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Edward J. Bloustein School
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Enhancing Local Public Health Capacity in New Jersey: *Opportunities for Modernization*

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Executive Summary

"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

A recent report from the national Bipartisan Policy Center creates a vision for future public health practice in the United States that calls for:

- Advances in health equity through the leadership of public health departments' collaboration with community-based stakeholders and with sectors including housing, food, and transportation;
- Sufficient, predictable, and flexible public health funding to support public health's leadership to promote healthy communities;
- A robust, modern, interoperable, and secure public health information system that delivers real-time, accurate, and actionable data to help public health officials detect new or growing threats;
- Modernized laws, policies, and statutes; and
- A highly skilled, trained, and diverse public health workforce (ARMOOH 2021).

New Jersey's local public health capacity can be seen as a microcosm of the findings of the Bipartisan Policy Center report. The purpose of this project was to assess challenges and opportunities associated with the structure and capacity of local public health in New Jersey. Public health agencies are increasingly on the front lines of addressing new health threats not necessarily contemplated when the authorities and underlying structure of local delivery of public health services were enacted. Examples include global pandemics, changing climate conditions and extreme weather events, greater recognition of the contribution that social determinants of health make to health disparities, the opioid addiction crisis, legalization of marijuana, and availability of e-cigarettes.

This project involved 5 tasks:

- Review of previous studies of public health structure and capacity in New Jersey over the past 30 years;
- Examination of structure and capacity of local public health in New Jersey in comparison to eight other states;
- Development of "case stories" that effectively communicate challenges and opportunities associated with public health capacity and structure in New Jersey;
- Assessment of New Jerseyans' perspectives of public health through a statewide poll by the Eagleton Center for Public Interest Polling;

- Convening New Jersey leaders to consider project outcomes to inform dialogue about opportunities for action.

New Jersey has a highly comprehensive set of public health practice standards that appears on par with standards of the national Public Health Accreditation Board (PHAB). Despite these comprehensive standards, in 2021, the Trust for America's Health found that, per capita, New Jersey ranks 31st in the nation in state funding for public health, and it ranks at the bottom (51st among 50 states and District of Columbia) in grant funding from the Centers for Disease Control and Prevention (TFAH 2021). Since 1966, New Jersey's only state appropriated, unrestricted funds for local health departments was the Public Health Priority Fund (PHPF) which provided Local Health Departments with flexibility to address local needs, emerging threats, and priorities outlined in the State Health Improvement Plan (FREUND 2000). A self-study by the state Department of Health and Senior Services concluded that local health departments in New Jersey are more dependent on local tax funds than in any other state (NJDHSS 2008). The PHPF was left unfunded starting in the 2011 state budget; as a result, local public health departments in New Jersey are funded via local property taxes and state and federal funding that is "earmarked" for certain purposes (e.g. vaccines, environmental health services, etc.)

Besides having a highly comprehensive set of public health standards, New Jersey is, by far, the most densely populated state with the most diverse population in comparison to the other states examined for this project. Additionally, New Jersey is most similar in median income and poverty levels to geographically closer states like Connecticut, Maryland and Massachusetts, but as noted, is more racially diverse than either Connecticut or Massachusetts. A comparison to a set of other states found that New Jersey and Massachusetts have the lowest local appropriation median per capita among all states. Although local appropriation (median per capita) has increased since 2013, it has stayed stagnant from 2016 to 2019. For state appropriations, New Jersey has the lowest median per capita funding for public health among all states. New Jersey has also among the smallest public health workforce per capita, at only half that of Connecticut, Maryland, Massachusetts and Oregon, for example.

A second capacity issue that is often raised in New Jersey is the structure of local public health. For the purposes of this study, the research team identified at least a dozen studies, commissions, initiatives, executive actions that, in some form, examined local public health infrastructure in New Jersey. While state regulations require all Local Boards of Health to provide the minimum practice standards outlined in N.J.A.C. 8:52, those services do not necessarily have to be provided by the Local Health Department itself. Some departments may choose to establish contracts with nonprofit agencies to offer some services or they may choose to participate in some form of shared services with other municipal Local Health Departments, a county health department, or a regional health commission. Some of the

previous studies of local health structure in New Jersey seem to assume that a transition to larger or regionalized health departments (i.e. county) would result in more effective and efficient services, although these studies provide limited quantification for such conclusions. On the contrary, several members of the Project Working Group for this project who work in Local Health Departments take the position that locally-based health agencies know their communities well and can deliver the services that are needed locally. Based on the May 2021 New Jersey Department of Health directory of Local Health Departments, 95% of municipalities participate in some form of shared services, either through inter-local agreement, a regional health commission or a county health department.

Nationally, there is a discussion about how the "invisibility" of public health contributes to challenges to establish adequate funding capacity. The statewide poll conducted for this project continues to point to this concept of "invisibility" of public health in New Jersey. Thirty percent of respondents to the New Jersey Eagleton poll indicated that they did not know what the top health-related issue is facing their community; 20% did not know what the meaning of "public health" is; 35% of respondents could not define the function of "public health;" and 48% said they were not too or not at all familiar with the functions of their local public health. At the same time, a large percentage (89%) of respondents said that they have been personally impacted by a service provided by their local health department at some point in their life, and more than 75% of respondents indicated a great deal or a moderate amount of trust in state and local health officials. Approximately 88% of New Jerseyans believe that it is either very or somewhat important for the state of New Jersey to establish a source of stable, dedicated funding that can only be used for local public health services and program; however, respondents expressed concern about how to pay for such funding.

An examination of efforts in several other states point to successful initiatives designed to increase unrestricted funding for local health departments to "modernize" and align their capacity with the increasing role of public health nationally. These successful efforts involve structured "campaigns" in which public health organizations form partnerships with other sectors to advance a shared goal of sustained, adequate and unrestricted funding for local public health. The national recognition of the increased pressures on local public health agencies as a result of reduced funding, a wave of retirements, new responsibilities is evident in New Jersey as well. Organizations and associations that represent local public health leaders and practitioners in New Jersey, many of whom served on the Project Working Group for this project, have worked proactively to form a shared agenda for enhancing the capacity of local public health in New Jersey to address emerging threats.

Related to identifying the keys to modernization of the state's local public health capacity to operate in the 21st century, the current inadequacy of unrestricted and sustainable funding appears to be the thread that weaves through previous studies of public health in New Jersey,

national studies, as well as the experiences of other states interviewed for this project. The pillars that have been advanced as part of successful efforts in other states, national efforts such as those of the Bipartisan Policy Center, and advocacy on the part of local public health associations in New Jersey is one of ensuring that public health has funding that is:

- *Adequate* – National studies point to the overall decline in funding support for public health. Public Health leaders indicate that this decline not only challenges the delivery of traditional, basic public health services but that it thwarts advancement of a "modernization" of public health in keeping with the concepts of Public Health 3.0. Some of the other states examined for this report quantified the gap in available funding for public health services compared to need as a basis for advancing reforms. The New Jersey Public Health Associations Collaborative Effort (NJPHACE) has projected that, if continued at its previous level, the Public Health Priority Fund would, in today's economy, be at a $11.2 million level. However, such estimates are different than a quantitative analysis of what the actual need is for Local Health Departments to not only delivery the state practice standards but also to advance an overall "modernization" of public health;
- *Unrestricted and flexible* – Nationally, public health funding pales in comparison to health care spending. The amount of public health funding that is not "earmarked" for certain purposes has shrunk both nationally and at the state level in New Jersey. Both nationally and at the state level, public health leaders are calling for greater funding that is not necessarily restricted to a certain purpose so that public health professionals can direct funds to where the greatest health challenges and disparities exist especially at a community level; and
- *Sustainable* – When funding for public health services are eliminated, programs often decline or discontinue. Successful efforts in other states to enhance the capacity of local public health has not only emphasized the need for adequate and flexible funding, but it has also focused on advancing more reliable revenue streams for public health. These efforts stress the need for steady and consistent funding sources as key to support longer term public health strategic planning and delivery of services.

The authors heard from the Project Working Group that there is a need for a greater voice from the public health community in developing the solutions to constrained public health capacity in New Jersey and that the voices of the public health community are different than the voices of health care providers. The authors heard a tremendous willingness on the part of the local public health community in the state to seek out opportunities to strengthen delivery of services while cautioning that the inadequacy of unrestricted funding is the biggest challenge to delivering a 21st century public health infrastructure for New Jersey.

I. Introduction

- Purpose of this project

The purpose of this project was to assess challenges and opportunities associated with the structure and capabilities of local public health in New Jersey. Public health agencies are increasingly on the front lines of addressing new health threats not necessarily contemplated when the authorities and underlying structure of local delivery of public health services were enacted. Examples include global pandemics, changing climate conditions and extreme weather events, greater recognition of the contribution that social determinants of health play to health disparities, the opioid addiction crisis, legalization of marijuana, and availability of e-cigarettes.

This project involved 5 tasks:

- Review of previous studies of public health structure and capacity in New Jersey over the past 25 years;
- Examination of structure and capacity of local public health in New Jersey in comparison to eight other states;
- Development of "case stories" that effectively communicate challenges and opportunities associated with public health capacity and structure in New Jersey;
- Assessing New Jerseyans' perspectives of public health through undertaking a statewide poll by the Eagleton Center for Public Interest Polling;
- Convening New Jersey leaders to consider project outcomes to inform dialogue about opportunities for action.

The Rutgers Team found several inherent challenges in undertaking this project. First, responsibilities of local health agencies differ from state to state; in comparing New Jersey's public health structure and capacity to other states, it was important to normalize indicators to ensure that "apples were being compared to apples." The public health practice standards adopted by New Jersey in N.J.A.C 8:52 are highly comprehensive and on par with the performance standards of the Public Health Accreditation Board. Second, there appears to be a history of confusing terminology associated with structure of local public health with interchangeable use of terms such as consolidation, regionalization, and shared services. Third, it was sometimes difficult to assess the extent to which previous evaluations of local public health capacity were informed by evidence-based research; for example, it is not clear the extent to which several previous evaluations that call for consolidation of local health departments are informed by evidence-based research. Finally, it is difficult to assess the extent to which any previous evaluations of local public health capacity and structure specifically led to any changes in funding or operations. For these reasons, the insights of the Project Working Group were invaluable to understanding how past efforts have led to the current structure and capacity of public health in New Jersey.

- Background

Since 2008, the National Association of County and City Health Officials (NACCHO) has periodically surveyed a random sample of local health departments (LHDs) to better understand issues affecting local health departments. In the 2018 "Forces of Change" Survey, conducted prior to the COVID-19 pandemic, NACCHO found the following factors were generally prominent as stressors:

- Workforce Issues – NACCHO reports that local health departments across the U.S. consistently reported budget cuts in recent years, as well as the elimination of more than 56,600 jobs over the past decade. The most recent Public Health Workforce Interest and Needs Survey (PH WINS), a collaborative effort of the deBeaumont Foundation, NACCHO, the Big Cities Health Coalition and the Association of State and Territorial Health Officials, found that nearly half of the government public health workforce plan to leave or retire from their public health organization over the upcoming five years (DEBEAUMONT 2017);
- Opioid Crisis – Overall, approximately two-thirds of LHDs reported conducting activities to address the opioid crisis in 2017;
- Population Health – While there are various meanings of the term "population health" local health departments responding to the NACCHO survey reported that they are increasing their work in population health—which includes addressing community infrastructure; community violence; family and social supports; food insecurity, hunger, and nutrition; and housing instability and homelessness, all of which affect health and well-being;
- Infectious Disease/Influenza – The 2017-2018 influenza season was particularly bad, with one of the dominant strains, H3N2, being associated with complications in people with certain conditions. Local health departments played important roles as communicators and conveners in their community immunization response;
- Technology – Informatics and health information technology (HIT) enable communication between providers to streamline healthcare systems, improve healthcare delivery, and ensure continuity in care across the lifespan. Most departments are using electronic surveillance systems to identify possible foodborne and influenza-like illnesses;
- Climate Change - Environmental health work at the local level protects the public's health against a wide range of threats that can be worsened by the impacts of climate change; however, fewer departments reported addressing climate change-related issues than five years ago. (NACCHO 2018).

Quoted in *The Hill*, Dr. Georges Benjamin, Executive Director of the American Public Health Association, said, "We have not had a year in our country where we've not had a public health emergency to address and we're continuing to do it on a shoestring budget." (HELLMAN 2020)

In fact, the Project Working Group (PWG) that informed this project points to several actions over the past 15 years as further constraining, rather than enhancing, operations of local public health agencies in New Jersey including: State Fiscal Year 2011 elimination of the Public Health Priority Fund, and a 2006 reorganization of the state Public Health Council.

Over the past two decades, local public health capacity and structure in New Jersey has been assessed multiple times by various parties leading to no significant structural changes. This apparent trend of greater responsibility with shrinking capacity of local health agencies is not relevant to New Jersey alone (TFAH 2021) and, based on discussions with several other states as part of this project, the Rutgers team learned of efforts in other states to address the underlying constraints faced by agencies.

> *Public Health is everywhere – safety, gun violence, opioids, flu shots, restaurant inspections, housing, pandemics, health services…. the list goes on and on. But our funding situation is always constricting us from ongoing work on these issues.*
> A local NJ public health official

Discussions held with local health professionals in New Jersey echo what the Rutgers team heard from other states: that the COVID-19 pandemic was not a singular strain placed on public health infrastructure but, rather, that the COVID-19 pandemic made apparent the existing and chronic challenges facing local health agencies. Additionally, the PWG also discussed how chronically constrained public health systems preclude public health professionals from advancing the concept of *the next generation* of public health in the United States launched by the U.S. Department of Health and Human Services in 2016, called *Public Health 3.0*. Public Health 3.0 offers a framework which emphasizes the role of local public health as being the "Chief Health Strategists, partnering across multiple sectors and leveraging data and resources to address social, environmental, and economic conditions that affect health and health equity" (Figure 1) (DESALVO 2017). According to the vision of Public Health 3.0, public health leaders "serve as Chief Health Strategists, partnering across multiple sectors and leveraging data and resources to address social, environmental, and economic conditions that affect health and health equity" (DESALVO 2017). The national conversation about public health 3.0 focuses on the concept that "for a community to address fundamental drivers of health while establishing readiness and resilience to crises requires a strong public health infrastructure, effective leadership, useable data, and adequate funding." One key recommendation for advancement of the concept of public health 3.0 is the enhancement and substantial modification of funding models for public health. "Blending and braiding of funds from multiple sources should be encouraged and allowed, including the recapturing and reinvesting of generated revenue. Funding should be identified to support core infrastructure as well as community-level work to address the social determinants

of health" (DESALVO 2017).

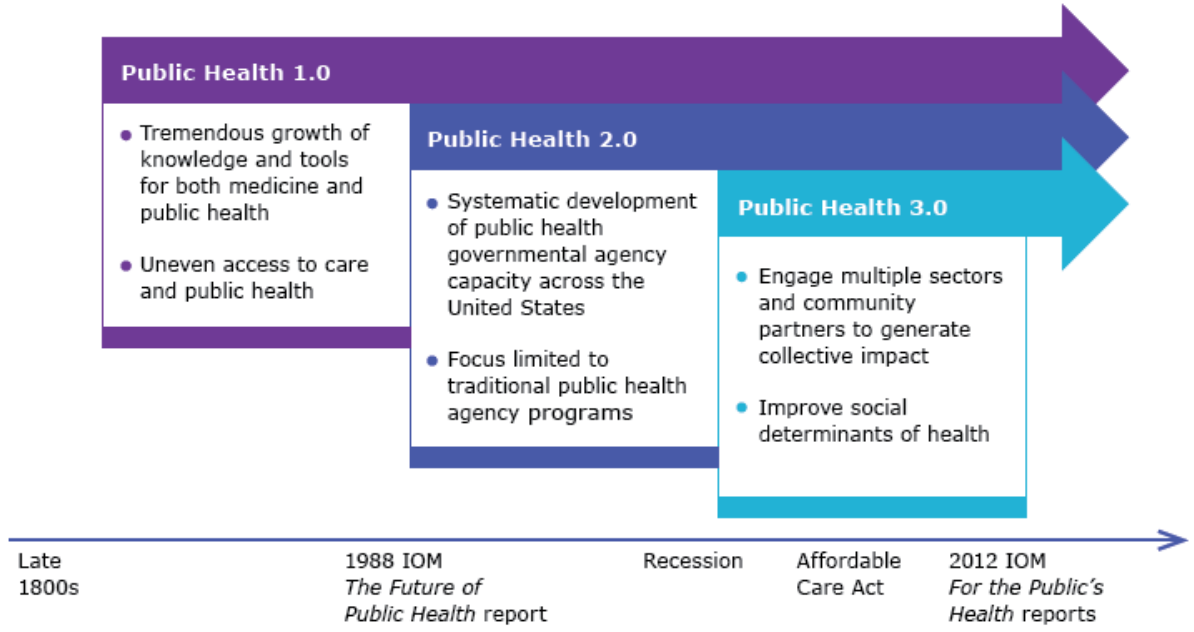


Figure 1
Credit: United States Centers for Disease Control and Prevention

- Status of Public Health Practice

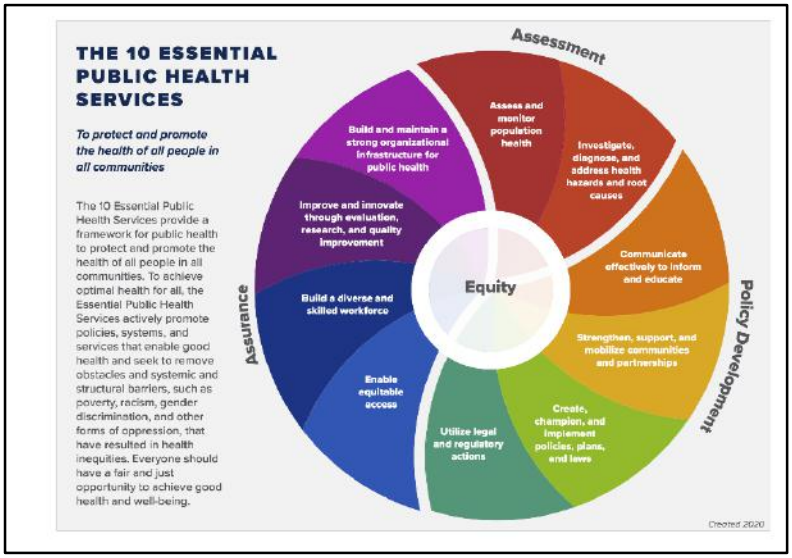


Figure 2
Credit: The Public Health National Center for Innovations

The 10 Essential Public Health Services (EPHS) outline the activities that public health systems should undertake in all communities. Originally established by a federal working group in 1994, the 10 Essential Public Health Services were updated through the Futures Initiative, a task force of public health experts, the DeBeaumont Foundation, and the Public Health National Center for Innovations in 2020 (PHNCIa 2021) to reflect a greater emphasis on "policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression." (CDC 2021). The 10 Services are organized by what are referred to as the three core functions of public health: assessment, policy development

and assurance (Figure 2) and they serve as the basis for health department accreditation by the Public Health Accreditation Board.

A 2012 National Academy of Medicine (NAM) Report found that "it is no longer sufficient to expect that reforms in the medical care delivery system (for example, changes in payment, access and quality) alone will improve the public's health. Large proportions of the U.S. disease burden are preventable." The NAM Committee referred to a "fixation on clinical care" which "eclipses attention to population-based activities that offer efficient and effective approaches to improving the nation's health." The Committee found that "population-based prevention efforts are critical for improving population health and that the public health infrastructure of federal, state, and local health departments is qualified to implement or support such efforts." Among its recommendations, the NAM report identified the need for a minimum package of "foundational" public health services that should be available in all communities. Additionally, the Committee recommended that there be a doubling of federal appropriations for public health to ensure delivery of a minimum package of public health services, and that "federal agencies design and implement funding opportunities in ways that incentivize coordination among public health system stakeholders." (IOM 2012)

"The easiest way to explain public health is that it deals with health from the perspective of populations, not individuals. The clinical health care provider — your doctor, nurse, or dentist — helps you with your own personal healthcare issues. Let's say you have asthma. It's the clinical care provider who listens to you describe your symptoms. He or she does the necessary tests, makes the diagnosis, and prescribes the right medicines. You go home breathing better.

The public health approach is different. Public health takes a look at the whole neighborhood (or city, county, state, etc.) and figures out how many people have asthma and what's putting them at risk. Then, public health professionals get to work figuring out how to reduce those exposures and cut down on the number of new asthma cases. Public health is also concerned with whether the people with asthma have access to doctors and are getting good care. If the folks on our side do their jobs right, the whole neighborhood breathes easier."

American Public Health Association, 2021

In response to the NAM recommendations, the Public Health Leadership Forum convened experts in 2013 to develop a set of foundational public health services which represent a core set of services and capabilities that should be present in all communities (PHLF 2021). The resultant foundational public health services include foundational capabilities - skills needed by state and local health agencies such as communications - and foundational areas - substantive areas of expertise or programmatic activity, such as communicable disease control. The Public Health National Center for Innovation maintains a learning community of states that are involved in adopting the foundational public health services including California, Colorado, Kansas, Kentucky, Massachusetts, Minnesota, Missouri, Ohio, Oregon and Washington (PHNCIb 2021).

Besides not having adequate funding to address all of the challenges public health is facing, too often the funding that we have is overly prescriptive, telling me exactly how I have to spend that money regardless of the particular needs of my community. That doesn't allow me to run my department in ways that I think will be most advantageous for my communities.

A NJ local public health official

According to the Public Health National Center on Innovations, the 10 Essential Public Health Services (EPHS) and Foundational Public Health Services are aligned but were developed for different reasons. "The 10 EPHS were developed to describe the activities the public health system should undertake in all communities, while FPHS was developed to represent a minimum package of governmental public health services to make the case for sustainable funding and to describe what is needed everywhere for public health to function anywhere. A table produced by PHNCI that outlines the relationship of the 10 Essential Public Health Services and the Foundational Public Health Services is contained in Appendix A to this report and a PHNCI layperson's summary of the relationship of foundational and essential public health services is included in Appendix B.

Almost a decade prior to its 2012 report, the National Academy of Medicine issued a 2003 report finding pointing to the historic gap in priorities for investment between public health and health care. Among its findings, the Committee found that "stove-pipe" (i.e. categorical) funding of public health is inflexible and contrary to evidence based planning and that an appropriate investment level is needed to assure that every community has access to the essential public health services. The committee found that many public health departments do not have dedicated funding needed to sustain their public health infrastructure. (IOM 2003). Eight years later, a 2020 study from the Trust for America's Health found that "while the United States spends an estimated $3.6 trillion annually on health, less than 3 percent of that spending is directed toward public health and prevention. Furthermore, public health spending as a proportion of total health spending has been decreasing since 2000 and falling in inflation-adjusted terms since the Great Recession. Health departments across the country are battling 21st-century health threats with 20th century resources" (TFAH 2020). The annual update to the Trust's 2020 report found that, in Fiscal Year 2021, CDC's budget was $7.8 billion, down 1 percent from the previous year, and that CDC's core budget fell by 2 percent when adjusted for inflation (TFAH 2021). The Public Health Leadership Forum's research finds a $13 per person gap nationally in annual spending and calls for establishment of a $4.5 billion Public Health Infrastructure Fund for state, territorial, local and tribal governmental public health to fully support core public health foundational capabilities (PHLFb 2021).

I think that one of the reasons that public health is not well-funded is because public health professionals just put our chins down and get the job done. Most people don't understand what we actually do and, as a result, they don't understand our funding challenges.

A NJ local public health official

- Modernization of Public Health

Throughout the course of this project, the Rutgers team had the opportunity to engage local public health leaders in other states and found a consistent trend of efforts in those states that seeks to "modernize" the public health structure, namely to reorient public health infrastructure towards one more in keeping with public health 3.0 and consistent with a recognition of the greater role that public health now plays in addressing threats that may have not been present in prior decades when public health authorities, programs and funding sources were initially established.

"Health departments across the country are battling 21st-century health threats with 20th century resources. The COVID-19 crisis demonstrates this reality in the starkest of terms." (TFAH 2020)

In December 2021, the Bipartisan Policy Center released a report, *Public Health Forward: Modernizing the U.S. Public Health System*, that is intended to identify a vision for health in the 21st century along with a set of actions for policymakers and public health officials. One of the report authors joined the December 1, 2021 virtual convening for this project to provide an overview of the report findings. The report concludes that pervasive disparities remain among communities regarding factors that affect an individual's physical and mental health, including food insecurity, housing, financial security and access to affordable medical care, etc. COVID-19 exposed numerous, long-standing, and deep fractures in the U.S. public health system. A disproportionate amount of attention is placed on medical care while public health takes a community-based approach to improving health and addressing the underlying social, economic and physical factors that contribute to good health. Public health serves a critical yet often invisible role in health and many Americans do not recognize the value that public health contributes to communities until there is a crisis (ARMOOH 2021).

Examples of efforts in other states reviewed as part of this report where concerted efforts led to a "modernization" or "transformation" of public health include: Connecticut, Kentucky, Maryland, Massachusetts, Minnesota, Oregon, Washington and New York. All of these states have recently undergone or begun some type of modernization effort consisting of some combination of enhanced public awareness and communication about public health functions, restructuring categories of essential services and/or obtaining higher amounts of dedicated funding to support public health. Our analysis of interviews and data from the other states points to several success factors, including the importance of building collaborations among state public health agencies and organizations to pool resources and efforts, as well as the key role of legislative and/or administrative champions.

- Structure of this report

Chapter II of this report summarizes current public health structure and capacity in New Jersey and examines previous studies and reports examining public health structure and capacity in New Jersey over the past 25 years. Chapter III provides a comparison of New Jersey to a set of

other states and highlights of efforts in these states to "modernize" public health and it summarizes the three New Jersey case stories that are featured on a short video that can be found at the project website. Chapter IV summarizes the outcomes of a poll conducted by the Eagleton Center for Public Interest Polling in consultation with the project team and the PWG. Chapter V offers observations and reflections based on the project tasks. The following appendices are included at the end of the report:

- Appendix A – PHCI table aligning the 10 Essential Public Health Services and the Foundational Public Health Services
- Appendix B – PHCI infographic summarizing foundational and essential public health services
- Appendix C – Summary of Public Health Services and Capabilities in New Jersey pursuant to N.J.A.C. 8:52
- Appendix D – Full report of the Eagleton Center for Public Interest Polling

All of the materials generated as a result of this project can be found at the project website at https://sites.rutgers.edu/nj-phi/ including videos of interviews with local public health officials in New Jersey and in other states. Additionally, many reports that were generated over the past 30 years that evaluate public health in New Jersey can be found on the project website as well.

II. Public Health in New Jersey

- Responsibilities and structure of Boards of Health and LHDs

The box below provides a list of major public health laws enacted in New Jersey.

- 1877 – Statutory establishment of the NJ State Board of Health;
- 1880 – NJ adopts a law requiring every town to create a local Board of Health and, in towns with populations greater than 10,000, require the Board of Health was required to hire a health inspector;
- 1877 – NJ adopts law establishing the basic structure for local public health in New Jersey;
- 1905 – NJ adopts a law requiring licensure of health officers;
- 1906 – NJ adopts a law allowing two or more municipalities to join together in employment of a health officer;
- 1929 – NJ adopts a law authorizing counties and/or municipalities to enter into joint contracts for public health services;
- 1938 – NJ adopts law allowing the creation of Regional Health Commissions;
- 1951 – Adoption of the Local Health District Act that that allowed for the creation of consolidated local health districts or county health districts through referendum;
- 1959 – Public Health Activities and Minimum Standards of Performance for Local Boards of Health adopted;
- 1961 – Legislative reorganization of the State Department of Health, authorizing the agency to establish standards of performance for local Boards of Health;
- 1966 – Adoption of the State Health Aid Act which appropriated funds (later known as the Public Health Priority Funding) to support local health Departments in towns with a minimum population of 25,000;
- 1975 – Adoption of the Local Health Services Act which governs current structure and activities of local Health Departments;
- 1977 – Adoption of the County Environmental Health Act which created county-based environmental health agencies under the supervision of the state Department of Environmental Protection;
- 2003 – Regulatory change from the Minimum Standards of Performance to the Public Health
- Practice Standards of Performance for Local Boards of Health in New Jersey (N.J.A.C. 8:52);

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. Each municipality is required to establish a local Board of Health which is responsible for supervising the public health activities of local health departments. A local Board of Health may meet these requirements by maintaining a municipal health department, contracting with another municipal health department, participating in a regional health commission or agreeing to come under the operations of a county health department. N.J.A.C. 8:52 defines a *local board of health* as "a county or municipal board of health, or a board of health of any regional, local, or special health district having the authority to regulate public health or sanitation by ordinance." It defines a *local health agency* as "any municipal local health agency, contracting local health agency, regional health commission, or county health department, administered by a full-time health officer, and responsible for delivering and ensuring population-based public health services." Figure 3 compares the structure of LHDs in 2008 to 2021.

Figure 3 – Comparison of structure of Local Health Departments (LHDs) in NJ

	Municipal LHDs solely covering their own municipality	Municipal LHDs serving other municipalities[1]	Regional Health Commissions[2]	County Health Departments serving at least one municipality	County Health Departments providing only county-wide services[3]	Summary % of municipalities that participate in some form of shared services, either through interlocal agreement, a regional health commission, or a county health dept.
2008 (DHSS 2008)	46	40	7	14	5	92%
2021[4] NJDOH, May 21, 2021)	30	32	6	18	2	95%

The Recognized Public Health Activities and Practice Standards of Performance for Local Boards of Health were first adopted in 1959 (NJDHSS 2008). While all health departments in the United States should provide the 10 Essential Public Health Services, those services do not necessarily have to be provided by the LHD itself. Some agencies may choose to establish contracts with nonprofit agencies to offer some services. In 2008, the New Jersey Department of Health and Senior Services indicated that "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 (NJDHSS 2008).

