A Study of New Jersey's Local Public Health System

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Executive Summary

This study addresses New Jersey's public health system to include structure, function, funding, and services. The goal is assessment of the efficacy of the system and identification of paths for improvement, continued quality provision of services, and means for implementing efficiencies in response to public health challenges that are local, regional, and statewide. The study considers the need to continuously strengthen the State's overall public health infrastructure without disrupting in-place strengths.

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. Although generally responsive to the local community, the system faces obstacles in dealing with routine and emergency regional and statewide events and is generally underfunded. Initial analysis of the available data does not provide a compelling case for recommending significant structural changes to the organization of local public health in New Jersey.

Overall Structure and Function

The organizational structure of local public health in New Jersey differs from that in the other 49 states in several significant ways including the composition of geographical area served, accountability, and jurisdiction. Compared to other states, New Jersey is also unique in that it is the only state that requires licensure of Health

Officers. Moreover, New Jersey compares less favorably in its level of state funding than in other states.

Municipal government has the primary responsibility for local public health services in New Jersey, and there is State statutory provision for providing these services. This has resulted in a diverse structure of 112 local health departments covering the State's 566 municipalities to include municipal health departments, regional health commissions and county health departments. Five hundred and twenty (520) municipalities participate in shared services arrangement for local public health services. The remaining 46 municipalities, many of which are large cities, have stand-alone municipal health departments.

Counties are authorized, but not required, to establish county health departments. Nineteen county health departments serve twenty of New Jersey's twenty-one counties and provide local public health services for a majority (59%) of the State's municipalities. Fourteen county health departments provide local public health services to some or all municipalities in their county.

The number and types of services provided and people employed by local health departments vary widely, largely dependant on the size and nature of the communities served. Most commonly performed services include clinical preventive services, immunizations, communicable disease investigations, environmental health inspections, community health education and emergency planning and response. Where the funding comes from significantly influences health department functions and focus.

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

regional and two city health departments are designated by the Department of Health and Senior Services (the Department) as LINCS (Local Information Network and Communication System) agencies, responsible for coordinating public health emergency preparedness and special services.

Supervision

Local Boards of Health are responsible for supervising the public health activities of local health departments. There is a statutory requirement for all municipalities to establish a local board of health; however, other statutes provide exceptions. In the majority of municipalities that have registered a Board of Health with the Department, the municipal governing body functions as the local board of health as authorized by the Optional Municipal Charter Act (aka Faulkner Act).

Counties may create a county board of health, which may assume the same responsibilities afforded the local boards and four counties have chosen this option. Municipalities may combine with other municipalities to form a regional health commission that assumes the powers of member municipalities' local boards of health.

Fiscal Overview

The cost per capita of providing public health services varies widely with the 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. Direction by local governing bodies to perform tasks other than the core public health

services may affect costs. Personnel costs, on average, account for over half (56%) of all local health department expenditures.

According to a national study, New Jersey ranks at the bottom in terms of per capita State funding for local public health departments. Since 1977 the only dedicated state funding available to local health departments is Public Health Priority Funding. This state line item allocation of $2.4 million is unchanged since FY2004 and is limited to municipal and regional health departments with populations less than 25,000. As a result, local health departments in New Jersey are more dependant on local tax funds than any in other state.

Next Steps

The Department's Office of Public Health Infrastructure (OPHI) in collaboration with New Jersey's local health departments and public health professional associations is undertaking a number of actions that will provide for the further study of local health departments and the local public health system, strengthen the current structure, and promote more effective coordination among public health agencies. These activities will result in identification of improvement opportunities for New Jersey's local public health system and the structure of its local health departments:

1. A structured assessment of public health on a statewide basis, using the Statewide Public Health System Performance Assessment tool developed by the Centers for Disease Control and Prevention (CDC) National Public Health Performance Standards Program;

2. Review and assessment of the annual report (Local Health Evaluation Report) that local health departments submit to the Department;

3. Review of current State statutes and rules governing public health practice;

4. Support and technical assistance to those communities that desire to explore changes to their public health services, including shared services and consolidation of health departments;

5. Development and implementation of a process for evaluating the structure and performance of local health departments and documenting their compliance with the *Practice Standards*.

6. A comprehensive review of the standards and procedures for licensure of Health Officers.

1. Introduction

> "It were well if statesmen and civilians would come more fully to realize the dependency of effective citizenship and State development upon a provident care of the public health."
> *Third Annual Report of the Board of Health of the State of New Jersey*, 1879

In March 2006, the Senior Assistant Commissioner of the Division of Health Infrastructure Preparedness and Emergency Response (HIPER) directed the Office of Public Health Infrastructure (OPHI) to conduct an analysis of the local public health infrastructure in New Jersey, including a historical perspective and a comparison with the public health structures of other states. This report is a summary of the information collected by OPHI in the course of its research.

In August 2006, the Governor called the State Legislature into special session in order to devise a means of reducing property tax rates in New Jersey. One of the special committees formed by the Legislature was the Joint Committee on Local Government Consolidation and Shared Services. That Committee called on the Department of Health and Senior Services (the Department) to provide it with information on the local government public health structure in New Jersey. This charge from the Legislature gave added urgency to this project.

The first draft of this report was completed in January 2007 and submitted for internal review by Department leadership. The draft report was subsequently revised, and a preliminary report was distributed to the Health Officers of local health departments and other stakeholders in October 2007 for review and comments. The final report completed in December 2007 incorporates this feedback and updated data.

2. Current Structure of the Local Public Health System in New Jersey

By statute (N.J.S.A. 26:3A2-10.c.), every municipality in New Jersey is required to provide a program of public health services meeting standards of performance as determined by the Commissioner of Health and Senior Services. These standards are defined by the Department in the *Public Health Practice Standards of Performance for Local Boards of Health in New Jersey* (N.J.A.C. 8:52). A municipality may meet this requirement by:

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

Every local health department is required to be under the direction of a full-time employed Health Officer. While there is a statutory requirement that anyone serving as a Health Officer be licensed by the Department, Health Officers are employees of local government.

Currently there are 112 local health departments in New Jersey, as of April 30, 2008, which are recognized by the Department of Health and Senior Services as meeting the statutory requirements. These include county, municipal and regional health departments. The distribution of each type (Table 1) is:

- 86 municipal health departments, of which:
    - 46 cover only their own municipality; and
    - 40 cover other municipalities through interlocal agreements, in addition to their own;
- 7 regional health commissions; and
- 19 county health departments, of which
    - 14 provide local health services to at least one municipality; and
    - 5 provide only county-wide services.

Looking at this structure from the municipal perspective (Table 2):

- 46 municipalities operate a stand-alone health department;
- 133 municipalities participate in an interlocal agreement to share local public health services provided through a municipal health department;
- 52 municipalities receive local health services from a regional health commission; and
- 335 municipalities receive local health services from a county health department.

These figures show that 92% of municipalities participate in some form of shared services arrangement for local health services, either through an interlocal agreement, a regional health commission, or a county health department. The majority (59%) of municipalities receive their local public health services from a county health department.

The populations covered by municipal health departments vary widely, ranging from 8,556 to 273,546. One-quarter of the municipal health departments (23 of 88) serve populations less than 25,000.

Regional Health Commissions

A separate statute allows municipalities to join together to form a regional health commission to provide public health services to the participating municipalities. There are seven regional health commissions, but only five of these function as multi-municipality local health departments. The coverage areas of these commissions range in size from two municipalities with a population of 30,230 to 24 municipalities with a total population of 157,733. There are also variants of this model. For example, the Northwest Bergen Regional Health Commission was created among three member municipalities, and it also has interlocal agreements with five other municipalities to provide them with public health services.

The other two regional health commissions - the Essex Regional Health Commission and the Hudson Regional Health Commission – provide County Environmental Health Act (CEHA) and emergency preparedness (LINCS) functions in support of the local health departments in their counties. These functions are provided by county health departments in the other counties (see the next section). Hudson Regional also provides some services to particular municipalities on a contractual basis. Neither Commission currently serves as the full-service local health department for any municipality. Each municipality in these counties has its own municipal health department or an interlocal agreement with another municipal health department. All municipalities in Hudson County are members of the Hudson Regional Health Commission. While only 14 of the 23 municipalities in Essex County are official members of the Essex Regional Health Commission, the Commission serves the entire county. Most of the remaining municipalities receive their local public health services

from the local health department of one of the participating municipalities. On both commissions, most of the municipalities are represented by their Health Officer.

