Testimony before the Local Unit Alignment Reorganization and Consolidation Commission
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Good morning Chairman Fisher, and members of the Committee. Thank you for the opportunity to speak today about opportunities to provide the best public health service to the citizens of New Jersey. My name is David Gruber, Senior Assistant Commissioner, at the Department of Health and Senior Services. I supervise the Division of Health Infrastructure Preparedness and Emergency Response at the Department. The Division of Health Infrastructure Preparedness is responsible for our state's local and regional health departments. On behalf of Commissioner Heather Howard, I am here to address any issues you may have regarding New Jersey's public health system. I've been asked to describe our current public health infrastructure, its administrative responsibilities, services, and the impact of consolidation.

In support of this testimony, I will first describe our public health system, discuss the results of a DHSS study focusing on local health operations and finances, provide an overview of the different options available to jurisdictions, and finally address specific questions advanced by the LUARC Commission.

The New Jersey Public Health System

DHSS has the statutory authority to promulgate minimum standards for local public health services. These are contained in the rule: Public Health Practice

Standards of Performance for Local Boards of Health in New Jersey (NJAC 8:52) and based on the nationally accepted Ten Essential Public Health Services listed below:

1. Monitor of community health status;
2. Protect people from health problems and health hazards;
3. Give people the information they need to make healthy choices;
4. Engage the community to identify and solve health problems;
5. Develop public health policies and plans;
6. Enforce public health laws and regulations;
7. Help people receive health services;
8. Maintain a competent public health workforce;
9. Evaluation and improve programs; and
10. Contribute to and apply the existing body of knowledge regarding public health.

Included in these services are the core services of communicable disease investigation, inspection, and emergency response.

The Practice Standards set forth minimum standards for local health departments (for example, minimum qualifications for staff) but are not prescriptive as to the services to be performed by each health department. Recognizing that there are significant differences in the populations served by local health departments and their needs, the Practice Standards require that each local health department “assure”, not “provide” these services. The local health department may provide certain services itself, contract with another agency, or determine that a particular need is adequately met by other health care providers or agencies.

Outside of the Practice Standards, there are a number of other State statutes and/or rules that delegate to the local health departments the responsibility for addressing particular public health problems. This set of rules, referred to as the State Sanitary Code, include investigation of communicable diseases,

immunization of school-age children, and oversight over a number of environmental and sanitary public health concerns, such as restaurants and other retail food establishments, private wells and septic systems, public bathing places, campgrounds, youth camps, and lead-based paint. However, because the regulated facilities under the Code are not present in all communities, not all local health departments perform these functions.

Organizational Structure of Public Health Services

Municipal government has the primary responsibility for local public health services and the municipality may meet this requirement by:

- maintaining a municipal health department;
- a shared services agreement with another municipality;
- participating in a regional health commission; or
- agreeing to come under the jurisdiction of, a county health department.

This has resulted in a diverse structure of 111 local health departments covering the State's 566 municipalities. [Note: this number is different than in our report, due to a recent consolidation.]

521 municipalities (92%) participate in some form of shared services arrangement for local public health services. Only 45 municipalities, many of which are large cities, have stand-alone municipal health departments.

Counties are authorized, but not required, to establish county health departments.

- Twenty of the 21 counties have some form of county health department (Who Doesn't)

- In fifteen counties the county health department provides the same core public health services as are provide by municipal health departments within that county

- In 8 counties, the county health department covers the whole county; these are all in the formerly rural areas in the Northwest and South Jersey.

- In 7 counties, the county health department covers some municipalities, while local health departments cover the remaining municipalities.

- All county health departments also perform specialized environmental services under the authority of the County Environmental Health Act (CEHA).

Study Results

As noted in my opening statement, DHSS conducted a study of local health department operations and finances during CY2006-07. Local health departments self-reported data elements either through the DHSS required Annual Report or surveys, therefore, our conclusions are limited by the constraints of self-reported data.

