missions and goals not clearly defined
B. manpower
1. inadequate - too much required of existing health professionals
C. identify, cultivate and support persons who choose public health careers

II. Coordinate, Collaborate and Cooperate
A. need leadership, more planning in existing programs

III. Funding
A. needs focus and priorities

Charles Snyder (NC Environmental Health Supervisors'Assoc.)

I. Inability to recruit and retain highly qualified professionals
A. Inadequate commitment
B. Inadequate funding

II. Ground Water protection
A. state and local government should form partnership

Patrice Roessler (N.C. Association of County Commissioners)

I. Environmental Health
   A. landfills/solid waste disposal
      1. counties need technical assistance in determining disposal strategies

   B. Better staffed state agencies

II. AIDS
   A. public education
   B. policy guidance
      1. employee relations
   C. training and education for law enforcement and emergency services personnel

III. Infant mortality
   A. adoption of legislative goal supporting expansion of Medicaid programs so that more pregnant women can receive prenatal care

IV. Competition from private sector

V. Cost of liability insurance
   A. reasons for physicians declining to provide services
      1. county jails also a problem.

Ted Parrish (N. C. Society of Public Health Education, Inc.)

I. Health promotion
   A. establish statewide health promotion program
      1. funds and resources
      2. mass media campaigns
      3. training for local practitioners
      4. innovative program development
      5. procedure for evaluation
      6. increased coordination of resources, planning, and action
   B. resources for qualified staff

II. School Health Coordinators - All school districts should be included in state funding

III. AIDS - Legislation (refers to H-361 (S-288) Not ratified
   A. Preventive educational program
      1. increase awareness of problem
      2. educate how to reduce risky behavior

Gary Bowers (N.C. Assoc. for Home Care)

I. Staff shortages
   A. Nurses in particular

II. Staff salaries
   A. Cannot compete with private sector

III. Indigent care
   A. uninsured and under-insured population growing
   B. Qualify more residents for Medicaid.

Stephen Morrisette (N. C. Hospital Association)

I. Medicaid Expansion

II. Medicaid Reimbursement

III. State Health Insurance Pool
   A. to provide coverage for those unable to obtain otherwise

James Bernstein (Chief, Health Resources Development, DHR)

I. Recruit Physicians
   A. for medically under-served areas

II. Develop new financial systems to pay for care provided for uninsured and under-insured.

OUTLINED SUMMARY OF PRESENTATIONS MADE TO THE PUBLIC HEALTH STUDY COMMISSION-JANUARY 31, 1990 MEETING

By: Jan Lee, Clerk

Dr. Arden Miller-UNC School of Public Health

I. Suggestions to improve infant mortality

A. Expansion of comprehensive care
-Care before, during, and after pregnancy

B. State assumption of responsibility

1. Upfront financing
2. Statewide, coordinated effort
3. Limit control of local governments

II. Method to prevent increased infant mortality

A. Early childhood sexuality education

B. Increased family planning services and access to contraceptives and abortions

Dr. Brett Williams-UNC School of Public Health

I. Factors contributing to infant mortality

A. Problem related to poverty

1. Poor women more likely to have attributes associated with infant mortality
   a. Lack of education
   b. Young age
   c. Minority status
   d. Poor nutritional habits
   e. Substance abuse

B. "Working Poor"

1. Uninsured
2. Under-insured

C. Inadequate facilities
1. Lack of funding
   a. Long waiting lists
   b. Decreased family planning services (less than 20 hours per week in more than 75% of counties.)

2. Funds for family planning services are now being diverted to cover cost of increased perinatal care.

D. Private physicians less likely to participate

1. Low fees
2. Extensive paperwork

II. Recommendations

A. Increased funding to provide for better staffed, more accessible public health clinics

B. Provide transportation and child care facilities for poor women to enable them to utilize public health clinics when necessary

Dr. Ronald Levine -State Public Health Director

I. Factors contributing to increased infant mortality

A. Decreased funding for family planning services

1. Funding for family planning increased in the 1970s and consequently, there was a decline in the infant mortality rate in N.C.
2. Funding decreased in 1980s - mortality rate increased.

B. Fewer families with adequate insurance

C. Decline in obstetrical physicians

1. Fear of suit
2. Inability to meet rising costs of medical liability insurance.

II. Recommendations

A. Increase "preconceptional health programs"
1. Provide care prior to, during, and after pregnancy
2. Increase family planning services

B. Increase utilization of maternal and infant care services

1. Increase staff
2. Provide transportation

C. Target high-risk groups

1. Factors to consider
a. Income
b. Race

c. Maternal age
d. Education level
e. Marital status
f. Previous pregnancy outcomes

D. Increase the Women's, Infants' and Children's Supplemental Food Program (WIC)

E. Increase reimbursement by Medicaid

F. Rural OB care incentive program
-Funds to assist payment of liability insurance premiums for physicians who practice obstetrics in rural counties

Mr. Tom Vitaglione, Div. Maternal and Child Health, Department of Environment, Health, and Natural Resources

I. How The Division of Maternal and Child Health Works

A. Women's health

1. Identify "risk" pregnancies
   a. 1/3 of all pregnancies handled in public health sector
2. Assign nurse to oversee

B. Children and youth -function is to enhance the growth and development of children

C. Special section dealing with women and children
D. Genetic health care
E. High priority infant program
F. School health program
G. Developmental Evaluation Centers
H. Children's special health services
I. Sickle Cell Syndrome program

II. Preventive rather than curative

A. Contraceptive counseling (family planning)
B. Continuim care
C. Preconceptual health

Dr. Rebecca Merivether, Division of Epidemiology, Department of Environment, Health, and Natural Resources

I. Statistics on AIDS in North Carolina

A. 1,119 cases have been reported since

1984

1. Over 600 (54%) have died
2. 282 (or 25%) of these cases were diagnosed in 1989.
3. 86 Counties have reported cases
4. 49% of cases occurred in Blacks
5. 10% in women
6. 23 cases in children under 13 years of age who acquired infection perinatally, at, or before birth
7. 35% of new cases occurred among injection drug users

II. Methods of Control

A. Education
   1. Counseling at local health departments
   2. Counseling by physicians
   3. School programs
   4. Media
   5. Other public and private institutions

B. Individualized counseling to "high risk" patients

C. Targeted outreach and intervention programs to communities at increased risk

   1. Minorities
   2. Injection drug users (fastest growing)
   3. Gay men

III. Impact on Health Care Resources

A. $15-20 Million Estimated Cost
   1. Under-reimbursed or paid by Medicaid
   2. Most patients too ill to work and consequently have no insurance coverage
   3. Cut in federal funding

B. Alternative Care
   1. Nursing homes
   2. Case management
   3. Housing assistance

IV. Treatment

A. AZT- a drug that decreases replication of the virus
B. Preventive therapies for pneumocystis
C. Early intervention care counseling

Ms. Meredith Cosby, Adult Health Services, Department of Environment, Health, and Natural Resources