County Health Departments

There are currently 19 county health departments recognized by the Department, serving 20 of the 21 counties in New Jersey. There are significant differences among these county agencies in their organizational structure and the services they provide. The services most commonly performed by county health departments are in three general categories:

1. Local public health services as defined in the *Practice Standards*. A county health department which provides these services to all or some of the municipalities in its county is referred to in the report as a "full-service" county health department.
2. Environmental health hazard investigations and enforcement as specified in the County Environmental Health Act (CEHA) of 1977 (N.J.S.A. 26:3A2-22). The New Jersey Department of Environmental Protection (DEP), which is responsible for the implementation of this law, has certified local health departments as the CEHA agencies for each county. All of the county health departments which are full-service departments are also the CEHA agencies in their counties, while other counties have formed departments to perform the CEHA responsibilities.
3. County-wide leadership, planning and coordination of health emergency planning and response, as defined in the Emergency Health Powers Act (Public Law 2005, c. 222). The Department has designated 22 local heath departments (18 county agencies, 2 regional health commissions and the cities of Newark and Paterson), known as LINCS (Local Information Network and Communication System) agencies, to

perform these functions. These agencies also provide specialized public health expertise and capacities, as defined in the *Practice Standards*, to the other local health departments in their county.

The 19 county health departments represent a wide variety of arrangements (Table 3) between the county and its constituent municipalities.

- Six counties (Burlington, Camden, Cape May, Gloucester, Hunterdon and Warren) have a full-service county health department which covers the entire county.
- Three counties (Atlantic, Ocean and Sussex) have a full service county health department which covers most, but not all, of the county. In each of these counties, a small number of municipalities maintain their own health departments.
- Four counties (Bergen, Middlesex, Monmouth and Somerset) maintain a full-service county health department that provides local public health services to those municipalities that chose to contract for those services, while other municipalities in these counties obtain these services from a municipal health department or regional health commission.
- Two counties (Cumberland and Salem) have agreed to combine their county health departments into a single full-service agency that covers all of both counties, with the exception of the City of Vineland which maintains its own health department.
- Four counties (Mercer, Morris, Passaic and Union) have county agencies that perform only CEHA and LINCS functions, and do not provide local public health services to any municipality.

- Essex County has a Department of Health and Rehabilitation which provides some environment services under CEHA, contracting the rest to the Essex Regional Health Commission. It is recognized as a local health department by DEP and the Department. The Department has designated the Essex Regional Health Commission as the LINCS agency for Essex County.

While Hudson County has a Department of Health and Human Services it does not provide any of the aforementioned public health services, and is therefore not recognized by the Department as a local health department. The Hudson Regional Health Commission is the designated CEHA and LINCS agency for Hudson County.

Although the Department recognizes 112 agencies as local health departments, seven of these are county-wide CEHA and/or LINCS agencies that do not provide *local* public health services, as defined in the *Practice Standards*, to any municipality. From this perspective, the number of *local* health departments in New Jersey would be 105.

These numbers do not include those instances where a municipality, which contracts with the health department of another municipality (or regional health commission or the county), also employs its own public health staff (such as Registered Environmental Health Specialists or Public Health Nurses) but not a Health Officer. A search of municipal Internet web sites found that at least 31 municipalities have a local government office that it identifies as its "health department". Since each of these municipalities is under the jurisdiction of another local health department, the Department does not recognize these local offices as local health departments.

The number of recognized local health departments in New Jersey has been in the range of 112 to 117 for more than 20 years. However, behind this apparent stability in

the number of health departments has been a significant amount of change in the arrangements among municipalities for local health services. Within the past two years, 23 municipalities have changed local health departments. These changes resulted in the creation or closing of some local health departments:

- the Sparta Health Department was merged into the Sussex County Health Department, bring with it five other municipalities with which it had agreements;
- the Summit Health Department was disbanded in favor of a shared services agreement with the Westfield Health Department; and
- Wayne Township (which formerly had an interlocal agreement with Montclair) created its own municipal health department.
- Westwood Borough left the Northwest Bergen Regional Health Commission in 2003 and formed is own local health department, only to re-merge with the Regional Health Commission in December 2007.

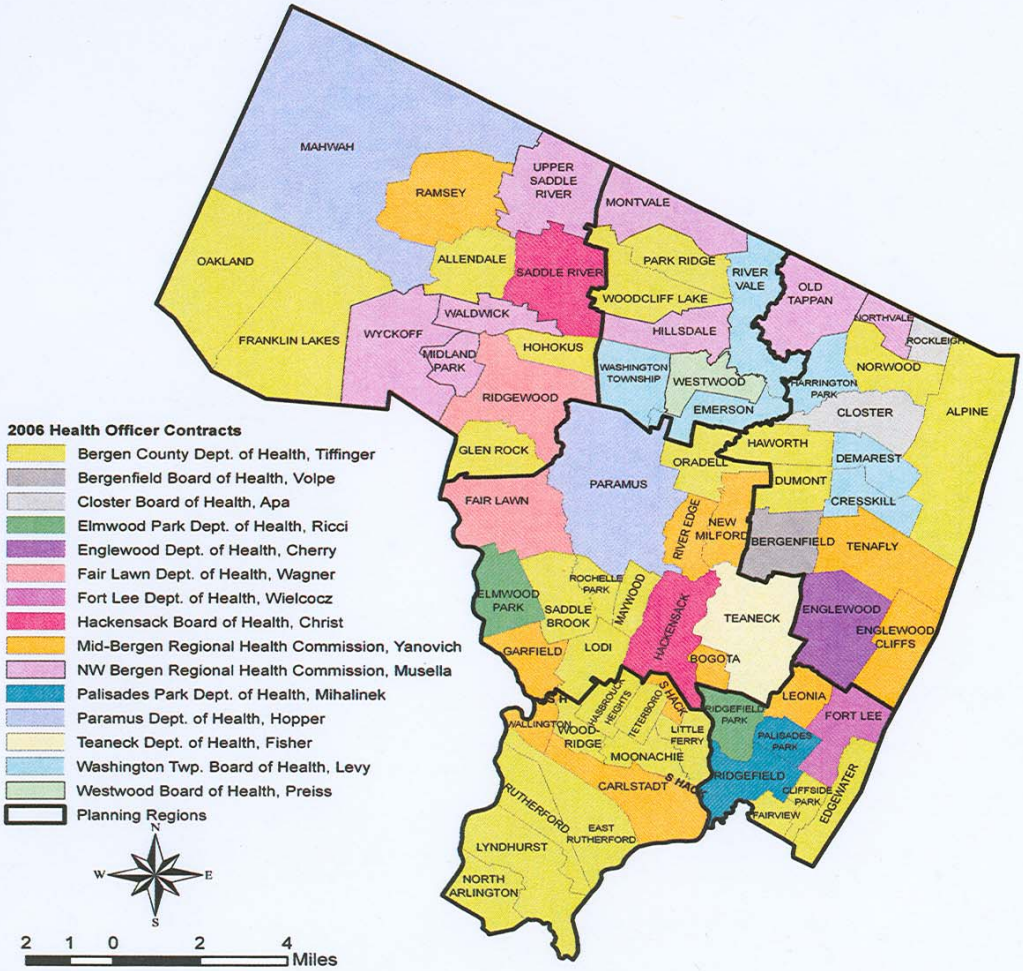
It is likely that the local public health structure in New Jersey will continue to change in the coming years. This report describes the number and distribution of local health departments as of April 2007. However, the Department is aware that several Health Officers are have recently retired or are scheduled to retire in 2008. As a result, negotiations are underway among some municipalities for changes in interlocal agreements for public health services. As a result of these events, the Department anticipates that the number of local health departments and the coverage areas of some local health departments will continue to change throughout 2008.