The cost per capita of providing public health services varies widely among local health departments with differences appearing to be related to the number and complexity of the services provided rather than to the size or the organizational structure of the local health department. There is not a strong correlation between the size of local health department and its operating cost per capita. The correlation is between the cost and the number of provided services.

Based on this data, we were unable to determine any clear evidence that consolidation of local health departments into larger units will guarantee a reduction in the cost per capita of providing services.

There are significant differences in the services provided by local health departments, depending upon local needs and the preferences of local elected officials. Local governing bodies frequently direct local health departments to perform tasks other than the core public health services. Which services a local health department provides directly affects costs.

Local government revenues are the sole or primary funding source for most local health departments, particularly municipal health departments. In the case of smaller municipal local health departments, the limited revenues available impact their ability to provide services and the quality of those services.

The primary finding of this study is that the “home rule” philosophy of government in New Jersey and the reliance on local tax revenue as the primary source of funding has resulted in a local public health system that is largely determined by, and responsive to, the needs of local communities and the priorities of local government officials.

The Department does view with concern how to effectively coordinate the activities of this structure so that it functions as a cohesive system in responding to public health challenges that are not local, but regional or statewide in scope.

Comparison with other States

Public health services in most other States are organized at the county level, with municipal health departments primarily in large cities.

In addition to New Jersey, only Connecticut and Massachusetts have public health services provided primarily at the municipal level. Both States have initiated efforts to consolidate single municipality health departments into larger regional units. As in New Jersey, the primary concerns driving these initiatives have been reducing the cost of services and better coordination of response to

public health emergencies and other large scale events. Both States are looking to create structures similar to the regional health commissions that are already an option here in New Jersey.

Regarding funding, a comparison of NJ data to a 2005 NACCHO survey of local health departments that indicated NJ local health departments are more dependant on local revenues that in any other State. State funding has been the primary mechanism used in other States to ensure compliance with uniform standards. For example, the way that Connecticut is promoting regionalization of local health departments is by providing a higher per capita rate of State aid for regional health departments than for single municipality health departments.

Potential Options for New Jersey's Public Health System

1. Make public health a county responsibility
    - Where they exist, county health departments have proven to be an effective means to provide public health services.
    - Potential cost savings due to economies of scale, particularly through consolidation of management and administrative functions.
    - Countywide tax base can equalize disparity among municipalities in ability to raise funds to support services
    - Historically, county health departments have been more successful than municipal health departments in attracting outside (State/Federal) funds, thus reducing burden on local tax base.
    - Would require repeal/revision of multiple statutes

    Concerns
    - Capability of county health departments to meet the needs of the largest municipalities.
    - Some urban counties – Essex, Hudson, and Union – currently do not have full-service county health departments. It will take time and

significant political will to develop effective county health agencies in these counties, whereas municipal and regional health departments in these counties are already functioning well in most cases.

2. Provide additional incentives to promote consolidation and shared services contracts
    - Funding for a “SHARE”-like program, specifically for public health, to support studies and/or implementation of local health department consolidation into county health departments, creation of new regional health commissions, or expansion of shared services agreements among municipalities
    - Revision of funding standards to promote larger public health agencies. The current minimum population to receive State Aid (Public Health Priority Funding) is 25,000 – unchanged since 1956.

    Concern
    - Planning for regional sharing of services needs to done in such a way as to promote effective provision of public health services, not simply to save money. The current system of inter-local agreements has promoted competition among local health departments to attract municipalities away from other health departments in order to increase their revenue base, which creates conflicts that inhibit collaboration among local health departments to meet regional public health challenges.

3. Allow current trends to continue to evolve
    - The number of local health departments has been decreasing in recent years – from in 115 in 2004 to 111 in 2008.