I. Purpose of statewide health promotion

A. Prevent mortality and morbidity from cardiovascular disease, cancer, injuries, and other leading health problems

1. 1987 Statistics:
   a. 19,000 deaths from heart disease
   b. 12,000 from cancer
   c. 4,500 from strokes
   d. over 3,000 from auto accidents

2. 51% mortality related to lifestyle
   a. Poor nutrition
   b. Obesity
   c. Alcohol misuse
   d. Lack of physical exercise
   e. Smoking
   f. Lack of use of seatbelts
   g. Uncontrolled hypertension

B. Increase Awareness Through Planned Health programs

1. Incorporate changes in social or physical environment to support behavioral changes

2. Public education through mass media

3. Increased funding
4. More trained professionals

Dr. Tom Cole, Injury Control, Department of Environment, Health, and Natural Resources

I. Causes of death by injuries

A. 50 deaths each year-farm related
B. House fires
C. Firearms
D. Automobiles

II. Methods of Treatment and Reduction

A. Injury control centers

1. More needed
2. More accessible

B. State Government

1. Agencies
2. Safety legislation

C. Local health departments

1. Education
2. Injury prevention programs

D. Citizens' Groups

1. Head Injury Foundation
2. MADD
3. AARP

E. Public participation

1. Seat belts
2. Motorcycle helmets
3. Safety in the home

Mr. Bob Prye, Health Consultant, Department of Public Instruction

I. Reasons for establishing Health Education Coordinators

A. 1979 Survey revealed no set standard of health education in North Carolina

B. Health education-unplanned, fragmented, and often based on invalid and obsolete information

II. "The Ten-Year Plan"

A. Established by General Assembly in 1978

B. Called for the establishment of 100 Health Coordinator positions

1. By 1989, 49 positions had been established
2. Serving 61 of 134 local school unites

C. Allocation-$43,603

1. For educator's salary
2. For costs of instructional materials
3. For training and curriculum development

III. Health Results

A. Difficult to determine

B. No standardized test in our state

Rep. James Green, Pharmaceutical Cooperative Programs

I. Establish public-private partnership to assist

specified patients in obtaining prescription drugs

A. Pharmacists sell to specified group at lower cost
B. State assistance

II. Implementation

A. Work with NC Pharmacy Network
B. Work with Social Services to determine how to provide these patients with identification that would enable them to utilize this special program

OUTLINED SUMMARY OF PRESENTATIONS MADE TO THE PUBLIC HEALTH STUDY COMMISSION-FEBRUARY 28, 1990 MEETING

By: Jan Lee, Clerk

Ms. Elizabeth Joyner, Director, Craven County Health Department

I. Problems

A. Lack of qualified health professionals
B. Inadequate funding
C. Physical facilities

II. Recommendations

A. Establish permanent public health study commission
B. Develop public health policy
   1. Ensure basic level of health services
   2. Provide for adequate per capita funding
      a. When given additional responsibilities, provide adequate funding
      b. Allow flexibility in use of funding
   3. Require well-trained health professionals
   4. Emphasize health outcomes
   5. Attract and retain qualified health professionals
      a. Improve salaries
      b. Better physical facilities

Dr. Hugh H. Tilson, Director, Epidemiology, Information and Surveillance Division, Burroughs Wellcome company, Research Triangle Park, North Carolina

I. Mission

A. Assuring conditions in which people can be healthy
B. Participation by everyone who takes positive action for public health, including private organizations, individuals and public agencies

II. Governmental Role in Public Health

A. Federal
   1. Establish nationwide health objectives
   2. Provide funds to state to strengthen their service capacity and to achieve national objectives
   3. Carry out actions of national public interest such as control of AIDS and other communicable diseases, interstate environmental actions, and food and drug inspection

B. State
   1. Assessment of health needs based on statewide data collection

2. Statutory base for state health activities
3. Statewide health objectives
4. Guarantee of essential health services
5. Support for local government services when necessary

C. Local
1. Assessment and monitoring of local health problems
2. Policy development emphasizing local needs ensuring services to all people
3. Assurance that the community receives its share of federal, state and local resources for public health
4. Informing community about available public health services

III. Implementing recommendations

A. State public health statutes should be reviewed and modified as needed
1. To clearly define the authority and responsibilities of state and local public health agencies and officials
2. Support modern disease control measures related to health problems such as AIDS, cancer, and heart disease.

B. State should examine their organizational structures to establish a clear focal point for public health responsibility.
1. Have a department of health to manage all primary health-related functions (health promotion and disease prevention, indigent health care, mental health and substance abuse, environmental health, and health planning and regulation).
2. Have a health council that reports on the health of state residents, makes policy recommendations to the governor and legislature, and reviews the work of the state health department.
3. Create standards specifying minimum services

IV. Special linkages

A. Environmental health
B. Mental Health
C. Social Services
D. Care of the indigent

V. Strategies for building capacity of public agencies

A. Technical--A uniform national data set should be established to permit valid comparison of local, state, and national health data.
B. Political--Public health leaders should develop relationship with other public health officials.
C. Managerial--Demonstrated management competence as well as

technical and professional skills should be required for upper-level management posts.

D. Programmatic--Public health professionals should place more emphasis on factors that influence health-related behavior and develop strategies that take these factors into account.

E. Fiscal--Federal support of state-level health programs should help balance disparities in revenue-generating capacities. State support of local health services should also balance local revenue-generating capacities.

VI. Education for public health

A. Schools of public health establish firm links with state and local public health agencies

B. Recruitment of faculty and students should give weight to prior public health experience as well as academic qualifications.

C. Schools of public health should be a resource to governments at all levels in developing public health policy.

D. Students should be taught the entire scope of public health (environmental, educational, personal health problems, basic epidemioligic and biostatistical techniques, and political and management skills).

E. Research should include subjects of relevance

F. Assist other institutions to prepare qualified professionals for positions in public health.

G. Continuing education should be offered to upgrade competence of public health workers

H. Educational programs for public health professionals should seek information about current employment opportunities and needs in the field.

Richard M. House, PhD., Associate Dean, UNC School of Public Health

Recommendations distilled from statewide forum on North Carolina's public health system

I. The NC General Assembly should establish, or mandate the establish of, a state health policy describing "essential public health services" that will be available for all citizens and/or communities in every county of the state.

A. Delegate power and responsbility to local agencies for assurance that essential public health services are provided, require involvement of relevant community agencies in the planning and delivery process.

B. Should provide for ensuring local accountability

C. Express legislative commitment to provide adequate state funds.

II. The NC General Assembly should establish, or cause to be established, statewide health outcome objectives and delivery standards.

III. The NC General Assembly should establish, or mandate the

establishment of a statewide system for assessing health status and health needs in every county of the state.

IV. The NC General Assembly should establish, or mandate the establishment of, standards that specify minimum education and experience requirements for public health workers delivering state mandated public health services in North Carolina.

V. The NC General Assembly should establish, or cause to be established, standards that specify the minimum salaries to be paid for public health workers anywhere in the state who are delivering state-mandated public health services.