I'm not sure we have done enough to expand the visibility of public health in New Jersey. After 30 years in the business, I want residents to understand that improving the health of individuals improves the health of the community and visa-versa. By addressing a disease outbreak among some individual, like tuberculosis, we protect the community. By addressing water quality, we protect the health of residents.

A NJ local public health official

[1] 83 municipalities are served by another municipality

[2] 49 municipalities are served by a regional health commission

[3] 374 municipalities are served by a county health department

[4] Note: For the column LHDs serving other municipalities, the authors counted a municipality serving another even if the current arrangement is listed as temporary, if a Health Officer is listed as serving another municipality, and where the six towns on Long Beach Island operate as a combined LHD.

Today, the Practice Standards of Performance for New Jersey Local Boards of Health are detailed in N.J.A.C. 8:52 which sets forth the obligations of local Boards of Health that are administered by local health agencies (NJLBOH 2020). These practice standards are outlined in detail in Appendix B of this report. With the exception of a minor change regarding public health nuisances to conform with court decisions, 8:52 was readopted by the New Jersey Department of Health without change in 2015 (LAKAT 2016). A 2011 study by Rutgers University under contract to the Department of Health and Senior Services involved research, a survey of LHDs, and interviews with local health officers. The study found that the following services are the primary responsibilities of LHDs:

- Ensuring the safety of retail food
- Conducting communicable disease surveillance and control
- Enforcing environmental health and sanitation regulations
- Enforcing public health nuisance codes
- Providing animal control services
- Effectively responding to emergencies that affect community health
- Developing and advocating for laws and regulations that improve the health of the population (MORRIS 2010)

> *Being in public health motivates me because you feel that you are actually having a positive impact on the community. I am a public servant and, like so many other public health professionals, I am dedicated to improving the health and well-being of the people I serve. I don't think most people understand the variety of community challenges that public health addresses – I could be dealing with a rabid animal one day, a pandemic the next day, a gasoline spill, food borne illness, or a Hepatitis A outbreak the next day. Every day is a different challenge.*
>
> A NJ local public health official

Additionally, the same study found that that the services listed in Figure 4, are specifically mentioned in N.J.A.C. 8:52 and are provided by more than 75% of LHDs in New Jersey:

Figure 4

Public Health Services (8:52) offered by 75% of LHDs in 2011 (MORRIS 2011)

- **Environmental health**
  - Recreational bathing inspections
  - Youth camp inspections
  - Child care center inspections
  - Body art / tattoo facility inspections
  - Noise pollution investigations
  - Solid waste control / enforcement
  - Environmental health education
  - Update Right-to-Know information for employers
  - Public health nuisance complaint investigations

- **Food Safety**
  - Vending machine inspections
  - Retail food establishment licensing
  - Product recall inspections
  - Retail food / restaurant inspection
  - Non-retail food inspections
  - Food safety education

- **Planning and Preparedness**
  - Emergency response to natural & man-made event
  - Community risk communication
  - Emergency preparedness education and planning
  - Pandemic influenza planning
  - Development / consultation for local ordinances

- **Maternal and Child Health:**
  - NJ Family Care referrals
  - Child health conferences and home nursing visits
  - Childhood immunizations
  - Childhood lead exposure health education
  - Childhood lead exposure investigations / referrals

- **Animal Control**
  - Rabies vaccination clinics for pets
  - Animal bite investigations / referrals
  - Rabies control (other than pet vaccination clinics)
  - Kennel, shelter, pound, and pet shop inspections

- **Communicable Disease**
  - Reportable disease / outbreak investigations
  - Communicable / infectious disease health education
  - Food and water sampling

- **Health Education**
  - Older adult health education
  - Cardiovascular disease health education
  - Diabetes health education
  - Nutrition health education
  - Cancer health education
  - Blood-borne pathogen / Right-to-Know health education

- **Clinical Services:**
  - Public health nursing activities
  - Hypertension screenings
  - Hypertension counseling / referrals
  - TB investigations / referrals
  - Diabetes referrals
  - HIV/AIDS referral
  - Hepatitis B immunization / screening for public employees
  - Cardiovascular disease screenings
  - Older adult immunizations

Public health officers in New Jersey are required to be licensed by the New Jersey Department of Health (NJAC 8:7-1.1-1.18), which is not often the case in other states. National accreditation (Public Health Accreditation Board) of health agencies is not required; the New Jersey Department of Health and four local agencies are accredited in New Jersey: Camden County Health Department, Montgomery Township Health Department, Princeton Health Department, Bloomfield Department of Health and Human Services (PHAB 2021). While most local health departments in New Jersey have not entered the national accreditation process, as mentioned previously, the public health practice standards established in N.J.A.C. 8:52, that all local health departments must abide by, are generally on par with the national accreditation performance standards.

- Funding

Sources of funding for LHDs in New Jersey come from multiple sources. Figure 4 outlines sources of funds for local health departments in 1994, 1997, 1998 that were provided via Brief #35 of the Forums Institute for Public Policy in 2000; the sources for Fiscal Year 2008 is the Department of Health and Senior Services 2008 report. (DHSS 2008). Accurate data for more recent years regarding contributions of funding for LHDs via local property taxes is not available from the state Department of Health; most of the Local Health Evaluation Report (LHER) was suspended by the state for the past two years in response to requests from local health officers during the COVID-10 pandemic. At this time, the LHER is focused on collecting basic data on infrastructure and metrics related to Healthy New Jersey. Currently, the state DOH maintains data on state and federal funds provided to LHDs through DOH but not on state funds that flow through other state agencies (e.g. County Environmental Health Act grants via the New Jersey Department of Environmental Protection); nor does the state DOH maintain data on federal funds provided to LHDs through other state agencies (e.g. Housing and Urban Development funds). (SEMPLE PERSONAL COMMUNICATION). Thus, drawing a comparison to the data provided below is not possible.

Table 1
Sources of funds for LHDs

Source	1994	1997	1998	FY 2008
Local taxes	63.20%	64.48%	53.28%	59%
State Funds (including Public Health Priority Funds)	12.8%	11.34%	12.17%	15%
Federal grants	14.6%	11.12%	11.29%	20%
Other	9.40%	13.06%	23.26%	6%

Beginning in 1966, the only dedicated source of state funds for LHDs was the Public Health Priority Funds (PHPF), an appropriation from the state budget, which was intended to support "priority health services to be rendered by local health agencies but shall not include grants from the special projects and development fund."[5] Municipal health departments and regional health commissions were eligible to receive PHPF if they served a population greater than 25,000 (NJDHSS 2008). The 1999 State Budget Act reduced the minimum population requirement for local health department eligibility for PHPF from 25,000 to 20,000. State PHPF eligible funds in 1995 were $3 million, $4.1 million in 1999 (FORUMS INSTITUTE, Briefing #35 2000), and $2.4 million which was unchanged since FY2004 (NJDHSS 2008). The Public Health Priority Funds "have been prioritized for use in building LHD infrastructure capacity in accordance with policy initiatives (e.g. Healthy People 2010, Practice Standards for Local Public Health Systems, bioterrorism, and so forth" (FREUND 2000).

> *"LHDs are the 'boots on the ground' workforce with centuries of collective expertise and experience. It is our diversity of backgrounds, cultures, thought, knowledge and expertise that allows our communities to thrive. Our vast knowledge and experience has allowed us to advance and improve the public's health practice…local public health has always been understaffed and underfunded and we are now in a state of crisis, since NJ's local governments, who fund nearly 100% of local public health budgets are now also suffering severe financial constraints."* (PHACE 2020)

A white paper prepared by the New Jersey Public Health Associations' Collaborative Effort (PHACE) indicates that "state funding to local health departments was $6.2 million statewide in 1990, which would equate to $11.2 million today" (PHACE 2020/2021). A 2009 self-study by the state Department of Health and Senior Services concluded that local health departments in New Jersey are more dependent on local tax funds than any in other state (NJDHSS 2008). The PHPF was eliminated in FY2011 when it was not included in the Governor's proposed state budget for adoption by the state Legislature, leaving local public health agencies with no unrestricted, dedicated source of state funding.

More recently, the Trust for America's Health found that, per capita, New Jersey ranks 31st in the nation in state funding for public health, and it ranks at the bottom (51st among 50 states and District of Columbia) in grant funding from the Centers for Disease Control and Prevention (TFAH 2021).[6]

[5] Title 26, Section 2F-3.

[6] Note: These figures do not include funding tied directly to the COVID-19 pandemic response. The U.S. total reflects grants and cooperative agreements to all 50 states and the District of Columbia, but it does not include territories, localities, or tribes for the purpose of comparability. Source: CDC Grant Funding Profiles

- Role of the state DOH

The New Jersey DOH (formerly named the New Jersey Department of Health and Senior Services) is charged with certain responsibilities:

- Monitor LHDs – DOH is required to develop a method for evaluation and determining adherence to standards of performance (N.J.A.C. 8:52-16). Information collected as part of the evaluation process may be used by NJDOH for compliance purposes, publication, and research (N.J.A.C. 8:52-1.4). If NJDOH finds a local health department to be deficient in meeting the standards of performance, the local board of health shall be required to submit a corrective action plan within 30 calendar days to NJDOH (8:52-1.3);
- License health officers – NJDOH is statutorily charged with licensing health officers (N.J.S.A. 26:1A-38). Additionally, NJDOH also licenses Registered Environmental Health Specialists (RHES) and NJDOH also chairs the Public Health Licensing and Examination Board which is currently fully staffed after nearly a decade of expired terms and vacancies. (SEMPLE PERSONAL COMMUNICATION);
- Register LHDs – NJDOH shall annually take registrations from each board of health through a format established by NJDOH. The registration shall include: members of the local board of health; experience, education and training relevant to public policy development; the type of local governance and the type of authority exercised (governing body, autonomous or advisory); jurisdictional areas by municipal code; the jurisdiction's annual public health budget; a schedule of meetings of the local board of health; identification of the local health agency and any other providers delivering services pursuant to the practice standards; and contact information for the local board of health leadership (8:52-1.5);
- Priority Health Funds – Pending passage of the state budget, the NJDOH shall notify each eligible local health agency as to the priority health services and the amount of public health priority funds estimated to be payable during the next calendar year to provide these services. The NJDOH shall accept applications from local health agencies for public health priority funds, including the budget of the agency and the plan of work. (N.J.S.A. 26:2F-9)[7];
- Public Health Council – The seven-member New Jersey Public Health Council is charged with ensuring the reasonable protection of the health of the public-at-large; reviewing and consulting with the Commissioner regarding the regulations for the State Sanitary Code; and reviewing the administration of funds under the Public Health Priority Funding Act of 1977 (NJDOHb 2021). The Council was reorganized in 2005 via an Executive Reorganization Plan of then Governor Codey which, essentially, minimized the regulatory authority of the Council making its role advisory in nature and focused on regulatory actions. (REORGANIZATION PLAN NO. 003-2005)

[7] Note: Funding for the PHPF was eliminated in Fiscal year 2011

Currently, the Council has three of its seven seats filled. The Council mostly did not meet during the course of the COVID-19 Public Health Emergency during which time rule expiration dates had been waived leaving no action items for the Council consistent with its role established by the 2005 Executive Reorganization. The Council did meet in February and March 2020 to address proposed regulatory amendments dealing with cottage food operation permits and, again, in July 2021 regarding the adoption of the cottage food operation permits and the recodification of regulations governing reporting of HIV infection (N.J.A.C. 8:57-2 as New N.J.A.C. 8:65).

In addition to the abovementioned statutory mandates, in 1997 NJDOH established the state's Local Information and Communications System (NJ LINCS) in cooperation with the state's local health departments. NJ LINCS is an electronic information system designed to support interactive reporting, health data analysis and the dissemination of public health information among state, federal (CDC), local public health and emergency service providers. LINCS is intended to connect public health professionals with electronic public health information to support identification and containment of diseases and hazardous conditions that may threaten public health. Local health agencies throughout the state have access to the NJ LINCS network. Establishment and local agency use of the NJ LINCS system was supported by Public Health Priority Funding and other sources (FORUMS INSTITUTE, Briefing #35 2000 and NJDOHc 2021).

- Previous efforts to review public health in New Jersey

There have been numerous efforts to review public health capacity in New Jersey over the eight decades; for the purpose of this report, we focused on efforts over the past 30 years. While the specific focus of these efforts may vary, it appears that one common outcome assessment from most of them is the need for additional resources to support public health agencies.

- **Capital Forums on Health and Medical Care (1992-2004) W**ith support from the Robert Wood Johnson Foundation, the New Jersey League of Women Voters convened a gathering of statewide policymakers to discuss the potential impact that health care reform at the national level would have on New Jersey. In 1997, the nonprofit, New Jersey-based *Forums Institute for Public Policy* was established to administer the ongoing effort. From 1992 to 2009, the Forums issued 55 issue briefs on various health related topics. Most of the issue briefs were on topics related to health care but nine had a specific focus on public health:
    - Issue brief 15 – Public Health at the crossroads: past, present, future. Part 1: national, state and local overview; June 1996
    - Issue brief 16 – Public Health at the crossroads: past, present, future. Part II: the urban-suburban connection; July 1996;

- Issue brief 29 - Demographics, diversity and accountability: the health of New Jersey's communities in 1999; February 1999;
- Issue brief 32 - New Jersey's public health agenda for the next millennium: Healthy New Jersey 2010; December 1999;
- Issue brief 35 - New Jersey public health financing in a changing environment: implications for policymakers; December 2000;
- Issue brief 39 - Domestic preparedness in the age of terrorism: the roles of public health and emergency response systems; April 2002;
- Issue brief 40- Domestic preparedness in the age of terrorism: the roles of public health and emergency response systems; May 2002;
- Issue brief 46 - Public health and emergency preparedness systems and resources: issues and status in 2004; March 2004; and
- Issue brief 47 - Public health and emergency preparedness in New Jersey: part II; June 2004 (FORUMS INSTITUTE).

Issue brief #35 (2000) offered the following insights:

Consistent or committed funding support for public health infrastructure continues to be a "weak link" in the public health financing construct. Although infrastructure goals are addressed in Healthy New Jersey 2010, there is no direct funding – either on federal or state levels – to support these goals. Historically, because categorical funding streams have in many ways "carved" the public health environment, advocates for funding support for infrastructure development are in direct competition for funds for more visible and quantifiable public health concerns, such as disease control and surveillance. (FORUMS INSTITUTE BRIEF #35, 2000).

- **Commissioner's Working Group on Local Health (1993)** - In 1993, the Commissioner of the Department of Health and Senior Services appointed a Working Group to help define the future roles and responsibilities of New Jersey's local health departments in an era of health care reform. (BIALEK 1994). Members of the Working Group included representatives of local health departments, the State health department and other State agencies, local Boards of Health, primary care organizations, the Public Health Council, local health planning agencies, health education organizations, and public health nursing organizations. Specific findings of the working group included:
  - "There has been a clear erosion of local public health services, over the past two decades. Other governmental and private agencies have assumed responsibilities once the province of local health departments. These actions of the State, combined with a significant loss of funds and personnel at the local level, have resulted in an increasingly fragmented public health system that does not perform in a manner that best serves the citizens of New Jersey.

- While local health departments are in the unique position to assess the public health needs of their communities, develop programs and policies to meet those needs, and assure that community needs are being met, neither the current funding levels provided by the State, nor the structure of health departments at the local level, has enabled development of a system that fully protects and serves the public. The current system with its 115 local health departments is cumbersome, lacks consistency in programs and data collection and reporting activities from one area to another, and is poorly financed by the State.
- Most state health departments around the country provide technical assistance and support to their local health departments. The New Jersey Department of Health, for the most part, does not provide these support activities to its local health departments" (BIALEK 1994).

While the Working Group recommended that the "local public health system should be restructured to promote regionalization of certain services and program" to improve efficiency and effectiveness through shared resources, the report did not offer any specific evidence pointing to what specific inefficiencies and ineffectiveness existed in the system at the time. It outlined a vision of "regionalization" that appears to be more akin to a shared service model in which county governments designate "lead agencies" that provide broad infrastructure support in areas such as planning, epidemiology, biostatistics, data collection, as well as help to coordinate programs such as communicable disease control, environmental and public health sanitation, Lyme disease control, etc. Individual agencies, whether county, municipal or otherwise, would continue to provide the services to meet the unique needs of their communities. (BIALEK 1994).

"Investing in a restructured and revitalized local public health system makes good sense."
Commissioner's Working Group 1993

Among its recommendations, the Working Group called for state investment in the local public health system noting "currently the state contributes only about 20% of local health department funds. A true partnership between state and local health departments required more balance in funding levels" (BIALEK 1994). Additionally, it called for greater collaboration between the state Department of Health and other state agencies on shared priorities (re: lead, asbestos, drinking water), and more comprehensive technical assistance efforts of the state Department of Health to local agencies. The Working Group noted that any efforts to develop shared services or regional delivery of services would not save money "in an already resource poor local public health system." Other specific recommendations included: development of a plan to strengthen the state's public health system that can be presented to state and local policy makers, communities, and interest groups; and reconstitution of the Working

Group to include other public and private organizations that can help to advance greater capacity in the public health system (BIALEK 1994).

- **Crafting a Restructured Environment; Turning Point (1999-2004)** With support from the Robert Wood Johnson Foundation, the Medical Society of New Jersey convened a two-year collaborative initiative involving 24 partner organizations called Public Health CARE (Crafting a Restructured Environment). The objective of the initiative was to create a new vision of the public health infrastructure for New Jersey through a series of summits and monthly meetings of project partners. The CARE 2001 final report recommended that funding for public health must be directed to infrastructure development, meaning being more flexible and moving away from programmatic earmarked funding. It also recommended that "the delivery of public health must be restructured into coherent, more easily accessible, geographic entities" although it did not define how such a coherent system may differ from the current one (TURNING POINT 2003).

- **NJDHSS researchers (2000)** – A research journal article prepared by two research scientists in the New Jersey Department of Health and Senior Services summarized the outcomes of a survey of 115 LHDs in collaboration with the New Jersey Health Officers Association (Freund 2000). Observations by the research scientists included:
  - "Structured, comprehensive communication and planning between and among the state health department, LHD s and LBOHs do not exist presently. Continuous quality assurance and accountability systems have not yet been developed to evaluate and monitor the quality of public health services in New Jersey. Therefore, local governments are forced to consider only cost without any measure of quality when determining how to best provide public health protection for their communities. These factors have had a great deal of influence on public health capacity in New Jersey.
  - The categorical nature of public health programming and financing at the federal level has given rise to varying degrees of public health infrastructure capacity as well. Those programs with strong constituencies and substantial funding have developed capacities for data and information management, specific programmatic training and evaluation activities. While there are no data at the present time to show a relationship between a well-developed infrastructure and good public health practice performance, it is reasonable to believe that the two are associated closely.

> *We feel the pinch of resources directly at the community and family levels. Working directly with community members is critical but it's also very time-consuming. Some grants have allowed us to go out into the community more, but when you lose those grants, it really hurts our efforts.*
>
> A NJ local public health officer

- Less than one percent of all health care dollars in the United States are spent for public health prevention activities that address the root causes of society's health problems. Public health infrastructure, the foundation on which new expertise and effective service delivery rely, will become increasingly important as public health challenges continue to change in nature and complexity over time" (FREUND 2000).

- **Executive Order #140 (2002) –** Following the events of September 11, 2001, former Acting Governor Richard Codey issued Executive Order #140 that established a Governor's Task Force on Public Health Emergency Planning which was charged with:
  - "examining the infrastructure of New Jersey's public health system (at all levels) to determine whether New Jersey is ready to serve the public health needs of its citizens in the event of a future terrorist attack or other public health emergency;
  - recommending a single definition of "public health" to allow the more than 600[8] Boards of Health and local health officials to coordinate their efforts and develop one coordinated public health system;
  - identifying the statutory and regulatory steps that should be taken to address any issues and/or shortfalls identified;
  - examining the relationships between local health officials and State health officials to determine whether there is adequate coordination and communication, whether the creation of county health departments is necessary and whether having approximately 525 Boards of Health and 115 local health agencies properly utilizes State resources;
  - determining whether the following public health system principles are being met:
    - preventing epidemics;
    - protecting the environment, workplace, housing, food and water;
    - promoting good health behaviors;
    - monitoring the health status of the population;
    - mobilizing community action;
    - responding rapidly and effectively to disaster;
    - promoting the quality, accessibility and accountability of medical care;
    - identifying and reaching out to link high-risk and inaccessible people to needed services;

[8] Authors' Note: there are multiple methods for calculating the number of local health departments in New Jersey. This number was included in the Executive Order but does not reflect current status.

- conducting research to develop new insights and innovative solutions; and
- leading the development of sound health policy and planning.

  - determining whether additional funding of our public health system is necessary;
  - recommending changes to New Jersey's public health system" (EXECUTIVE ORDER #140 2002).

Outcomes of the Task Force's deliberations were focused on the public health emergencies elements of the Task Force's charge which led to the adoption of the 2005 New Jersey Emergency Health Powers Act which, most recently has been invoked by current Governor Phil Murphy to address the COVID-19 pandemic (BOOKBINDER PERSONAL COMMUNICATION). The Task Force was terminated by former Governor Christie in 2010 (EXECUTIVE ORDER #40 2010).

- **Public Health Governance Performance Assessment (2005) –** The CDC *National Public Health Performance Standards Program* developed survey instruments that are intended to guide state and local agencies in evaluating current performance compared to the Essential Public Health Services (CDC 2013). In January of 2004, the New Jersey Department for Health and Senior Services (DHSS) commissioned three units within Rutgers University to coordinate with the New Jersey Local Boards of Health Association, to manage the process of administering the Local Public Health System Governance Performance Assessment Instrument to local Boards of Health in New Jersey with more than 150 local and county Boards of Health and Regional Health Commissions participating in the survey assessment. Overall, the assessment found that the participating local Boards of Health felt that they met 90.70 percent of the Essential Public Health services. The analysis indicated that local boards of health reported three areas where they had the least capacity:
  - Oversight of public health service evaluation;
  - Oversight to assure public health innovation and research; and
  - Oversight of public health policy making and planning.

  The researchers made a set of recommendations for actions to address the identified capacity limitations. (RUTGERS/NJLBHA 2005)

- **NJDHSS Report Review of Local Public Health Systems (2008)** – Completed in 2007 and released publicly in 2008, this internal study by the Department of Health and Senior Services was "designed to assess the efficacy of the state's public health 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." In general, the assessment found that 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. "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" (NJDHSS 2008). The report identified a number of actions that NJDHSS was undertaking at the time to strengthen the current public health structure in the state and promote more effective coordination among public health agencies, including:

  > *"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."*
  > NJDHSS 2008

  - 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;
  - Assessment of the annual report (Local Health Evaluation Report) that local health departments submit to the Department;
  - Review of current State statutes and rules governing public health practice;
  - 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;
  - Development of a process for evaluating the structure and performance of local health departments and documenting their compliance with the Practice Standards;
  - A comprehensive review of the standards and procedures for licensure of Health Officers.

- **NJ Health Officers Association (2009)** - Under contract to the New Jersey Health Officers Association, the Johns Hopkins School of Public Health conducted a two-part study to offer recommendations for strengthening the state's public health system (EDWARDS 2009). The first part of the study focused on presenting the state's structural, demographic, and economic background and an inventory of the existing public health system. The study summarizes previous reports and compares New

Jersey's public health system to other states. The second part of the study provides conclusions and recommendations. Specific findings of the two-part Hopkins study include:

- "Reduced funding has led to a steady decline in public health staffing across the state, putting the public's health at risk. Some in the New Jersey public health community are very worried about this, since there are no minimum public health staffing requirements. This decline in staffing also was mentioned in NJDHSS' application to the CDC for enhanced funding for public health infrastructure and could serve as the impetus for crafting minimum New Jersey staffing requirements;
- The most common age of the New Jersey on-line survey respondents (48%) was 50 –59 years and most anticipated retirement within the next 6 to 10 years (23%). These New Jersey age and anticipated retirement data are similar to other national public health workforce findings;
- The desire was strong among interviewees from all entities that obtaining and using public health data at a smaller geographical level than the county level data now available, is crucial;
- The political will to change public health laws in New Jersey, as needed, is not assured, but will be needed in order to introduce new laws, or amendments to existing New Jersey laws, as mentioned below. Working with appropriate state bodies, the need for identifying in law a sustainable source of New Jersey public health funding seems crucial" (EDWARDS 2009 AND EDWARDS 2010)

> *We have funding to do what we're required to do, but, typically, we're lacking in funds to do the things that we know we need to do. Sometimes we start projects, but we cannot end them because the funding doesn't stay. It would be great if we had a line item from the state every year that provides a set amount of fund for our region and we are allowed to use it as we see fit.*
>
> A NJ local public health official

- **Rutgers review of local health monitoring (2010)** – A study commissioned by the New Jersey Department of Health and Senior Services to Rutgers University Office of Continuing Professional Education was designed to study the existing Local Health Evaluation Report (LHER) that local health agencies are required to submit annually to the NJDHSS Office of Public Health Infrastructure. (MORRIS 2010). In general, the study found that the existing LHER is the State's single most comprehensive source of information on local health agency capacity and performance but it failed to support efforts to assess local health agency capacity in order to implement system-wide improvements. The study recommended that the Office of Public Health Infrastructure use a process of revising the LHER to "initiate a statewide public health data collection effort and support state and local quality improvement efforts while minimizing the reporting burden imposed on LHAs." Further, the study recommended that: data collected via a revised LHER be internally consistent with the practice standards of

N.J.A.C. 8:52; data be collected electronically and be made accessible via a database-driven performance training system that allows local health agencies to internally monitor their own performance and outcomes and that allow for the generation of reports that evaluate performance in comparison to local health agencies responsibilities, cost effectiveness, community health status and other variables; and the data be used to produce an annual "Health of the State" report that summarizes the capacity, performance, and outcomes of New Jersey's local public health system. The study found that a comprehensive and accessible system of monitoring of local health agencies would support the establishment and maintenance of a New Jersey-specific "best/ promising practice" website that provides local health agencies with access to quality improvement tools and guidance, regulatory resources, public health data and reports, and best-practices drawn from other New Jersey local health agencies (MORRIS 2010)

- **Local Unit Alignment, Reorganization and Consolidation Commission (2010)** – The Local Unit Alignment, Reorganization and Consolidation Commission (LUARCC) was established on March 15, 2007 as part of P.L. 2007, c. 54.(N.J.S.A. 52:27D-502). The Commission was directed to study the structure and functions of county and municipal government. In its 2010 Progress Report, the Commission wrote that it "began its hearings on the local public health system from the perspective of seeking greater cost-efficiency in service delivery, but soon became aware of the challenges facing public health in New Jersey. As noted earlier, the State contributes relatively little toward the cost of delivering local public health services and the State's role is mainly to promulgate practice standards. With relatively little State investment, the State lacks the leverage usually associated with financial subsidy" (LUARCC 2010). Additionally, the Commission acknowledged the state Department of Health and Senior Services was "implementing a 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 are to assist local health departments in improving their performance, while taking appropriate actions against non-compliant local health departments" (LUARCC 2010). The reforms of the Monitoring and Evaluation Initiative were adopted as revisions to the Local Health Evaluation Report (LHER) in 2013 until the NJDOH's decision to suspend most of the LHER in 2020 and 2021 in response to requests from local health departments, the resources of which were constrained by the COVID-19 pandemic. (SEMPLE PERSONAL COMMUNICATION). Additionally, the LUARCC Commission recommended that the Department of Health and Senior Services (DHSS) encourage larger health service units that produce greater compliance on the assumption that larger units would produce improved outcomes more efficiently. A 2014 report by Rutgers University researchers found that greater efficiency of government services is

not directly related to agency size: “to contradict the prevailing folk hypothesis in two fundamental areas: first, that the state may have too many municipalities, and second, that smaller municipalities are more expensive than larger municipalities, thus contributing to the overall state property tax challenge.” In fact, the 2014 Rutgers study found that “the average cost of municipal government per capita, as demonstrated in each of ten population size groups of municipalities, does not differ significantly between large or small government population groups.” (CAPRIO 2014).
A 2013 presentation by representatives from the NJDOH and the Rutgers School of Public Health at the Public Health Services and Systems Research and Practice-Based Research Networks National Coordinating Center summarized the *Multi-Network Practice and Outcome Variation Examination (MPROVE) Study* and its relationship to the relationship to the LHER (PAWLENKO 2013). The presentation summarized the assessment leading to revisions of the LHER, including an electronic survey of 55 LHDs, one-on-phone interviews, pilot testing of a revised LHER with three LHDs and engagement of a project steering committee. The presentation indicated that priorities for what to measure via the LHER include: programs and services delivered directly or through partners; resources used to deliver the services; and outcomes achieved by the services. The revised LHER, that would be initiated in January 2014, was expected to streamline data management and reporting through use of electronic systems, collect timely and local data, and generate easy-to-read reports on demand (PAWLENKO 2013).