The arrangements for public health services in Bergen County (see map on page 17) illustrate the diversity and complexity of local public health in New Jersey. There are 14 local health departments serving 70 municipalities, including:

- the county health department, which provides some services (including CEHA, LINCS, and county-funded services) on a countywide basis, and which also has contracts to provide local public health services to 28 of the municipalities;
- two regional health commissions which, between them, cover 20 municipalities;
- seven municipal health departments which have interlocal agreements with other municipalities (11 municipalities receive services under these agreements); and
- four stand-alone municipal health departments.

In addition, there are 15 Bergen County municipalities that have agreements to receive public health services from one of the recognized local health departments, but which also maintain a municipal office that it identifies as its "health department."

2006 Local Health Departments and Health Officers in Bergen County, NJ



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3. Governance Structure (Local Boards of Health)

State statute (N.J.S.A. 26:3-1) requires the establishment of a board of health in every municipality in the State. It is through the boards of health that the local health departments derive their authority. Every local health department is responsible to a local board of health (or multiple boards of health), or to the municipal governing body serving as the board of health. The make-up of the local board of health varies, depending on the type of municipality.

A local board of health established in accordance with this statute (often called an "autonomous" board of health) has the authority to "pass, alter or amend ordinances and make rules and regulations in regard to the public health within its jurisdiction" (N.J.S.A. 26:3-31). It also "may employ such personnel as it may deem necessary to carry into effect the powers vested in it." Under this provision of the statute, the local health department and its employees are under the supervision of the board of health.

However, there is an exception. Any municipality operating under the Optional Municipal Charter Act (N.J.S.A. 40:69A-1), better known as the "Faulkner Act", is not required to establish a separate board of health. In these municipalities, the governing body is authorized to act as the board of health. It may also establish an advisory board of health, which monitors public health issues within its jurisdiction, but only in an advisory capacity to the municipal governing body. In these municipalities, the local health department and its employees are under the authority of the municipal government.

Another statute (N.J.S.A. 26:3-84) allows municipalities to combine with other municipalities to form a regional health commission (RHC) to provide public health

services to all of them. When a regional health commission is created, it assumes the powers of the local boards of health that are members of the commission, as well as jurisdiction over the entire area of these municipalities.

State law also allows, but does not require, counties to create a County Board of Health. The county board of health is empowered to exercise within its area of jurisdiction (which may or may not include the entire county) all the powers of a local board of health. Three counties (Cumberland, Monmouth and Ocean) have established county boards of health. In Atlantic County, the Board of Freeholders has designated itself as the county's board of health.

Those local health departments that cover multiple municipalities through interlocal agreements, including the county health departments in those counties without a county board of health, are responsible to the boards of health of each of the municipalities that they serve. For example, the Burlington County Health Department is accountable to 40 municipal boards of health.

State regulations (N.J.A.C. 8:52-1.5) require that each local board of health register with the Department. As of December 2007, 377 of the 566 municipalities (67%) had registered their local board of health (Table 4). Of these (Table 5):

- 133 had an autonomous board of health;
- 59 had advisory boards;
- 140 stated that the municipal governing body functioned as the board of health
- 35 stated that they were covered by a county board of health; and
- 10 municipalities stated that they have no local board of health.

Advisory boards are, by definition, advisory to a municipal governing body that is exercising the powers of a local board of health. Therefore, adding the number of advisory boards to the number of municipal governing bodies registered shows that the governing body is the functioning local board of health in the majority (199 of 377) of the registered municipalities.

4. Services Provided

All health departments in the United States, whether they are local, state or federal, are expected to be able to provide the 10 Essential Public Health Services (Table 6). The State regulations governing local health department activities in New Jersey are set forth in the *Public Health Practice Standards for Local Boards of Health in New Jersey* (N.J.A.C. 8:52). The types of services that local public health departments are expected to provide in accordance with the Practice Standards and/or the provisions of the regulations contained in the *New Jersey State Sanitary Code* are listed in Table 7.

While every local health department is required to assure that these services are available to the people in their communities, not all of these services are directly performed by every local health department. There is a great variety in the types of services provided by local health departments and the way in which they provide them. If it does not directly provide a service, the local health department may contract with or otherwise arrange for another entity to provide the service. For example, a local health department might contract with a hospital or a nursing agency to provide health screening and immunization services. The core services that are performed directly by almost all local health departments in New Jersey include communicable disease investigations, Sanitary Code inspections, and public health emergency response.

The National Association of County and City Health Officials (NACCHO) developed a list of 79 public health services frequently performed by local health departments in the United States as part of a national survey of local health departments conducted in 2005. The OPHI obtained the survey data from NACCHO, and conducted a follow-up survey of those local health departments who had not responded to NACCHO.

Responses from the 96 local health departments who completed these surveys show that, on average, local health departments in New Jersey perform 33 of these services. There is a wide variance (from 2 to 60) in the number of services performed by each local health department and in the types of services each provides. Table 8 lists each service and the number of local health departments who provide them.

There are some generalities that can be drawn from this data. The services most frequently provided by local health departments in New Jersey are sanitary inspection and environmental health services, while primary prevention and treatment services for communicable and chronic diseases are less frequently provided. Full service county health departments and large city health departments perform more services than do health departments serving smaller populations (Table 9). The types of services performed by a local health department depend largely on the nature of the area it serves. Local health departments covering suburban and rural areas usually provide environmental services such as campground, septic system and swimming pool inspections and drinking water protection, while urban health departments are less likely to perform these services but more likely to provide health screening and treatment.

Since local health departments in New Jersey are agencies of local government, they may be directed by their governing bodies to perform tasks other than the core public health services. The New Jersey Health Officers Association has compiled a list of 129 activities (Table 10) which are performed by at least one local health department in New Jersey. These include public services other than public health services, such as municipal solid waste, recycling collection and human services programs.

5. Staffing

Employment data for 2005 was obtained from the 93 local health departments which completed that section of the NACCHO survey form. These local health departments employ a total of 3,287 people. The largest numbers of staff employed, by occupational classification, are nurses, Registered Environmental Health Specialists, and clerical/administrative staff.

The reported number of staff employed by each local health department ranges from three to 380. Six local health departments employ less than five people, and 26 employ less than ten people. One-third of the RHCs and municipal health departments for which the Department has employment data have a staff of less than ten employees. The number of people employed by a RHC or municipal health department is directly related to the size of the population served (Table 11). Among the local health departments for which the Department has employment data, the 17 health departments serving less than 25,000 population employ, on average, 8 people, and all employ fewer than 15 people. Among the 28 health departments serving between 25,000 and 50,000 population, nine (32%) employ fewer than ten people, and all but one employ fewer than 20 people. Local (non-county) health departments serving at least 75,000 population employ an average of 39 people, with the largest having 100 employees. County health departments employ an average of 98 people, with a range from three to 380 employees.

While complete employment data is not available for the 21 local health departments that did not complete the NACCHO survey form, other data sources available to the Department indicate that in some of these local health departments, the Health Officer is the only full-time professional employee.

6. Finances

The total amount of expenditures reported by local health departments in their annual reports to the Department for calendar year 2006 was **$212,968,061**. Of this amount, county-level agencies (including the countywide RHCs) spent $97,388,253, while municipal health departments and RHCs spent $115,579,808. Personnel costs, on average, accounted for 56% of the total expenditures of all local health departments.

The average cost per capita among all local health departments in New Jersey was $25.27. The average cost per capita by type of local health department (Table 12) was:

- County health department $25.99
- Regional Health Commission $12.75
- Municipal health department $24.39
    - Multi-municipality health department $15.44
    - Single municipality health department $32.74.

There was great variation among local health departments in their cost per capita. This is particularly true among single municipality health departments, where the cost per capita ranged from $3.46 to $118.39. In general, large urban municipalities tended to have higher per capita costs than smaller municipalities. When data from the six largest city health departments (Atlantic City, Vineland, East Orange, Newark, Jersey City and Trenton) were separated from the rest of the single municipality health departments, the city health departments had an average cost of $70.39 per capita, while the rest of the single municipality health departments had an average cost of $14.51 per capita, comparable to the average cost for regional health commissions and multiple municipality health departments.