VI. The NC General Assembly should establish, or cause to be established, a mechanism to ensure that all NC public health professionals and board members carrying out state-mandated public health functions have the opportunity to receive appropriate continuing education needed to remain current in their respective disciplines and public health roles.

VII. The NC General Assembly should develop and adopt an overall plan for financing public health services (specifically including the above recommendations) in North Carolina.

Robert S. Parker, President, North Carolina Public Health Association

I. Problems in public health

A. Personnel vacancies most difficult to fill
1. Nurses
2. Sanitarians
3. Health educators
4. Physical Therapists
5. Occupational Therapists
6. Social workers
7. Speech therapist
8. Medical lab tech
9. Clerical

B. Factors making recruitment difficult
1. Low pay
2. Lack of qualified applicants
3. Competition for surrounding counties
4. Non-competitive salary and fringe benefits
5. Very rural area
6. Pay scale lower than private industry
7. Salaries not commensurate with educational requirements
8. No longer try to hire therapists, contract
9. General shortage of nurses
10. Poor benefits
11. Hostile working environment
12. Personnell requirements
13. Hard work/on call duty

14. No resources to recruit
15. No benefits to part-time employees

II. Recommendations

A. Statewide activities to improve public awareness of county programs
B. Public health employees' images need to be enhanced
C. Statewide activites should be developed to improve the program understanding of boards of commissioners, managers, and local agency boards.
D. Counties should be encouraged to provide attractive benefit plans as part of the overall compensation package for their employees.
E. The NCACC should negotiate as an equal partner with the Legislature and state agencies in setting policy and funding goals to meet human resource needs.

III. Objectives

A. Local salary levels in public health departments should equal 90% of state pay levels. Local and state governments must work together to find ways to secure necessary resources.
B. New public health facilities constructed in most counties.
C. Mandated basic Public Health Policy assuring minimum level of public health services in every county in this state.
D. Requirements for a well-trained public health work force.
E. Better evaluation programs to ensure that funds are being spent appropriately.

1990 AHEC Public Health Department Personnel Survey
83 of 87 North Carolina Health Departments Responding

Table I: Summary Table

Personnel	Budgeted FTE's	Vacancies	Additional FTE's Needed	Service* Gap
Nurses	1726.9	144.7	134.1	278.8
Environmental Hlth Spec	627.0	45.2	60.0	105.2
Health Educators	194.6	11.0	41.1	52.1
Social Workers	106.6	13.1	33.0	46.1
Nutritionists	228.7	27.2	26.5	53.7
Lab Personnel	159.8	6.0	25.1	31.1
Physician Extenders	188.3	21.1	24.4	45.5
Physicians	51.8	4.1	14.0	18.1
Therapists	142.9	21.0	13.0	34.0
Health Directors	81.1	3.0	1.0	4.0

* Vacancies plus additional FTE's needed in existing programs.

Proposed Mission and Essential Services for the N.C. Public Health System

Introduction

Representative Wiser, Senator Harris, and members of the commission, I am pleased to share with you a progress report from our Ad Hoc Committee. I will briefly review our report, then other members of the committee will be asked to add comments if they so desire. After that we will be happy to respond to questions.

You will recall that the committee was charged with drafting a proposed mission statement for the public health system, and a list of essential health services which should be available to people throughout the state, with the public health system having the responsibility to assure that the services are available and accessible.

Process

Before discussing our proposed mission statement and list of essential services, I would like to comment on the process we used to develop them. Dr. Levine convened the group for two days and one night in Durham. Unfortunately, Ms. Pam Silberman was unable to join us. But, all the other members were present. We worked very intensively, without being interrupted by telephones. In fact, when we were there, the telephones were out of order.

We engaged in spirited and thoughtful debate about both the mission statement and the essential services. It was a very open meeting with everyone encouraged to participate fully.

It was significant to me that we did not start with a current mission statement or list of services for the public health system. Instead, we

created our own mission statement and list of essential services. After doing so, we checked our list against the current public health standards. During our deliberations, we also reviewed mission statements and essential public health services from many other states.

We began by developing a proposed mission statement with the belief that the essential services proposed should be consistent with the mission. I should emphasize that we decided to propose a mission statement for the North Carolina Public Health System, and by Public Health System we mean the local health departments and the health divisions in the North Carolina Department of Environment, Health and Natural Resources. Our definition is not intended to embrace all activities which might be called public health, broadly speaking. Rather, it focuses on the governmental role in public health in the state.

Mission Statement

In the opinion of our committee: (Overhead I)

"The mission of the public health system is to promote and contribute to the highest level of health possible for the people of North Carolina by:

- *Identifying and reducing health risks in the community,*
- *Detecting, investigating and preventing the spread of disease,*
- *Promoting healthy lifestyles,*
- *Promoting a safe and healthful environment,*
- *Promoting the availability and accessibility of quality health care services through the private sector and,*
- *Providing quality health care services to those with limited access.*

I recognize that there may be questions or comments relating to the proposed mission statement. However, because of the relationship

between the mission statement and the list of essential services, I am going to ask that we share the list first and then have questions about both the mission and the services proposed by the committee.

Essential Public Health Services

There are several points which need to be made regarding the list of essential services which we have proposed. First, there are a number of health or health related services which the state funds and/or mandates which will not be on our list. It is important that you understand that we are not suggesting that such services are not vital to the health and well being of the people of the state. Nor are we saying that the state should in any way reduce its support for these services. What we are saying is that those services which appear on our list are essential to the health and well being of the people in our state, and the public health system should be mandated to assure that they are available and accessible. After reviewing our list of essential health services, I will point out some of the others which are vitally important but which could be the responsibility of organizations other than the public health system.

I should also emphasize that the service areas on our list are broad in scope. We have not identified all the related services which would be included under a broad service category like Maternal Health. You might say that what we have at this point is a broad outline rather than a specific plan for essential public health services.

We have not placed the services in any kind of priority order. As we review the list, you will notice that we have grouped them. The first four are what the committee views as essential health support services. They are systemwide services which are related to and required for the achievement of the other services which follow. The next two are viewed as environmental health services and the last group of seven are personal health services.

In the opinion of the committee, the following represents the Essential Public Health Services to be assured by the North Carolina Public Health System. (Overhead II)

- Assessment of health status, health needs, and environmental risks to health
- Patient and community education
- Public health laboratory
- Registration of vital events

- On-site domestic sewage disposal
- Water and food safety and sanitation

- Child health
- Chronic disease control
- Communicable Disease Control
- Dental public health
- Family planning
- Health promotion and risk reduction
- Maternal health

As I indicated earlier, it is our opinion that the public health system should be mandated to assure the availability and accessability of the above essential public health services, and the state should provide adequate funds for the public health system to do so.

Some of the vital services which are health or health related but not on our list include:

- Solid and hazardous waste
- Radiation protection
- Home health
- Purchase of medical care for individual patients (cancer, kidney, crippled children, migrant, hemophilia, sickle cell anemia)

- Occupational health
- Indigent care
- Medical examiner system

In general, the committee felt that the above services and others as well are, or could logically be, the responsibility of some organizations other than the public health system. However, it is recognized that the public health system may serve as a home for some of the above services because of specific mandates from state or local government.