- **Quality Improvement (2011-2014)** - Strengthening the Community of Practice for Public Health Improvement (COPPHI) was a 2011-2014 effort led by the National Network of Public Health Institutes with support from the Robert Wood Johnson Foundation to build capacity among the nation’s public health departments to meet national standards for accreditation and to conduct quality improvement (RWJF 2021). The effort involved three components: Grants and technical assistance to 60 public health organizations; open forums for public health practitioners share information about best practices related to quality improvement; and development of a searchable database with information on quality improvement projects (PHQIX 2021). New Jersey Public Health practitioners participated in the open forums. In New Jersey this effort was preceded by a project funded by the NNPHI to the New Jersey Association for County and City Health Officials and the Rutgers School of Public Health to offer trainings on quality improvement and health department accreditation. The effort was extended in 2017-2018 with funding from the U.S. Centers for Disease Control and Prevention and in partnership with several New Jersey local public health associations and, as a result of this funding, the Rutgers Public Health Training Center provided additional training on quality improvement to local health departments. Training for the public health workforce continues to be offered through the Rutgers Center for Public Health Workforce Development which includes the NJ Public Health Training Center, funded by

the Health Resources and Services Administration, and the Center for School and Community Health Education (https://rutgerstraining.sph.rutgers.edu/).

- **New Jersey Local Public Health Agencies (2018)** – In a memo to Governor-elect Phil Murphy and his transition team, the New Jersey Public Health Associations Collaborative Effort (PHACE) offered a set of recommendations for action to support LHDs, including that the state:
    - *"Study the local public health infrastructure in New Jersey and the adequacy of the funding to support that structure* - We believe that the resources attributed to protect the public's health and support the structure are inadequate to assure the health and safety of our constituents and therefore welcome its investigation.
    - *Reinstate the statutory authority of the Public Health Council* – The Public Health Council was created in statute to serve as New Jersey's State Board of Health. However, an Executive Order during the Codey Administration downgraded it to an advisory body. We believe that the statutory authority of the Council needs to be reinstated, to assist the State Department of Health in its development and adoption of public health policy, and to provide a diverse perspective that represents the State of New Jersey;
    - *Encourage all members of the new Administration to consider the known and potential public health impacts and implications in ALL policy development, proposals, and adoptions, as well as in all actions of state government* - The social determinants of health, such as socio-economic status, education, etc., are all known to be significant contributors to individual and community health outcomes. However, we tend to ignore the implications of our actions and their impact on health. We encourage the changing of the culture to consider these issues" (PHACE 2018).

Relatedly, the New Jersey Local Boards of Health Association provided testimony at a NJDOH Budget Listening Session on February 6, 2020 and called for:

- Restoration of the Public Health Priority Funding budget to at least $11.2 million/annually (ROMAN PERSONAL COMMUNICATION);
- Earmarked funds for continuing education for health officers and REHS;
- Support to its association to deliver governance training to local Boards of Health as was previously done;
- Restoration of the authority of the NJ Public Health Council. (ROMAN 2020)

III. Comparison to Other States and New Jersey Case Stories

This chapter consists of two parts. The first part is an analysis of public health structure, resources and mandates from a set of other U.S. states. The second part is a summary of the interviews conducted with three public health officers from New Jersey; excerpts of these interviews are included in video format on the project website.

- State Comparative Analysis

In order to provide more context for understanding New Jersey public health and to uncover potential examples or models for modernization in New Jersey, a comparison of public health structures and resource capacities in other states was conducted. The analysis consisted first of a comparative analysis of data and statistics gathered from US Census and other trusted public health informational reports issued by CDC, Trust for America's Health and others (U.S. CDC 2020, TFAH 2019). The second step was to create mini-case studies for each of the other studied states through conducting informational interviews with public health leaders in each of the states, supplemented with other information resources on the states' websites or obtained from interviewees.

Comparison States:
Connecticut
Kentucky
Maryland
Massachusetts
Minnesota
New York
Oregon
Washington

We first highlight the key findings and messages drawn from the analysis. We then present the more detailed comparative statistical analysis, followed by brief summaries of the case stories from each state.

1. **Key Findings and Messages: Themes and Lessons from State Comparative Research**

The highlighted findings of the state data analysis comparison are:

- New Jersey is the most densely populated and most diverse state among the states in the comparison.
- New Jersey has the lowest median per capita state appropriation for public health among the states in the comparison.
- New Jersey has among the smallest public health workforce per capita among states in the comparison, at only half that of regional neighbors Connecticut, Maryland, and Massachusetts.

We highlight these key messages from the comparative research that could serve as lessons in the development of recommendations for building additional capacity to support public health in New Jersey:

- ***Identify Core, Basic or Foundational Services and Assessing Needs/Gaps:*** In all of the comparison states, there was an effort, usually started by a task force created at the

state level due to an opportune alignment of public advocacy, a salient issue and political will, to pull together public health leaders to review functions of public health and to determine a set of essential services (and/or capacities) performed by the sector. Developing consensus and consistency around this set of core services then allows costs to be attached to each, and facilitates easier and clearer discussions around needs to provide resources to sustain those services.

- ***Focus on a Priority Outcome***: In the other comparison states, the efforts that generally led to increased capacity for public health focused on individual outcomes rather than a large suite of reform measures. These focused efforts generally led with the message that the role of public health has changed tremendously since the initial inception of public health funding in the state and that more had to be done to ensure that adequate, stable and unrestricted resources are available to support public health's 21st century role in addressing critical public health challenges not previously anticipated including pandemics, vaping, social determinants of health, climate change, etc.
- ***Secure Stable Unrestricted Funding for LHDs:*** Some states had continued dedicated unrestricted support for public health departments for decades. Others only secured it recently or expect it in the next budget cycle. Other states indicate that stable, unrestricted funds are not a panacea and it only partially covers the true cost of public health functions. However, they also indicated that stable, unrestricted state funds provide them with the opportunity to have flexibility to respond to emerging local public health challenges, to work in partnership with residents and community leaders, and to ensure follow-through on new initiatives that may be grant funded. Champions from either the legislature or from within state government are often necessary to move along these proposals.
- ***Form Collaborations:*** Efforts to advocate for modernization benefit greatly when the various agencies and associations with public health missions and roles in the state (BOH, Health Officers), joined by healthcare provider organizations, pool resources to build stronger capacities, either formally through creation of a new umbrella group or informally through a collaborative arrangement. If funding or sponsorship for a dedicated leader of this group can be secured, the effort is further strengthened.
- ***Increase Public Awareness and Support for Local Public Health:*** In several of the states, and primarily those that had formed strong and funded collaborative entities to promote and lobby for public health, an important part of the initiative includes promotion of the role, functions and accomplishments of the public health sector to the legislature, the Executive Branch, and to the general public. This is done through taking a professional approach to preparing not only persuasive briefing sheets, but broadcasting educational messages through websites, local media outlets and social media to build public awareness.
- ***Inform Public Policy:*** Experiences in the other states to build coalitions with other organizations that support public health and health equity goals also led to

opportunities to more significantly influence public policy. Other states reported that their efforts to work with cross-sector partners that share health equity as a primary goal, to engage decision-makers, and to collaborate with executive and legislative branch champions, empowered their efforts to give public health a greater voice in policy-making.

2. Comparative Analysis of Demographics, Socioeconomics and Public Health Structures

States were selected based on those that would closely provide close comparisons with New Jersey regarding similarity of political structure and structure of public health system, along with a priority on states closer geographically to New Jersey and also those considered to have good performance. The list was refined and finalized in consultation with the Project Working Group to include these eight states: ***Connecticut, Kentucky, Maryland, Massachusetts, Minnesota, New York, Oregon, and Washington.***

Summary points from the demographic and socioeconomic comparative profile that provide an important context in which to interpret public health needs and constraints include:

- New Jersey is by far the ***most densely populated*** (about 40% more dense than next closest – Massachusetts).
- New Jersey has the ***most diverse*** population. (While New Jersey does not have the lowest percentage of non-Hispanic white population, it is the only state in the group with ten or more percent population in each of the Black, Hispanic and Asian demographics.)
- New Jersey is ***around the middle of the comparison group in percentage of very young and of older adults***.
- New Jersey is ***most similar in median income and poverty levels to geographically closer states*** like Connecticut, Maryland and Massachusetts, but as noted, is more racially diverse than either Connecticut or Massachusetts.

Table 2. Demographic and Socioeconomic Characteristics

	CT	KY	MD	MA	MN	NY	OR	WA	NJ
Pop. est.	3.56 mill	4.47 mill	6.05 mill	6.89 mill	5.64 mill	19.45 mill	4.22 mill	7.61 mill	8.88 mill
Pop. Dens. (pop/sq-mile)	736	113	623	883.65	71	413	44	115	1208
Age <5 yrs old	5.1%	6.1%	6%	5.2%	6.2%	5.8%	5.4%	6%	5.8%

Age >65 yrs old	17.7%	16.8%	15.9%	17.0%	16.3%	16.9%	18.2%	15.9%	16.6%
Med HH Income	$78,444	$50,589	$84,805	$81,215	$71,306	$68,486	$62,818	$73,775	$82,545
Under poverty	10.0%	16.3%	9.0%	9.4%	9.0%	13.0%	11.4%	9.8%	9.2%
Race/ethnicity									
Non-Hispanic White	65.9%	84.1%	50%	71.1%	79.1%	55.3%	75.1%	67.5%	54.6%
Black	12.2%	8.5%	31.1%	9.0%	7.0%	17.6%	2.2%	4.4%	15.1%
Hispanic	16.9%	3.9%	10.6%	12.4%	5.6%	19.3%	13.4%	13.0%	20.9%
Asian	5.0%	1.6%	6.7%	7.2%	5.2%	9.0%	4.9%	9.6%	10.0%
Native Am/Alaska/HI	0.7%	0.4%	0.7%	0.6%	1.5%	1.1%	2.3%	2.7%	0.7%

Source: (U.S. Quick Facts (2019), US Census Bureau, https://www.census.gov/quickfacts/NJ)

Figure 5 provides a state-by-state listing of "basic services" provided by local public health. This figure is provided to caution the reader to not compare "apples to oranges" between the different responsibilities of local public health among the comparison states. Of note is the comprehensive nature of New Jersey's public health practice standards codified in N.J.A.C. 8:52 which appears to incorporate at least all of the responsibilities of the comparison state, as outlined in Figure 4 and Appendix B of this report. Commonalities among the comparison states are environmental health, communicable disease prevention and some kind of general population health assurance, tracking and/or assessment. Some include emergency services, maternal and family, vital records and administration as either services or capabilities and others do not. Again, all of these services provided by any of the comparison states appears in the New Jersey public health practice standards in N.J.A.C. 8:52.

Figure 5. Public Health Basic Services by State

Connecticut – Basic Health Program (10)

- Monitoring health status
- Investigating and diagnosing problems
- Informing, educating and empowering
- Mobilizing partnerships
- Developing policies and plans
- Enforcing laws and regulations
- Connecting persons to services
- Assuring a competent workforce
- Evaluating effectiveness of health services
- Researching to find solutions

Kentucky (5):

- Population Health
- Enforcement of Regulations
- Emergency Preparedness and Response
- Communicable Disease Control
- Administration and Organizational Infrastructure

Maryland – Core Public Health Services (7):

- Administration and Communication
- Adult and Geriatric Health
- Communicable Disease
- Environmental Health
- Family Planning
- Maternal and Child Health
- Wellness Promotion

Massachusetts - Required Duties of LBOH (12)

- Record-keeping
- Healthcare and disease control
- Housing inspection
- Hazardous Wastes
- Solid Waste
- Septage and Garbage
- Nuisances
- Food
- Pools and beaches
- Camps, motels and mobile parks
- Miscellaneous
- Smoking

Minnesota – Basic Services (6)

- Assure an adequate local public health infrastructure
- Promote healthy communities and healthy behavior
- Prevent the spread of communicable diseases
- Protect against environmental health hazards
- Prepare and respond to emergencies
- Assure health services

New York – Core Services (5)

- Assessing the health of the community
- Disease control and prevention
- Family health services
- Health education
- Environmental health

Oregon – Foundational Programs (4) and Foundational Capabilities (7)

Foundational Programs:

- Communicable disease control
- Access to clinical preventive services
- Environmental health
- Prevention and health promotion

Foundational Capabilities:

- Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- Assessment and epidemiology
- Policy and planning
- Communications
- Emergency Preparedness and Response

Washington – Foundational Public Heatlh Services (6) Capabilities (6)

Services:

- Communicable disease control
- Chronic disease and injury prevention
- Maternal child family health
- Access to clinical care
- Environmental public health
- Vital records

Capabilities:

- Assessment (Surveillance and Epidemiology)
- Policy Development and support
- Communications
- Emergency Preparedness and response
- Community partnerhips development
- Business Competence

The table below shows that only Massachusetts houses public health at the municipal level exclusively. The number and jurisdiction size of LHDs in the comparison varies widely, from only 24 in Maryland to more than 350 in Massachusetts.

Table 3. Public Health Structure and Authority

	CT	KY	MD	MA	MN	NY	OR	WA	NJ
# of LHD*	73	51	24	351	92	58	34	35	104
LHD Unit	64	County (38) + 13 District	County (plus Baltimore)	Municipal	City and County	County (plus NYC)	County + 1 District	County (plus Sea-Tac and Tribal)	Municipal, county, regional
State Code	CT Public Health Code	Duties of county health departments Kentucky Revised Statute (KRS 212.240)	COMAR-Title 10-Health and Mental Hygiene COMAR-Title 26-Environment	DPH regulation Code of Massachusetts Regulation(CMR)	Local Public Health Act Public Health responsibility Minn. Stat. § 145A.04 subd. 1a	Consolidated law of New York PBH Public Health	Local Public Health Authority (ORS 431.416)	Agency rules, WAC 246	Public Health Practice Standards of Performance for LBOH in NJ (N.J.A.C. 8:52)

*LHD = Local Health Department

Table 4 shows that New Jersey and Massachusetts have the lowest local appropriation median per capita among all states. Although local appropriation (median per capita) has increased since 2013, it has stayed stagnant from 2016 to 2019. For state appropriations, New Jersey has the lowest median per capita funding among all states. All comparison states except New York show a decrease in state appropriation median per capita funding from 2013 to 2019.
New Jersey has the second lowest total revenue (from other sources that are non-state or local) median per capita among other states. Maryland has the highest total revenue, state appropriation and local appropriation median per capita. New Jersey has also among the smallest public health workforce per capita, at only half that of Connecticut, Maryland, Massachusetts and Oregon, for example.

Table 4. Public Health Funding and Workforce*

Local appropriation median percentage	CT	KY	MD	MA	MN	NY	WA	OR	NJ
2019	$ 0.16	$0.22	$ 0.37	$ 0.02	$ 0.13	$ 0.05	$ 0.05	$ 0.30	$ 0.06
2016	$ 0.12	$ 0.11	$ 0.54	$ 0.03	$ 0.09	$ 0.02	$ 0.07	$ 0.13	$ 0.06
2013	$ 0.13	$ 0.17	$ 0.54	$ 0.02	$ 0.08	$ 0.10	$ 0.11	$ 0.11	$ 0.04

State appropriation median percentage	CT	KY	MD	MA	MN	NY	WA	OR	NJ
2019	$ 0.03	$ 0. 13	$ 0.96	$ 0.00	$ 0.14	$ 0.25	$ 0.04	$ 0.05	$ 0.002
2016	$ 0.03	$ 0.12	$ 0.92		$ 0.09	$ 0.09	$ 0.08	$ 0.10	
2013	$ 0.06	$ 0.31	$ 1.42		$ 0.15	$ 0.21	$ 0.21	$ 0.21	$ 0.000

Total revenue median percentage	CT	KY	MD	MA	MN	NY	WA	OR	NJ
2019	$ 0.28	$ 0. 73	$ 2.66	$ 0.02	$ 0.40	$ 0.23	$ 0.30	$ 0.72	$ 0.08
2016	$ 0.19	$ 0.61	$ 2.48	$ 0.03	$ 0.45	$ 0.18	$ 0.38	$ 0.50	$ 0.07
2013	$ 0.25	$ 0.71	$ 2.77	$ 0.02	$ 0.36	$ 0.48	$ 0.39	$ 0.55	$ 0.07

Estimated size of LHD workforce (avg.) per 10,000 people	CT	KY	MD	MA	MN	NY	WA	OR	NJ
2019	0.281	0.12	2.664	0.022	0.404	0.233	0.304	0.716	0.075
2016	0.190	0.11	2.484	0.031	0.454	0.177	0.378	0.503	0.068
2013	0.246	0.15	2.773	0.015	0.364	0.478	0.395	0.552	0.075

*Sources: TFAH, 2019; NACCHO, 2013, 2016

3. Case Stories of Comparison States: Modernization Efforts

We provide a summary of the highlights of the conversations with lead figures in the public health modernization efforts in the eight states in the comparative analysis. The summaries describe public health structure in the states, and then focus on context and development of modernization efforts, with an emphasis on those aspects that could most apply to New Jersey.

Connecticut - *Health District Model Promising, But Needs Support*

Connecticut has 169 individual towns with individual governments, and no county government structure. There are a total of 73 LHD's, with varying structures:

- Full-time municipal (larger cities)
- Districts (20, ranging from 2 to 17 towns in each)
- Small towns with part-time health director (there is a movement to eliminate these)

Enabling legislation in the 1960's allows towns to voluntarily form multi-jurisdictional entities (districts) for health, funded by localities and state per capita money that required a report on usage. Originally, per capita funding was higher for towns that were part of districts, but the legislature eliminated this state appropriation, thus eliminating an incentive for shared service. A Governor's task force on public health was established approximately ten years ago. At the time, the state's standard included eight antiquated essential services. The Task Force effort led to the adoption of the 10 essential services. A spring 2021 legislative effort was aimed at adopting a $1.85 to $2.60 per capita increase for unrestricted public health support with a total of $4 million anticipated (KERTANIS PERSONAL COMMUNICATION).

> *If we want to make public health governance effective, we have to invest in it.*
> A State Public Health Representative

Regardless of the adoption of the 10 essential services, funding levels have not increased and the local public health community indicates that it has not been adequate. As a result, researchers found that local health departments were forced to make adjustments including increasing fees for services and reducing their workforce. (PRUST 2015)

Kentucky - *Collaborating and Advocating for Public Health at Politically Opportune Times*

Kentucky's counties have either individual health departments (38), or have combined into multi-county regional departments (13). Most are funded by local and other taxes. Over the years, public health became very under-funded and largely consisted of clinical services, Medicaid, etc. A new health commissioner in Kentucky was "hugely instrumental" in understanding the problems in public health, and worked with the state Health Department Association (HDA) to put together a strategic plan. The political opportunity arose to tie full funding of health departments to the rescue of the state's failed pension fund, and this "selling point" proved successful and eliminated resistance.

The process involved first determining a set of Foundational Public Health Services (FPHS), and Kentucky tweaked the Institute of Medicine categories to match the state. This set of services was then used to determine how much money is needed to fund the FPHS each year in each county. (See graphic on following page.) The "Public Health Transformation" bill passed in 2019 to provide funding for statutorily required services through evidence-based practices.
The onset of COVID has delayed the regulatory process, and, in the meantime, a new governor and health commissioner have also shifted momentum. There is now a plan to resume the funds allocation as part of the next biennial budget (2022). A total of $96 million will be requested to support the FPHS in each county, according to population and tax base, with a minimum local match. The LHD's, through the Kentucky HDA, have requested that a critical component of the implementation is individual budget allocations for each LHD to be sure each receives an equitable portion of state funding.

In Kentucky, three of the statewide health associations (Kentucky Public Health Association, Kentucky Health Department Association, Kentucky Association of Local Boards of Health) recently combined and hired an advocate to target the legislature and also to increase public awareness. In another move to professionalize the sector and advocate for more resources, the State Association of City and County Health Officers (SACCHO) hired a new Executive Director who has legislative experience (HEISE PERSONAL COMMUNICATION).

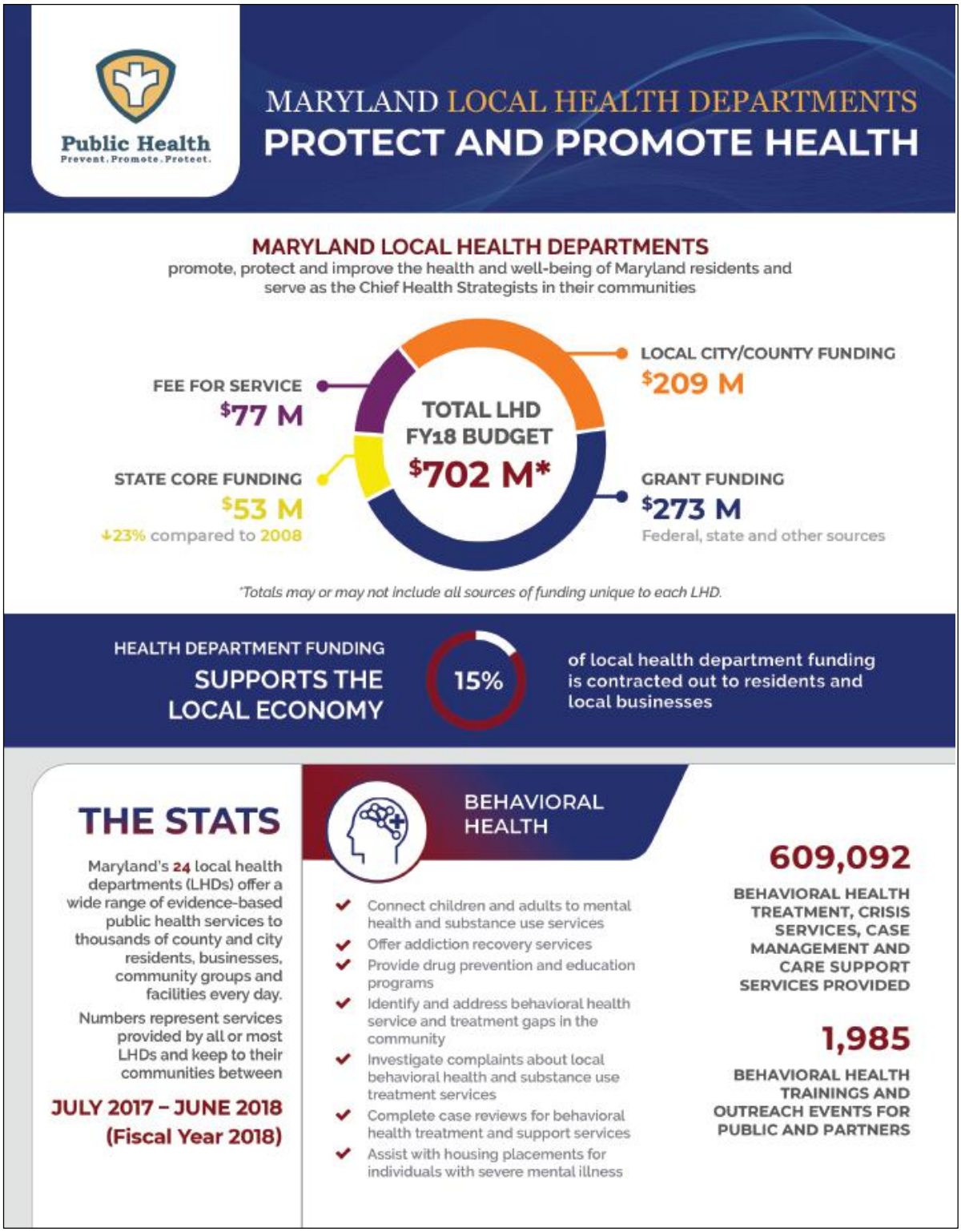
Figure 6. Kentucky Core Public Health Graphic

Maryland - *University Partnership, Positive Media Important for Support of Core Funding*
Maryland has 24 LHD's at the county level, and the City of Baltimore has its own department. Maryland provides state funding to LHD's called "Core" funding through legislative appropriation. It is intended to provide a base amount of funding to support a minimum public health department. Thus, the core services (seven areas) are state-funded with a county match. There is a report back to the state on usage of the state funds. Since 2013, state funding of LHD's has not increased in pace with other budget items, so two current bills would formalize the Core funding, tying it to a consumer price index for medical care with the intent of building more funding stability.

An initiative of note occurred in Prince George's County in the mid-2010's, when staff "mapped" regulations, mandates and funding, and determined what they *needed* to do and the cost of those services, comparing those needs with what was funded, what was unfunded. The result was a list of services categorized as "Important and funded" and "Important but not funded" and "Would be nice." The County then presented this "story" to show the County Council what they do, and what they cannot afford to keep doing without further support. In Maryland, Johns Hopkins University supports the State Association of City and County Health Officers (SACCHO) Exec. Dir. on a contract basis. All local Health Officers are able to affiliate with JHU, teach, and access University resources.

The Maryland public health sector benefits from positive media coverage in the local press and the larger Washington DC area media. The graphic on the following page explains the mission and support of public health and what it does. The rest of this brochure elaborates on activities and metrics achieved under each of the core services (MAIORANA PERSONAL COMMUNICATION).

Figure 7. Maryland Local Health Department Graphic (Partial)



Massachusetts - *State Government Leads from Blueprint to Action*

Massachusetts has the most decentralized public health system in the U.S., with 351 independent LHDs. There are a handful of regional departments. Because the LHD's are funded with property taxes, it is inequitable, ranging from some departments with little capacity to fund public health to others that are able to support a more comprehensive department.

Until recently, there were no funds from the state. In 2016, the legislature created a Special Commission on Public Health which issued its final report in 2019. The final report[9] (called the "Blueprint") outlined steps for future action, including recommendations on shared services, minimum standards, credentialing, and funding. The Special Commission report formed the basis for the 2020 adoption of the State Action for Public Health Excellence (SAPHE) which offered a series of reforms of local public health. (See SAPHE fact sheet on following page.) A key to passage of the SAPHE law was the presence of legislative champions. Now the state is moving forward with providing funding for SAPHE. Through the state budget and via state appropriations, the legislature appropriated $10 million for implementation of SAPHE (January 2021).

> *Local health is invisible unless there's an emergency.*
>
> State Public Health Representative

LHDs apply for the SAPHE funds in grants of $150,000 to $200,000 which can be used for shared core services. It's an incentive-based approach towards promoting "shared services," and there is some language in the granting that provides "preference" for marginalized communities. The Health Officers Association is now lobbying to bring the SAPHE appropriated total to $20 million in the next fiscal year (SIBOR PERSONAL COMMUNICATION).

[9] https://www.mass.gov/orgs/special-commission-on-local-and-regional-public-health

Figure 8. Massachusetts SAPHE Fact Sheet

MAHB

MASSACHUSETTS PUBLIC HEALTH ASSOCIATION

Establishing the State Action for Public Health Excellence (SAPHE) Program

Please Co-Sponsor HD2682/SD922 by Representatives Kane and Garlick & Senator Lewis

HD2682/SD922 will advance the goals identified by the Special Commission on Local and Regional Public Health by:

1. **Ensuring that all members of the local public health workforce have access to essential training.** Directs the Department of Public Health to hold the Foundations of Public Health Course free of charge at least four times a year in geographically diverse areas of the state.
2. **Creating an incentive grant program to support more effective and efficient delivery of services by increasing sharing across municipalities.** Creates the SAPHE Program, a grant program that incentivizes health departments to adopt best practices including workforce standards, data reporting, and sharing of services across municipalities to increase capacity and ability to meet statutory requirements.

3. **Moving Massachusetts toward national standards for a 21st century public health system.** Directs the Special Commission on Local and Regional Public Health to determine and assess a foundational standard for local public health services in Massachusetts in alignment with national standards.

The 25-member Special Commission on Local & Regional Public Health, created by the legislature in 2016, includes representatives of the legislature, local public health workforce, Executive Office of Administration & Finance and other executive branch agencies, MA Taxpayers Foundation, MA Municipal Association, health care providers, and academia. The Special Commission released an interim report in May 2018 and will release its final report in spring 2019.

CHALLENGES OF THE LOCAL PUBLIC HEALTH SYSTEM

Massachusetts has 351 boards of health at the municipal level that provide many of the protections we all rely on.

- Ensuring food safety in restaurants and public kitchens
- Ensuring the safety of children's recreational camps
- Preventing the spread of communicable disease including tuberculosis
- Ensuring municipal readiness to respond to potential public health emergencies
- Enforcing tobacco and lead regulations
- Responding to reports of housing code violations
- Ensuring proper installation of septic systems
- Monitoring water quality at public swimming pools and beaches

The local public health system significant challenges meeting statutory responsibilities which include:

- **Inconsistency across municipalities.** With no recommended funding levels, municipalities with the same population have widely varying levels of staffing and quality of services.
- **Small towns struggle.** Of the 105 towns with fewer than 5,000 residents, 78% lack full time staff and 58% have no health inspector. Of western Massachusetts communities with little or no staff, 22% don't keep records of reportable diseases, compared to 1.6% of metro Boston communities.
- **Variability in staff credentials.** The education levels and credentials of local health department staff members vary widely, with no current standards or requirements.
- **Shared services proceeding slowly.** Efforts to promote sharing across municipalities, which has been shown to increase capacity, have proceeded slowly and federal funds to support collaboration have dried up.
- **Inconsistent data reporting.** Compliance with mandated data reporting to the state is inconsistent across municipalities, creating difficulty in assessing the ability of Boards of Health to meet statutorily required services.

For more information, contact Melanie O'Malley at: momalley@mapublichealth.org or (857) 302-7238.