The size of the local health department with respect to the population served seemed to make little difference with regard to the cost of providing local health services. The average cost per capita for non-county health departments, categorized by population served (Table 13), was:

• less than 25,000	$18.14
• 25,000 – 50,000	$18.97
• 50,000 – 75,000	$24.59
• 75,000 – 100,000	$17.34
• more than 100,000	$29.86.

The higher per capita cost of the largest health departments reflects the inclusion of most of the large city health departments in this group. The per capita cost of the 50,000-75,000 group is likewise affected by the inclusion of the East Orange Health Department in this group.

There is a direct correlation between per capita cost and the number of services provided by a local health department, as measured by the responses to the NACCHO survey (Table 14). In particular, the higher cost per capita found in the county and urban health departments reflects the greater number of services provided by these agencies. As noted in the Services section, the city health departments provide, in addition to the core public health services, personal health care services that are not usually provided by the rural and suburban health departments. County health departments also provide some countywide services that are available to all residents in the county, including those living in municipalities covered by other local health departments. For example, in Ocean and

Warren counties, the county health departments operate countywide home health care agencies, and this is reflected in a higher per capita cost for these health departments in comparison to the other county health departments.

The funding that local health departments use to cover these expenditures came from multiple sources (Table 15). The primary source was local taxes, which provided the majority (59%) of local health department funding - 55% for county health departments (including the two countywide regional health commissions) and 62% for municipal health departments and RHCs. If the large urban health departments, which receive a substantial amount of State and federal funding, are separated out, the percentage of funding for the other non-county health departments derived from local taxes increases to 85%. For 72% of non-county RHCs and municipal health departments, more than 90% of their funding is from local taxes.

At this time, the only dedicated State funding for local health departments is Public Health Priority Funding (PHPF). The current (SFY 2008) funding for PHPF is $2.4 million. This figure has been stable since SFY 2004. Municipal health departments and regional health commissions (but not county health departments) are eligible to receive PHPF if they serve a population of at least 25,000 people, have a full-time Health Officer, and submit an application to the Department documenting how the funds will be utilized in compliance with the Priority Health Services Guidelines issued by the Department. At this time, 71 local health departments are eligible to receive PHPF.

A statute adopted in 2003 dedicated of a portion of the proceeds from the supplemental real estate transfer tax to support designated public health priority services provided by county health departments. This funding is essentially in lieu of the PHPF

funds that county health departments were eligible for prior to that time. However, the statute limited the applicability of this provision to county health departments that had received PHPF in SFY 2003, and effectively limited the amount of funding to that which the eligible county health departments were entitled to receive in PHPF for SFY 2003.

The Department also provides grants to local health departments to support specific services. Each grant is awarded to support the provision of a specific service (e.g. Tuberculosis Control) or category of services (e.g. Early Intervention Services for Developmentally Delayed/Disabled Children), as determined by the source of the funding. The funds used for these grants come to the Department either through grants and Cooperative Agreements from federal government agencies, or through line item appropriations in the State Budget. Most of the funding used for these grants is a pass-through of Federal funds awarded to the Department. In SFY 2007, the Department awarded $42,357,887 in grant funds to local health departments. More than 90% of these funds went to county or large urban municipal health departments. Pandemic Influenza Preparedness was the only grant program where funds were distributed to all local health departments.

7. Historical Review of the Development of New Jersey's Public Health Structure

The State Legislature established the New Jersey State Board of Health in 1877. The newly created Board studied the public health situation in the State and in 1879 recommended to the Legislature that every city or borough establish a local board of health to supervise local activities for the protection and improvement of the public's health in their community. On March 11, 1880, the Legislature passed a law requiring "every city, or borough, or incorporated town, or any town governed by a commission" to create a local board of health. It also specified that in each township, the township committee would serve as the local board of health. In cities with populations greater than 10,000, the board of health was required to hire a city health inspector. In its Annual Report for 1880, the State Board of Health reported than about 200 city or township boards had been established by the end of the year. In 1887, the Legislature adopted a law that modified and strengthened these requirements. These laws of the 1880s created the basic structure for local public health in New Jersey. The 1887 statute, amended several times, is still in effect.

Initially, this structure did not always function as well as the State Board of Health had intended. The Annual Reports of the Board in the following years document an ever increasing frustration at the failure of many municipalities to provide sufficient attention to public health. These reports frequently cite the failure of these municipalities to maintain an active board of health, adopt local health ordinances and/or to hire professional staff to investigate disease outbreaks and remediate health hazards.

One initiative to improve the quality of local public health services was to set minimum standards for the persons hired by the local boards of health to investigate

health hazards and enforce the ordinances and orders promulgated by the board. The State Board of Health worked with Rutgers University to create a course and qualifying examinations for Health Officers and Sanitary Inspectors. In 1905, the Legislature adopted a statute requiring licensure of the people in these positions.

Over the years, there have been multiple proposals, some of which became law, to improve the provision of public health. Many of these focused on creating larger public health units. The first of these was Chapter 129 of the Laws of 1906, which authorized two or more adjacent municipalities or townships to join in the employment of a health officer. This was further developed by Public Law 1929, chapter 148, which authorized any county, and/or one or more municipalities, to enter into a joint contract for public health services. This was the beginning of the current system of interlocal agreements. In 1938, the Legislature adopted the law allowing the creation of Regional Health Commissions (P.L 1938, c. 67).

The Local Health District Act of 1951 allowed the creation of consolidated local health districts or county health districts through a referendum process. The provisions of this law have never been implemented. This process was attempted only once. A referendum in 1953 to create a county health district in Hunterdon County was defeated in every municipality.

In 1960, the first county health department was formed, in Cape May County. Its creation was stimulated by public pressure following the failure of local boards of health to adequately respond to a deadly outbreak of eastern encephalitis. The 1960's saw the further development of county health departments. These were based on a model of

county-based coordination of public health activities through the development of agreements between the county and the local boards of health of each municipality.

Two events in the 1950s and 60s led to a significant reformation of public health services in New Jersey.

- The Recognized Public Health Activities and Minimum Standards of Performance for Local Boards of Health were adopted in December 1959, effective April 1, 1961. Public Law 1947, chapter 177, which reorganized the State Department of Health, authorized the Commissioner of Health to establish standards of performance for local boards of health. Extensive work was done during the 1950s by committees appointed by the Commissioner, in association with the New Jersey Health Officers Association, to develop these standards. The creation of Minimum Standards, and their enforcement by the Department, led many local boards of health to either hire a full-time Health Officer for the first time, or to make arrangements for coverage by another municipality who already had a Health Officer. It also provided a major impetus for the creation of county health departments in the rural southern and northwestern areas of the State.
- The State Health Aid Act of 1966 provided State funds to support local health departments. The Act required a minimum population of 25,000 in order to receive funds. The minimum population requirement of the State Health Aid Act led to significant consolidation of local health departments, and accelerated the formation of new county health departments. This funding continues today as Public Health Priority Funding.

It was only with the adoption of the Minimum Standards that local health departments came into existence in New Jersey. Prior to that, there was no defined structure for the professional staff hired by local boards of health. Except for the largest cities, local boards of health employed, if anyone, only a Health Officer and/or Sanitary Inspector. The Minimum Standards and the availability of State Aid resulted in a simultaneous increase in the number of municipalities which employed professional staff and the consolidation of services through shared services agreements among municipalities and counties.

Some published commentaries on local public health in New Jersey have stated there once were over 500 local health departments in New Jersey, based on the statutory requirement for each municipality to have a board of health. The reports of the State Board of Health do not document anywhere near that number of local health departments. As late as 1955, only 195 of the then existing 567 municipalities in the State employed a full or part-time health officer. In 1974, after the implementation of the Minimum Standards and State Aid, there were 291 local health departments. At that time, there were still 177 municipalities that did not have the services of a full-time health officer.

This situation led to the Local Health Services Act of 1975, which is the statute that governs the current structure and activities of local health departments in New Jersey. The requirements of the Act resulted in a significant reduction in the number of local health departments in the late 1970's. By 1980 the total number of health departments was 120. There has been only a minimal reduction in the number of local health departments since then. Whatever consolidation of local health departments

has occurred in the past 25 years has been offset by the creation of new municipal and county health departments (Table 16).