Closing comments

We recognize that much more work needs to be done in preparing recommendations for the 1991 Session of the Legislature. The commission may want to get some reactions from others regarding the proposed list of essential health services. Or perhaps the commission will want to charge our committee to do some additional work in that regard.

We appreciate the opportunity to share with you our work to date.

Before we get into questions and comments by the commission, I would like to ask other members of the committee to add to my comments if they so desire.

Comments by other members of committee

Questions and comments by commission members

Presented to the Public Health Legislative Study Commission
by Richard M. House
on May 9, 1990

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-020(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Public Health Mission. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE MISSION AND ESSENTIAL SERVICES OF THE PUBLIC HEALTH SYSTEM.

The General Assembly of North Carolina enacts:

Section 1. Article 1 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-1.1. Mission and Essential Services.**

(a) The General Assembly recognizes that unified purpose and direction of the public health system is necessary to assure that all citizens in the State have equal access to essential public health services. The General Assembly declares that the mission of the public health system is to promote and contribute to the highest level of health possible for the people of North Carolina by:

(1) Identifying and reducing health risks in the community;

(2) Detecting, investigating, and preventing the spread of disease;

(3) Promoting healthy lifestyles;

(4) Promoting a safe and healthful environment;

(5) Promoting the availability and accessibility of quality health care services through the private sector, and

(6) Providing quality health care services when not otherwise available.

(b) As used in this section, the term 'essential public health services' means those services that the State shall assure because they are essential to promoting and contributing to the highest level of health possible for the citizens of North Carolina. The Department of Environment, Health, and Natural Resources shall assure that the following essential public health services are available and accessible to all citizens of the State, and shall account for the financing of these services:

(1) Health Support:
  a. Assessment of health status, health needs and environmental risks to health;
  b. Patient and community education;
  c. Public health laboratory;
  d. Registration of vital events;
(2) Environmental Health:
  a. Lodging and institutional sanitation;
  b. On-site domestic sewage disposal;
  c. Water and food safety and sanitation; and
(3) Personal Health:
  a. Child health;
  b. Chronic disease control;
  c. Communicable disease control;
  d. Dental public health;
  e. Family planning;
  f. Health promotion and risk reduction;
  g. Maternal health.

The Commission for Health Services shall determine specific services to be provided under each of the essential public health services categories listed above.

(c) The General Assembly recognizes that there are health-related services currently provided by State and local government and the private sector that are important to maintaining a healthy social and ecological environment but that are not included on the list of essential public health services required under this section. Omission of these services from the list of essential public health services shall not be construed as an intent to prohibit or decrease their availability. Rather, such omission means only that the omitted services may be more appropriately assured by government agencies or private entities other than the public health system.

(d) The list of essential public health services required by this section shall not be construed to limit or restrict the

powers and duties of the Commission for Health Services or the Department of Environment, Health, and Natural Resources as otherwise conferred by State law.

Sec. 2. This act shall become effective October 1, 1991.

EXPLANATION 91-LNU-020 PUBLIC HEALTH MISSION & ESSENTIAL SERVICES

This bill establishes the mission of the public health system and defines the essential services that shall be available and accessible to all citizens.

Section 1	Codifies the mission of the public health system in the chapter of the General Statutes pertaining to public health.
Page 1, lines 15-23 thru page 2, line 2	Indicates what activities the State will engage in to accomplish the public health mission.
Page 2, lines 3-7	Defines what is meant by "essential public health services.
Page 2, lines 7-10	Requires EH&NR to do whatever is necessary to assure that the listed essential services are available and accessible to all citizens, and requires EH&NR to account for the financing of the services.
Page 2, lines 11-28	Establishes what constitutes essential public health services.
Page 2, lines 29-31	Requires the Commission for Health Services to determine what specific services are included under each of the service headings provided in lines 11-28. For example, the Commission for Health Services must determine what kinds of services come under the essential services of "child health", or "water and food safety and sanitation".
Page 2, lines 32-42	Establishes that in stating what essential public health services shall be provided by the State, it is not the intent of the General Assembly to omit or decrease the availability of services now being provided

	that are not on the list. Rather, it is the intent of the General Assembly to prioritize public health services into those that are "essential" and thus shall be provided by the State, and those that may be more appropriately provided by entities other than the public health system.
Page 2, lines 43-44 thru page 3, line 3	Provides that the establishment of essential health services does not by itself interfere with other duties and responsibilities conferred upon the Commission for Health Services or EH&NR by State law.
Page 3, line 4	Makes the act effective October 1, 1991.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-021A(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Public Health Study. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"Article 22.

"The Public Health Study Commission.

"**§ 120-195. Commission created; purpose.**

There is established the Public Health Study Commission. The Commission shall examine the public health system to determine its effectiveness and efficiency in assuring the delivery of public health services to the citizens of North Carolina.

"**§ 120-196. Commission duties.**

The Commission shall study the availability and accessibility of public health services to all citizens throughout the State. In conducting the study the Commission shall:

(1) Evaluate whether the current organizational structure of the public health system is effective in meeting public health needs and the likelihood that such structure will be able to achieve the State's public health mandate in the future.

(2) Ascertain what public health services are currently available in each county or district health

department and the degree to which those services are meeting the health-related needs of residents served by the county or district health department;

(3) Study the personnel structure and needs of each county or district health department, including salary levels, professional credentials, and continuing education requirements, and determine the impact that shortages of public health professional personnel has on the delivery of public health services in each county or district health department;

(4) Establish a standing subcommittee of not more than eleven members to study and make recommendations on financing of the public health system. Commission cochairmen shall appoint members and non-members of the Commission to the subcommittee, provided that at least seven of the appointments shall be Commission members. The subcommittee shall consider recommendations in the 1989-90 Public Health Study Commission's final report.

(5) Determine whether there is a need for ongoing orientation and training programs for local boards of health, and, if so, what the State's role should be in assuring that such programs are available.

(6) Review the status and needs of local health departments relative to facilities, and the need for the development of minimum standards governing the provision and maintenance of these facilities.

(7) Propose a long-range plan for improving and funding the public health system, which plan shall include a review and evaluation of the current structure and financing of public health in North Carolina, and any other recommendations the Commission deems appropriate based on its study activities. The Commission may request that the long-range plan be developed by the State Health Director in consultation with the Commission for Health Services and submitted to the Study Commission for its consideration.

(8) Establish a standing subcommittee of not more than nine members to study and make recommendations on injury prevention and control. The Cochairmen of the Commission shall appoint members and nonmembers of the Commission to the subcommittee, provided

that at least five of the appointments shall be Commission members. The subcommittee shall review periodically but at least annually, the injury problem in North Carolina and make recommendations to the Commission for measures to alleviate this problem.

(9) Examine the need for additional legislation to deal with Acquired Immune Deficiency Syndrome - AIDS within this State and recommend legislation, as needed.

(10) Conduct any other studies or evaluations the Commissions considers necessary to effectuate its purpose.