***Minnesota** - Coordinated Initiative to Determine Appropriate Support for Basic Services*

Most of the 51 LHDs in Minnesota, referred to as "Community Health Boards," are county based, with 11 tribal nations and four large cities that operate as the LHD. While there are credential requirements for the Administrator, there is a lot of freedom to structure the departments. The state law authorizing LHDs identifies six "basic" services that are mandated; however, that mandate is very broad and there is lack of clarity as to roles for the state versus the LHDs in performing services. For example, there are some mandates that all LHDs do (such as environmental health), and others that are optional, and they can choose to not do it and then the state does it.

The state maintains an unrestricted source of funding, the "local public health grant[10]," that provides population-based funding for basic services. The fund was cut in the early 2000's. For most LHDs, 50% of their funding is from the local tax levy (property taxes), 35% from earmarked federal sources, and the rest from the state with about 6% being from the local public health grant. The COVID pandemic stalled this effort, and also "laid bare" the lack of capacity and the need for modernization, and the inequities that result from this system. The State DOH monitors the use of the state dollars.

> *Public health works behind the scenes to prevent public health disasters from happening so most people don't see what public health is doing.*
>
> A State Public Health Representative

Prompted by a general recognition from the counties, the LHDs and the state DOH, Minnesota initiated the "21st Century Public Health Initiative" in 2019. It is facilitated by the state, with participation by health experts, county commissioners, and LHDs. The impetus for the initiative was the need to (a) clarify what the state should be doing in terms of the six basic services and what the LHDs should be doing, (b) articulate the foundational services/conditions that all residents should have access to for health, and (c) figure out responsibilities versus capacities (OLDFIELD PERSONAL COMMUNICATION).

***New York** - Unrestricted Base Funding for Core Services*

New York has a county-based system of LHDs (58), including New York City with its own health department. However, 27 of the LHDs provide partial services and the rest provide total services. For the 27 that only provide partial services, the state oversees provisions of services not provided by the LHD.

Article 6, funded by NY state appropriations, provides state aid as a reimbursement for LHD implementation of core public health services that are unrestricted and not earmarked for a

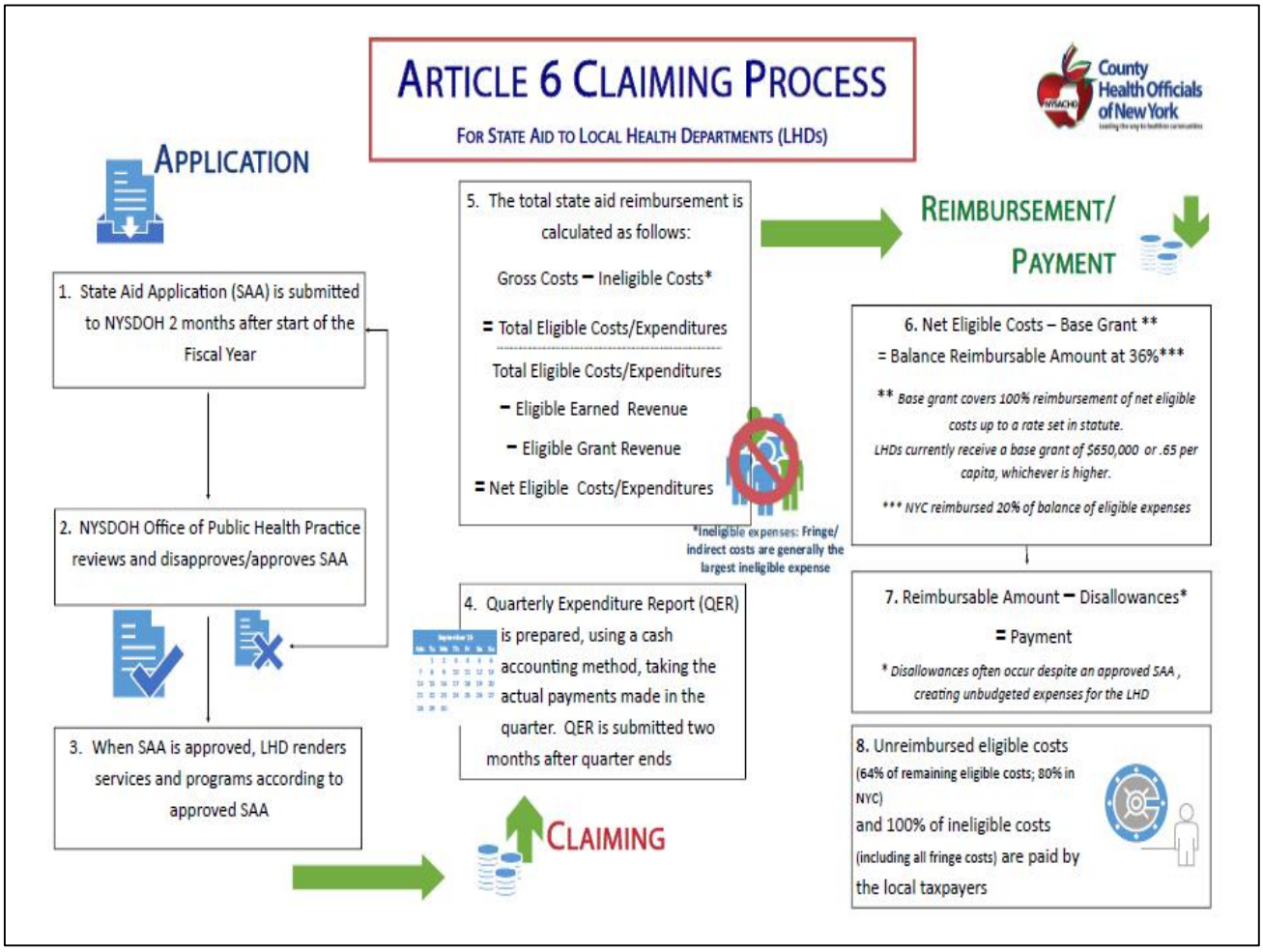
[10] https://www.health.state.mn.us/communities/practice/lphact/lphgrant/index.html

particular purpose. Under Article 6, every county gets a base grant consistent with a funding formula, and the funds can be used for provision of any core public health services but there are some ineligible costs such as fringe benefits. (See claiming process graphic on following page.) To cover ineligible costs and to make up the difference between costs beyond a LHD's base grant, the LHDs raise revenue via property taxes.

Health agencies are currently calling for the following revisions to Article 6:

- Allow for fringe benefits to be charged.
- Increase funding levels.
- Increase coverage of some eligible funds, such as having a greater focus on preventive care (RAVENHALL PERSONAL COMMUNICATION).

Figure 9. New York Article 6 Claiming Process Graphic



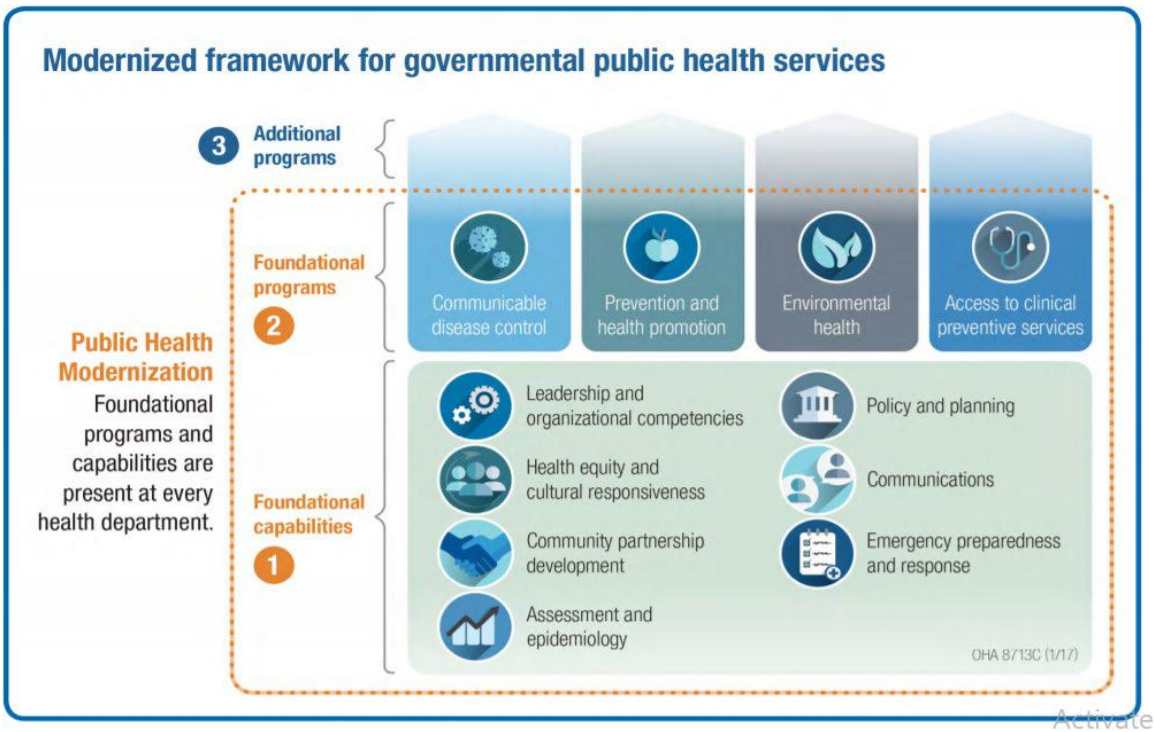
***Oregon** - Task Force and Polling Leads to Funding for Modernization*

Oregon has 36 counties and 33 public health authorities. Regional capacity is present around certain foundational functions. In general, local public health is funded via local property taxes.

Legislation in 2013 established a Task Force on the Future of Public Health to study and assess needs of the state's public health services to "modernize." The task force determined that "foundational" services were not funded at the time. It also determined that, since these are the functions that serve all Oregon residents, they should be supported evenly across the state. (See diagram below). Analysis pointed to a $210 million gap between the actual cost of public health functions and the level of support.[11]

Following the task force report, several initiatives began, such as work with the National Public Health Innovation Center for public interest polling. The result of all of this work was a 2015 law governing public health that adopted the Institute of Medicine's framework for public health. In 2017, the legislature approved $5 million for modernization and in 2019, an additional $10 million was authorized. Of this $15 million total amount, $3 million is designated to support regional collaborative efforts (shared services). Currently, the public health community has requested an additional $70 million, and the administration appears to be supporting an additional $30 million (COWLING PERSONAL COMMUNICATION).

Figure 10. Oregon Modernized framework diagram



[11] Legislative cycle in Oregon is every two years including state budget adoption

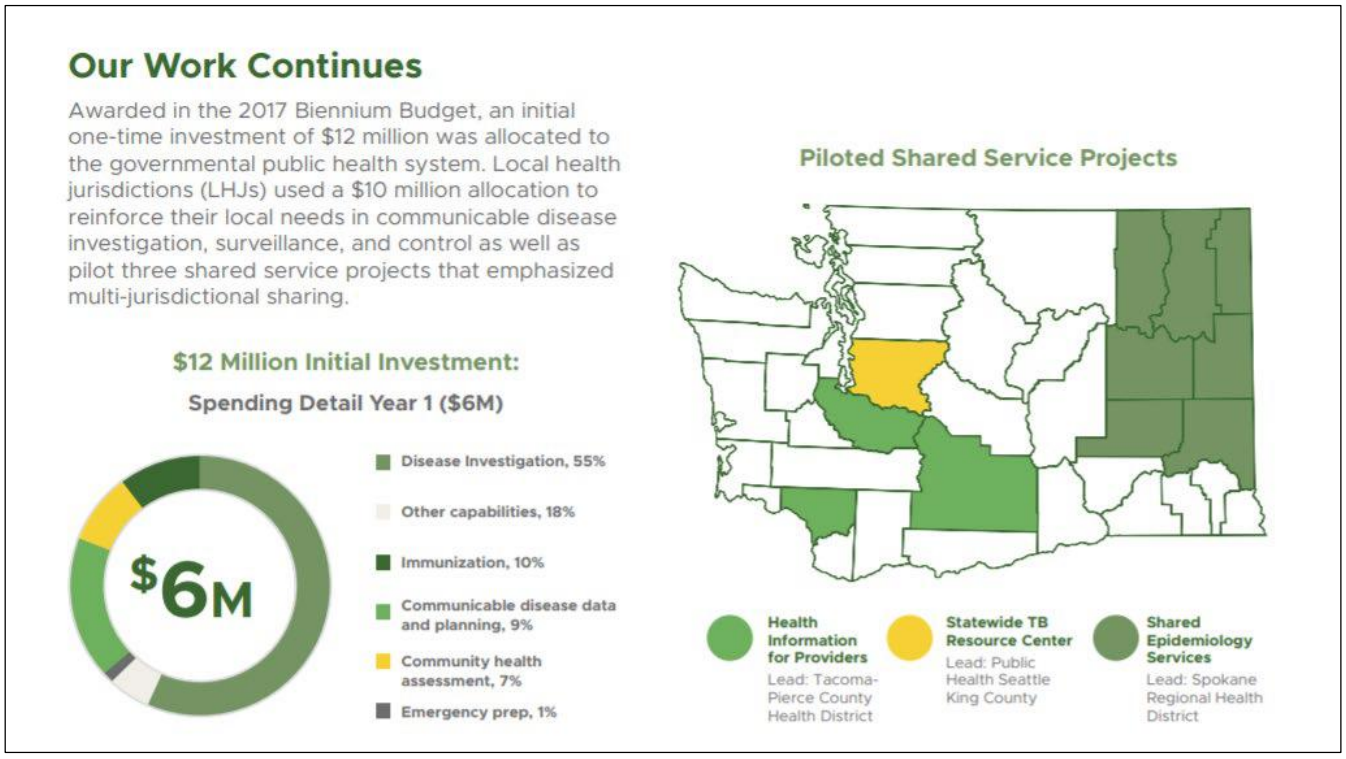
Washington - *Local and State Health Departments Join to Support Investment in Foundational Services*

Washington has 35 county-based LHDs, with two that are multi-county, and city-county in Seattle and Tacoma. Sources of funding for LHDs are about 30% local revenue, 20% federal, 20% fees and 30% state. State review of LHDs is limited to an annual report on the use of the state Foundational Public Health Services money. There are no performance standards.
In 2015, the Washington State Department of Health, representatives of local health jurisdictions (LHJs), the Washington State Association of Counties, and other public health partners initiated work to develop a set of public health programs and services that every citizen should have access to – the Foundational Public Health Services (FPHS). The goal is to have a responsive and sustainable public health system and ensure healthy and economically vital communities across Washington.

In 2018, local health jurisdictions, the State Department of Health, and the State Board of Health completed a deep needs assessment that included LHDs identifying their gaps. The study produced a cost estimate for fully funding the FPHS of $450 million a biennium. After the gap analysis, the committee developed an "investment plan" and took it to the state, where the legislature awarded $10 million in 2017 as one-time "test" funding. (See graphic on following page). In 2018, $15 million was awarded, with legislative language saying the funds would be ongoing. The ongoing aspect was important because it allows for hiring staff, and doing critical planning. In 2020, the amount increased to $28 million (biannual).

The efforts to advance these initiatives were led by a Steering Committee that was established by Washington State Association of Local Public Health Officers (WSALPHO). In spring 2021, a bill was introduced in the legislature to formalize the Steering Committee and to establish a concurrence process on how the money is spent. A boost to the effort comes from the fact that the state Health Commissioner was previously a LHD officer, and one of the legislative champions (house speaker) works in a LHD (BODDEN PERSONAL COMMUNICATION).

Figure 11. Washington Legislative Priorities Brochure (excerpt): Public Health Services



- New Jersey Public Health Officers - Interview Summary

In order to better understand how the issues discussed in this report are reflected in the practice of public health, we interviewed three public health officers currently working in New Jersey.

The interviewees represent a range of geographical areas and settings: an urban location in north Jersey, a mixed urban and suburban district in central Jersey, and a largely rural district in south Jersey. They also have considerable experience. Two have been public health professionals for roughly 12 years, the third for about 34 years.

The interviewees were asked a series of questions about funding and organizational structure, professional challenges and successes. They were also asked how the practice of public health has changed during their careers and how the public health system in New Jersey might be modernized to more effectively address emerging public health issues and support the changing roles of public health officials. Lastly, the interviewees were invited to discuss any other topics they felt relevant.

The interviews lasted about 45 minutes each. They were videotaped and transcribed.

The Changing Role of Public Health Officers

The interviewees indicated that the public health landscape has broadened significantly during their careers. Signal events such as the terrorist attacks of September 11, 2001, and Hurricane Sandy in 2012 focused public health on emerging threats such as bioterrorism and climate-related disasters. While traditional services such as environmental health inspections, communicable disease prevention, and health education remained a cornerstone of public health practice, the global scale of events such as the H1N1 pandemic of 2009-10 and the current COVID-19 pandemic, placed significant stress on the public health system, underscoring long-term inadequacies in funding and staffing.

> *COVID-19 has really highlighted the fact that health departments are severely understaffed.*
>
> A NJ local public health official

Another significant shift in public health is a growing awareness of the social determinants of health and their impact on health equity – specifically, how differences in the overall conditions in which people live and work, including the availability of suitable housing, transportation, healthy foods, safe working conditions, and recreational facilities, can create disparities in health and well-being.

One interviewee described public health officials in this expanded capacity as "strategists." The responsibility of public health agencies isn't "just inspections and doing your nurse jobs," she said. It requires forging partnerships with community members and decision-makers to advocate for and implement policy changes, programs, and facilities to make long-term, community-wide improvements in the social determinants of health. "It's really understanding your role in the community to really coordinate and connect and make things happen."

> *Now we're looking at health equity, we're looking at health in all policies, and we're looking at our role as a health department expanding within the community. So it's not just protecting public health, but it's also helping to control social determinants of health.*
>
> A NJ local public health official

As an example, the same interviewee cited her efforts to secure a Federally Qualified Health Center in her district to improve access to primary care and wraparound services for an underserved population. The effort involved working directly with community members, cultivating support from elected and appointed officials, coordinating multiple government and private-sector entities, and, it should be noted, a great deal of perseverance.

Funding

All three interviewees expressed the view that New Jersey's public health system is underfunded. The interviewees stressed the importance of a dedicated funding source; one interviewee gave the example of a line item in the state budget.

> *Unfortunately, over the years … our funding has been decimated.*
>
> A NJ local public health official

> *The monies that we've received are for very specific programs and tasks, and it doesn't allow me to run my department or to staff my department in ways that I think will be most advantageous for my communities.*
>
> A NJ local public health official

The interviewees also cited the need for unrestricted funds, giving them the flexibility to spend money on the resources that are needed most. One interviewee explained that even at times of crisis when additional federal and state money is available, such as during the COVID-19 pandemic, funds are often restricted to certain uses that may not address actual needs.

Grant funding is seen as a useful supplement but is time-consuming to secure, limited in application, and short term. Programs tend to end abruptly when grant funding expires and do little to build long-term organizational capacity. By contrast, one interviewee referenced the success of her agency's Childhood Lead Program, which she attributed to sustained funding.

> *I feel like we start projects, but we can never end them because the funding doesn't stay.*
>
> A NJ local public health official

'An Invisible Workforce'

The interviewees described their public health colleagues as committed professionals providing a vital, though often unrecognized, service to their communities. A chronic lack of resources makes creativity and cooperation a necessity. And while the profession occasionally comes to the public's attention during events such as the COVID-19 pandemic, public health officials "tend to be an invisible workforce."

> *We've all become very creative in this field because we've had to work with less.*
>
> A NJ local public health official

> *One of the things in public health that people don't realize is how much we actually cover. You know, we do restaurant inspections, and we do public health nuisances, and we do health education campaigns. We target chronic disease, we target acute disease, we target communicable diseases. We inspect pools, schools, and daycares. And some of us inspect nail salons, and hair salons, and waxing, and everything in between. Public health really is part of your everyday life, including the air you breathe. So I think as a society, people don't realize how important public health is.*
>
> A NJ local public health official

The interviewees noted that community members and even government officials are frequently surprised at the wide range of services public health agencies provide.

In general, there was concern that policymakers and community members often do not understand the value of the public health system and the investment required to keep it operating effectively given the breadth of modern public health practice. More to the point, there was concern that decisions are being made by people who are not sufficiently knowledgeable about what public health officers do and how the system functions.

> *Oftentimes I would like for them [politicians] to understand that we know our job, we know how to do it, what we need to do it, and we need the resources to do it, and we'll do it right.*
>
> A NJ local public health official

Organizational Structure

The interviewees were asked to share their thoughts on the organizational structure of the public health system in New Jersey. The responses were mixed, but there seemed to be a general agreement that different parts of the state required different solutions. One interviewee, in a rural district with a population of about 150,000, appreciated the simplicity of working in a countywide department. In contrast, a second interviewee felt it would be extremely difficult in her county, with more than 50 municipalities and a population of approximately 618,000, for a single health department to meet the specific needs of local communities and maintain the necessary personal connections with members of those communities. She noted, however, that local health departments need access to the resources of larger, regional agencies. The third interviewee expressed a similar thought regarding

> *I've gotten to know my population, I've gotten to know my stakeholders, I know my community, I know who to reach out to when I need things, and that's vital. Especially during something like a pandemic, where you need to get in touch with your religious leaders, and your school leaders, and people who are influential in the community, and also community members … That intimate relationship is so important.*
>
> A NJ local public health official

the importance of personal contacts within her community but was skeptical of the practice of shared services: “When you start sharing services and you have public health staff that sit over five and six towns you just don't get the services that you would if there was enough allotted staff for those individual areas.”

None of the interviewees had specific recommendations about organizational issues, but wholesale restructuring – such as consolidation of local agencies into county or regional entities – wasn’t proposed as a statewide solution.

IV. Summary of Eagleton Center for Public Interest Polling results

As part of this project, the team engaged the Eagleton Center for Public Interest Polling to gauge New Jerseyans' understanding of and support for public health. Eagleton conducted a telephone survey from November 19-28, 2021 with a random sample of 1,005 New Jersey adults. The survey was available in Spanish for respondents who requested it. The full final Eagleton report is included in this report as Appendix D (KONING 2021).

The survey pointed to interesting outcomes that can be valuable to informing statewide discussions about public health capacity in New Jersey. When asked about top health-related issues facing communities right now (aside from COVID-19), respondents did not center around a single concern, but rather were spread out among an array of issues. The highest response was 10% of respondents identifying access to health care as the top issue; 6% citing mental health, obesity and the cold or flu; 5% identifying addiction and drugs and COVID; 4% identifying pollution and environmental issues; 3 percent siting food insecurity; and 2 percent saying cost of living and cancer. Of note is that almost a third of survey respondents (30%) indicated that they did not know what the top health-related issue is facing their community.

A large majority of respondents (72%) said that people, themselves, should take on the most responsibility in making sure they are leading healthy lives, more than any other entity or organization such as government or businesses. Almost 80% of respondents said they understood what public health is very well or somewhat well, yet almost 20% said they did not know what the meaning of public health is. When asked to define the term "public health" themselves, 26% of respondents said "public health" refers to something about the health of the population but 35% of respondents said they did not know. Following the questions regarding the definition of public health, the pollsters provided the following definition of "public health:" *For the purpose of this survey, when we refer to 'public health,' we are referring to the work done to keep communities healthy and prevent illnesses and the spread of diseases. While a doctor treats individuals who are sick, public health professionals work with community partners to prevent entire communities from getting sick or injured in the first place. While we understand much of the focus of public health right now is on COVID-19, we are asking about public health issues aside from COVID-19.*

This poll was especially interested in understanding New Jerseyans' perceptions of and support for the role of local public health departments. Half (50%) of respondents said they are very familiar or somewhat familiar with the role of their local health department. However, 48% said they were not too or not at all familiar with the functions of their local public health department. Almost a quarter (23%) said they don't know if their local health department is doing enough or too little to ensure that people are leading healthy lifestyles.

When asked whether the following services were main responsibilities of local public health departments, each service was considered a main responsibility by a majority of respondents, in this order:

- Infectious disease prevention, monitoring and reporting (87%)
- Emergency planning and preparedness (81%)
- Food safety inspections, education and licensing (80%)
- Environmental health (77%)
- Clinical services (76%)
- Health and nutrition education (75%)
- Maternal and child health (71%)
- Animal control (62%)

Of these responsibilities, respondents identified infectious disease prevention, monitoring and reporting as being the most important service provided by local health departments.

Almost half of respondents recall receiving information from their local public health department at some point. A large percentage (89%) of respondents said that they have been personally impacted by a service provided by their local health department at some point in their life with encounters such as:

- 56% by infectious disease prevention, monitoring and reporting
- 49% by food safety inspections;
- 47% by emergency planning and preparedness;
- 44% by clinical services;
- 41% by health and nutrition education;
- 39% by environmental health
- 38% by animal control; and
- 30% by maternal health services.

An additional focus of the survey was better understanding New Jerseyans' trust of public health professionals and their willingness to support an expansion of capacity of public health in New Jersey. When asked about how likely it would be for respondents to seek out information from certain sources to address a question or concern about a public health issue, more than 90% of respondents said they would be very or somewhat likely to seek out information from a doctor or nurse. Additionally, 68% and 66% of respondents said that they would be very or somewhat likely to seek out information from a state or local health department, respectively. A very similar pattern emerges when it comes to who New Jerseyans trust most to provide accurate health information. Respondents said they most trust information from a doctor or nurse: more than 90% of respondents said they trust information coming from a doctor or nurse a moderate amount or a great deal. The next most trusted sources of health information identified by respondents are state and local health officials for

which more than 75% of respondents indicated a great deal or a moderate amount of trust. Respondents least trust the internet or social media for public health information; just over one-third indicated a great deal or moderate amount of trust in these sources.

Approximately 88% of New Jerseyans believe that it is either very or somewhat important for the state of New Jersey to establish a source of stable, dedicated funding that can only be used for local public health services and program. However, respondents expressed concern about how to pay for such funding. Half of respondents would strongly or somewhat support a small tax on unhealthy foods and sugary drinks, but 44 percent, on the other hand, would oppose it. Approximately a third of respondents would somewhat or strongly support a small increase in their state income tax, while two-thirds would not. A small increase in local property taxes is least popular with just 9% strongly supporting this concept and 54% strongly opposing it.

V. Observations and Opportunities

The purpose of this chapter is to provide observations drawn from various elements of this project, including:

- Analysis of public health capacity and infrastructure in New Jersey compared to other states,
- A review of three decades' worth of reports and studies examining local public health in New Jersey,
- Engagement of efforts in a set of other states to better understand their public health capacity and infrastructure,
- Interviewing several local public health practitioners in New Jersey,
- Active engagement of a Project Working Group throughout the project that included representation from local public health practitioners and the NJDOH, and
- Conducting a statewide public opinion survey to gauge understanding of and support for public health in New Jersey.

• Observations

The authors offer the following observations:

1. **National recognition of the need to modernize public health** - Nationally, there is widespread recognition of the need to modernize governmental public health. Research led by the Trust for America's Health points to a national decline in public funding for public health and coalitions such as the initiative "Public Health Forward: Modernizing the U.S. Public Health System" led by the Bipartisan Policy Center are focused on advancing strategic investments in public health at the federal, state and local levels. This decline in public funding for public health comes at a time when public health is increasingly under pressure to broaden its jurisdictional reach to address emerging threats including global pandemics, social determinants of health that drive health inequities, the opioid addiction crisis, and climate change. The traditional application of "earmarked" funds for public health for specific uses further constricts the ability of local public health practitioners to advance integrated, community-based solutions that are focused "upstream" on root causes of health disparities and to address locally identified public health needs. Use of the term *modernize* emphasizes the concept that the historic capacity of public health is inadequate to address these 21st century challenges.
2. **New Jersey's comprehensive public health standards** – Mandates and standards that Local Health Departments must meet vary from state-to-state. This research team finds that New Jersey's standards appear to be highly comprehensive compared to the other states reviewed. Ohio requires its local health departments to seek Public Health Advisory Board (PHAB) accreditation; Local Health Departments in Florida share joint PHAB accreditation with the state department of health as a "public health system"; and

North Carolina, maintains its own, long-standing, state-run accreditation for local health departments. Nevertheless, while accreditation is not required in New Jersey, the public health practice standards set forth in New Jersey's governing code (N.J.A.C. 8:52) for public health practice are closely aligned with the Standards and Measures of the national Public Health Accreditation Board, meaning that Local Health Departments in New Jersey meet a "high bar" of performance as a result of the state's adopted Practice Standards.

3. **New Jersey funding constraints** - While New Jersey is not alone compared to the national trend of declining public funding for public health, research led by the Trust for American's Health finds that, per capita, New Jersey may be in a worse funding situation, ranking 31st in the nation in state public health funding and at the bottom of state grant funding from the CDC. In 2011, the New Jersey state budget eliminated dollars in the only "non-earmarked" source of state appropriation for public health, the Public Health Priority Fund. The case stories developed for this project point to the impact that those cuts and declines in funding have had on local public health efforts.
4. **Extensive study of New Jersey local public health structure** - Historically, there has been a tremendous amount of study of the structure and capacity of local public health in New Jersey. This report identifies at least 13 studies, initiatives or reports that included a review of local public health in New Jersey. A common theme from many of these efforts is the general recognition of the inadequacy of unrestricted local public health funding in New Jersey. Some of these identified efforts also offer recommendations with regard to structure of local public health in New Jersey, often with an automatic, yet unsubstantiated, reaction that larger local public health departments deliver better services more cost effectively.