Concerns

- This trend has not been entirely in the direction of fewer/larger health departments. During this same period, two new single municipality health departments were created.
- Same concern as for #2 above. The current system promotes competition for municipalities (which health department can provide the service for less) that can result in cost savings but undermines collaboration on responding to critical public issues.

With your permission, I'd now like to address some specific questions that have been passed to the Department in advance of this testimony.

1. Status of DHSS efforts (Study and CDC Performance Appraisal Tool)

The Department has reached an agreement with PHACE – the Public Health Associations Cooperative Effort – an organization representing all of the statewide public health professional organizations, to collaborate in conducting the State Public Health System Performance Assessment. A steering committee has been formed to direct this effort. The current plan is to convene a statewide meeting to complete the CDC assessment instrument during the 2nd quarter of CY2009.

The Department has also begun working on the other studies recommended in the report. Stakeholder committees have been formed review the *Practice Standards* and the Health Officer licensure rules. We are in process of obtaining approval of an outside contractor to advise us on revision of the Local Health Evaluation Report. Staff from the Office of Public Health Infrastructure has begun conducting site visits to evaluate local health departments.

2. Correlate Practice Standards with actual LHD activities (Study Table 7, 10).

Table 7 lists all the services that are covered either by the *Practice Standards* or the State Sanitary Code. These are the services that a local health department is responsible for making sure are available in each community, if needed. But not all communities need every one of these services. For example, not every community has a public beach or swimming pool. And a local health department may not need to directly perform a particular service (for example, counseling pregnant women) if the communities need is already being met by someone else. Therefore, data will not necessarily match requirements and actually LHD performed activities. There will be a match between requirements and assurance of requirements.

3. Explain why Table 7 "13 core activities and Table 8 list of activities correlated to the "core activities" are not identical.

The question about the required core activities is addressed under the question above.

Table 8 was developed from a national survey performed by the National Association of County and City Health Officials (NACCHO). The 60 services listed represent the services commonly provided by local health departments across the United States. This list, which goes far beyond the services covered by New Jersey's *Practice Standards* and Sanitary Code, illustrates the diversity among local health departments across the country. For example, in some parts of the country, the local health department is the primary provider of primary care medical services, particularly in rural areas; with the large number of medical providers in NJ, very few local health departments NJ provide direct medical care. Another example, in some cities the health department runs the emergency medical services; EMS in NJ is provided by other public and private agencies and not by health departments.

There is no national standard as to what are the "core activities" of local health departments. Where States do have standards, they differ from State to State. The closest thing to a national consensus is the "Operational Definition of a Local Health Department", developed by NACCHO. Our NJ *Practice Standards* align very closely with the Operational Definition, which contains recommendations for the organizational structure of the department.

4. Who is responsible for ensuring a local department "contracts" for services that they do not provide?

Many local health departments do contract, either formally or informally, with other entities that provide public health services. It is the responsibility of the local Board of Health, which represents the local community, to see to it that affected clients are informed of what is available to them and where to access it. With the current reporting system, it is difficult for the Department to track and verify these arrangements. However, as part of our auditing procedure, we have begun to assess this type of information and, with a new reporting system; we have increased our ability to collect this information.

5. Table 10 list "services provided" as determined by local health officers. Again, are these correlated to "required activities" and if so, then why the wide variation in performance?

Table 10 was compiled by the New Jersey Health Officers Association. It is meant to be a comprehensive list of all NJ local health departments' activities, but no local health department does everything on this list. The extent of the services included goes far beyond the services addressed in State statutes or rules. This list demonstrates the great variety in the kind of services that local officials believe are needed from their local health department.

6. How can a local department be said to be providing "local public health services" given the fewness of activities provided by some departments as delineated in tables 8 and 9?

There are small local health departments serving a single municipality or a small number of municipalities in affluent suburban or rural areas that have only the most basic public health needs and are able to meet the minimum requirements of the *Practice Standards* by addressing only those needs.