The increased environmental awareness of the 1970s and the recognition that local health departments were not equipped to address environmental health hazards led to the County Environmental Health Act (CEHA) of 1977, which created county-based environmental health agencies under the supervision of the Department of Environmental Protection. Where county health departments existed, these took on the responsibility for the CEHA activities, but the other counties had to create new agencies to perform these tasks. It took nearly 30 years until every county had a CEHA agency.

In 1998 the Department created the Local Information Network and Communication System (LINCS) and designated local health departments as LINCS agencies for every county and the major cities. The original mission of the LINCS agencies was to serve as a "hub" for communication and information sharing between the State and local health departments, and among local health departments, hospitals, health care providers, laboratories and emergency responders in their area, with the goal of establishing a better coordinated public health system for the identification and containment of public health threats. Federal and State public health emergency preparedness funding received by the Department subsequent to September 11, 2001 has been used to expand the role of the LINCS agencies to providing countywide (and citywide) leadership and coordination of public health emergency planning and response and regionalized specialized public health expertise and capacities.

With regard to the State health department's role in the public health structure, one of the principal strategies used by the Department to assure that public health threats

were properly responded to had been to divide the State into health districts and to assign staff to work out of district offices. Starting in 1919 (not long after the State Department of Health was established in 1915) each district office had the dual role of advising local boards of health on their responsibilities and providing services directly in the rural areas where local boards of health did not employ their own staff, or where specialized expertise was required. For example, State staff working out of the district offices inspected dairies. In 1951, the Department reorganized its operations into four districts. From the 1920s through the 1960s, the district offices were the Department's primary means of contact with local boards of health and a large number of staff was assigned to work out of the district offices. The district offices were downsized in the 1970s and eliminated in 1992 due to State budget cuts.

The Minimum Standards of Performance were replaced by the *Public Health Practice Standards of Performance for Local Boards of Health in New Jersey* (N.J.A.C. 8:52), adopted in February 2003. The new rules emphasize community-wide health assessment and planning, assuring that services are available to meet the identified community needs, and participation in regional systems, rather than a minimum level of services to be directly provided by every local health department. The new rules also called for local health departments to have access to regional specialized public health capacity and expertise which are intended to be provided by the LINCS agencies. The Department is currently in the process of readopting the Practice Standards.

While these new rules have not resulted in further consolidation, they have led to a greater focus on the provision of public health services based on need and the beginnings of better coordinated public health planning and service delivery. This has

been accomplished in part through the formation of Governmental Public Health Partnerships (local Health Officer collaboratives), community public health partnerships and the utilization of formal, nationally recognized planning methodologies, including Mobilizing for Action through Planning and Partnerships (MAPP), and the Local Public Health System Performance Assessment and Local Public Health Governance Performance Assessment instruments developed as part of the Centers for Disease Control and Prevention's (CDC) National Public Health Performance Standards.

8. Public Health System Reform Efforts

- The Princeton Local Government Survey on Readjusting Local Services and Areas Report (1937) stated that public health had ceased to be a local function and that adequate service could no longer be realized on a municipal basis. It recommended the creation of regional health districts comprising contiguous municipalities with a combined population of 50,000 or more, or county health units that would exclude municipalities of 50,000 or more population if these had adequate public health services. While these recommendations were not adopted, they influenced the law creating regional health commissions, which was adopted the following year.
- A committee of the New Jersey Health Officers Association (1942) recommended establishing minimum standards of local health services and staffing, and combining municipalities with populations of 25,000 or less into local health districts.
- The Governor's Committee on Local Health Administration issued an Interim Report on June 1, 1950, which concluded that "there must be fewer, much larger, more effective and better local health departments", and recommended "an integration of the official services or local boards of health; or of the local health boards of municipalities in a county or part of a county; or integration on a multi-municipal health jurisdiction basis regardless of county lines." The Committee's efforts lead to the passage of the Local Health District Act of 1951.
- In the early 1970s, the New Jersey County and Municipal Government Study Commission conducted a study of local public health in the State. Its report, *Community Health Services: Existing Patterns – Emerging Trends*, issued in November 1974, concluded that "the present system of health delivery as

administered by most independent municipal health departments is clearly inadequate." It recommended:

- consolidation of local health departments;
- steps to improve the quality and qualifications of local health personnel;
- upgrading of Minimum Standards and their vigorous enforcement;
- changes in State Health Aid to encourage and facilitate consolidation; and
- establishment of county health and environmental services agencies.

While the recommendations of the Commission were never fully implemented, they influenced the provisions of the Local Health Services Act of 1975 and the County Environmental Health Act of 1977.

- In 1987, the Department issued a position paper on "The Role of Local Health Departments in New Jersey" which recommended a regional approach to the planning and provision of local public health services.
- In September 1993, a Commissioner's Working Group on Local Health was convened by the Department and given the charge to "help define the future roles and responsibilities of New Jersey's local health departments in an era of health care reform." It produced a "working draft" report in May 1994 which concluded that the new public health problems which emerged in the 1980's, ranging from AIDS to Radon, "have resulted in an increasingly fragmented public health system that does not perform in a manner that best serves the citizens of New Jersey." The report recommended that local public health be restructured to promote regionalization of certain services and programs. The means to accomplish this would be the designation of a Lead Agency for each county, as well as the large urban areas. The

Lead Agency would not be a new structure, but rather the designation of one of the existing local health departments as the coordinating agency for the county or region. However: "Individual local health departments would still continue to provide services tailored to their communities."

- In 1997, the Commissioner appointed a 31-member Public Health Task Force and charged it to critically examine New Jersey's local governmental public health system. That Task Force recommended revisions in the Minimum Standards, based on the concept of a local governmental health partnership, with capacity and expertise built on a countywide or multi-county basis at selected local health agencies throughout the State.
- In 1999, the Robert Wood Johnson Foundation funded a two-year collaborative initiative involving 29 partner organizations called Public Health CARE, which stood for "Crafting a Restructured Environment." The final report to the Foundation (2001) concluded that "New Jersey's current public health system is antiquated, outdated and ill-equipped to respond to 21st century imperatives." The report recommended:
  - "Funding for public health must be directed to infrastructure development", and
  - "The delivery of public health must be restructured into coherent, more easily accessible, geographic entities."

None of the recommendations made in the most recent reports have resulted in any significant changes to the fundamental structure of local health departments. They have, however, influenced Department initiatives to enhance local public health, specifically the formation of the LINCS agencies and revisions to the rules governing local health departments.

9. Comparison with Organizational Models in Other States

There is no standard model for the organization of local public health services in the United States. The structure of public health in each state reflects the unique geography, history, politics, demographics, and socioeconomic factors of that state. Nevertheless, there are some common methods of public health organization that each state has adapted to meet its particular needs.

There are three models of public health organization in the U.S.:

- the state health department, or equivalent agency, has primary responsibility for public health statewide, or for most of the state (18 states);
- state and local government share in the responsibility for public health (five states); and
- local government has the primary responsibility for public health, through the operation of local health departments (27 states, including New Jersey). Depending on the particular legal and regulatory structure of each state, the state health departments in each of these states have varying degrees of oversight over the operations of the local health departments.

The other key factor in public health organization is the geographic level at which public health services are provided:

- 39 states organize local public health services primarily at the county level;
- five states organize local public health services primarily at the municipal level;
- two states (New Jersey and Ohio) have local health agencies organized at both the county and municipal levels; and
- in two states, public health services are centralized at the state level.

This list does not include Alaska and Hawaii, which have public health systems that reflect the unique geographic challenges of those states.

County health departments are the predominant form of local public health agency in the United States. However, there is considerable variation as to how these county-level units are organized, administered, and the level of services they provide. In 12 states, the county health departments are local offices of the state health department. In some states, county health departments are full-service public health agencies, while in others they provide a more limited package of services. And some states have more than one type of county health department.

Only five states have more local health departments than New Jersey: Georgia (159), Massachusetts (324), Ohio (134), Texas (143) and Virginia (119).

New Jersey's neighboring states illustrate the variety of forms that the organization of public health can take.