> *A cookie-cutter 21-county system is not the answer to improving public health in New Jersey. When we talk about some of the new challenges facing local public health, it's critically important for us to advance solutions that are integrated with community-based efforts. Each community is different and what works in one place won't necessarily work in another.*
>
> A local NJ Public Health Official

5. **"Invisibility" of public health** - The public health community often refers to the "invisibility" of public health as a factor in declining public funding. "The work of public health is often invisible. It is only when there is a disaster or outbreak that the safety net of public health becomes apparent. In our daily lives, we rarely consider the safety of the food we eat, the air we breathe, or the water we drink."[12] As part of this project, we learned about successful efforts in several other states to increase capacity to support local public health for the purpose of "modernizing" its scope to be better prepared to address emerging challenges. These efforts achieve progress through the building of coalitions with public health and other sectors, engagement of legislative and Executive Branch champions, and documenting the role of public health and its contributions to vibrant communities.

[12] NACCHO Voice. February 20, 2022.

6. **Public support** - From the statewide poll conducted for this project, we learned that, similar to other national findings, New Jerseyans have a mixed understanding of the role of public health adding to the national discussion of public health's "invisibility." Thirty percent of respondents to the New Jersey Eagleton poll indicated that they did not know what the top health-related issue is facing their community; 20% indicated that they did not know what the meaning of "public health" is; 35% of respondents indicated that they could not define the function of "public health;" and 48% said they were not too or not at all familiar with the functions of their local public health department. At the same time, a large percentage (89%) of respondents said that they have been personally impacted by a service provided by their local health department at some point in their life, and that more than 75% of respondents indicated a great deal or a moderate amount of trust in state and local health officials. Approximately 88% of New Jerseyans believe that it is either very or somewhat important for the state of New Jersey to establish a source of stable, dedicated funding that can only be used for local public health services and program, however, respondents expressed concern about how to pay for such funding.

- Opportunities

In many ways and, ironically, given the important role that the public health community has played in addressing the COVID-19 pandemic, local public health departments are faced with ever-increasing pressures such as a wave of retirements and harassment, threats, and violence in response to public health measures taken during the COVID-19 pandemic. These threats add to additional burdens faced by local public health agencies to address new and emerging public health threats in the face of shrinking resources. The capacity pressures facing public health in New Jersey are not different from those nationally and from other states examined for this project. Organizations and associations that represent local public health leaders and practitioners in New Jersey, many of whom served on the Project Working Group for this project, have worked proactively to form a shared agenda for enhancing the capacity of local public health in New Jersey to address emerging threats. Similar to the experience in other states, the current inadequacy of unrestricted and sustainable funding appears to be the thread that weaves through previous studies of public health in New Jersey, national studies as well as the experiences of other states interviewed for this project in terms of modernizing the state's local public health capacity to operate in the 21st century. The pillars that have been advanced as part of successful efforts in other states, national efforts such as those of the Bipartisan Policy Center, and advocacy on the part of local public health associations in New Jersey is one of ensuring that public health has funding that is:

> *Wherever New Jersey goes in terms of its efforts to improve public health, I really hope that there will be adequate input from the public health professionals who are here doing the work every day, and with an eye toward where we need to be within the community, affecting social determinants of health and health equity.*
>
> A NJ Local Public Health Official

- *Adequate* – National studies point to the overall decline in funding support for public health. Public Health leaders indicate that this decline not only challenges the delivery of traditional, basic public health services but that it thwarts advancement of a "modernization" of public health in keeping with the concepts of Public Health 3.0. Some of the other states examined for this report quantified the gap in available funding for public health services compared to need as a basis for advancing reforms. The New Jersey Public Health Associations Collaborative Effort (NJPHACE) has projected that, if continued at its previous level, the Public Health Priority Fund would, in today's economy, be at a $11.2 million level. However, such estimates are different than a quantitative analysis of what the actual need is for Local Health Departments to not only delivery the state practice standards but also to advance an overall "modernization" of public health;
- *Unrestricted and flexible* – Nationally, public health funding pales in comparison to health care spending. The amount of public health funding that is not "earmarked" for certain purposes has shrunk both nationally and at the state level in New Jersey. Both nationally and at the state level, public health leaders are calling for greater funding that is not necessarily restricted to a certain purpose so that public health professionals can direct funds to where the greatest health challenges and disparities exist especially at a community level; and
- *Sustainable* – When funding for public health services are eliminated, programs often decline or discontinue. Successful efforts in other states to enhance the capacity of local public health has not only emphasized the need for adequate and flexible funding, but it has also focused on advancing more reliable revenue streams for public health. These efforts stress the need for steady and consistent funding sources as key to support longer term public health strategic planning and delivery of services.

The authors heard from the Project Working Group that there is a need for a greater voice from the public health community in developing the solutions to constrained public health capacity in New Jersey and that the voices of the public health community are different than the voices of health care providers. The authors heard a tremendous willingness on the part of the local public health community in the state to seek out opportunities to strengthen delivery of services while cautioning that the inadequacy of unrestricted funding is the biggest challenge to delivering a 21st century public health infrastructure for New Jersey.

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April 6, 2021. Jaime Bodden, Washington State Association of Local Public Health Officers
May 3, 2021. Sylvia Bookbinder, former Deputy Director; Office of Local Public Health, NJDOH
March 26, 2021. Morgan Cowling, State Director, Oregon State Association of City and County Health Officers
April 21, 2021. Georgia Heise, Kentucky Health Department Association
May 6, 2021. Jennifer Kertanis, former Exec. Dir, Connecticut State Association of City and County Health Officers
April 2, 2021. Ruth Maiorana, Exec. Director, Maryland State Association of City and County Health Officers
April 5, 2021. Kari Oldfield, Director, Local Public Health Association of Minnesota
March 29, 2021. Sarah Ravenhall, County Health Officials of NY
July 17, 2021. Paul Roman
March 30, 2021. Dawn Sibor, MA Health Officers Association

Appendices

- Appendix A – PHCI table aligning the 10 Essential Public Health Services and the Foundational Public Health Services
- Appendix B – PHCI infographic summarizing foundational and essential health services
- Appendix C – Summary of Public Health Services and Capabilities in New Jersey pursuant to N.J.A.C. 8:52
- Appendix D – Full report of Eagleton Center for Public Interest Polling

Appendix A – PHCI table aligning the 10 Essential Public Health Services and the Foundational Public Health Services

Introduction
This document explains the alignment between the revised 10 Essential Public Health Services (EPHS) language and the suite of skills, programs, and activities that supports implementation of the foundational public health services (FPHS).

10 Essential Public Health Services Overview
The original 10 EPHS framework was developed in 1994 by a federal working group and serves as the description of the activities that **the public health system (including governmental and non-governmental system partners)** should undertake in all communities. Organized around the three core functions of public health – assessment, policy development, and assurance – the colorful, circular framework is a familiar graphic in the public health field and has provided a roadmap of goals for carrying out the mission of public health in communities around the nation. However, the public health landscape has shifted dramatically over the past 25 years, and many public health leaders agreed it was time to revisit how the framework can better reflect current and future practice and how it can be used to create communities where people can achieve their best possible health.

The Futures Initiative, a partnership between the de Beaumont Foundation, PHNCI, and a Task Force of public health experts, formed in spring 2019 to bring the Essential Services national framework in line with current and emerging public health practice needs. This effort engaged the public health field through a variety of input opportunities, including live crowdsourcing events, in-person and virtual townhalls, think tank discussions, and open questionnaires. All direct feedback on the Essential Services and how they might be revised was considered, resulting in a revised version of the 10 EPHS that now centers equity and incorporates concepts relevant to current and future public health practice.

Foundational Public Health Services Overview
FPHS are the public health infrastructure and programs that no **governmental public health department** should be without and for which costs can be estimated. Public health infrastructure consists of the foundational capabilities, which are the cross-cutting skills and capacities needed to support basic public health protections and other programs and activities that are key to ensuring the community's health and achieving equitable health outcomes. Public health programs, or foundational areas, are those basic public health, topic-specific programs that are aimed at improving the health of the community affected by certain diseases or public health threats. Examples of these include, but are not limited to, chronic disease prevention, community disease control, environmental public health, and maternal, child, and family health. Local protections and services unique to a community's needs are those determined to be of additional critical significance to a specific community's health and are supported by the public health infrastructure and programs. This work is essential to a given community and cannot be visually depicted because it varies by jurisdiction.

Alignment between the 10 EPHS and FPHS
The 10 EPHS and FPHS were developed for different reasons. The 10 EPHS was developed to describe the activities the public health system should undertake in all communities, while FPHS was developed to represent a minimum package of governmental public health services to make the case for sustainable funding and to describe what is needed everywhere for public health to function anywhere. Despite this difference, the 10 EPHS and FPHS were both developed by the

field for the field and describe core elements of public health practice. There is significant alignment between the two as outlined in the following tables and the relevant components of each foundational capability and area (which may relate to more than one Essential Service) are included and aligned with the corresponding EPHS. Table 1 provides an overview of alignment at the statement level and Table 2 provides more details on the components of each foundational capability and area.

Table 1. Alignment Summary

ES	Revised EPHS	Foundational Capability	Foundational Area
1	Assess and monitor population health status, factors that influence health, and community needs and assets	– Assessment/Surveillance – Emergency Preparedness and Response	– Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health
2	Investigate, diagnose, and address health problems and hazards affecting the population	– Assessment/Surveillance – Emergency Preparedness and Response	– Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health
3	Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it	– Communications – Emergency Preparedness and Response	– Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health
4	Strengthen, support, and mobilize communities and partnerships to improve health	– Community Partnership Development	– Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health
5	Create, champion, and implement policies, plans, and laws that impact health	– Policy Development and Support	– Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health

6	Utilize legal and regulatory actions designed to improve and protect the public's health	– Policy Development and Support	– Access to and Linkage with Clinical Care – Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health
7	Assure an effective system that enables equitable access to the individual services and care needed to be healthy	Organizational/Administrative Competencies – Health Equity – Information Technology Services, including Privacy and Security – Human Resources Services	– Access to and Linkage with Clinical Care – Communicable Disease Control
8	Build and support a diverse and skilled public health workforce	Organizational/Administrative Competencies – Leadership and Governance – Human Resources Services	– Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health
9	Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement	Accountability/Performance Management – Quality Improvement	
10	Build and maintain a strong organizational infrastructure for public health	Organizational/Administrative Competencies – Leadership and Governance – Health Equity – Information Technology Services, including Privacy and Security – Human Resources Services – Financial Management, Contract, and Procurement Services, including Facilities and Operations – Legal Services and Analysis	– Access to and Linkage with Clinical Care – Chronic Disease and Injury Prevention – Communicable Disease Control – Environmental Public Health – Maternal, Child, and Family Health

Table 2. Detailed Alignment

ES	Revised EPHS Language	Foundational Capability Language	Foundational Area Language
1	Assess and monitor population health status, factors that influence health, and community needs and assets – Maintaining an ongoing understanding of health in the jurisdiction by collecting, monitoring, and analyzing data on health and factors that influence health to identify threats, patterns, and emerging issues, with a particular emphasis on disproportionately affected populations. – Using data and information to determine the root causes of health disparities and inequities. – Working with the community to understand health status, needs, assets, key influences, and narrative. – Collaborating and facilitating data sharing with partners, including multi-sector partners. – Using innovative technologies, data collection methods, and data sets. – Utilizing various methods and technology to interpret and communicate data to diverse audiences. – Analyzing and using disaggregated data (e.g., by race) to track issues and inform equitable action. – Engaging community members as experts and key partners.	<u>Assessment/Surveillance</u> – Ability to collect sufficient foundational data to develop and maintain electronic information systems to guide public health planning and decision making at the state and local level. Foundational data include Behavioral Risk Factor Surveillance Survey (BRFSS), a youth survey (such as YRBS), and vital records, including the personnel and software and hardware development that enable the collection of foundational data. – Ability to access, analyze, and use data from (at least) seven specific information sources, including (1) U.S. Census data, (2) vital statistics, (3) notifiable conditions data, (4) certain health care clinical and administrative data sets including available hospital discharge, insurance claims data, and Electronic Health Records (EHRs), (5) BRFSS, (6) nontraditional community and environmental health indicators, such as housing, transportation, walkability/green space, agriculture, labor, and education, and (7) local and state chart of accounts. – Ability to prioritize and respond to data requests, including vital records, and to translate data into information and reports that are valid, statistically accurate, and accessible to the intended audiences.	<u>Chronic Disease and Injury Prevention</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on chronic disease and injury prevention and control. – Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and seek funding for high priority initiatives.

		– Ability to conduct a community and statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities.	
		<u>Emergency Preparedness and Response</u> – Ability and capacity to develop, exercise, and maintain preparedness and response strategies and plans, in accordance with established guidelines, to address natural or other disasters and emergencies, including special protection of vulnerable populations. – Ability and capacity to lead the Emergency Support Function 8 – Public Health & Medical for the county, region, jurisdiction, and state. – Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders; and operate within, and as necessary lead, the incident management system. – Ability to maintain and execute a continuity of operations plan that includes a plan to access financial resources to execute an emergency and recovery response. – Ability to establish and promote basic, ongoing community readiness, resilience,	<u>Communicable Disease Control</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control. – Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and seek funding for high priority initiatives. <u>Environmental Public Health</u> – Provide timely, statewide, and locally relevant and accurate information to the state, health care system, and community on environmental public health issues and health impacts from common environmental or toxic exposures. – Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and seek action funding for high priority initiatives. <u>Maternal, Child, and Family Health</u>

		and preparedness by enabling the public to take necessary action before, during, or after a disaster. – Ability to issue and enforce emergency health orders. – Ability to be notified of and respond to events on a 24/7 basis.	– Provide timely, statewide, and locally relevant and accurate information to the health care system and community on emerging and on-going maternal child health trends. – Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and seek funding for high priority initiatives.
2	Investigate, diagnose, and address health problems and hazards affecting the population – Anticipating, preventing, and mitigating emerging health threats through epidemiologic identification. – Monitoring real-time health status and identifying patterns to develop strategies to address chronic diseases and injuries. – Using real-time data to identify and respond to acute outbreaks, emergencies, and other health hazards. – Using public health laboratory capabilities and modern technology to conduct rapid screening and high-volume testing. – Analyzing and utilizing inputs from multiple sectors and sources to consider social, economic, and environmental root causes of health status.	<u>Assessment/Surveillance</u> – Ability to collect sufficient foundational data to develop and maintain electronic information systems to guide public health planning and decision making at the state and local level. Foundational data include Behavioral Risk Factor Surveillance Survey (BRFSS), a youth survey (such as YRBS), and vital records, including the personnel and software and hardware development that enable the collection of foundational data. – Ability to access, analyze, and use data from (at least) seven specific information sources, including (1) U.S. Census data, (2) vital statistics, (3) notifiable conditions data, (4) certain health care clinical and administrative data sets including available hospital discharge, insurance claims data, and Electronic Health Records (EHRs), (5) BRFSS, (6) nontraditional community and	<u>Chronic Disease and Injury Prevention</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on chronic disease and injury prevention and control. – Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and seek funding for high priority initiatives. – Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand smoke exposure, as well as exposure to harmful substances.

	– Identifying, analyzing, and distributing information from new, big, and real-time data sources.	environmental health indicators, such as housing, transportation, walkability/green space, agriculture, labor, and education, and (7) local and state chart of accounts. – Ability to prioritize and respond to data requests, including vital records, and to translate data into information and reports that are valid, statistically accurate, and accessible to the intended audiences. – Ability to access 24/7 laboratory resources capable of providing rapid detection.	– Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and emerging practices aligned with national, state, and local guidelines for healthy eating and active living.
		<u>Emergency Preparedness and Response</u> – Ability and capacity to develop, exercise, and maintain preparedness and response strategies and plans, in accordance with established guidelines, to address natural or other disasters and emergencies, including special protection of vulnerable populations. – Ability and capacity to lead the Emergency Support Function 8 – Public Health & Medical for the county, region, jurisdiction, and state. – Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders; and operate within, and as	<u>Communicable Disease Control</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control. – Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and seek funding for high priority initiatives. – Receive laboratory reports and other relevant data, conduct disease investigations, including contact tracing and notification, and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.

		necessary lead, the incident management system. – Ability to maintain and execute a continuity of operations plan that includes a plan to access financial resources to execute an emergency and recovery response. – Ability to establish and promote basic, ongoing community readiness, resilience, and preparedness by enabling the public to take necessary action before, during, or after a disaster. – Ability to issue and enforce emergency health orders. – Ability to be notified of and respond to events on a 24/7 basis. – Ability to function as a Laboratory Response Network (LRN) Reference laboratory for biological agents and as an LRN chemical laboratory at a level designated by CDC.	– Assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV according to CDC guidelines. – Assure the appropriate treatment of individuals who have active tuberculosis, including the provision of directly-observed therapy in accordance with local and state laws and Centers for Disease Control and Prevention (CDC) guidelines. – Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual, at the appropriate level. <u>Environmental Public Health</u> – Provide timely, statewide, and locally relevant and accurate information to the state, health care system, and community on environmental public health issues and health impacts from common environmental or toxic exposures. – Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and seek action funding for high priority initiatives. – Conduct mandated environmental public health laboratory testing, inspections, and

			oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and, identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations. <u>Maternal, Child, and Family Health</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on emerging and on-going maternal child health trends. – Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and seek funding for high priority initiatives. – Identify, disseminate, and promote emerging and evidence-based information about early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development. – Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back, following up, and service engagement activities.

3	Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it – Developing and disseminating accessible health information and resources, including through collaboration with multi-sector partners. – Communicating with accuracy and necessary speed. – Using appropriate communications channels (e.g., social media, peer-to-peer networks, mass media, and other channels) to effectively reach the intended populations. – Developing and deploying culturally and linguistically appropriate and relevant communications and educational resources, which includes working with stakeholders and influencers in the community to create effective and culturally resonant materials. – Employing the principles of risk communication, health literacy, and health education to inform the public, when appropriate. – Actively engaging in two-way communication to build trust with populations served and ensure accuracy and effectiveness of prevention and health promotion strategies. – Ensuring public health communications and education efforts are asset-based when appropriate and do not reinforce narratives	<u>Communications</u> – Ability to maintain ongoing relations with local and statewide media including the ability to write a press release, conduct a press conference, and use electronic communication tools to interact with the media. – Ability to write and implement a routine communication plan that articulates the health department's mission, value, role, and responsibilities in its community, and support department and community leadership in communicating these messages. – Ability to develop and implement a risk communication strategy, in accordance with Public Health Accreditation Board Standards, to increase visibility of a specific public health issue and communicate risk. This includes the ability to provide information on health risks and associated behaviors. – Ability to transmit and receive routine communications to and from the public in an appropriate, timely, and accurate manner, on a 24/7 basis. – Ability to develop and implement a proactive health education/health prevention strategy (distinct from other risk communications) that disseminates timely and accurate information to the public in culturally and linguistically appropriate (i.e.,	<u>Chronic Disease and Injury Prevention</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on chronic disease and injury prevention and control.

	that are damaging to disproportionately affected populations.	508 compliant) formats for the various communities served, including through the use of electronic communication tools.	
		<u>Emergency Preparedness and Response</u> – Ability and capacity to lead the Emergency Support Function 8 – Public Health & Medical for the county, region, jurisdiction, and state. – Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders; and operate within, and as necessary lead, the incident management system. – Ability to establish and promote basic, ongoing community readiness, resilience, and preparedness by enabling the public to take necessary action before, during, or after a disaster. – Ability to issue and enforce emergency health orders. – Ability to be notified of and respond to events on a 24/7 basis.	<u>Communicable Disease Control</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control. <u>Environmental Public Health</u> – Provide timely, statewide, and locally relevant and accurate information to the state, health care system, and community on environmental public health issues and health impacts from common environmental or toxic exposures. <u>Maternal, Child, and Family Health</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on emerging and on-going maternal child health trends. – Identify, disseminate, and promote emerging and evidence-based information about early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development.

4	Strengthen, support, and mobilize communities and partnerships to improve health – Convening and facilitating multi-sector partnerships and coalitions that include sectors that influence health (e.g., planning, transportation, housing, education, etc.). – Fostering and building genuine, strengths-based relationships with a diverse group of partners that reflect the community and the population. – Authentically engaging with community members and organizations to develop public health solutions. – Learning from, and supporting, existing community partnerships, and contributing public health expertise.	<u>Community Partnership Development</u> – Ability to create, convene, and sustain strategic, non-program specific relationships with key health-related organizations; community groups or organizations representing populations experiencing health disparities or inequities; private businesses and health care organizations; and relevant federal, tribal, state, and local government agencies and non-elected officials. – Ability to create, convene, and support strategic partnerships. – Ability to maintain trust with and engage community residents at the grassroots level. – Ability to strategically select and articulate governmental public health roles in programmatic and policy activities and coordinate with these partners. – Ability to convene across governmental agencies, such as departments of transportation, aging, substance abuse/mental health, education, planning and development, or others, to promote health, prevent disease, and protect residents of the health department's geopolitical jurisdiction. – Ability to engage members of the community in a community health improvement process that draws from community health assessment data and establishes a plan for addressing priorities.	<u>Chronic Disease and Injury Prevention</u> – Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and seek funding for high priority initiatives. – Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and emerging practices aligned with national, state, and local guidelines for healthy eating and active living. <u>Communicable Disease Control</u> – Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and seek funding for high priority initiatives. <u>Environmental Public Health</u> – Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and seek action funding for high priority initiatives. <u>Maternal, Child, and Family Health</u> – Identify local maternal and child health community partners and their capacities;

		The community health improvement plan can serve as the basis for partnership development and coordination of effort and resources.	using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and seek funding for high priority initiatives.
5	Create, champion, and implement policies, plans, and laws that impact health – Developing and championing policies, plans, and laws that guide the practice of public health. – Examining and improving existing policies, plans, and laws to correct historical injustices. – Ensuring that policies, plans, and laws provide a fair and just opportunity for all to achieve optimal health. – Providing input into policies, plans, and laws to ensure that health impact is considered. – Continuously monitoring and developing policies, plans, and laws that improve public health and preparedness and strengthen community resilience. – Collaborating with all partners, including multi-sector partners, to develop and support policies, plans, and laws. – Working across partners and with the community to systematically and continuously develop and implement health improvement strategies and plans, and evaluate and improve those plans.	<u>Policy Development and Support</u> – Ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based, grounded in law, and legally defendable. This ability includes researching, analyzing, costing out, and articulating the impact of such policies and rules where appropriate, as well as the ability to organize support for these policies and rules and place them before an entity with the legal authority to adopt them. – Ability to effectively inform and influence polices being considered by other governmental and non-governmental agencies within your jurisdiction that can improve the physical, environmental, social, and economic conditions affecting health but are beyond the immediate scope or authority of the governmental public health department.	<u>Chronic Disease and Injury Prevention</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on chronic disease and injury prevention and control. – Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and seek funding for high priority initiatives. – Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and emerging practices aligned with national, state, and local guidelines for healthy eating and active living. <u>Communicable Disease Control</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control. – Identify statewide and local communicable disease control community partners and

			their capacities, develop, and implement a prioritized communicable disease control plan, and seek funding for high priority initiatives. Environmental Public Health – Provide timely, statewide, and locally relevant and accurate information to the state, health care system, and community on environmental public health issues and health impacts from common environmental or toxic exposures. – Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and seek action funding for high priority initiatives.
6	Utilize legal and regulatory actions designed to improve and protect the public's health – Ensuring that applicable laws are equitably applied to protect the public's health. – Conducting enforcement activities that may include, but are not limited to sanitary codes, especially in the food industry; full protection of drinking water supplies; and timely follow-up on hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings.	Policy Development and Support – Ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based, grounded in law, and legally defendable. This ability includes researching, analyzing, costing out, and articulating the impact of such policies and rules where appropriate, as well as the ability to organize support for these policies and rules and place them before an entity with the legal authority to adopt them.	Access to and Linkage with Clinical Care – Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable. Chronic Disease and Injury Prevention – Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand smoke exposure, as well as exposure to harmful substances.

	– Licensing and monitoring the quality of healthcare services (e.g., laboratory, nursing homes, and home healthcare). – Reviewing new drug, biologic, and medical device applications. – Licensing and credentialing the healthcare workforce. – Including health considerations in laws from other sectors (e.g., zoning).	– Ability to effectively inform and influence polices being considered by other governmental and non-governmental agencies within your jurisdiction that can improve the physical, environmental, social, and economic conditions affecting health but are beyond the immediate scope or authority of the governmental public health department.	<u>Communicable Disease Control</u> – Assure the appropriate treatment of individuals who have active tuberculosis, including the provision of directly-observed therapy in accordance with local and state laws and Centers for Disease Control and Prevention (CDC) guidelines. <u>Environmental Public Health</u> – Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and, identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations. – Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations – Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. housing and urban development, recreational facilities, and transportation systems) and resilient communities.

7	Assure an effective system that enables equitable access to the individual services and care needed to be healthy – Connecting the population to needed health and social services that support the whole person, including preventive services. – Ensuring access to high-quality and cost-effective healthcare and social services, including behavioral and mental health services, that are culturally and linguistically appropriate. – Engaging health delivery systems to assess and address gaps and barriers in accessing needed health services, including behavioral and mental health. – Addressing and removing barriers to care. – Building relationships with payers and healthcare providers, including the sharing of data across partners to foster health and well-being. – Contributing to the development of a competent healthcare workforce.	<u>Organizational/Administrative Competencies</u> – Health Equity: Ability to strategically coordinate health equity programming through a high level, strategic vision and/or subject matter expertise which can lead and act as a resource to support such work across the department. – Information Technology Services, including Privacy and Security: Ability to maintain and procure the hardware and software needed to access electronic health information and to support the department's operations and analysis of health data. Ability to support, use, and maintain communication technologies needed to interact with community residents. Ability to have the proper systems in place to keep health and human resources data confidential. – Human Resources Services: Ability to develop and maintain a competent workforce, including recruitment, retention, and succession planning; training; and performance review and accountability.	<u>Access to and Linkage with Clinical Care</u> – Provide timely, statewide, and locally relevant and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost. – Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable. – In concert with national and statewide groups and local providers of health care, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives. – Coordinate and integrate categorically-funded clinical health care. <u>Communicable Disease Control</u> – Assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV according to CDC guidelines. – Assure the appropriate treatment of individuals who have active tuberculosis, including the provision of directly-observed therapy in accordance with local and state laws and Centers for Disease Control and Prevention (CDC) guidelines.

8	Build and support a diverse and skilled public health workforce – Providing education and training that encompasses a spectrum of public health competencies, including technical, strategic, and leadership skills. – Ensuring that the public health workforce is the appropriate size to meet the public's needs. – Building a culturally competent public health workforce and leadership that reflects the community and practices cultural humility. – Incorporating public health principles in non-public health curricula. – Cultivating and building active partnerships with academia and other professional training programs and schools to assure community-relevant learning experiences for all learners. – Promoting a culture of lifelong learning in public health. – Building a pipeline of future public health practitioners. – Fostering leadership skills at all levels.	<u>Organizational/Administrative Competencies</u> – Leadership and Governance: Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the public face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction of public health initiatives. Ability to engage with the appropriate governing entity about the department's public health legal authorities and what new laws and policies might be needed. – Human Resources Services: Ability to develop and maintain a competent workforce, including recruitment, retention, and succession planning; training; and performance review and accountability.	<u>Chronic Disease and Injury Prevention</u> – Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services. <u>Communicable Disease Control</u> – Coordinate and integrate categorically-funded communicable disease programs and services. <u>Environmental Public Health</u> – Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations – Coordinate and integrate categorically-funded environmental public health programs and services. <u>Maternal, Child, and Family Health</u> – Coordinate and integrate categorically funded maternal, child, and family health programs and services.
9	Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement – Building and fostering a culture of quality in public health organizations and activities.	<u>Accountability/Performance Management</u> – Quality Improvement: Ability to perform according to accepted business standards and to be accountable in accordance with applicable relevant federal, state, and local laws and policies and to assure compliance	

	– Linking public health research with public health practice. – Using research, evidence, practice-based insights, and other forms of information to inform decision-making. – Contributing to the evidence base of effective public health practice. – Evaluating services, policies, plans, and laws continuously to ensure they are contributing to health and not creating undue harm. – Establishing and using engagement and decision-making structures to work with the community in all stages of research. – Valuing and using qualitative, quantitative, and lived experience as data and information to inform decision-making.	with national and Public Health Accreditation Board Standards. Ability to maintain a performance management system to monitor achievement of organizational objectives. Ability to identify and use evidence-based and/or promising practices when implementing new or revised processes, programs and/or interventions at the organizational level. Ability to maintain an organization-wide culture of quality improvement using nationally recognized framework quality improvement tools and methods.	
10	Build and maintain a strong organizational infrastructure for public health – Developing an understanding of the broader organizational infrastructures and roles that support the entire public health system in a jurisdiction (e.g., government agencies, elected officials, and non-governmental organizations). – Ensuring that appropriate, needed resources are allocated equitably for the public's health. – Exhibiting effective and ethical leadership, decision-making, and governance.	<u>Organizational/Administrative Competencies</u> – Leadership and Governance: Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the public face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction of public health initiatives. Ability to engage with the appropriate governing entity about the department's public health	<u>Access to and Linkage with Clinical Care</u> – Coordinate and integrate categorically-funded clinical health care. <u>Chronic Disease and Injury Prevention</u> – Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services. <u>Communicable Disease Control</u> – Coordinate and integrate categorically-funded communicable disease programs and services. <u>Environmental Public Health</u>

	– Managing financial and human resources effectively. – Employing communications and strategic planning capacities and skills. – Having robust information technology services that are current and meet privacy and security standards. – Being accountable, transparent, and inclusive with all partners and the community in all aspects of practice.	legal authorities and what new laws and policies might be needed. – Health Equity: Ability to strategically coordinate health equity programming through a high level, strategic vision and/or subject matter expertise which can lead and act as a resource to support such work across the department. – Information Technology Services, including Privacy and Security: Ability to maintain and procure the hardware and software needed to access electronic health information and to support the department's operations and analysis of health data. Ability to support, use, and maintain communication technologies needed to interact with community residents. Ability to have the proper systems in place to keep health and human resources data confidential. – Human Resources Services: Ability to develop and maintain a competent workforce, including recruitment, retention, and succession planning; training; and performance review and accountability. – Financial Management, Contract, and Procurement Services, including Facilities and Operations: Ability to establish a budgeting, auditing, billing, and financial system and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies. Ability to secure grants or other funding	– Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. housing and urban development, recreational facilities, and transportation systems) and resilient communities. – Coordinate and integrate categorically-funded environmental public health programs and services. <u>Maternal, Child, and Family Health</u> – Coordinate and integrate categorically funded maternal, child, and family health programs and services.