"**§ 120-197. Commission membership.**

The Commission shall consist of 21 members. The Speaker of the House of Representatives shall appoint seven members, a minimum of four of whom shall be members of the House of Representatives. The President Pro Tempore of the Senate shall appoint seven members, a minimum of four of whom shall be members of the Senate. The Governor shall appoint seven members, as follows: one of whom shall be a recipient of public health services, one of whom shall be a public health director, one of whom shall be a county commissioner, one of whom shall be an advocate for low-income people who is familiar with public health services in North Carolina, one of whom shall be the Secretary of the Department of Human Resources or a designee thereof, one of whom shall be a physician licensed to practice medicine under Chapter 90 of the General Statutes, and one of whom shall be an individual involved in the administration or funding of public health services.

Vacancies shall be filled by the official who made the initial appointment using the same criteria as provided by this section. All initial appointments shall be made within one calendar month from the effective date of this Article. Members' terms shall last for two years. Members may be reappointed for two consecutive terms and may be appointed again after having been off the Commission for two years.

"**§ 120-198. Commission meetings.**

The Commission shall have its initial meeting no later than sixty days after adjournment of the 1991 General Assembly, first session, at the call of the President Pro Tempore of the Senate and the Speaker of the House of Representatives. The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall appoint a cochairman each from the

membership of the Commission. The Commission shall meet upon the call of the cochairmen.

"**§ 120-199. Commission reimbursement.**

The Commission members shall receive no salary as a result of serving on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 120-3.1, G.S. 138-5, and G.S. 138-6, as applicable.

"**§ 120-200. Commission public hearings**

The Commission may hold public hearings across the State to solicit public input with respect to issues affecting public health in North Carolina.

"**§ 120-201. Commission authority.**

The Commission has the authority to obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duties, pursuant to the provisions of G.S. 120-19, as if it were a committee of the General Assembly. The Commission shall also have the authority to call witnesses, compel testimony relevant to any matter property before the Commission, and subpoena records and documents, provided that any patient record shall have patient identifying information removed. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission as if it were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this section, the subpoena shall also be signed by the cochairmen of the Commission. Any cost of providing information to the Commission not covered by G.S. 120-19.3 may be reimbursed by the Commission from funds appropriated to it for its continuing study.

"**§ 120-202. Commission reports.**

The Commission shall report to the General Assembly and the Governor the results of its study and recommendations. A written report shall be submitted to each biennial session of the General Assembly not later than 30 days after its convening. The report made to the 1993 session shall include the long-range plan required under G.S. 120-196(7).

"**§ 120-203. Commission staff; meeting place.**

The Commission may contract for clerical or professional staff or for any other services it may require in the course of its on-going study. At the request of the Commission, the Legislative Services Commission may supply members of the staff of the Legislative Services Office and clerical assistance to the Commission as the Legislative Services Commission deems appropriate.

The Commission may, with the approval of the Legislative Services Commission, meet in the State Legislative Building or the Legislative Office Building."

Sec. 2. There is appropriated from the General Fund to the Legislative Services Commission the sum of $50,000 for the 1991-92 fiscal year and the sum of $50,000 for the 1992-93 fiscal year to fund the first two years of the Commission's study established by this act.

Sec. 3. The Department of Environment, Health, and Natural Resources shall carry out the following tasks and shall report to the Public Health Study Commission established under this act on the implementation status of each task:

(1) Implement a plan to increase the Department's capability and the capability of local health departments to secure private sector financial resources to supplement public health activities and services mandated by the State;

(2) Establish a statewide system for assessing health status and health needs in every county. In establishing the system the Department shall solicit input from private providers, community groups and agencies, the general public, and policy makers in determining commmunity health needs;

(3) Plan for the development of a computerized statewide data collection and retrieval system that will permit comparisons of State and local health data with those of the nation and of other states and localities. The system should be standardized with respect to local reporting of health status and needs, health services delivered, funds expended, and outcomes achieved, and should be adaptable to systems currently used by local health departments. In developing the Plan, the Department shall consider data collection and retrieval capabilities currently in place in the State, and shall determine the level of State funding that will be needed to implement the system statewide and to provide financial assistance to counties for local system integration into the statewide system. The Department shall present the plan to the Public Health Study Commission not later than October 1, 1992.

(4) The Commission for Health Services shall establish statewide health outcome objectives and delivery

standards, taking into account funds available to implement them. The Department shall implement statewide health outcome objectives and delivery standards established by the Commission for Health Services, and shall develop and implement a monitoring and evaluation program to measure local health department progress in applying standards and achieving objectives.

Sec. 4. This act shall become effective July 1, 1991.

EXPLANATION 91-LNU-021A PUBLIC HEALTH STUDY COMMISSION

This bill establishes a permanent Public Health Study Commission and appropriates funds in each fiscal year of the 1991-93 biennium for the Commission's study.

Section 1	Codifies the Commission in Chapter 120 of the General Statutes which pertains to the General Assembly.
Page 1, lines 7-13	Establishes the Commission and states its general purpose.
Page 1, lines 14-24 thru page 3, line 13	Sets forth specific duties of the Commission.
Page 3, lines 14-37	Establishes the Commission membership; appointing authority; categories and terms of membership.
Page 3, lines 38-44	Requires the Commission to have its first meeting not later than 60 days after adjournment of the 1991 General Assembly, first session, at the call of the President Pro Tempore of the Senate and the Speaker of the House of Representatives.
Page 3, lines 3-7	Provides for expense reimbursement for Commission members, consistent with State law governing such reimbursement.
Page 3, lines 8-29	Authorizes the Commission to hold public hearings, obtain information from State entities, subpoena witnesses and compel testimony on matters relevant to its study.
Page 3, lines 30-36	Requires the Commission to report to the General Assembly and the Governor.
Page 3, lines 37-44	Authorizes Commission to hire staff and meet in the

	Legislative Building or Legislative Office Building.
Section 2.	Appropriates $50,000 in each fiscal year of the 1991-93 bienniuim to fund the Commission.
Section 3.	Requires EH&NR to carry out specified tasks as recommended in the 1989-91 Public Health Study Commission final report to the General Assembly.
Section 4.	Makes the act effective July 1, 1991.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-024(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: State Health Projects. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES TO CONDUCT VARIOUS HEALTH-RELATED PROJECTS.

The General Assembly of North Carolina enacts:

Section 1. (a) The Department of Environment, Health, and Natural Resources shall do the following to improve the State public health system:

(1) Develop and conduct activities designed to expand the Department's capability and the capability of local health departments or districts to secure private sector financial resources to supplement public health activities and services mandated by the State.

(2) Develop a plan for the establishment of a statewide system for assessing health status and health needs in every county. In determining community health status and needs, the Department shall solicit and consider input from private providers, community groups and agencies, the general public, and policy makers.

(3) Plan for the development and implementation of a computerized statewide data collection and retrieval system that will permit comparisons of health data and indices, and that will enable local

health departments to have access to data collected. In developing the plan the Department shall consider recommendations in the 1989-90 Public Health Study Commission's final report pertaining to standardization, adaptability, and costs of integrating local data collection systems with the State system.