- **New York** is an example of a State supported and regulated, but locally administered, public health system. The state has 57 county health departments, plus the New York City Department of Health. There are two types of county health departments, with the smaller counties relying on the state health department to provide environmental health services. New York provides $250 million annually in State funding to its county health departments.
- **Pennsylvania** is an example of a mixed State/local system. The state health department provides direct services to most of the Commonwealth, operating six health districts which provide services through state health centers in 62 counties.

Twelve urban city and/or county governments have opted to operate their own local health departments.

- **Delaware** has a centralized public health structure. All public health services are provided directly by the state health department. There are no local health departments.
- **Connecticut** has a local government-based public health system. It has 82 local health departments, including municipal health departments and multi-town district health departments (Connecticut does not have counties). The state health department has implemented a "transition program" to encourage smaller local health departments to become part of a district. This initiative has resulted in a reduction from 97 local health departments to 82 in the past two years.

New Jersey is the only state to use licensure as the means to qualify persons to be Health Officers. Most other states have adopted minimum qualifications for the Health Officer (or equivalent title) position, but leave it to the appointing authority to determine if an individual meets these qualifications. In a majority of the states, county Health Officers are either state employees, or their appointment is subject to the approval of the chief executive of the state health agency. In the past many states required that Health Officers be physicians, but there has been a trend away from this requirement due to a shortage of public health physicians.

All states provide some funding in support of local public health services. States use a variety of funding mechanisms to support local health departments. Most states provide grants of state and federal funds to support specific categorical services. The research conducted for this report found that 12 states provide state support to local

health departments on a formula or per capita basis, similar to New Jersey's Public Health Priority Funding (PHPF). Some other states provide matching funds based on a specified percent of a local health department's budget. In most cases, state approval of the local health department's budget is required in order to be eligible for state funding.

The mean annual expenditure level in 2005 for all local health departments in the United States was $32 per capita, according to data collected in the national survey of local health departments conducted by the National Association of County and City Health Officials (NACCHO). NACCHO's report ranked New Jersey in the lowest quartile in terms of the median annual expenditures per capita among the local health departments participating in this survey. The same survey reported that local health departments in New Jersey derive a higher percentage of their operating budgets from local funds than in any other State. The New Jersey local health departments participating in the survey reported that an average of 60% of their funding came from local sources (including property taxes), compared with a national average of 29%. The NACCHO survey also reported that New Jersey is among the states that provide the lowest level of state funding for local health departments. It is one of four states reported as providing less than $.50 per capita in state funding.

In summary, the structure of local public health in New Jersey is unlike that in any other state. The primary areas where New Jersey's public health structure differs from the other states are:

- New Jersey is the only state to license Health Officers:
- Among the states that utilize county health departments, New Jersey is the only one that does not have one in every county;

- Regional health departments in other states are composed of geographically contiguous municipalities and/or counties, whereas local health departments in New Jersey frequently cover geographically dispersed municipalities;
- Local health department jurisdictions in other states are established through statute or long term agreements, whereas the jurisdictions of local health departments in New Jersey are largely determined by interlocal agreements among municipalities, which subject to change every two years;
- New Jersey is the only state where a local health department may be accountable to more than one local board of health; and
- Local health departments in New Jersey are more dependant on local government funds, and receive less state funding, than those in other states.

10. Discussion

The structure of local public health in New Jersey reflects the "home rule" philosophy that is prevalent in most governmental activity in this State. Municipal government has the primary responsibility for protecting the health of its residents and the primary authority to take actions to address public health hazards. This responsibility and authority comes from a statute in effect since 1887, which envisioned the simple concept (radical in its time) that every municipality should have a body of citizens with the primary responsibility to take measures to respond to, and ultimately to prevent, disease outbreaks in their community, and to employ trained professionals to carry out those measures. While additional entities have been added to the public health infrastructure over the past 120 years, including regional health commissions, county health departments, CEHA agencies and LINCS agencies, the primary responsibility still resides with the municipality.

Public health in this state can be seen as a model of shared services, in that nearly all municipalities participate in some form of shared services arrangement for public health. Only 47 municipalities have a stand alone local health department, and many of these are large cities, such as Newark, Jersey City, Elizabeth, East Orange, Trenton and Atlantic City. While most of the local health departments in New Jersey are municipal government agencies, a majority of the municipalities in the state are covered by county health departments.

The statute governing local public health envisioned that it would be overseen by a local board of health. However, subsequent statutes have modified this to the point where the local governing body is the responsible party for oversight of public health in a

majority of municipalities. Less than one quarter of the reporting municipalities have a functioning local board of health.

There is only limited data available on the expenditures, staffing and services of local health departments. The available data do not show any correlation between the size or organizational structure of a local health department and its expenditures on a per capita basis. The only discernable trend that emerges from the analysis of the expenditure data is that there seems to be a direct correlation between per capita cost and the number of services provided by a local health department. However, these analyses are based on the average expenditures for each category of local health department. The very wide range in reported expenditures among apparently similar local health departments raises questions as to the consistency of data reported. Unless all local health departments use consistent criteria for reporting their expenditures, valid comparisons are not possible. The analysis of the available data does not provide a compelling case for recommending significant structural changes to the organization of local public health in New Jersey. The strongest conclusion that can be made from this study is that better, more consistent data are needed before any decisions can be made with regard to the efficacy of the current local public health structure.

The primary finding of this study is that the "home rule" philosophy of government prevalent in New Jersey, and the its 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 responsiveness of local health departments to the needs of the communities that they serve is the strength of New Jersey's public health structure. The concern is

how to effectively coordinate the activities of this diverse and complex structure so that it functions as a system in responding to public health challenges that are not local, but regional or statewide (even global) in scope. The challenge is how to continuously strengthen the State's overall public health infrastructure without disrupting the places in which it is already strong and effective.

The ultimate vision is a cohesive public health system for New Jersey in which local, county and State public health agencies work together to meet the public health needs of the entire State.

11. Next Steps

In response to the findings of this study, the Office of Public Health Infrastructure (OPHI), in collaboration with the local health departments and the public health professional associations, is undertaking a number of actions to that will provide for the further study of local health departments and the local public health system, strengthen the current structure and promote more effective coordination among public health agencies. The actions planned or underway are:

1. Perform a structured assessment of public health on a statewide basis, using the Statewide Public Health System Performance Assessment tool developed by the CDC National Public Health Performance Standards Program. This assessment uses a nationally recognized questionnaire to document the strengths and weaknesses of the current system and develop a plan for improvement. It will be done using a collaborative process which includes representatives of local health departments, local boards of health, statewide organizations and private sector partners. The assessment questionnaire and process are similar to the Local Public Health System Performance Assessment which was used in the development of the Community Health Improvement Plans completed in most New Jersey counties, as well as the cities of Newark and Paterson, over the past two years.
2. Review and revise the annual report (Local Health Evaluation Report) that local health departments submit to the Department so that it is a better measure of local health department structure and performance, and provides better data for analysis of public health services in the State.

3. Conduct a review of the current State statutes and rules to see where these need to be changed to better reflect current public health practice and to remove barriers to structural changes where these are desired. This includes revising the *Public Health Practice Standards of Performance* rule. While the Department is proceeding with readopting the Practice Standards without changes so that they don't expire in February 2008, OPHI is also engaging in an on-going process of reviewing the current standards, obtaining stakeholder comments and suggestions, and looking at ways that they can be improved and strengthened.
4. Continue to provide support and technical assistance to those communities that desire to explore changes to their public health services, including shared services and consolidation of health departments. OPHI will continue to collaborate with the Office of Local Government Services in the Department of Community Affairs to assist interested local governments in obtaining financial support for such changes, through the SHARE grant program.
5. Implement the Monitoring and Evaluation Initiative, which will be a comprehensive process of evaluating the structure and performance of local health departments and documenting their compliance with the Practice Standards. The goals of this initiative will be to assist local health departments in improving their performance, while taking appropriate actions against those local health departments that are not in compliance with the rule. This and other evaluation and quality improvement activities are to be aligned with national standards, so as to support New Jersey's local health departments in participating in the emerging national local health department accreditation program.

6. Conduct a comprehensive review of the standards for the Health Officer license and the licensing examination process. The goal of this initiative will be to assure that newly licensed Health Officers possess the competencies required to lead local health departments capable of meeting the State and national standards. It will also assure that New Jersey's licensing standards are consistent with emerging national efforts to credential public health professionals.