		(governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized. Ability to procure, maintain, and manage safe facilities and efficient operations. – Legal Services and Analysis: Ability to access and appropriately use legal services in planning, implementing, and enforcing, public health initiatives, including relevant administrative rules and due process.	

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.	The revised framework adds a new statement to elevate the importance of equity in public health practice. The concept is centered within the framework itself to highlight the overarching goal of protecting and promoting the health of all people in all communities. Equity is embedded in each essential service statement and corresponding language to address the social, structural, environmental, and political determinants of health, and to emphasize how critical authentic and active community engagement is in identifying and solving community health problems.

Appendix B – PHCI infographic summarizing foundational and essential health services

Foundational Public Health Services

Overview

Health departments provide public health protections in a number of areas, including: preventing the spread of communicable disease, ensuring food, air, and water quality are safe, supporting maternal and child health, improving access to clinical care services, and preventing chronic disease and injury. In addition, public health departments provide local protections and services unique to their community's needs.

The infrastructure needed to provide these protections strives to provide fair opportunities for all to be healthy and includes seven capabilities: 1) Assessment/Surveillance, 2) Emergency Preparedness and Response, 3) Policy Development and Support, 4) Communications, 5) Community Partnership Development, 6) Organizational Administrative Competencies and 7) Accountability/Performance Management. Practically put, health departments have to be ready 24/7 to serve their communities. That requires access to a wide range of critical data sources, robust laboratory capacity, preparedness and policy planning capacity, and expert staff to leverage them in support of public health protections.

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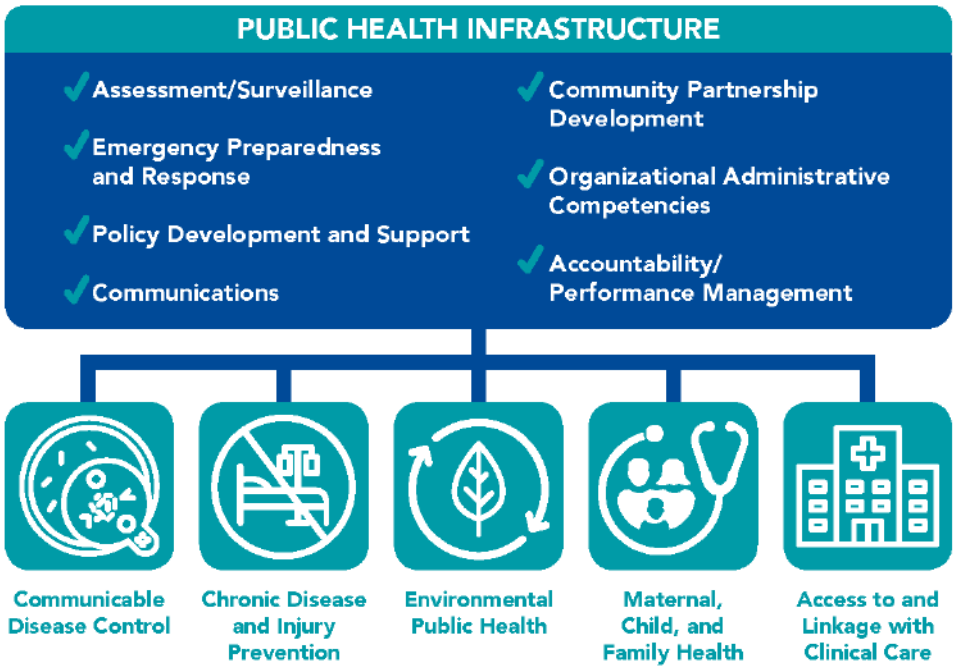

Public health infrastructure consists of the foundational capabilities, which are the cross-cutting skills and capacities needed to support basic public health protections and other programs and activities that are key to ensuring the community's health and achieving equitable health outcomes.

Public health programs, or foundational areas, are those basic public health, topic-specific programs that are aimed at improving the health of the community affected by certain diseases or public health threats. Examples of these include, but are not limited to, chronic disease prevention, community disease control, environmental public health, and maternal, child, and family health.

Local protections and services unique to a community's needs are those determined to be of additional critical significance to a specific community's health and are supported by the public health infrastructure and programs. This work is essential to a given community and cannot be visually depicted because it varies by jurisdiction.

Public Health Infrastructure (Foundational Capabilities)

Assessment/Surveillance

- Ability to collect sufficient foundational data to develop and maintain electronic information systems to guide public health planning and decision making at the state and local level. Foundational data include Behavioral Risk Factor Surveillance Survey (BRFSS), a youth survey (such as YRBS), and vital records, including the personnel and software and hardware development that enable the collection of foundational data.
- Ability to access, analyze, and use data from (at least) seven specific information sources, including (1) U.S. Census data, (2) vital statistics, (3) notifiable conditions data, (4) certain health care clinical and administrative data sets including available hospital discharge, insurance claims data, and Electronic Health Records (EHRs), (5) BRFSS, (6) nontraditional community and environmental health indicators, such as housing, transportation, walkability/green space, agriculture, labor, and education, and (7) local and state chart of accounts.

- Ability to prioritize and respond to data requests, including vital records, and to translate data into information and reports that are valid, statistically accurate, and accessible to the intended audiences.
- Ability to conduct a community and statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities.
- Ability to access 24/7 laboratory resources capable of providing rapid detection.

Emergency Preparedness and Response

- Ability and capacity to develop, exercise, and maintain preparedness and response strategies and plans, in accordance with established guidelines, to address natural or other disasters and emergencies, including special protection of vulnerable populations.
- Ability and capacity to lead the Emergency Support Function 8 – Public Health & Medical for the county, region, jurisdiction, and state.
- Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders; and operate within, and as necessary lead, the incident management system.
- Ability to maintain and execute a continuity of operations plan that includes a plan to access financial resources to execute an emergency and recovery response.
- Ability to establish and promote basic, ongoing community readiness, resilience, and preparedness by enabling the public to take necessary action before, during, or after a disaster.
- Ability to issue and enforce emergency health orders.
- Ability to be notified of and respond to events on a 24/7 basis.
- Ability to function as a Laboratory Response Network (LRN) Reference laboratory for biological agents and as an LRN chemical laboratory at a level designated by CDC.

Policy Development and Support

- Ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based, grounded in law, and legally defendable. This ability includes researching, analyzing, costing out, and articulating the impact of such policies and rules where appropriate, as well as the ability to organize support for these policies and rules and place them before an entity with the legal authority to adopt them.
- Ability to effectively inform and influence polices being considered by other governmental and non-governmental agencies within your jurisdiction that can improve the physical, environmental, social, and economic conditions affecting health but are beyond the immediate scope or authority of the governmental public health department.

Communications

- Ability to maintain ongoing relations with local and statewide media including the ability to write a press release, conduct a press conference, and use electronic communication tools to interact with the media.
- Ability to write and implement a routine communication plan that articulates the health department's mission, value, role, and responsibilities in its community, and support department and community leadership in communicating these messages.
- Ability to develop and implement a risk communication strategy, in accordance with Public Health Accreditation Board Standards, to increase visibility of a specific public health issue and communicate risk. This includes the ability to provide information on health risks and associated behaviors.
- Ability to transmit and receive routine communications to and from the public in an appropriate, timely, and accurate manner, on a 24/7 basis.
- Ability to develop and implement a proactive health education/health prevention strategy (distinct from other risk communications) that disseminates timely and accurate information to the public in culturally and linguistically appropriate (i.e., 508 compliant) formats for the various communities served, including through the use of electronic communication tools.

Community Partnership Development

- Ability to create, convene, and sustain strategic, non-program specific relationships with key health-related organizations; community groups or organizations representing populations experiencing health disparities or inequities; private businesses and health care organizations; and relevant federal, tribal, state, and local government agencies and non-elected officials.
- Ability to create, convene, and support strategic partnerships.
- Ability to maintain trust with and engage community residents at the grassroots level.
- Ability to strategically select and articulate governmental public health roles in programmatic and policy activities and coordinate with these partners.

- Ability to convene across governmental agencies, such as departments of transportation, aging, substance abuse/mental health, education, planning and development, or others, to promote health, prevent disease, and protect residents of the health department's geopolitical jurisdiction.
- Ability to engage members of the community in a community health improvement process that draws from community health assessment data and establishes a plan for addressing priorities. The community health improvement plan can serve as the basis for partnership development and coordination of effort and resources.

Organizational Administrative Competencies

- Leadership and Governance: Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the public face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction of public health initiatives. Ability to engage with the appropriate governing entity about the department's public health legal authorities and what new laws and policies might be needed.
- Health Equity: Ability to strategically coordinate health equity programming through a high level, strategic vision and/or subject matter expertise which can lead and act as a resource to support such work across the department.
- Information Technology Services, including Privacy and Security: Ability to maintain and procure the hardware and software needed to access electronic health information and to support the department's operations and analysis of health data. Ability to support, use, and maintain communication technologies needed to interact with community residents. Ability to have the proper systems in place to keep health and human resources data confidential.
- Human Resources Services: Ability to develop and maintain a competent workforce, including recruitment, retention, and succession planning; training; and performance review and accountability.
- Financial Management, Contract, and Procurement Services, including Facilities and Operations: Ability to establish a budgeting, auditing, billing, and financial system and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies. Ability to secure grants or other funding (governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized. Ability to procure, maintain, and manage safe facilities and efficient operations.
- Legal Services and Analysis: Ability to access and appropriately use legal services in planning, implementing, and enforcing, public health initiatives, including relevant administrative rules and due process.

Accountability/Performance Management

- Quality Improvement: Ability to perform according to accepted business standards and to be accountable in accordance with applicable relevant federal, state, and local laws and policies and to assure compliance with national and Public Health Accreditation Board Standards. Ability to maintain a performance management system to monitor achievement of organizational objectives. Ability to identify and use evidence-based and/or promising practices when implementing new or revised processes, programs and/or interventions at the organizational level. Ability to maintain an organization-wide culture of quality improvement using nationally recognized framework quality improvement tools and methods.

Public Health Programs (Foundational Areas)

Communicable Disease Control

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.
- Identify statewide and local communicable disease control community partners and their capacities, develop and implement a prioritized communicable disease control plan, and seek funding for high priority initiatives.
- Receive laboratory reports and other relevant data, conduct disease investigations, including contact tracing and notification, and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national and state mandates and guidelines.
- Assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV according to CDC guidelines.
- Assure the appropriate treatment of individuals who have active tuberculosis, including the provision of directly-observed therapy in accordance with local and state laws and Centers for Disease Control and Prevention (CDC) guidelines.
- Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual, at the appropriate level.
- Coordinate and integrate categorically-funded communicable disease programs and services.

Chronic Disease and Injury Prevention

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on chronic disease and injury prevention and control.
- Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop and implement a prioritized prevention plan, and seek funding for high priority initiatives.
- Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand smoke exposure, as well as exposure to harmful substances.
- Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and emerging practices aligned with national, state, and local guidelines for healthy eating and active living.
- Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.

Environmental Public Health

- Provide timely, statewide, and locally relevant and accurate information to the state, health care system, and community on environmental public health issues and health impacts from common environmental or toxic exposures.
- Identify statewide and local community environmental public health partners and their capacities, develop and implement a prioritized plan, and seek action funding for high priority initiatives.
- Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and, identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.
- Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations
- Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. housing and urban development, recreational facilities, and transportation systems) and resilient communities.
- Coordinate and integrate categorically-funded environmental public health programs and services.

Maternal, Child, and Family Health

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on emerging and on-going maternal child health trends.
- Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and seek funding for high priority initiatives.
- Identify, disseminate, and promote emerging and evidence-based information about early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development.
- Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back, following up, and service engagement activities.
- Coordinate and integrate categorically funded maternal, child, and family health programs and services.

Access to and Linkage with Clinical Care

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost.
- Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.
- In concert with national and statewide groups and local providers of health care, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.
- Coordinate and integrate categorically-funded clinical health care.

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Appendix C – Summary of Public Health Services and Capabilities in New Jersey pursuant to N.J.A.C. 8:52

Public Health Practice Standards of Performance for local Boards of Health in NJ - N.J.A.C. 8:52

(pursuant to N.J.S.A. 26:1A-15 and 26:3A2-1 et. seq., and Reorganization Plan Number 003-2005).

Each local Board of Health in New Jersey is required to ensure that a set of minimum services and a minimum level of capacity are maintained as set forth in N.J.A.C. 8:52-3. *Local Board of Health* is a county or municipal board of health, or a board of health of any regional, local, or special health district having the authority to regulate public health or sanitation by ordinance. *Local health agency* is any municipal local health agency, contracting local health agency, regional health commission, or county health department, administered by a full-time health officer, and responsible for delivering and ensuring population-based public health services as set forth in 8:52-3.

Pages 1-7 below summarize required minimum services; page 8 summarizes minimum capacity.

ADMINISTRATIVE SERVICES

Management and leadership (8:52-5.2). Includes:

• Develop a countywide or multi-countywide Community Health Profile, Community Health Assessment and Community Health Improvement.

• Complete an evaluation of the capacity of the local health agency.

• Develop goals and objectives for each program conducted by the local health agency and the development of a continuous quality improvement process to ensure progress in achieving the local health agency's goals.

• Develop an internal monitoring plan that measures progress in achieving each of the local health agency's goals and objectives and development of improvement plan to address performance deficiencies which are revealed during the Continuous Quality Improvement process.

• Ensure that: the local health agency's resources are organized to promote the health outcomes identified through the countywide or multi-countywide Community Health Improvement Plan; competent leadership is assigned responsibility for each major activity and core responsibility; the local health agency prepares and has on file a current table of organization which depicts reporting relationships within the local health agency.

• Ensure that: all professional public health staff who require licensure, certification, or authorization to perform their activities shall be currently licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey; all public health staff receive adequate training for the activities they are expected to perform; all professional public health staff who require licensure, certification, or authorization to perform their activities shall perform within the scope of their license, certificate, or authority.

• Ensure appropriate coordination and response to public health problems that follow established scientific guidelines.

• Have access to a financial officer for assistance in managing and overseeing all public health budgets and have access to an attorney for assistance in interpreting, developing, and/or guiding the enforcement of public health laws, rules, regulations, and ordinances.

• Report annually local board of health performance data as required in the Local Health Evaluation Report by February 15 of each year on a format provided by DOH and shall include: Registration of the local board of health; Information regarding a local health agency's capacity; Information regarding specialized regional expertise and capacity; Information regarding workforce assessment; Training of each local board of health member; Evaluation of each community's public health partnerships effectiveness; County Health Status Indicators Report; Community health planning information; Community Health Improvement Plan; Epidemiological, economic, and health services research finding.

• Report all diseases, threats, and emergencies in accordance with all applicable State and Federal laws.

• Participate in the Local Information Network and Communications System (LINCS) and use LINCS to report all diseases and threats to the public health to DOH and monitor LINCS email twice per day, and immediately report to the DOH emergencies that threaten the health or safety of the citizens in its jurisdiction.

• Maintain all records in accordance with State record retention standards.

Community public health activities (8:52-5.3). Includes:

• Ensure that there is a mechanism that provides leadership to develop partnerships with community organizations and/or agencies which have a demonstrable affect on, or compelling interest in, the health status of the population.

• Conduct an annual public meeting to report the status of the community's health and the local health agency's progress and performance in accomplishing its mission and achieving its objectives.

Public health system assurance (8:52-5.4). Includes:

• Shall actively participate in countywide or multi-countywide meetings to assess the health status of the population, to develop a Community Health Improvement Plan, and to determine his or her local health agency's roles and responsibilities within the Plan.

• Shall ensure the development of local policies and programs that are consistent with the Community Health Improvement Plan. ■

HEALTH EDUCATION SERVICES

Health education and promotion (8:52-6.2). Includes:

• Shall provide a comprehensive health education and health promotion program which is developed and overseen by a health educator and provides integrated support to the daily operation of the local health agency. Shall implement and evaluate culturally and linguistically appropriate population-based health education and health promotion activities. Shall ensure that health education and health promotion services provide deliver the 10 essential health services. These efforts shall include the following activities:

1. Assessment and analysis of individual and community needs and assets;
2. Planning of theory-based health education programs which includes the development of appropriate and measurable objectives;
3. Implementation of population-based health education programs which match various educational strategies and methods to the identified issues. Strategies may include, but are not limited to, direct programming, train-the-trainer programs, community organization methods, media campaigns, and advocacy initiatives;
4. Provision of process, impact, and outcome evaluation of health education programs in order to measure achievement and success;
5. Management of health education programs, personnel, and budgets;
6. Development of in-service training programs for staff, volunteers, and other interested parties;
7. Recruitment and training of volunteers to build and support community coalitions and partnerships;
8. Identification of and facilitation among agencies and community resources to reduce duplication and enhance services;
9. Provision of client referral and assistance to health and social service resources;
10. Development of risk communication plans to manage community concern and convey appropriate and accurate information;
11. Advise and/or serve as a spokesperson and liaison to the media;
12. Provision of public health advocacy for policies and funding that support social justice principles and which will improve the health status of communities;
13. Provision of grant writing to support local health agency objectives, the Community Health Improvement Plan, and health education programs;
14. Development of audio, visual, and print materials which support program initiatives;
15. Use of quantitative and qualitative research techniques to advance the quality of public health practice.

• Shall plan and develop health education programs and interventions regarding the uninsured, underinsured, immigrant, indigent, and other vulnerable populations within its jurisdiction.

• Inventory health promotion and health education services delivered by all agencies in their jurisdiction and compare existing services with those outlined in the Community Health Improvement Plan in order to identify gaps, reduce duplication, and to identify opportunities for collaborative partnerships. ■

PUBLIC HEALTH NURSING SERVICES

Public health nursing services (8:52-7.2). Includes:

• Shall provide comprehensive public health nursing services that provide integrated support to the daily operation of the local health agency and that ensure that public health nursing practice provides the core public health functions and the delivery of the 10 essential public health services. These services shall be developed and overseen by a public health nurse and shall include, but not be limited to the following activites:

1. Assessing and identifying populations at risk;
2. Providing outreach and case finding using population-based services;
3. Using systematic, relevant data collection from public health nursing practice for community health assessment;
4. Using case information and epidemiological methods to link epidemiology and a clinical understanding of health and illness;
5. Developing and implementing health guidance, counseling, and educational plans using the established nursing process;
6. Providing health plans to assure health promotion efforts that include primary clinical prevention and early intervention strategies;
7. Using the nursing process and triage to determine priorities for interventions and services based on risk assessment and community needs especially for underserved populations;
8. Advocating policies and funding that create clinical programs and improve health status;
9. Establishing procedures and processes which ensure competent implementation of prevention measures and treatment schedules;
10. Providing clinical preventive services, including clinical screenings and preventive care;
11. Facilitating access to care through the use of nursing assessment, referral for risk reduction, prevention, restorative, and rehabilitative services, and the establishing clinical programs and services;
12. Participating in all components of communicable disease prevention and control, including clinical surveillance, case identification, and treatment;
13. Planning, developing, and initiating interdisciplinary nursing plans for care and case management;
14. Establishing and maintaining written procedures and protocols for clinical care;
15. Identifying, defining, coordinating, and evaluating enhanced clinical services for complex populations and special risk groups.

Environmental health services (8:52-7.A.2). Includes:

• Shall provide a comprehensive environmental health program that is developed and overseen by a Registered Environmental Health Specialist and that is in accordance with the State Sanitary Code and other regulations;

• Shall assure compliance with regulations;

• Shall be responsible for the performance of all environmental health activities including the following:

1. Assessing environmental health risks to and influences on humans and the environment;
2. Utilizing discrete data and epidemiological methods, as applicable, to determine the etiology of, and recommend corrective actions for, diseases spread through humans, animals and the environmental media of air, soil, water and food;

3. Providing professional and technical support to local, State and Federal agencies on matters within their expertise;
4. Developing and implementing a proactive environmental health program in an effort to preclude health threats to the public;
5. Reviewing plans for residential, commercial, and industrial development as necessary to ensure health and safety code compliance;
6. Collection of water, food and other specimens as needed for laboratory analysis, and interpretation of the results of same;
7. Planning and performing routine and emergency environmental health inspections and investigations to ensure operator or owner conformance with established regulations;
8. Maintaining, updating and analyzing environmental health records, inspection findings and other data to ensure proper documentation and continuity of environmental health protection;
9. Preparing reports and findings as witness to environmental health violations in court cases and hearings;
10. Advocating for local and State policy that protects the public's health and safety;
11. Reviewing new environmental health policy and implementing the requirements of new policies as necessary;
12. Educating and communicating environmental risks to the public, media, and other interested parties;
13. Assisting the public, local health agency personnel and other officials with recommendations and resources on various environmental health matters per code requirements and suitable abatement practices;
14. Investigating foodborne, airborne, waterborne and other suspected disease outbreaks as required;
15. Maintaining the most current knowledge of environmental health technologies, information systems and technical advancements in the field. ■

10 ESSENTIAL PUBLIC HEALTH SERVICES

1. Monitor health status to identify community health problems (8:52-10).

• Collecting, compiling, interpreting, reporting, and communicating vital statistics and health status measures of populations or sub-populations, as available, within one or more counties.

• Assessing health service needs;

• Timely analyzing, communicating, and publishing information on access to, utilization of, quality of, and outcomes of personal health services;

2. Diagnose and investigate health problems in the community (8:52-12).

• Identifying emerging epidemiological health threats;

• Supporting prevention efforts with public health laboratory capabilities;

• Supporting active infectious disease prevention and control efforts;

• Acquiring and sustaining technical capacity for epidemiological investigation of disease outbreaks and patterns of chronic disease and injury;

3. Inform, educate, and empower people regarding health issues (N.J.A.C. 8:52-6).

• Social marketing and targeted public media communications regarding public health issues;

• Providing accessible health information resources at the community level;

• Collaborating with personal health care providers to reinforce health promotion messages and programs;

• Initiating health education with schools, community groups, special populations, and occupational sites;

4. Mobilize community partnerships to identify and solve health problems (8:52-9).

• Convening community groups and associations that have access to populations and resources to facilitate prevention, screening, rehabilitation, and support activities;

• Identifying and organizing community resources through skilled coalition building to support the goals and activities of a countywide public health system;

5. Develop policies and plans which support individual and community health efforts (8:52-11).

• Systematic countywide and State level planning for health improvement;

• Development and tracking of measurable health objectives as a part of a continuous quality improvement strategy;

• Development of consistent policies regarding prevention and treatment services;

• Development of codes, regulations, and legislation to authorize and guide the practice of public health;

6. Enforce the laws and regulations that protect health and ensure safety (N.J.A.C. 8:52-14).

• Enforcement of the State Sanitary Code;

• Protection of food and drinking water supplies;

• Compliance with environmental health activities regarding air, water, noise, and nuisances;

• Investigation of health hazards, preventable injuries, and exposure-related diseases in both the work and community settings;

7. Link people to needed personal health services and assure health care when it is otherwise unavailable (N.J.A.C. 8:52-13).

• Access to the personal health care system by socially disadvantaged individuals;

• Culturally and linguistically appropriate materials and staff to assure linkage to services for special populations;

• Continuous care management; iv. Transportation services; v. Technical assistance and health information for high risk groups;

• Occupational health programs;

8. Ensure a competent local public health system and assure a competent personal health care workforce (8:52-8).

• Assessing existing and needed competencies at the community and organizational levels;

• Establishing standards for public health professionals;

• Evaluating job performance;

• Requiring continuing education; and

• Training management and leadership;

9. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services (8:52-16).

• Evaluating the effectiveness, accessibility, and quality of personal and population-based health services;

• Developing objectives and measurements and collecting and analyzing data and information which are used to compare performance with agreed upon standards;

• Determining the success or failure of a program or activity;

•Recommending for improvement, expansion or termination a program or activity;

10. Research for innovative solutions to health problems as set forth at (8:52-15).

• The continuous linkage between the practice of public health and academic and research institutions;

• The capacity to perform timely epidemiological and economic analyses;

• The ability to conduct health services and health practice research;

• The appropriate utilization of research findings. ■

MINIMUM LOCAL HEALTH AGENCY CAPACITY (8:52-3.2)

Each local health agency shall, at a minimum, have the capacity to deliver:

1. Basic public health services set forth in "Public Health Practice Standards of Performance for Local Boards of Health, (8:52-1 et seq);

2. Administrative services consistent with N.J.A.C. 8:52-5;

3. Environmental health services that integrate Registered Environmental Health Specialist practice as set forth in the State Sanitary Code (N.J.A.C. 8:21, 8:22, 8:23, 8:23A, 8:24, 8:25, 8:26, 8:27, 8:51, 10:122 , 5:17 and 7:9A, and N.J.S.A. 24:14A-1 et seq., 26:3-69.1 and 58:11-33);

4. Health education and health promotion services consistent with N.J.A.C. 8:52-6;

5. Preventive health services, that integrate public health nursing practice and health education and/or health promotion programs, and shall be consistent with N.J.A.C. 8:52- 13;

6. Public health nursing services consistent with N.J.A.C. 8:52-7

7. All other public health services required by the State Sanitary Code (N.J.A.C. 8:21, 8:22, 8:23, 8:23A, 8:24, 8:25, 8:26, 8:27, 8:51, 8:57-1 through 4, 10:122, 5:17 and 7:9A, and N.J.S.A. 24:14A-1 et seq., 26:3-69.1 and 58:11-23);

8. Emergency response services consistent with N.J.A.C. 8:52-12;

9. Enforcement services consistent with N.J.A.C. 8:52-14; and

10. Specialized services consistent with N.J.A.C. 8:52-3.4. ■

Appendix D – Full report of Eagleton Center for Public Interest Polling

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Eagleton Institute of Politics
CENTER FOR PUBLIC INTEREST POLLING

December 10, 2021

REPORT

Public Health Awareness, Perceptions, and Attitudes in New Jersey

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Eagleton Center for Public Interest Polling

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Eagleton Center for Public Interest Polling

The Eagleton Center for Public Interest Polling (ECPIP), home of the Rutgers-Eagleton Poll, was established in 1971. Now celebrating its 50th anniversary and publication of over 200 public opinion polls on the state of New Jersey, ECPIP is the first university-based statewide public opinion poll and survey research center in the United States.

Our mission is to provide scientifically sound, non-partisan information about public opinion. ECPIP conducts research for all levels of government and nonprofit organizations with a public interest mission, as well as college and university-based researchers and staff. ECPIP makes it a priority to design opportunities for undergraduate and graduate students to learn how to read, analyze, design, and administer polls. We pride ourselves on integrity, quality, and objectivity.

To read more about ECPIP and view all of our press releases and published research, please visit our website: eagletonpoll.rutgers.edu.

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AMERICAN ASSOCIATION FOR PUBLIC OPINION RESEARCH

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Methodology

The survey was conducted by telephone using live interviewers November 19-28, 2021, with a scientifically selected random sample of 1,005 New Jersey adults, 18 or older. Persons without a telephone could not be included in the random selection process. Respondents within a household are selected by asking randomly for the youngest adult male or female currently available. If the named gender is not available, the youngest adult of the other gender is interviewed. The survey was available in Spanish for respondents who requested it. This poll included 322 adults reached on a landline phone and 683 adults reached on a cell phone, all acquired through random digit dialing; 87 of the cell phone completes were acquired through one-to-one SMS text messaging by live interviewers that led respondents to an online version of the survey. Distribution of phone use in this sample is:

Cell Only	44%
Dual Use, Reached on Cell	24%
Dual Use, Reached on LL	29%
Landline Only	3%

The data were weighted to be representative of the non-institutionalized adult population of New Jersey. The weighting balanced sample demographics to target population parameters. The sample is balanced, by form, to match parameters for sex, age, education, region, race/ethnicity and phone use. The sex, age, education, race/ethnicity, and region parameters were derived from 2019 American Community Survey PUMS data. The phone use parameter was derived from estimates provided by the National Health Interview Survey Early Release Program.[1]

Weighting was done in two stages. The first stage of weighting corrects for different probabilities of selection across the RDD samples associated with the number of adults in each household and each respondent's telephone usage patterns. This adjustment also accounts for the overlapping landline and cell sample frames and the relative sizes of each frame and each sample.[2]

[1] NCHS, National Health Interview Survey, 2014–2018; U.S. Census Bureau, American Community Survey, 2013–2018.

[2] Buskirk, T. D., & Best, J. (2012). Venn Diagrams, Probability 101 and Sampling Weights Computed for Dual Frame Telephone RDD Designs. Journal of Statistics and Mathematics, 15, 3696-3710.

The second stage of weighting balances sample demographics to match target population benchmarks. This weighting was accomplished using SPSSINC RAKE, an SPSS extension module that simultaneously balances the distributions of all variables using the GENLOG procedure. Weights were trimmed to prevent individual interviews from having too much influence on survey estimates. The use of these weights in statistical analysis ensures that the demographic characteristics of the sample closely approximate the demographic characteristics of the target population.