(4) Implement a monitoring and evaluation program to measure local health department progress in applying health outcome standards and achieving health outcome objectives established by the Commission for Health Services under G.S. 130A-29(c)(7). The Department shall conduct monitoring and evaluation on a regularly scheduled basis, and shall provide assistance to local health departments that are having difficulty meeting objectives.

(b) The Department of Environment Health and Natural Resources shall report to the North Carolina Public Health Study Commission, if the Commission is established by the General Assembly, on the status of each project in subsection (a) of this section. The Department shall report to the Commission at the Commission's request. If the General Assembly does not establish the North Carolina Study Commission on Public Health, then the Department shall report the status of the project activity required under subsection (a) to the Joint Legislative Commission on Governmental Operations in March, 1992.

Sec. 2. G.S. 130A-29 reads as rewritten:

"**§ 130A-29. Commission for Health Services -- creation, powers and duties.**

(a) The Commission for Health Services is created with the authority and duty to adopt rules to protect and promote the public health.

(b) The Commission is authorized to adopt rules necessary to implement the public health programs administered by the Department as provided in this Chapter.

(c) The Commission shall adopt rules:

(1) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1022, s. 5.

(2) Establishing standards for approving sewage-treatment devices and holding tanks for marine toilets as provided in G.S. 75A-6(o);

(3) Establishing specifications for sanitary privies for schools where water-carried sewage facilities are unavailable as provided in G.S. 115C-522;
(4) Establishing requirements for the sanitation of local confinement facilities as provided in Part 2 of Article 10 of Chapter 153A of the General Statutes; ~~and~~
(5) Repealed by Session Laws 1989 (Regular Session, 1990), c. 1075, s. 1, effective July 28, 1990.
(6) Requiring proper treatment and disposal of sewage and other waste from chemical and portable ~~toilets.~~ toilets; and
(7) Establishing statewide health outcome objectives and delivery standards.

(d) The Commission is authorized to create:
(1) Metropolitan water districts as provided in G.S. 162A-33;
(2) Sanitary districts as provided in Part 2 of Article 2 of this Chapter; and
(3) Mosquito control districts as provided in Part 2 of Article 12 of this Chapter.

(e) Rules adopted by the Commission for Health Services shall be enforced by the Department of Environment, Health, and Natural Resources."

Sec. 3. This act is effective upon ratification.

EXPLANATION 91-LNU-024 STATE HEALTH PROJECTS

This bill directs the Department of Environment, Health, and Natural Resources to conduct various public health related projects, and directs the Commission for Health Services to establish health-related standards.

Page 1, lines 5-24 thru page 2, line 17	EH&NR must conduct projects listed in subdivisions (1) through (4).
Page 2, lines 18-27	EH&NR must report to the permanent Public Health Study Commission on the status of each project listed in subsection (a). If the permanent Commission is not established, EH&NR must report on project status to Governmental Operations.
Page 3, lines 13-14	Directs the Commission for Health Services to establish statewide health outcome objectives and delivery standards.
Page 3, line 25	Act is effective upon ratification.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-023A(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Public Health Salary Funds. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES FOR ALLOCATION TO ELIGIBLE COUNTIES TO INCREASE SALARY RANGES OF CERTAIN PUBLIC HEALTH WORKERS.

WHEREAS, the General Assembly recognizes that the accomplishment of its public health mission depends in large part upon the employment of well qualified and dedicated public health employees in local health departments; and

WHEREAS, limited local resources and competition from private sector employment has seriously eroded the capability of local health departments to recruit and retain qualified public health personnel; and

WHEREAS, vacancies in critical public health employment positions due, in part, to private sector competition have reduced the efficiency and effectiveness of local health departments in delivering State-mandated public health services to local communities; Now therefore,

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources the sum of $1,937,322 for the 1991-92 fiscal year and the sum of $1,937,322 for the 1992-93 fiscal year for allocation to eligible counties as incentive funds to increase the salary ranges and

related fringe benefits for public health directors, public health nurses, health educators, and environmental specialists. Counties eligible for funds under this act are those who apply for such funds to the Department and whose salary ranges as of July 1, 1990 for public health directors, public health nurses, health educators, or environmental specialists are below 90% of the State recommended salary range for those positions. Counties that are part of a district health department may apply for incentive funds provided that all counties comprising a district health department apply jointly for funds to the Department. The Department shall allocate sufficient funds to each eligible county to raise the salary range for public health director, public health nurse, health educator, or environmental specialist positions, as appropriate, to at least 90% of the State recommended salary range. Counties may phase-in the salary range increase over the 1991-93 biennium. Funds allocated to counties for public health salary incentives under this act shall be used to supplement and not supplant local funds allocated for public health services.

Sec. 2. The Department of Environment, Health, and Natural Resources shall establish guidelines for administering salary incentive funds appropriated under this act. Of the funds appropriated in section 2 of this act, the Department may use up to $33,000 in each fiscal year for administrative costs.

Sec. 3. This act becomes effective July 1, 1991.

EXPLANATION 91-LNU-023A PUBLIC HEALTH SALARY FUNDS

This bill appropriates money to the Department of Environment, Health, and Natural Resources for allocation to eligible counties sufficient funds to increase the salary ranges of public health directors, public health nurses, health educators, and environmental specialists.

Page 1, lines 20-24 thru page 2, line 2	Appropriates $1,937,322 in each fiscal year of the 1991-93 biennium to EH&NR for allocation to eligible counties to increase salary ranges and related fringe benefits for public health directors, public health nurses, health educators, and environmental specialists.
Page 2, lines 3-10	Counties eligible for funds under this act are those who apply for the funds and whose salary ranges for the specified positions are below 90% of the State recommended salary range for the positions. Counties that comprise a district health department must apply jointly for funds.
Page 2, lines 11-16	Directs EH&NR to allocate monies to eligible counties that apply. Permits counties to phase-in the salary increase over the 1991-93 fiscal year period. State funds allocated under this act may not be used to supplant local funds allocated for public health services.
Page 2, lines 20-24	Requires EH&NR to establish guidelines for administering funds under this act. Department may use up to $33,000 in each fiscal year for administrative costs.
Page 2, line 25	Act is effective July 1, 1991.

EXPLANATION 91-LNU-022 ENVIRONMENTAL SPECIALISTS FUNDS

This bill appropriates money to the Department of Environment, Health, and Natural Resources for allocation to counties to assist in salary expenses for environmental health specialists.

Page 1, lines 19-23	Appropriates $1.9 million to the Department in each fiscal year of the 1991-93 biennium to assist with salary-related costs for one environmental health specialist in each county.
Page 1, line 24 thru page 2, line 2	Directs the Department to allocate $19,000 in each fiscal year of the 1991-93 biennium to each of the 100 counties for the purpose stated in section 1.
Page 2, lines 2-4	Directs that the $19,000 allocated to each county may not be used to supplant local funds allocated for public health purposes.
Page 2, line 5	The act is effective July 1, 1991.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-022(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Environmental Specialist Funds. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES FOR ALLOCATION TO COUNTIES TO ASSIST WITH ENVIRONMENTAL SPECIALIST SALARY EXPENSES.