Since the report primarily focuses on the cost of local public health in NJ, these tables show only those services directly provided by the local health department. There are likely to be other services that these local health departments have arranged for through contracts with other entities, or that the local health department has identified are already done by some other provider.

7. What specific services/activities (not generalized responsibilities) are actually required in NJ to assure reasonable public health safety? What authority does the Department have to determine and require these essential services/activities? How can the Department insure that in fact the "core public health functions' are being provided to the citizenry of the state?

The Department has statutory authority to set "minimum standards" for local boards of health. The specific services required by the Sanitary Code are each authorized by separate statutes.

The Department ensures that local health departments are providing these services through a number of mechanisms: a) local health departments submit an annual Local Health Evaluation Report, b) enforcement of the Sanitary Code requirements are reported to the various Divisions of the Department responsible for each specific requirement, and c) the Department has begun making site visits to evaluate local health departments.

8. Assuming all local health departments provide services directly or indirectly (through a publicized contract or inter-local service arrangement) do they provide a specific report to the State on why such services / activities are not required in their geopolitical area?

Local health departments must provide or ensure services either directly or indirectly. With respect to services which are not required in a geopolitical area, each health department is required to participate in a regional (county-based) process which assesses the public health needs of the communities therein and make recommendations for best meeting those needs.

9. Why LINCS?

LINCS deals primarily with public health emergency preparedness and response, not routine public health services. It is an acknowledgement that public health emergencies are not likely to be limited to a particular municipality, and therefore separately developed plans for each municipality would not be adequate to address a widespread emergency incident. The other intent of LINCS is to provide specialized expertise not otherwise available to all local health departments. Both LINCS and the Governmental Public Health Partnerships were established to promote improved coordination and collaboration between local health departments on areas of common concern. They are not necessarily a judgment on the ability of local health departments to provide local services to their own communities.

10. Is state law is in an impediment to redesigning the public health delivery system?

We have been told on numerous occasions that the current statutes have been an impediment to consolidation of local health departments. According to the Local Health District Act of 1951, if a health department is absorbed or consolidated with another LHD, all FTEs are guaranteed comparable duties and compensation. These statutory provisions were originally adopted to address concerns of local health department employees regarding their job security so as to gain their support for a previous initiative to promote larger public health jurisdictions. This guarantee that the employees would not lose their jobs if consolidation occurred was intended to gain the employee's acceptance of consolidation. This has in many cases resulted in the opposite affect as absorbing LHDs cannot afford or are not willing to accept these costs and additional employees.

11. Why the huge variation in the local department performance of core public health activities?

The differences reflect both variances in community needs and variances in public officials' perceptions of their community's needs, and what they are willing to fund. This variance is the inevitable result of a system based on "home rule."

12. What is the correlation between the service activities and costs?

A comparison of local health department costs in relation to services received by the community is potentially misleading. While small and larger municipalities may not be getting the same amount of services, they also are not paying for unnecessary services. For example, childhood lead poisoning prevention is a "core" public health service, but communities with low lead poisoning rates don't need the same level of services as communities with high rates.

13. The report implies that larger scale organization, serving larger population bases (or land areas) are providing needed services in a far more cost effective manner than many small departments. If this is so, should the State be forcing the creation of these larger more cost effective and service response agencies as the preferred mechanism?

Many previous studies of public health in New Jersey, going back to the 1930s, have reached this same conclusion. But there has never been a politically viable consensus as to what the "larger scale organization" is, or how it would be funded.

Any major reorganization of the public health structure in New Jersey will have to include a reassessment of the underlying statutes and funding mechanisms. Currently, the municipality has the primary responsibility for identification of services and is the primary funding source. In most other States, State government is either the direct provider of public health services through local offices of the State Health Department, or the State provides a substantial percentage of the funding for local public health services, and thereby has greater control over what they do. Any increase in State oversight of local health departments to ensure that particular services or being performed and/or that they are meeting any other requirements will require increased spending at the State level to monitor their performance.