Post-data collection statistical adjustments require analysis procedures that reflect departures from simple random sampling. We calculate the effects of these design features so that an appropriate adjustment can be incorporated into tests of statistical significance when using these data. The so-called "design effect" or *deff* represents the loss in statistical efficiency that results from a disproportionate sample design and systematic non-response.[3]

All surveys are subject to sampling error, which is the expected probable difference between interviewing everyone in a population versus a scientific sampling drawn from that population. Sampling error should be adjusted to recognize the effect of weighting the data to better match the population.

In this poll, the simple sampling error for 1,005 New Jersey adults is +/-3.1 percentage points at a 95 percent confidence interval.[4] This means that in 95 out every 100 samples using the same methodology, estimated proportions based on the entire sample will be no more than 3.1 percentage points away from their true values in the population. The design effect[5] is 1.31, making the adjusted margin of error +/- 3.5 percentage points. Thus, if 50 percent of New Jersey adults in this sample favor a particular

[3] The composite design effect for a sample of size n, with each case having a weight, w, is computed as deff=nw2w2.

[4] The survey's maximum margin of error is the largest 95% confidence interval for any estimated proportion based on the total sample – one around 50%.

[5] Post-data collection statistical adjustments require analysis procedures that reflect departures from simple random sampling. We calculate the effects of these design features so that an appropriate adjustment can be incorporated into tests of statistical significance when using these data. The so-called "design effect" or *deff* represents the loss in statistical efficiency that results from a disproportionate sample design and systematic non-response.

position, we would be 95 percent sure that the true figure is between 46.5 and 53.5 percent (50 +/- 3.5) if all New Jersey adults had been interviewed, rather than just a sample.

Sampling error does not consider other sources of variation inherent in public opinion studies, such as non-response, question wording, or context effects.

This survey was fielded by Braun Research, Inc. with sample from Dynata. The questionnaire was developed and all data analyses were completed in house by the Eagleton Center for Public Interest Polling (ECPIP). Jessica Roman, MPP, assisted with analysis and preparation of this report. The Eagleton Center for Public Interest Polling is sponsored by the Eagleton Institute of Politics at Rutgers, The State University of New Jersey, a non-partisan academic center for the study of politics and the political process. For more information, please contact poll@eagleton.rutgers.edu.

Weighted Sample Characteristics

1,005 New Jersey Adults

Democrat	39%
Independent	41%
Republican	20%
Male	48%
Female	52%
White	58%
Black	13%
Hispanic	18%
Other	12%
18-34	27%
35-49	25%
50-64	27%
65+	21%
<$50K	17%
$50K-<$100K	35%
$100K-<$150K	14%
$150K+	17%
Urban	17%
Suburb	35%
Exurban	14%
Phil/South	17%
Shore	17%
HS or Less	28%
Some College	31%
College Grad	23%
Grad Work	17%

Report

Access to Healthcare a Top Health Concern

When it comes to the top health-related issue facing local communities right now – aside from COVID-19, that is – New Jerseyans have difficulty coalescing around just one concern (see Figure 1). Instead, opinions are spread out among an array of issues: 10 percent mention something about access to health care, including cost, insurance, and quality; 6 percent each say something about mental health issues, obesity, and the cold or flu; 5 percent each say something about the COVID-19 pandemic and addiction and drugs; 4 percent cite something about pollution or environmental issues, including clean water; 3 percent say something regarding food insecurity; and 2 percent each mention something about the cost of living and cancer.

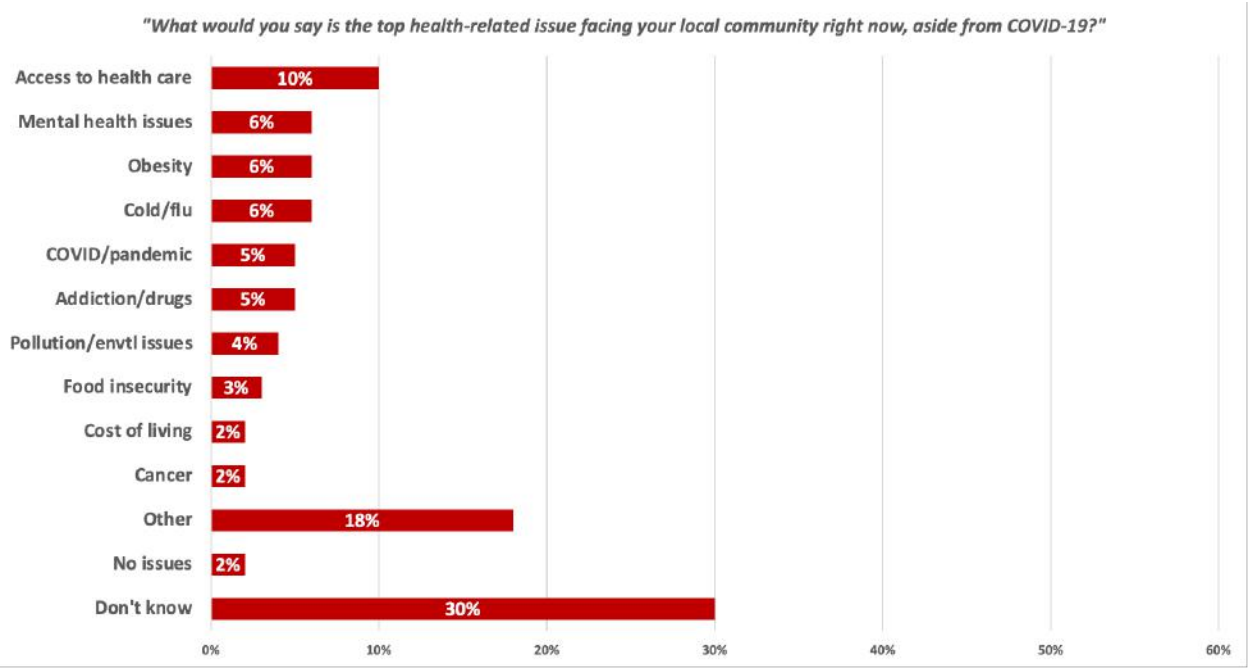
Access to healthcare is the top issue among Democrats (15%) and independents (9%); Republicans, on the other hand, are more likely to mention obesity (9%) and the pandemic (8%). Health care is also the most mentioned topic among Black residents (15%) and White residents (10%), whereas Hispanic residents are as likely to mention the pandemic and cold and flu (each at 9%). Mentioning something about healthcare is especially prevalent among those 50 to 64 years old; those in higher income brackets; those living in urban (13%), suburban (11%), and shore areas (12%); and those with at least some college education.

Individuals Should Take on Most Responsibility for Leading Healthy Lives

New Jerseyans believe that the people themselves should take on the most responsibility in making sure they are leading healthy lives, more than any other entity or organization (see Figure 2): 72 percent say individuals have “a lot” of responsibility in this area, 16 percent say “some,” 8 percent say “a little,” and just 3 percent say “none.” The belief that individuals have “a lot” of this responsibility is especially strong among Republicans (77%), men (75%), White residents (77%), those 35 to 49 years old (82%), upper income residents, and those with higher

levels of education. In contrast, Black residents, Hispanic residents, 18- to 34-year-olds, those in lower income brackets, and those with a high school degree or less are least likely to feel this way.

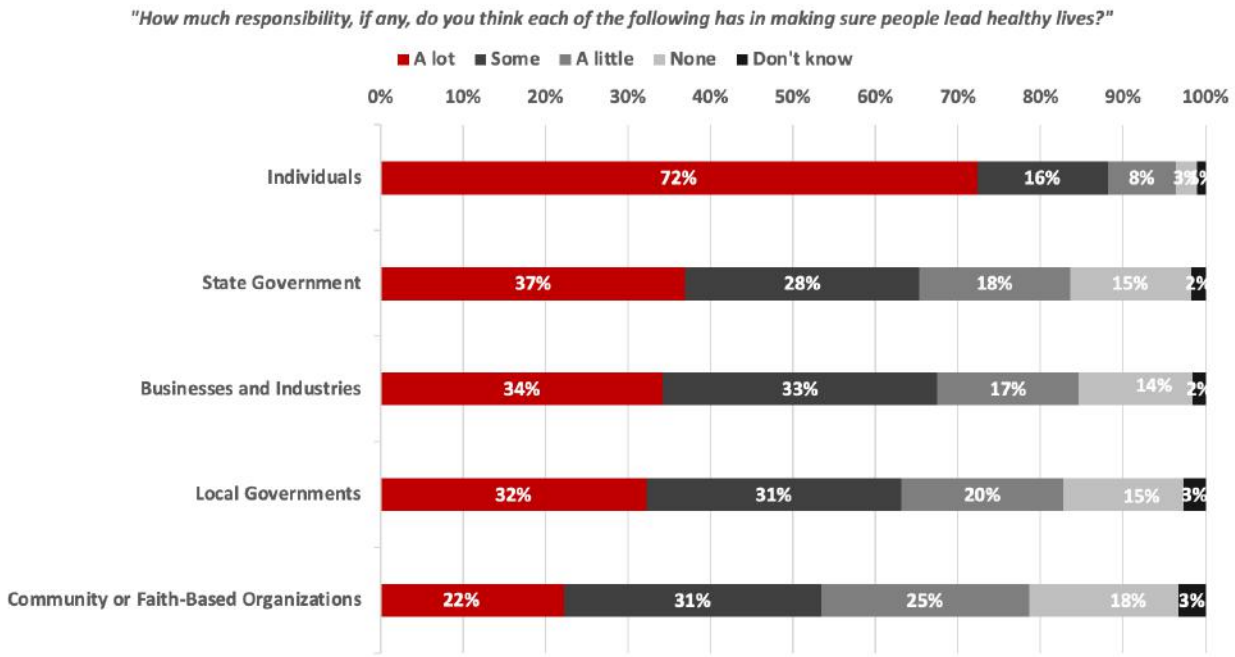
Figure 1: Top Health-Related Issue Facing One's Local Community



State government comes in a distant second, with 37 percent saying it should take on "a lot" of responsibility, 28 percent "some," 18 percent "a little," and 15 percent "none." Democrats (47%), Black residents (50%), 18- to 34-year-olds (46%), and urban residents (45%) are especially more likely to say the state government has "a lot" of responsibility. Overall views and demographic patterns are similar when it comes to the role of local government (32% "a lot," 31% "some").

New Jerseyans assign a similar amount of responsibility to business and industries (34% "a lot," 33% "some") and – though to a lesser extent – community and faith-based organizations (22% "a lot," 31% "some") as they do to government.

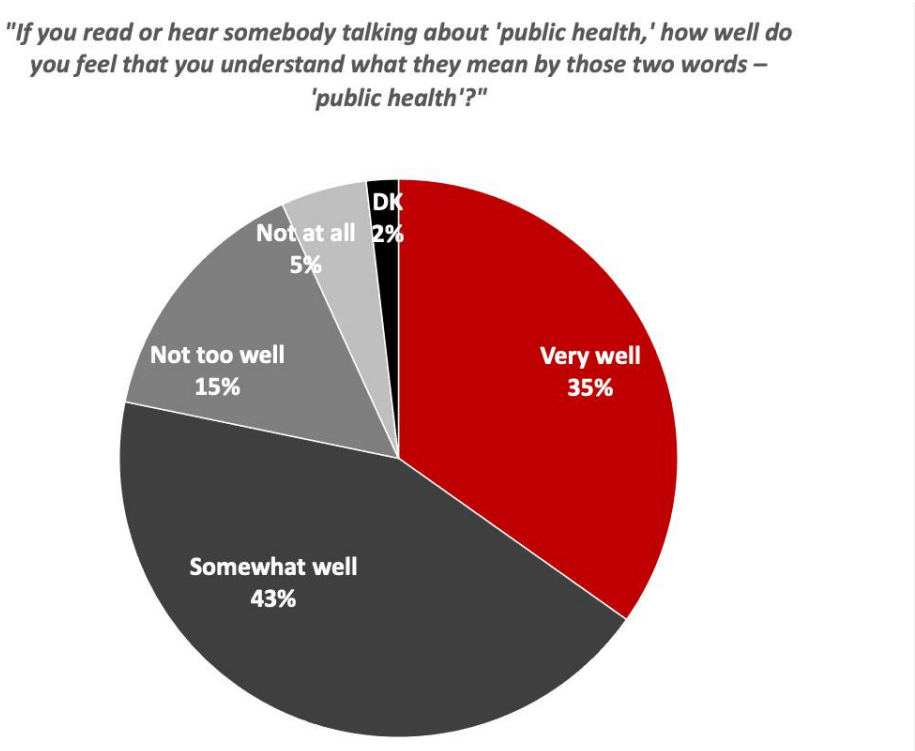
Figure 2: How Much Each Entity is Responsible for People Leading Healthy Lives



Understanding the Meaning of "Public Health"

New Jerseyans have somewhat of a grasp on what "public health" actually means – or so they claim (see Figure 3). Eight in 10 (35% "very well," 44% "somewhat well") feel they understand what is meant by the term "public health," with "somewhat well" being the modal response across most demographic groups; one in five, on the other hand, do not (15% "not very well," 4% "not at all"). Republicans and senior citizens were slightly more likely than others to say they did not understand the term, while Black residents, those in higher income brackets, and those with higher levels of education were some of the most likely to say they understood it "very well."

Figure 3: How Well New Jerseyans Feel They Understand What is Meant by "Public Health"



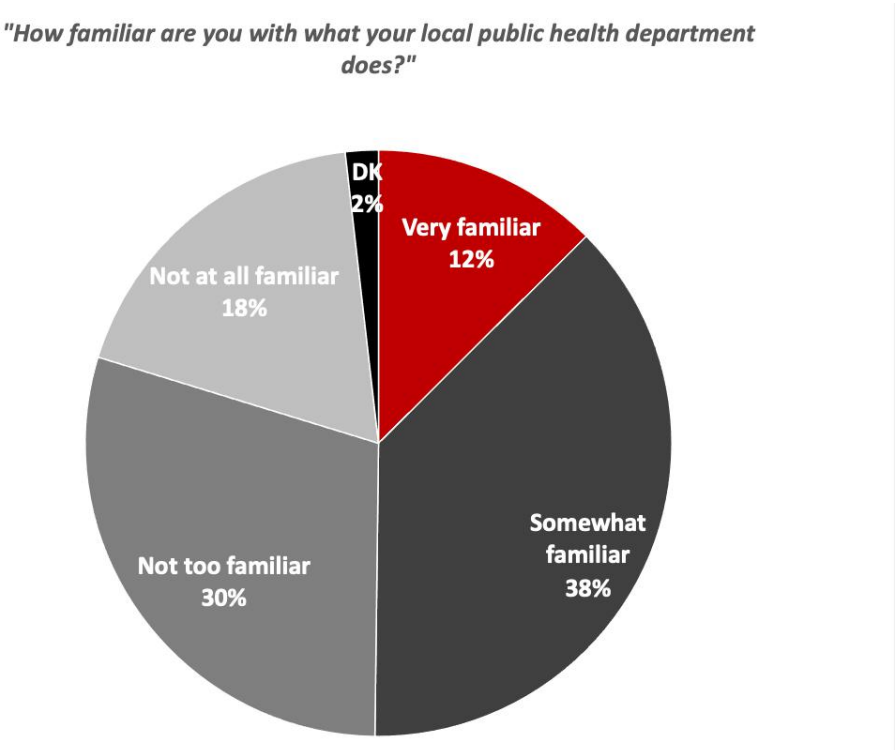
When asked to define the term themselves, 26% say "public health" refers to something about the health of the population (see Appendix A). Others define "public health" as having to do with health services, programs, and information; government and community response to health-related issues; and the science related to health.[6] Republicans and senior citizens are more unsure than their counterparts about how best to define the term. Uncertainty about how to define "public health" decreases as income and education rise.

[6] For the remainder of the survey, respondents were provided with the following definition of "public health": "For the purpose of this survey, when we refer to 'public health,' we are referring to the work done to keep communities healthy and prevent illnesses and the spread of diseases. While a doctor treats individuals who are sick, public health professionals work with community partners to prevent entire communities from getting sick or injured in the first place. While we understand much of the focus of public health right now is on COVID-19, we are asking about public health issues aside from COVID-19."

Local Public Health Department Awareness, Ratings, and Responsibilities

Half of New Jerseyans say they are familiar (13% "very familiar," 38% "somewhat familiar") with what their local public health department does to some degree; three in 10 are "not too familiar" and just under one in five are "not at all familiar" (see Figure 4). While there are minimal differences across various demographic groups, women are slightly more likely than men to be familiar with what their local public health department does, as are urban residents compared to those living elsewhere in the state. Familiarity rises with educational attainment.

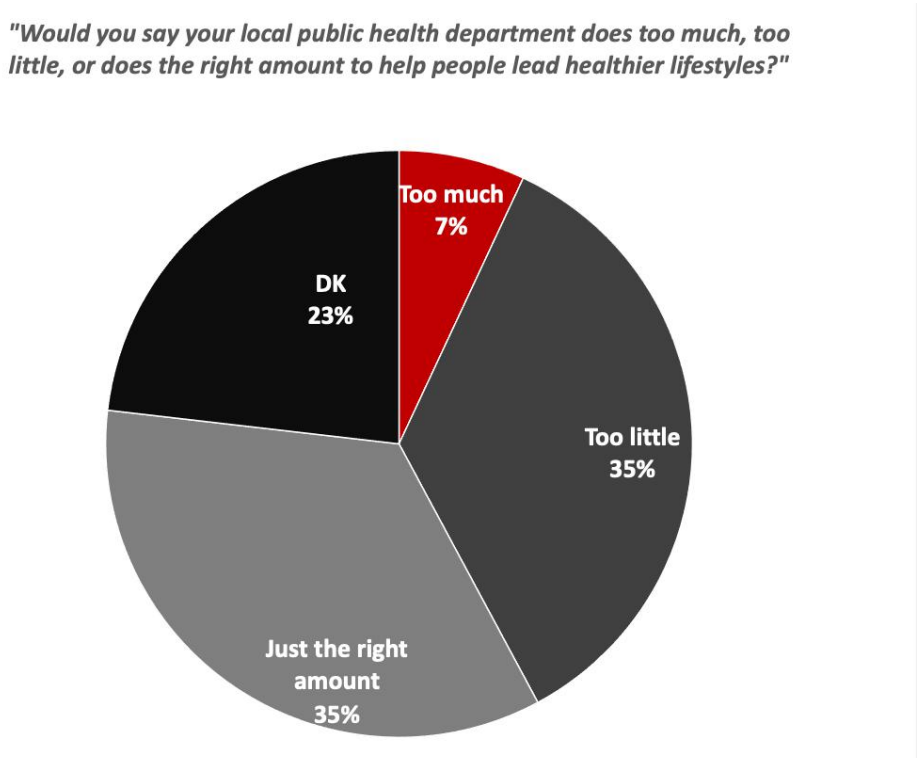
Figure 4: How Familiar New Jerseyans are with What Their Local Health Department Does



Residents are split on whether their local public health department does just the right amount (35%) or too little (35%); just 7% feel it does too much, and 23% are unsure (see Figure 5). Democrats (42%), Black residents (45%), Hispanic residents (40%), young adults (41%), those in

lower income brackets, and those with less education would like to see their local departments do more.

Figure 5: Whether Local Public Health Departments Do Too Much, Too Little, or the Right Amount to Encourage Healthier Lives



Majorities are aware of local public health departments' various responsibilities (see Figure 6). Eight in 10 or more consider infectious disease prevention (87%), emergency planning and preparedness (81%), and food inspection (80%) to be main priorities of local public health departments. About three-quarters classify environmental health (77%), clinical services (76%), and health and nutrition promotion and education (75%) as main areas that these departments tackle. Seven in 10 (71%) consider maternal health a major responsibility, and six in 10 (62%) say the same about animal control.

While any differences are often slight, there are some disparities in terms of awareness of responsibilities by key demographics. Democrats are more likely than independents or Republicans to consider environmental health, maternal and child health, infectious disease prevention, health and nutrition promotion and education, and clinical services as main responsibilities. Women are more likely than men to consider all services listed as main responsibilities of their local public health department.

Hispanic residents and those who do not identify as White, Black, or Hispanic are more likely than their counterparts to say that food safety inspection is a main responsibility. Black residents are more likely to say clinical services and maternal and child health compared to other racial and ethnic groups but are less likely to say emergency preparedness. Both Hispanic residents and Black residents are slightly more likely to say environmental health. White residents are more likely than others to say animal control is a primary service but less likely to say maternal and child health.

What is perceived as a main responsibility also differs by age. Those aged 50 to 64 are more likely than other cohorts to consider the top three items overall as main responsibilities. Those 18 to 34 years old are slightly more likely to consider maternal and child health a main responsibility than other groups; 35- to 49-year-olds, on the other hand, are more likely than other age brackets to consider health and nutrition promotion and education, as well as clinical services main responsibilities; and those 65 and older are more likely than younger residents to consider environmental health and animal control main responsibilities.

Senior citizens are less likely than other age cohorts to say that food safety inspection, maternal and child health, infectious disease prevention, and health promotion and education are all main responsibilities. Knowledge of animal control being a local public health department

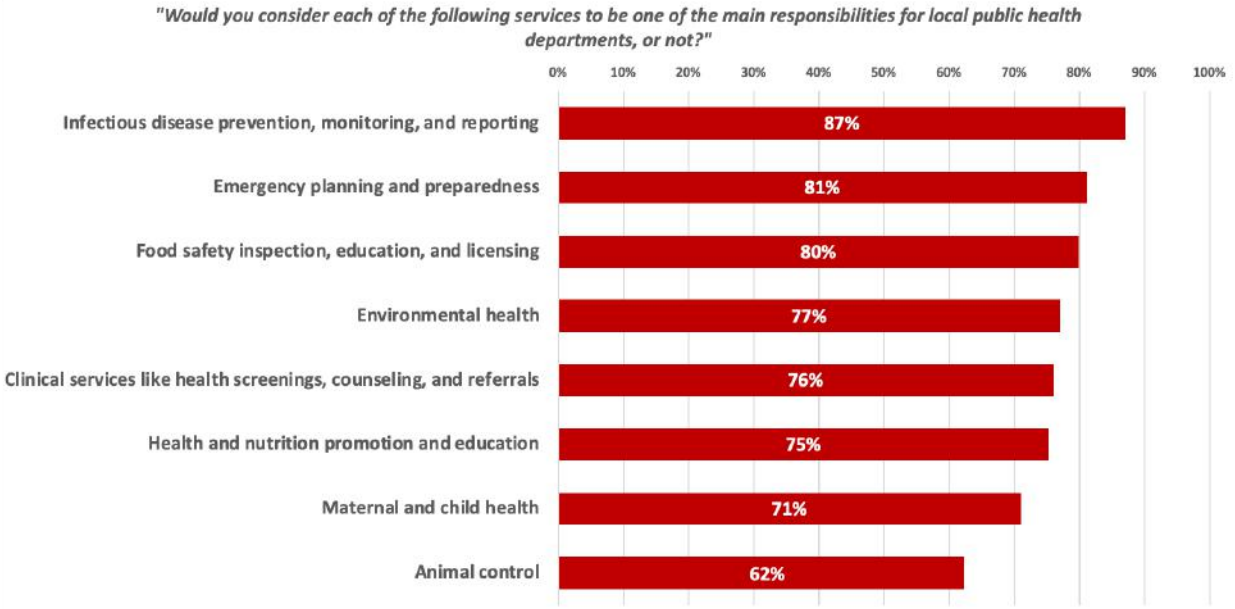
service increases with age. Those 35 to 49 years old are the most likely to say that health promotion and education is a service.

Urban residents are more likely than residents in other areas of the state to consider clinical services, health and nutrition promotion and education, and maternal and child health as main responsibilities of local public health departments; conversely, exurban residents are least likely to be aware of these services, as are shore residents when it comes to clinical services. Exurbanites are also least likely to say infectious disease prevention, yet most likely to say animal control. Shore residents are also least likely to say infectious disease prevention, as well as least likely to say environmental health. Residents living in southern New Jersey near Philadelphia are most likely to say infectious disease prevention, yet one of the least likely – along with shore residents – to say animal control.

Awareness of clinical services and maternal and child health as main responsibilities declines as income rises; those in the highest income bracket are also the least likely to say health and nutrition promotion and education is a service. Residents from the most affluent households, on the other hand, are most likely to say infectious disease prevention is a main responsibility. Those in higher income brackets are more likely than those in lower income brackets to consider emergency planning and animal control main responsibilities. Those in the lowest income bracket are the most likely to say maternal health is a major service.

Knowledge of infectious disease prevention as a major service increases with educational attainment. Those with a high school diploma or less are least likely to say that health and nutrition promotion and education is a main responsibility. Those with lower levels of education are slightly more aware of local public health departments' clinical services, while those with a college degree or higher are slightly less aware.

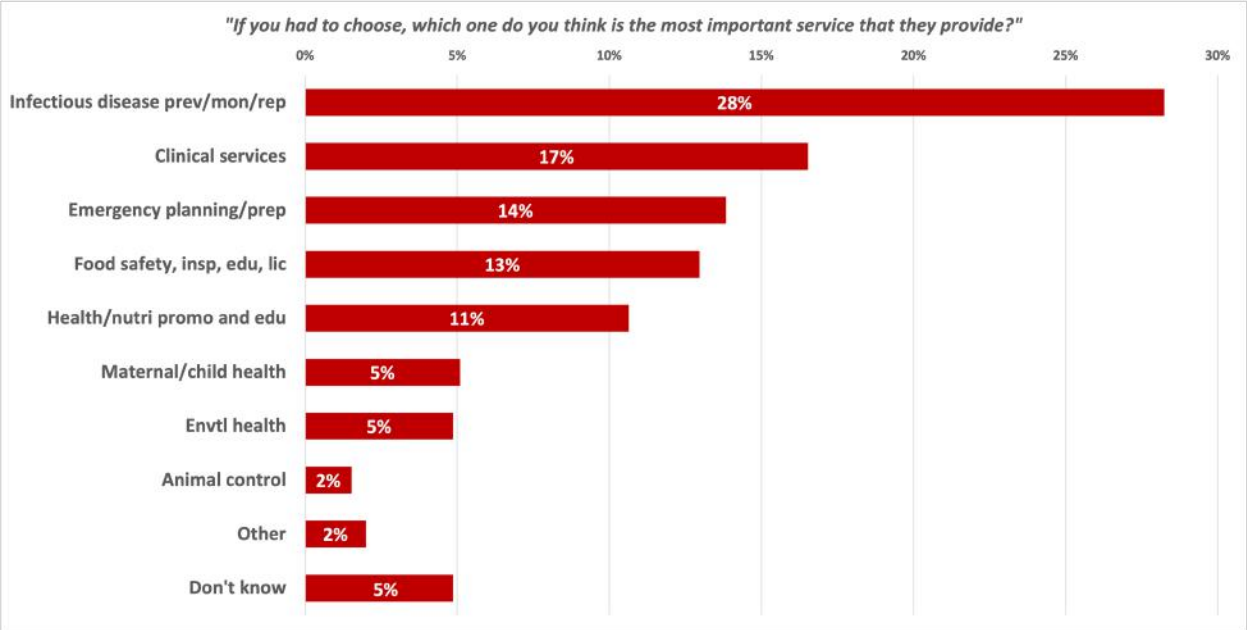
Figure 6: Main Responsibilities of Local Public Health Departments



Among that same list of services, New Jerseyans rank infectious disease prevention, monitoring, and reporting as the most important service that their local public health department provides (28%), followed by clinical services (17%), emergency planning and preparedness (14%), food safety and inspection (13%), health and nutrition promotion and education (11%), maternal and child health (5%), environmental health (5%), and lastly animal control (2%) (see Figure 7).

While infectious disease prevention is the top pick across the board, some groups are more likely than their counterparts to mention other services, as well. Republicans are especially likely to say emergency preparedness (20%), as are independents (15%); Democrats, on the other hand, are the most likely of almost any group to say infectious disease prevention. Clinical services are more likely to be mentioned by women (19%), Black residents (20%), Hispanic residents (18%), 50- to 64-year-olds (19%), those in households making less than $50,000 (21%), those living in shore (21%) or southern regions (19%) of the state, and those who have some college education or less (18%).

Figure 7: Most Important Service Provided by Local Public Health Department



Local Public Health Department Personal Impact

Almost half (48%) recall engaging with, or receiving information from, their local public health department at some point. Democrats (53%), younger to middle aged adults, and those with higher levels of education are all more likely than their counterparts to say they have interacted with their local department.