WHEREAS, economic development throughout the State has contributed to increases in the number of business establishments covered by State and local sanitation inspection requirements; and

WHEREAS, sanitation inspections to ensure compliance with public health laws are the joint responsibility of the State and local health departments; and

WHEREAS, financial resources have not kept pace with increased demands on local health department personnel charged with conducting sanitation inspections; and

WHEREAS, public health policy and laws of this State are developed and enacted to preserve and protect the health of its citizens; Now therefore,

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources the sum of $1,900,000 for the 1991-92 fiscal year and the sum of $1,900,000 for the 1992-93 fiscal year to assist with salary and related costs for one environmental specialist in each county. From the funds appropriated in this act, the Department shall

allocate $19,000 to each county for each fiscal year for this purpose. State funds appropriated under this act shall be used to supplement and not supplant local funds allocated for public health purposes.

Sec. 2. This act shall become effective July 1, 1991.

EXPLANATION **91-LNU-022** **ENVIRONMENTAL SPECIALISTS FUNDS**

This bill appropriates money to the Department of Environment, Health, and Natural Resources for allocation to counties to assist in salary expenses for environmental health specialists.

Page 1, lines 19-23	Appropriates $1.9 million to the Department in each fiscal year of the 1991-93 biennium to assist with salary-related costs for one environmental health specialist in each county.
Page 1, line 24 thru page 2, line 2	Directs the Department to allocate $19,000 in each fiscal year of the 1991-93 biennium to each of the 100 counties for the purpose stated in section 1.
Page 2, lines 2-4	Directs that the $19,000 allocated to each county may not be used to supplant local funds allocated for public health purposes.
Page 2, line 5	The act is effective July 1, 1991.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-025A(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Health Director Qualifications. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE QUALIFICATIONS FOR THE POSITION OF LOCAL HEALTH DIRECTOR, AND TO ESTABLISH A HEALTH DIRECTORS QUALIFICATION REVIEW COMMITTEE.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 1992, G.S. 130A-40 reads as rewritten:

"**§ 130A-40. Appointment of local health director.**

(a) A local board of health, after consulting with the appropriate county board or boards of commissioners, shall appoint a local health director. ~~The State Personnel Commission, after consulting with the Commission for Health Services, shall establish qualifications for a local health director. The qualifications shall give equal emphasis to education and experience. However, a local health director shall not be required to be a physician.~~ Effective January 1, 1992, all persons who are appointed to the position of local health director on or after that date, must possess minimum education and experience requirements for that position, as follows:

(1) A medical doctorate and at least one year of experience managing health programs or health services; or

(2) A Master's degree in Public Health Administration, and at least one year of experience managing health programs or health services; or

(3) A Master's degree in a public health discipline other than public health administration, and at least three years of experience in managing health programs or health services; or

(4) A Master's degree in a field related to public health, and at least three years of experience in managing health programs or health services.

(b) Before appointing a person to the position of local health director under subsection (a)(4) of this section, the local board of health shall forward the application and other pertinent materials of such candidate to the Local Health Director Qualification Review Committee. If the Review Committee determines that the candidate's Master's degree is in a field not related to public health, the Review Committee shall so notify the local board of health within 45 days of the Committee's receipt of the application and materials, and such candidate shall be deemed not to meet the education requirements of subsection (a)(4) of this section. If the Review Committee fails to act upon the application within 45 days of its receipt of the application and materials from the local board of health, the application shall be deemed approved with respect to the education requirements of subsection (a)(4), and the local board of health may proceed with its appointment process.

(c) When a local board of health fails to appoint a local health director within 60 days of the creation of a vacancy, the State Health Director may appoint a local health director to serve until the local board of health appoints a local health director in accordance with this section."

Sec. 2. Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-40.1. Local Health Director Qualification Review Committee.**

(a) A Local Health Director Qualification Review Committee is established within the Office of State Personnel to review the education qualifications of candidates for local health director positions under G.S. 130A-40(a)(4).

(b) The Office of State Personnel shall provide staff assistance to the Committee.

(c) The Committee shall consist of three members, one of whom shall be the Dean of the School of Public Health at the University of North Carolina, one of whom shall be the President

of the Association of Local Health Directors, and one of whom shall be the State Health Director.

(d) The Review Committee shall meet within 30 days of notification from a local board of health requesting a determination on whether an applicant for the position of local health director under G.S. 130A-40(a)(4) meets the education requirements of G.S. 130A-40(a)(4). The Review Committee shall act upon requests under its review within 45 days of receipt of applications and pertinent materials from the local board of health, and shall notify the local board, in writing, of its decision within the 45 day period. The Review Committee shall, by majority vote, determine a candidate's qualification under subsection (a)(4) of this section based solely on whether the candidate's Master's degree field is related to public health. If the Review Committee determines that a candidate's degree field is not related to public health, the Committee shall state the reasons therefor in its written decision to the local board.

(e) The Review Committee shall review requests of educational institutions to determine whether a particular masters degree offered by the requesting institution is related to public health for the purposes of G.S. 130A-40(a)(4). The Review Committee shall act upon such requests within 90 days of receipt of the request and pertinent materials from the institution, and shall notify the institution of its determination in writing within the 90 day review period. The determination shall be by majority vote of the Review Committee. If the Review Committee determines that an institution's particular masters degree is not related to public health, the Review Committee shall include the reasons therefor in its written determination to the institution.

(f) Members of the Committee shall receive per diem and necessary travel and subsistence expenses as provided in G.S. 138-5."

Sec. 3. This act is effective upon ratification.

EXPLANATION 91-LNU-025A HEALTH DIRECTOR QUALIFICATIONS

This bill establishes the qualifications for local health directors, and establishes a committee to review applications of persons who do not have a Masters Degree in Public Health to determine if the academic area of their degree is sufficiently related to public health to meet the qualifications.

Page 1, lines 9-19	Requires that all persons appointed to the position of local health director on or after January 1, 1992, must possess the qualifications set forth in this section.
Page 1, lines 20-22 thru page 2, line 10	Requires that a person hired as local health director must be qualified under one of the four qualifications subdivisions of this section.
Page 2, lines 11-26	If a local board of health wants to hire an applicant for local health director, which applicant purports to qualify under subdivision (a)(4) of this section, the board must first forward the application materials of that applicant to the Local Health Director Qualification Review Committee. If the Committee determines that such candidate's master's degree is in a field that is not related to public health, then the Committee must notify the local board of this and the board may not appoint the candidate. If the Committee does not act upon an application within 45 days of receipt, then the applicant will be deemed qualified under subsection (a)(4) and the local board may proceed with the appointment process.
Page 2, lines 34- 44 thru page 3, line 32	Establishes the Local Health Director Qualification Review

	Committee within the Office of State Personnel. Members of the Committee are the State Health Director, Dean of the School of Public Health at UNC, and President of the Local Health Directors Association. The Committee may only review the qualifications of candidates who apply under subsection (a)(4) based on whether the degree is related to public health. Committee shall review requests of educational institutions to determine whether a particular master's degree offered by the requesting institution is a degree related to public health. The Committee shall act by majority vote.
Page 3, line 33.	Act is effective upon ratification.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-026(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Health Director Orientation. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A HEALTH DIRECTOR ORIENTATION PROGRAM WITHIN THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES.