It is expected that these activities will result in a greater breadth and depth of knowledge of New Jersey's local public health system by providing additional and more comprehensive information on local health department practice, performance and structure. The opportunities for improvement that may be identified through these activities will be given serious consideration in terms of future recommendations for strengthening New Jersey's local public health system and the structure of its local health departments.

APPENDIX

Data Sources

The following sources were used in the preparation of this report:

1. The annual report submitted to the Department by all local health departments in New Jersey, including the Local Health Evaluation Report, Budget by Funding Source Report, and the Local Board of Health Registration. The initial analysis was done using the 2005 annual reports. This information was then updated when data from the 2006 annual reports became available.

2. To gather additional data on services, funding, and staffing, the Office obtained from the National Association of County and City Health Officials (NACCHO) the information submitted by New Jersey local health departments as part of a national survey that NACCHO conducted in 2005.

3. Since only 69 of the (then) 115 local health departments in New Jersey participated in the NACCHO survey, OPHI sent an abridged version of the survey to the non-responding local health departments. Responses were received from 27 of the remaining 46.

4. Research on the history of local public health in New Jersey was conducted through the review of an on-line database containing all of the Annual Reports of the New Jersey State Board of Health and the New Jersey State Department of Health from 1877 to 1969, and through reading the reports of previous studies of local health reform in New Jersey located in Department files or through the State Library. The on-line archive of Annual Reports is maintained by the UMDNJ – University Libraries Special Collections, and can be accessed at: http://www.umdnj.edu/librweb/speccoll/njhs/statistics.html .

5. To obtain information on the public health structures in other states, information was gathered from published reports on local public health practice authored by the U.S. Centers for Disease Control and Prevention's National Public Health Performance Program, the Association of State and Territorial Health Officials (ASTHO), and NACCHO, and the websites of every state health department. In addition, a survey was sent to state health departments through the assistance of the Association of State and Territorial Local Health Liaison Officials (ASTLHLO).

6. Additional information on the structure of local boards of health and local health departments was obtained through a search of county, municipal and local health department websites.

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Table 1

Local Health Departments in New Jersey

- 86 municipal health departments
    - 46 cover only their own municipality
    - 40 also cover other municipalities through interlocal agreements

- 7 regional health commissions

- 19 county health departments
    - 14 are full service health departments which provide local health services to at least one municipality in their county
    - 5 are CEHA and/or LINCS agencies.

Table 2

Municipal Coverage for Local Public Health Services

- 46 municipalities operate a stand-alone health department
- 133 municipalities participate in interlocal agreements
- 52 municipalities participate in regional health commissions
- 335 municipalities covered by county health departments

Table 3
County Health Departments

County	# municipalities in county	# municipalities provided local PH by county DH	Notes
Atlantic	23	22	Atlantic City has own LHD
Bergen	70	28	13 other LHDs
Burlington	40	40	
Camden	37	37	
Cape May	16	16	
Cumberland/ Salem	29	28	Vineland has own LHD
Essex	22	0	CEHA
Gloucester	24	24	
Hunterdon	26	26	
Mercer	13	0	CEHA & LINCS
Middlesex	25	20	5 other LHDs
Monmouth	53	22	6 other LHDs
Morris	39	0	CEHA & LINCS
Ocean (6 towns) has own LHD	33	27	Long Beach Island
Passaic	16	0	CEHA & LINCS
Somerset	21	1	CEHA & LINCS
Sussex have own LHDs	24	22	Hopatcong and Vernon
Union	21	0	CEHA & LINCS
Warren	22	22	

Table 4

Registered Local Boards of Health By County

County	number of municipalities	# of registered boards of health
Atlantic	23	1
Bergen	70	34
Burlington	40	40
Camden	37	32
Cape May	16	16
Cumberland	14	1
Essex	22	20
Gloucester	24	24
Hudson	12	3
Hunterdon	26	0
Mercer	13	11
Middlesex	25	19
Monmouth	53	35
Morris	39	35
Ocean	33	7
Passaic	16	9
Salem	15	15
Somerset	21	20
Sussex	24	18
Union	21	15
Warren	22	22

Source: Local Board of Health registration database

Table 5

Registered Local Boards of Health By Type

- Autonomous 133
- Advisory 59
- Local Governing Body 140
- Covered by County BoH 35
- None 10

Source: Local Board of Health registration database

Table 6

Ten Essential Public Health Services

1. Monitor 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. Evaluate and improve programs
10. Contribute to and apply the existing body of knowledge regarding public health.

Table 7

Core Public Health Services
Provided by Local Health Departments
As required by Practice Standards and/or NJ Sanitary Code

- Investigation of citizen complaints related to public health nuisances and enforcing their removal
- Conducting inspections and enforcing State and local requirements for beaches and other public bathing places, campgrounds, youth camps, and restaurants and other retail food establishments
- Conducting investigations of reports of communicable diseases
- Immunization of children and senior citizens against communicable diseases
- Enforcement of licensing and rabies vaccination requirements for domestic animals
- Diagnosis, treatment, and follow-up for tuberculosis and sexually transmitted diseases
- Health screening for infants and children
- Investigation of reports of childhood lead poisoning and enforcing the removal of lead hazards
- Counseling and nutrition services for pregnant women and mothers of young children
- Health screening of adults for cancer, diabetes, high blood pressure, and other chronic diseases
- Community-wide health promotion and health education programs
- Monitoring of data on the health status of their community and developing plans to address health problems and improve the community's health
- Responding to emergencies involving a threat to the public health.

Table 8
Public Health Activities

Services	**LHDs in NJ providing the service**	
Number	**Percent***	
Immunization		
• Adult immunizations	76	80%
• Child immunizations	61	64%
Screening for diseases/conditions		
• HIV/AIDS	19	20%
• Other STDs	23	24%
• Tuberculosis	35	36%
• Cancer	54	56%
• Cardiovascular disease	60	63%
• Diabetes	56	58%
• High blood pressure	69	72%
• Blood lead	60	63%
Treatment for communicable diseases		
• HIV/AIDS	8	8%
• Other STDs	19	20%
• Tuberculosis	24	25%
Maternal and Child Health		
• Family Planning	15	16%
• Prenatal Care	18	19%
• Obstetrical Care	6	6%
• WIC	25	26%
• EDSPT	11	11%
Other Health Services		
• Comprehensive primary care	6	6%
• Home health care	19	20%
• Oral health	13	14%
• Behavioral/mental health services	7	7%
• Substance abuse services	18	19%

Services	**LHDs in NJ providing the service**	
Number	**Percent***	
Epidemiology and Surveillance		
• Communicable/infectious disease	88	92%
• Chronic disease	48	50%
• Injury	26	27%
• Behavioral risk factors	32	33%
• Environmental health	87	91%
• Syndromic	24	25%
Population-based Primary Prevention Services		
• Injury	20	21%
• Unintended pregnancy	12	13%
• Obesity	39	41%
• Violence	16	17%
• Tobacco	61	64%
• Substance abuse	39	41%
• Mental illness	15	16%
Regulation, Inspection and/or Licensing Activities		
• Mobile homes	20	21%
• Campgrounds and RVs	49	51%
• Solid waste disposal sites	40	42%
• Solid waste haulers	28	29%
• Septic tank installation	64	67%
• Hotels/motels	42	44%
• School/daycare	83	86%
• Cosmetology businesses	27	28%
• Swimming pools (public)	89	93%
• Tobacco retailers	67	70%
• Smoke-free ordinances	74	77%
• Lead inspection	83	86%
• Food processing	48	50%
• Milk processing	19	20%
• Public drinking water	46	48%
• Private drinking water	62	65%
• Food service establishments	89	93%

Services	LHDs in NJ providing the service	
	Number	Percent*
• Health-related facilities	67	70%
• Housing inspections	60	63%
Other Environmental Health Activities		
• Indoor air quality	68	71%
• Food safety education	80	83%
• Radiation control	26	27%
• Vector control	80	83%
• Land use planning	15	16%
• Groundwater protection	63	66%
• Surface water protection	66	69%
• Hazmat response	47	49%
• Hazardous waste disposal	24	25%
• Pollution prevention	67	70%
• Noise pollution	77	80%
Other Activities		
• Emergency medical services	2	2%
• Animal control	56	58%
• Occupational health and safety	62	65%
• Veterinarian public health activities	34	35%
• Laboratory services	15	16%
• Outreach and enrollment for medical insurance	34	35%
• School-based clinics	20	21%
• School health	38	40%
• Correctional health	8	8%

***** Percentage based on 96 local health departments who responded to the survey.

Sources:

National Association of County and City Health Officials (NACCHO), 2005 Profile of Local Public Health Agencies.