The General Assembly of North Carolina enacts:

Section 1. Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-14. Local Health Director Orientation Program.**

The Department shall establish and implement statewide a program to coordinate and strengthen orientation programs for local health directors. In establishing the program the Department shall consider input from the School of Public Health of the University of North Carolina at Chapel Hill, the Institute of Government, Area Health Education Centers, and other appropriate agencies. All local health directors with less than two years experience as local health director in North Carolina shall attend a minimum number of orientation program hours during the first two years of employment as health director. The Department shall establish minimum attendance hour requirements for local health directors.

Local health departments shall permit local health directors to attend orientation sessions during working hours, as necessary, to comply with minimum attendance hour requirements established by the Department. The Department shall reimburse local health departments for tuition, travel, or other actual costs incurred

to comply with the Department's minimum attendance requirements. Minimum attendance requirements of this section are applicable only to the extent that funds for travel, tuition and other program costs are appropriated to the Department for that purpose by the General Assembly, or are otherwise available to the Department from other sources."

Sec. 2. There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources the sum of $10,000 for the 1991-92 fiscal year and the sum of $20,000 for the 1992-93 fiscal year for travel, tuition, and other program costs of the Local Health Director Orientation Program established in section 1 of this act.

Sec. 3. This act is effective upon ratification and applies to local health directors who have less than two years experience beginning January 1, 1992.

EXPLANATION 91-LNU-026 HEALTH DIRECTOR ORIENTATION PROGRAM

This bill establishes within the Department of Environment, Health, and Natural Resources, a program to strengthen and coordinate orientation programs for local health directors, and appropriates funds to carry out the program.

Page 1, lines 7-19	Establishes the Health Director Orientation Program within EH&NR. Directs EH&NR to consider input from specified sources when developing the program. Requires all local health directors who have less than 2 years experience as local health directors in N.C. to attend a minimum number of orientation hours established by EH&NR.
Page 1, lines 20-24 thru page 2, line 6	Directs local health departments to permit local health directors to attend orientation programs during working hours, if necessary, to comply with minimum attendance hour requirements. Requires Department to reimburse local health departments for tuition, travel or other actual costs incurred by local health directors attending in compliance with minimum hour requirements. Provides that minimum hour requirements are only applicable to the extent that funds are appropriated by the General Assembly to pay tuition, travel, and other reimbursable costs.
Page 2, lines 7-12	Appropriates money in each fiscal year to cover the cost of reimbursing for attendance at orientation programs.
Page 2, lines 13-15	Act effective upon ratification and applies to local health directors who have less than

two years experience beginning January 1, 1992.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

S/H **D**

91-LNU-027(1.1)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Health Director Interns. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE HEALTH DIRECTOR INTERN PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-14. Health Director Intern Program.**

(a) There is established in the Department of Environment, Health, and Natural Resources, the Health Director Intern Program. The purpose of the program is to address problems in recruiting local health directors who have experience in the administration of public health programs, by providing an opportunity for qualified individuals to serve internships in selected local health departments as assistants to the health director.

(b) The Department shall develop a Health Director Intern Program for the implementation of internship projects in local health departments. The Department shall develop a process whereby each county may apply to the Health Director Intern Committee to participate in the program as one of the five project sites. If application is made for a project site to be located in a district health department, the application shall be jointly filed by the counties constituting the district health department. Interns shall be selected by the local board of

health of the participating health department in accordance with qualifications established by the Health Director Internship Committee, and shall serve for an internship period of two years; provided, however, that interns hired for the first two years in which the Health Director Intern Program is implemented may serve for less than two years to accommodate program or project start-up requirements. Interns shall be local government employees for the duration of the internship. Not more than fifty percent of the salary and benefits expense for each intern shall be paid from State funds that are appropriated exclusively for that purpose.

At the end of the fifth year of implementation of the Health Director Intern Program, the Department shall report to the Joint Legislative Commission on Governmental Operations on whether the Program is serving the purpose for which it was established."

Sec. 2. Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-15. Health Director Intern Committee; membership, duties.**

(a) The Health Director Intern Committee is established within the Department of Environment, Health, and Natural Resources.

(b) The Committee shall consist of four members, as follows:

(1) The State Health Director, or his designee;

(2) The President of the Local Health Directors Association, or his designee;

(3) The President of the North Carolina Public Health Association, or his designee; and

(4) A representative of the County Commissioners Association, appointed by the Governor.

(c) The Committee shall have the following duties and responsibilities:

(1) Development of criteria for the selection of project sites;

(2) Development of qualifications for interns;

(3) Review and selection of applicants for participation as project sites;

(4) Development of criteria for long and short-range evaluation of the program; and

(5) Other activities as may be necessary to assist the Department in the administration of the Health Director Intern Program.

(d) Members of the Committee shall receive per diem and necessary travel and subsistence expenses in accordance with Chapter 138 of the General Statutes.

(e) The Department shall provide staff assistance to the Committee.

Sec. 3. There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources the sum of $130,826 for fiscal year 1991-92 and the sum of $180,905 for fiscal year 1992-93 to establish and support five, two-year project sites for the Health Director Internship Program established in section 1 of this act. Of the funds appropriated under this section, the Department may use up to $4,500 in each fiscal year for administrative costs of the Health Director Intern Program.

Sec. 4. This act becomes effective July 1, 1991 and shall expire July 1, 1997.

EXPLANATION 91-LNU-027 HEALTH DIRECTOR INTERN PROGRAM

This bill establishes within the Department of Environment, Health, and Natural Resources a Health Director Internship Program, and appropriates funds for the implementation of the program.

Page 1, lines 7-15	Establishes in EH&NR the Health Director Intern Program, and states the prose of the program.
Page 1, lines 16-24 thru page 2, line 11	Directors EH&NR to develop the program for implementation of internship projects in local health departments. Department shall develop a process whereby counties may apply for participation as project site. Interns shall be selected and hired by local board of health in accordance with qualifications established by the Health Director Intern Committee. Internships shall be for a period of two years; interns shall be local employees for the duration of the internship. The State shall pay 50% of the salary and benefits expense for each intern.
Page 2, lines 12-15	EH&NR must report to Governmental Operations at the end of the fifth year of the program.
Page 2, lines 18-44 thru page 3, line 2	Establishes a Health Director Intern Committee in EH&NR; sets membership of Committee and duties. Department provides staff assistance to Committee.

Page 3, lines 3-11	Appropriates money in each fiscal year of the biennium to implement the program. Authorizes EH&NR to spend $4,500 in each fiscal year for administrative costs.
Page 3, lines 12-13	Act becomes effective July 1, 1991 and expires July 1, 1997.