NJDHSS Survey of Local Health Departments, using NACCHO survey form, 2006

Table 9

Services provided by municipal health departments and regional health commissions by population served

Population	Average # of services provided	Range
less than 25,000	25	12 - 39
25,000 – 50,000	34	18 - 53
50,000 – 75,000	35	18 - 48
75,000 – 100,000	33	13 - 53
more than 100,000	39	22 – 51

Sources:

National Association of County and City Health Officials (NACCHO), 2005 Profile of Local Public Health Agencies.

NJDHSS Survey of Local Health Departments, using NACCHO survey form, 2006

Table 10

Services Performed by Local Health Departments
In New Jersey

Adult daycare facility inspection
Adult immunizations, including flu and pneumonia
Air pollution control
Alcohol and substance abuse
Alzheimer's disease education
Americans with Disabilities compliance
Animal bite and quarantine enforcement
Animal control services
Animal sheltering
Asbestos removal project plan review and monitoring
Assurance of safe drinking water
Beauty parlor, barber shop and nail salon inspection
Bioterrorism and emergency response
Blood chemistry screenings, counseling and referrals
Bloodborne Pathogen program (inoculation, training, exposure control plan, etc.)
Board of Health training, communication and meeting administration
Boarding home inspection
Body art facility inspection
Budget preparation and oversight
Burials for the indigent
Campground and mobile home park inspection
Certificate of occupancy and/or habitability inspection and compliance
Certified Emergency Response Team (CERT) Program management
Child care center inspection
Child health conferences/well baby clinics
Child health consortia
Child immunizations
Childhood lead poisoning investigation and abatement
Church, club, non-profit kitchen and temporary food event inspection
Clinical breast exams and cancer education
Clothing and food program for indigent families
Commercial Drivers License (CDL) alcohol and drug testing
Community DARE/MAC program

Community health education
Community health fairs
Contract review and negotiation for services
Control of insect vectors of disease
Control of rodent vectors of disease
Cross-connection inspection
Demolition inspection and/or recommendations
Dental health program
Diabetes screenings and education
Dog and cat licensing
Educating the public
Emergency response (24 hours per day, seven days per week)
Enforcement of state and local standards
Entertainment and amusement device licensing and inspection
Food and beverage vending machine inspections
Foodborne illness outbreak investigation
Grant writing and administration
Gypsy moth survey program and coordination of aerial spraying
Hazard Communication Standard training and compliance
Hazardous material incidence response and storage inspections
Health spa inspection
Healthy Bones program
Hearing screenings
Heart disease screenings and education
Hepatitis B immunization and antibody testing for public employees
HIPPA compliance for community
Hotel, motel and multiple dwelling inspection
Human services program
Immigrant/migrant worker health services
Improved pregnancy outcome
Infectious disease reporting and investigation
Inspection of private well installation
Laboratory sampling of food, potable water, recreational bathing water and other surface waters for microbiological standards, safety and quality
Lakefront and ocean beach inspection and enforcement
Licensure of various commercial interests
Local Emergency Planning Committee (LEPC)
Low cost mammography

Massage establishment inspection
Maternal health program
Mayors Wellness Program
Medical Reserve Corps oversight
Medical waste collection, storage, transport recommendations
Mental health services
Municipal recycling program
Municipal safety committee
N-95 mask fit testing and record maintenance
NJ Clean Communities program
NJ Family Care information and referrals
NJ Right to Know program
Noise control
Nursing visits for homebound elderly and infirmed
Nursing home and continuing care facility inspection
Nutrition counseling
Occupational health complaint investigation/referral
Office of Emergency Management
Ordinance production
Pandemic influenza planning
Parenting education
Pet shop and kennel inspections
Plan reviews for various municipal boards
Pool and spa inspection and enforcement
Prostate and cervical cancer screenings and education
Public Employee Occupational Safety and Health (PEOSH) program
Public health nuisance complaint investigation (residential, commercial, industrial)
Public relations and press
Public rest room inspection
Public water system coordinator
Rabies inoculation and veterinary services
Radon testing, mitigation and education
Recycling program administration and coordination
Registrar of Vital Statistics (marriage, birth & death records)
Retail food establishment inspection, training and plan review
Right to Know (RTK) program
School nursing for non-public schools
Scoliosis screening

Septic system installation, including soil and site evaluation, plan review, inspection and assurance
Sewer line tie-in inspections
Sexually transmitted disease program/clinics
Site plan review
Social services and welfare
Solid waste control and enforcement
Speech screenings
Stormwater Management Regulation compliance
Stroke assessments and education
Tanning salon inspection
Tobacco Age of Sale enforcement
Tobacco prevention programs
Training of future public health professionals
Tuberculosis investigation and follow up
Underground storage tank removal inspection and follow up
Vision screenings
Wastewater Management Plan coordination
Watershed protection
Weapons of mass destruction advisory boards
Women, Infants and Children (WIC) program
Youth camp safety program

Source: New Jersey Health Officers Association

Table 11

Staff employed by municipal health departments and regional health commissions by population served

Population	Average # of staff	Range
less than 25,000	8	3 - 13
25,000 – 50,000	14	4 - 75
50,000 – 75,000	24	8 - 72
75,000 – 100,000	39	9 - 100
more than 100,000	39	11 – 96

Sources:

National Association of County and City Health Officials (NACCHO), 2005 Profile of Local Public Health Agencies.

NJDHSS Survey of Local Health Departments, using NACCHO survey form, 2006

Table 12

Average cost per capita by type of local health department

Type of health department	Average	Range
• County health department	$25.99	$4.92 - $71.25
• Regional Health Commission	$12.75	$4.07 – 28.28
• Municipal health department	$24.39	$3.46 - $118.39
o Multi-municipality health department	$15.44	$6.91 - $56.05
o Single municipality health department	$32.74	$3.46 - $118.39

Source:

NJDHSS, Calendar Year 2006 Local Health Evaluation Report, Budget by Funding Source.

Note: In order to provide a proper comparison, the county health department figure was calculated using only the 14 county health departments that provide local public health services to at least one of the municipalities in the county. For those counties that do not provide full services to the entire county, the cost per capita was calculated based on the population of the municipalities that receive local services from the county health department, rather than the total population of the county.

Table 13

Average cost per capita regional and municipal health departments by population served

Population	Average cost per capita
• less than 25,000	$18.14
• 25,000 – 50,000	$18.97
• 50,000 – 75,000	$24.59
• 75,000 – 100,000	$17.34
• more than 100,000	$29.86

Source:

NJDHSS, Calendar Year 2006 Local Health Evaluation Report, Budget by Funding Source.

Table 14

Average cost per capita
All local health departments providing local services
by number of services provided

Services provided	Average cost per capita
• 6-19	$11.92
• 20-29	$14.03
• 30-39	$25.64
• 40-60	$28.99

Sources:

National Association of County and City Health Officials (NACCHO), 2005 Profile of Local Public Health Agencies.

NJDHSS Survey of Local Health Departments, using NACCHO survey form, 2006

Table 15

Funding by Source

Source	County HDs*	Local HDs**	All
Local taxes	55%	62%	59%
State funds^	20%	11%	15%
Federal	14%	25%	20%
Other	11%	2%	6%

* Includes the two countywide Regional Health Commissions

** Municipal health departments and regional health commissions

^ Includes Public Health Priority Funds

Source: NJDHSS, Calendar Year 2006 Local Health Evaluation Report, Budget by Funding Source.

Table 16

Number of Recognized Local Health Departments in New Jersey

Year	Number
1955	195
1974	291
1980	120
1991	113
2006	115
2008	112