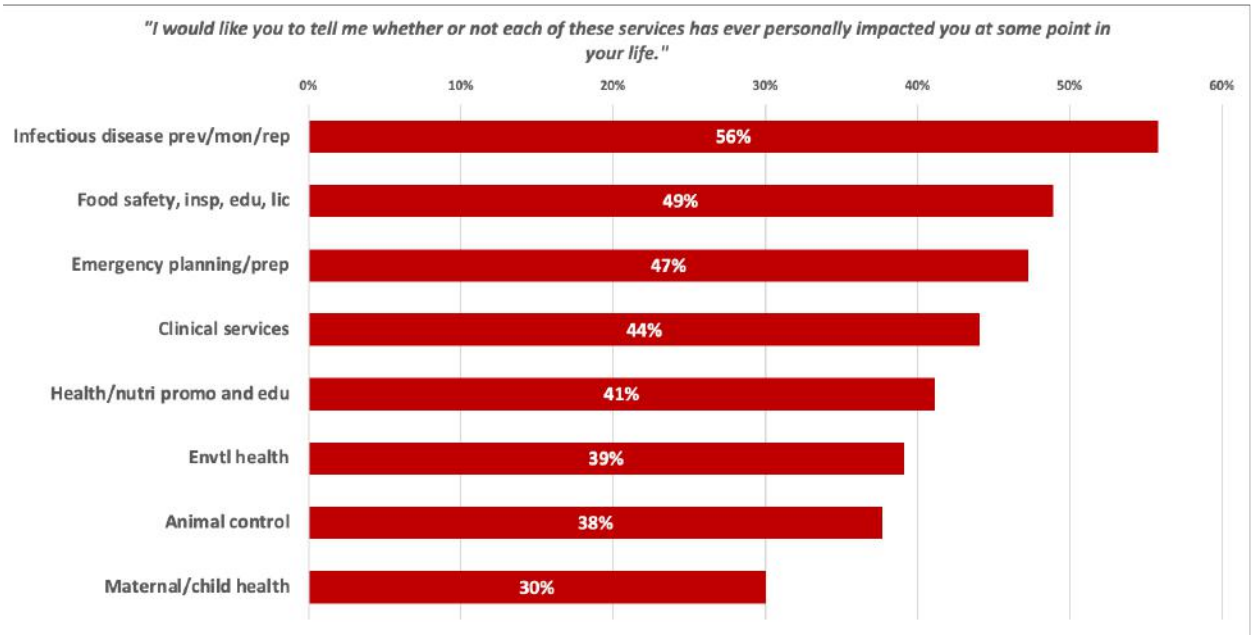
Eighty-nine percent say they have been personally impacted by a service their local health department offered at some point in their life: 56% by infectious disease prevention, monitoring, and reporting; 49% by food safety inspection; 47% by emergency planning and preparedness; 44% by clinical services; 41% by health and nutrition promotion and education; 39% by environmental health; 38% by animal control; and 30% by maternal health (see Figure 8).

Democrats are more likely than independents or Republicans – often by double digits – to report being impacted by most services, with the exception of food inspection, emergency planning, and animal control. Women are more likely than men to say they have been impacted by most services, as well, except for food inspection and animal control. Urban residents are more likely to say they have been impacted by all services than those living in other parts of the state. Young adults are more likely than older residents to say they have been personally impacted by all services except animal control.

The reported personal impact of health and nutrition education and clinical services declines as income rises; those in the lowest income bracket are also more likely than those in more affluent households to report being personally impacted by maternal health, yet least likely to say they have been impacted by animal control. Those earning $100,000 to less than $150,000 are more likely than their counterparts to say they have been impacted by infectious disease prevention, food inspection, environmental health, and animal control. The state's higher earners are slightly more likely than others to say they have been impacted by emergency planning and preparedness and infectious disease prevention.

Residents who have completed graduate work are more likely than those with less education to report being personally impacted by all services – except for clinical services, health and nutrition promotion and education, and maternal health, for which they are the least likely. Those with a high school degree or less are more likely than residents with higher levels of education to mention the former, while those with some college are most likely to mention the latter two.

Figure 8: Ever Personally Impacted by Various Local Health Department Services



Local Public Health Department Funding

Almost all New Jerseyans believe that it is either "very" (59%) or "somewhat" (29%) important for the state of New Jersey to establish a source of stable, dedicated funding that can only be used for local public health services and programs (see Figure 9). Large majorities across the board, to varying degrees, see the value in it – especially Democrats, women, non-white residents, younger residents, and urban residents.

Residents are much less enthusiastic about how to pay for such funding, however. About half would "strongly" (28%) or "somewhat" (26%) support a small tax on unhealthy foods and sugary drinks; 44 percent, on the other hand, would oppose it (14% "somewhat," 30% "strongly"). About a third would support (12% "somewhat," 23% "strongly") a small increase in their state income tax, while two-thirds would not (18% "somewhat oppose," 45% "strongly oppose"). A small increase in local property taxes is least popular: just 9% "strongly support"

this proposal to fund local public health, 20% "somewhat support" it, 16% "somewhat oppose" it, and 54% "strongly oppose" it.

Figure 9: Importance of Establishing Stable, Dedicated Funding for Local Public Health Services and Programs

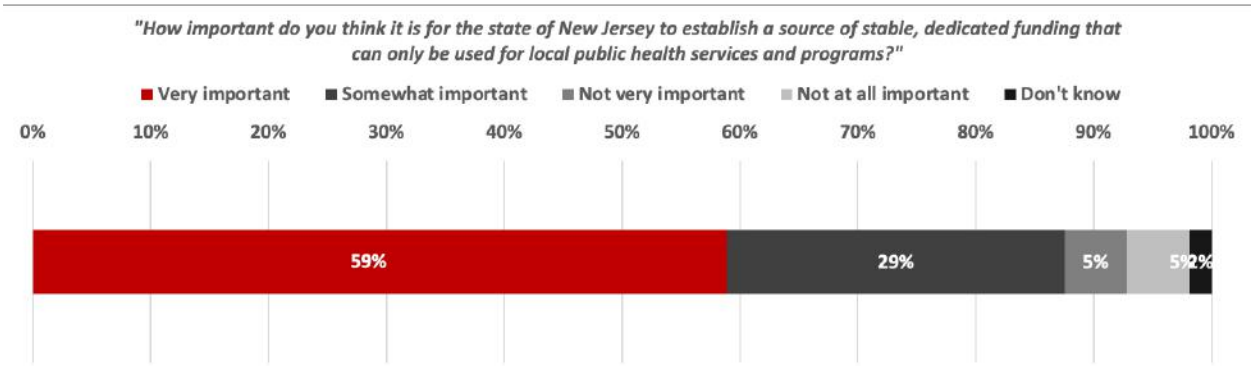
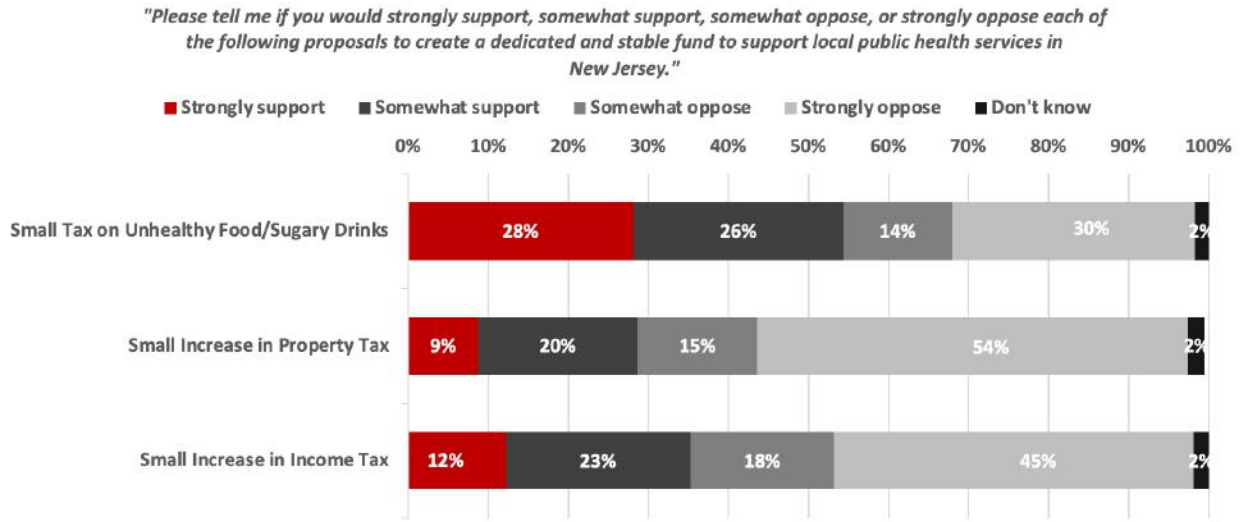


Figure 10: Support for Proposals to Create a Dedicated Local Public Health Services Fund in New Jersey



Sources of Public Health Information and Trust

New Jerseyans say they would be most likely to seek out information from a doctor or nurse if they had a question or concern about a public health issue: almost all say they would be "very" (67%) or "somewhat" (24%) likely to do so (see Figure 11). Residents would be next most likely

to seek out information from the state (36% "very," 32% "somewhat") or their local (32% "very," 34% "somewhat") health department. A similar number say they would likely obtain information from family, friends, or neighbors (30% "very," 43% "somewhat").

Just over half say they would be likely to get information from various forms of media – whether more traditional ones like newspapers, television, magazines, or radio (25% "very," 32% "somewhat") or newer mediums like the internet, including social media platforms (25% "very," 27% "somewhat"). Under half (15% "very likely," 32% "somewhat likely") say they would go to a community or faith-based organization or public community center for public health information.

Breaking trends down by demographics, there is variation of which groups are at least somewhat likely to seek public health information from different sources. Democrats are more significantly more likely than independents or Republicans to say they would seek information from their state or local health department as well as traditional media and community or faith-based organizations or public community centers. Differences are especially pronounced by willingness to seek information from both state and local health departments.

Women are more likely than men to seek information from both the state health department and their local health department.

White residents are more likely than both Black and Hispanic residents to say they would obtain information from a doctor or nurse about a public health issue. Non-White residents are more likely than their counterparts to search the internet for public health information. Black residents are more likely than those of all other races and ethnicities to turn to a faith-based or community organization.

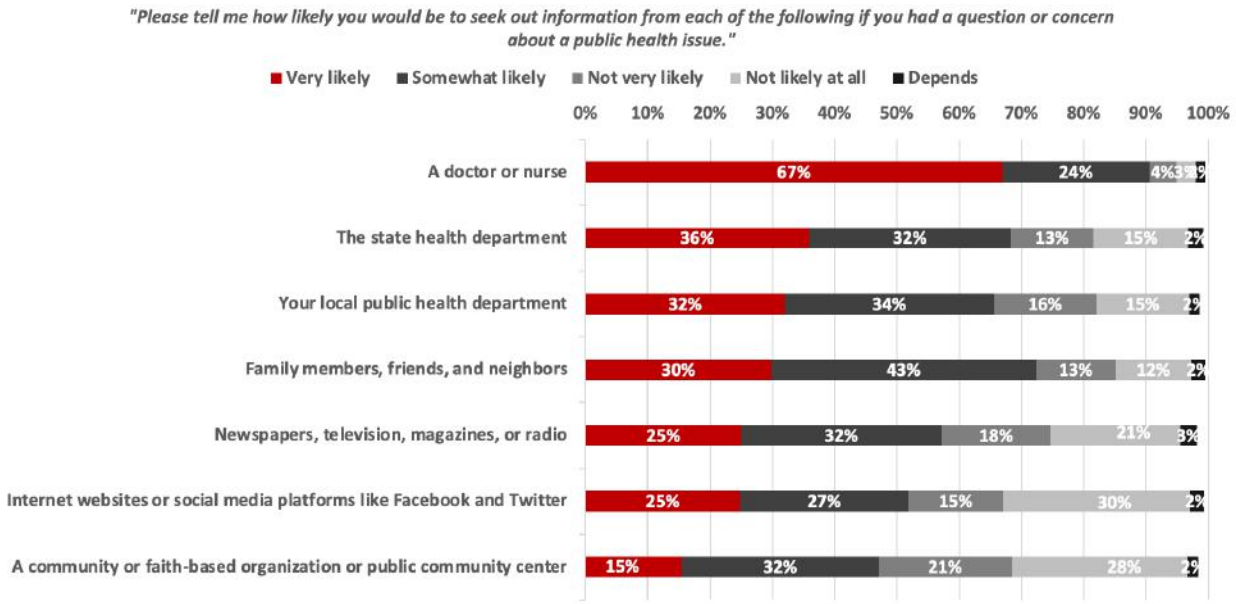
Senior citizens are more likely than other age groups to obtain information from a medical professional and traditional media but are less likely to look to the state health department; family, friends, or neighbors; and the internet. Those aged 35 to 49 are more likely than any other age group to seek information from their local health department.

Those in the highest income bracket are less likely than those in less affluent households to seek public health information from their local health department.

Urbanites are more likely to turn to the state health department and local health department than those from other parts of New Jersey, while shore residents are less likely than others to use the internet.

As compared to those with less educational attainment, New Jerseyans who did graduate work are more likely to turn to traditional news sources, like newspapers, television, magazines, and radio, when it comes to seeking public health information.

Figure 11: Likelihood of Seeking Out Information from Various Sources About a Public Health Issue



A very similar pattern emerges when it comes to who New Jerseyans trust most to provide accurate health information (see Figure 12). The state's residents say they most trust information from a doctor or nurse: nearly all trust this source "a great deal" (69%) or "a moderate amount" (25%). Residents next place the most trust in the state (38% "great deal," 39% "moderate amount") or local (37% "great deal," 39% "moderate amount") health department. About seven in 10 say they trust public health information from family, friends, or neighbors (19% "great deal," 50% "moderate amount").

Fifty-five percent of residents say they trust public health information from traditional media, like newspapers, television, magazines, or radio (15% "great deal," 40% "moderate amount"). Slightly fewer trust community or faith-based organizations or public community centers (14% "great deal," 39% "moderate amount"). New Jerseyans least trust the internet or social media for public health information; just over one-third say they trust this source (10% "great deal," 25% "moderate amount").

Examining these trends by demographics, there are some group differences in who at least moderately trusts each source. Democrats are more likely than their counterparts to trust the state and local public health departments as well as traditional media. Independents are less likely than both Democrats and Republicans to trust public health information from their family, friends, or neighbors.

Women are more likely to trust their family, friends, and neighbors than men; however, men are more like than women to trust the internet for public health information.

Black New Jerseyans are at least slightly more likely to trust the state health department and local public health department, except as compared to residents who do not identify as White,

Black, or Hispanic. Black residents are more likely than all racial or ethnic groups, though, to place trust in community or faith-based organizations or public community centers. Meanwhile, White residents are least likely to trust the internet as compared to Black and Hispanic residents.

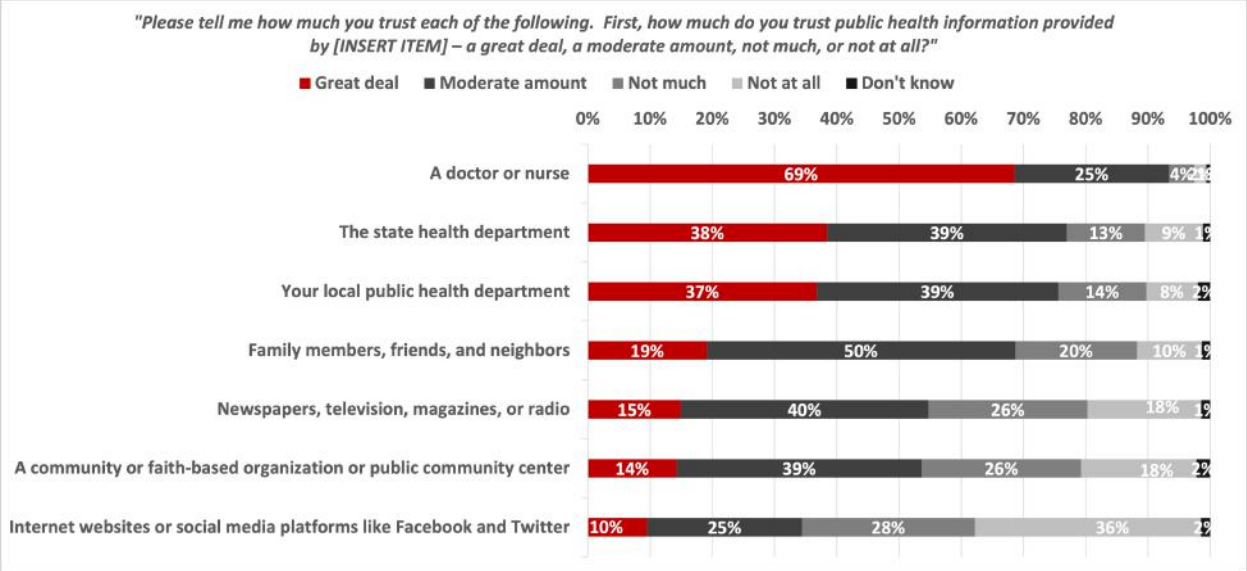
When it comes to age, senior citizens are most trusting of medical professionals as compared to other age groups. On the other end of the spectrum, young adults are more likely than their counterparts to trust the internet.

There are few differences in trust by household income level and the majority of those differences are not statistically significant.

Regionally, urbanites are more likely to trust the state and local health departments, in addition to traditional media. Shore residents are least likely than those from any other region to trust information from the internet or social media.

Finally, by educational attainment, those with some college education are less likely than their counterparts to trust public health information from traditional media, such as newspapers, television, magazines, or radio.

Figure 12: Extent to Which New Jerseyans Trust Public Health information Provided by Each of the Following Sources



Appendix A

SURVEY INSTRUMENT WITH FREQUENCIES

** Please note, totals may equal slightly more or less than 100% due to rounding.*

EAGLETON CENTER FOR PUBLIC INTEREST POLLING
PUBLIC HEALTH AWARENESS QUESTIONNAIRE
November/December 2021
n=1,000

Introduction/Recruitment Language

QD5. May I please have your zip code?

_____ (RECORD)

88888 Don't Know (VOL)
99999 Refused (VOL)

QD5A. And what county do you currently live in?

[Choose from list of NJ Counties]

IF NOT NEW JERSEY BASED ON COUNTY, TERMINATE: Thank you, we are only talking to New Jersey residents today.

[CODE GENDER BY OBSERVATION]

QD26. Respondent Gender

1 Male
2 Female

Male	48%
Female	52%
Unweighted N=	994

WHAT MAKES A HEALTHY COMMUNITY

HC1 In just a few words, what would you say is the top health-related issue facing your local community right now, aside from COVID-19? By health related issues, I do not necessarily mean specific diseases but rather issues or conditions that impact the overall health of your local community.

[OPEN-ENDED RESPONSE]

8 Don't know (VOL)
9 Refused (VOL)

[recoded]

Access to health care (incl. cost, insurance, quality)	10%
Mental health issues	6%
Obesity	6%
Cold/flu	6%
COVID/pandemic (incl. neg/pos reactions to regulations)	5%
Addiction/opioids/drug problems	5%
Pollution/environmental issues (incl clean water)	4%
Food insecurity (incl. access to nutritious foods)	3%
Cost of living (incl. mention of poverty)	2%
Cancer	2%
Other	18%
No issues	3%
Don't know	30%
Unweighted N=	995

HC3. How much responsibility, if any, do you think each of the following has in making sure people lead healthy lives?

[RANDOMIZE ORDER]
A Individuals
B Businesses and industries, such as retailers or manufacturers of food and drink
C The state government
D Local governments
F Community or faith-based organizations

1 A lot
2 Some

3 A little
4 None
8 Don't know (VOL)
9 Refused (VOL)

	Individuals	Businesses and Industries	State Government	Local Government	Community/ Faith-Based Organizations
A lot	72%	34%	37%	32%	22%
Some	16%	33%	28%	31%	31%
A little	8%	17%	18%	20%	25%
None	3%	14%	15%	15%	18%
Don't know (VOL)	1%	2%	2%	3%	3%
Unweighted N=	1003	1003	999	1004	1002

UNDERSTANDING OF PUBLIC HEALTH

Now, for some questions about public health.

UPH1. In just a few words, how would you define the term "public health?" If you're not sure, just say so.

[OPEN ENDED RESPONSE]
88 Not sure
99 Refused

[recoded]

Health of a population	26%
Health services/programs available (incl. equal access, affordability)	5%
Government response to health care/issues	5%
Community response to health/taking care of each other	4%
Health issues which impact society	3%
Response to health care/issues (no responsibility designated)	3%
Individual health care/outcomes/responsibility	3%
Informing public about health issues/programs/services	2%
All issues (directly health and otherwise) which impact society	2%
Type of science related to health	1%
Other	11%
Don't know (VOL)	35%
Unweighted N=	986

UPH2. If you read or hear somebody talking about "public health," how well do you feel that you understand what they mean by those two words – "*public health*"? Very well, somewhat well, not too well, or not at all?

1 Very well
2 Somewhat well
3 Not too well
4 Not at all
8 Don't know (VOL)
9 Refused (VOL)

Very well	35%
Somewhat well	44%
Not too well	15%
Not at all	5%
Don't know	2%
Unweighted N=	1000

For the purpose of this survey, when we refer to "*public health*," we are referring to the work done to keep communities healthy and prevent illnesses and the spread of diseases. While a doctor treats individuals who are sick, public health professionals work with community partners to prevent entire communities from getting sick or injured in the first place. While we understand much of the focus of public health right now is on COVID-19, we are asking about public health issues aside from COVID-19.

PUBLIC HEALTH DEPARTMENT RATINGS

DR1. How familiar are you with what your local public health department does? Are you very familiar, somewhat familiar, not too familiar, or not familiar at all with what it does?

1 Very familiar
2 Somewhat familiar
3 Not too familiar
4 Not familiar at all
8 Don't know (VOL)
9 Refused (VOL)

Very familiar	13%
Somewhat familiar	38%
Not too familiar	30%
Not familiar at all	18%
Don't know	2%
Unweighted N=	1000

DR2. Would you say your local public health department does too much, too little, or does the right amount to help people lead healthier lifestyles?

1 Too much
2 Too little
3 Just the right amount
8 Don't know (VOL)
9 Refused (VOL)

Too much	7%
Too little	35%
Just the right amount	35%
Don't know	23%
Unweighted N=	994

PUBLIC HEALTH DEPARTMENT RESPONSIBILITIES AND PRIORITIES

Let's talk about some different areas of public health and the services that local health departments provide.

RP1 Would you consider each of the following services to be one of the main responsibilities for local public health departments, or not? Just tell me yes or no for each. First:

[RANDOMIZE ORDER]

A Environmental health
B Food safety inspection, education, and licensing
C Emergency planning and preparedness
D Maternal and child health
E Animal control
F Infectious disease prevention, monitoring, and reporting
G Health and nutrition promotion and education
H Clinical services like health screenings, counseling, and referrals

1 Yes
2 No
8 Don't know/unsure (VOL)
9 Refused (VOL)

	Infectious disease prevention, monitoring, & reporting	Emergency planning & preparedness	Food safety inspection, education, & licensing	Environmental health
Yes	87%	81%	80%	77%
No	9%	13%	15%	17%
Don't know (VOL)	4%	6%	6%	6%
Unweighted N=	1002	1002	1004	999

	Clinical services (i.e., health screenings, counseling, & referrals)	Health & nutrition promotion & education	Maternal & child health	Animal control
Yes	76%	75%	71%	62%
No	19%	18%	21%	28%
Don't know (VOL)	5%	7%	8%	10%
Unweighted N=	1002	1003	1004	1003

RP2. I am going to read you the same list of services that your local public health department provides. If you had to choose, which one do you think is the most important service that they provide? Is it:

[RANDOMIZE ORDER 1-9; READ ALOUD 1-10]

1 Environmental health
2 Food safety inspection, education, and licensing
3 Emergency planning and preparedness
4 Maternal and child health
5 Animal control
6 Infectious disease prevention, monitoring, and reporting
7 Health and nutrition promotion and education
8 Clinical services like health screenings, counseling, and referrals
9 Or is it something else [PLEASE SPECIFY]?
88 Don't know (VOL)
99 Refused (VOL)

Infectious disease prevention, monitoring, and reporting	28%
Clinical services like health screenings, counseling, and referrals	17%
Emergency planning and preparedness	14%
Food safety, inspection, education, and licensing	13%
Health and nutrition promotion and education	11%
Environmental health	5%
Maternal and child health	5%
Animal control	2%
Something else	2%
Don’t know (VOL)	5%
Unweighted N=	998

RP3. I am going to once again read you that same list of services that your local public health department provides, and now I would like you to tell me whether or not each of these services has ever personally impacted you at some point in your life. First:

A Environmental health
B Food safety inspection, education, and licensing
C Emergency planning and preparedness
D Maternal and child health
E Animal control

F Infectious disease prevention, monitoring, and reporting
G Health and nutrition promotion and education
H Clinical services like health screenings, counseling, and referrals

1 Yes, it has
2 No, it has not
8 Don't know (VOL)
9 Refused (VOL)

Any Service	
Yes	89%
No	12%
Don't know	6%
Unweighted N=	975

	Infectious disease prevention, monitoring, & reporting	**Food safety inspection, education, & licensing**	**Emergency planning & preparedness**	**Clinical services (i.e. health screenings, counseling, & referrals)**
Yes	56%	49%	47%	44%
No	40%	46%	48%	53%
Don't know (VOL)	4%	6%	5%	3%
Unweighted N=	1004	1003	1003	1001

	Health & nutrition promotion & education	**Environmental health**	**Animal control**	**Maternal & child health**
Yes	41%	39%	38%	30%
No	55%	54%	57%	66%
Don't know (VOL)	4%	7%	5%	5%
Unweighted N=	1000	1002	1003	1001

PUBLIC HEALTH EXPERIENCE

E1. To the best of your recollection, have you ever engaged with, or received any information from, your local public health department? This may have been through a

health fair or event, service or training, educational materials, or some other way. Again, this would be aside from anything related to COVID-19.

1 Yes
2 No
8 Don't know (VOL)
9 Refused (VOL)

Yes	48%
No	47%
Don't know (VOL)	6%
Unweighted N=	1001

PUBLIC HEALTH FUNDING

Let's talk a bit about how to fund local public health departments.

F1. How important do you think it is for the state of New Jersey to establish a source of stable, dedicated funding that can only be used for local public health services and programs – very important, somewhat important, not very important, or not at all important?

1 Very important
2 Somewhat important
3 Not very important
4 Not at all important
8 Don't know (VOL)
9 Refused (VOL)

Very important	59%
Somewhat important	29%
Not very important	5%
Not at all important	5%
Don't know (VOL)	2%
Unweighted N=	1002

F2. Please tell me if you would strongly support, somewhat support, somewhat oppose, or strongly oppose each of the following proposals to create a dedicated and stable fund to support local public health services in New Jersey. First:

[RANDOMIZE ORDER]

A A small increase in your New Jersey income tax
B A small increase in your local property tax
C A small tax on unhealthy foods and sugary drinks

1 Strongly support
2 Somewhat support
3 Somewhat oppose
4 Strongly oppose
8 Don't know (VOL)
9 Refused (VOL)

	A small tax on unhealthy foods and sugary drinks	A small increase in your New Jersey income tax	A small increase in your local property tax
Strongly support	28%	12%	9%
Somewhat support	26%	23%	20%
Somewhat oppose	14%	18%	16%
Strongly oppose	30%	45%	54%
Don't know (VOL)	2%	2%	2%
Unweighted N=	1000	992	997

INFORMATION AND TRUST

Next, I'm going to ask some questions about how and from whom you learn about public health issues – such as immunizations, mental health, air and water quality, food safety and security, environmental public health emergencies, and access to quality health care. Again, while we understand much of the focus on public health right now is on COVID-19, we are asking about public health issues aside from COVID-19.

T1. People seek out information from various sources when they have a question or concern about public health issues. Please tell me how likely you would be to seek out information from each of the following if you had a question or concern about a public health issue. First, would you be very likely, somewhat likely, not very likely, or not likely at all to seek out information from [INSERT ITEM]? NEXT:

[RANDOMIZE ORDER]

[PROMPT IF NEEDED: "Would you be very likely, somewhat likely, not very likely, or not likely at all to seek out information from this source?"]

A Family members, friends, and neighbors
B Newspapers, television, magazines, or radio
C Internet websites or social media platforms like Facebook and Twitter
D A doctor or nurse
E Your *local* public health department
F The *state* health department
H A community or faith-based organization or public community center

1. Very likely
2. Somewhat likely
3. Not very likely
4. Not likely at all
5. Depends (VOL)
8. Don't Know (VOL)
9. Refused (VOL)

	A doctor or nurse	The state health department	Your local public health department	Family members, friends, and neighbors
Very likely	67%	36%	32%	30%
Somewhat likely	24%	32%	34%	43%
Not very likely	4%	13%	16%	13%
Not likely at all	3%	15%	15%	12%
Depends (VOL)	2%	2%	2%	2%
Don't know (VOL)	1%	1%	1%	1%
Unweighted N=	1004	1002	1005	1004

	Newspapers, television, magazines, or radio	Internet websites or social media platforms	A community- or faith-based organization or public community center
Very likely	25%	25%	16%
Somewhat likely	32%	27%	32%
Not very likely	18%	15%	21%
Not likely at all	21%	30%	28%
Depends (VOL)	3%	2%	2%
Don't know (VOL)	2%	1%	2%
Unweighted N=	1001	998	996

T2. People trust some sources more than others when it comes to providing accurate public health information. Please tell me how much you trust each of the following. First, how much do you trust public health information provided by [INSERT ITEM] – a great deal, a moderate amount, not much, or not at all? First: (50)

[RANDOMIZE ORDER]

A Family members, friends, and neighbors
B Newspapers, television, magazines, or radio
C Internet websites or social media platforms like Facebook and Twitter
D A doctor or nurse
E Your *local* public health department
F The *state* health department
H A community or faith-based organization or public community center

1. A great deal
2. A moderate amount
3. Not much
4. Not at all
8. Don't Know (VOL)
9. Refused

	A doctor or nurse	The state health department	Your local public health department	Family members, friends, and neighbors
A great deal	69%	38%	37%	19%
A moderate amount	25%	39%	39%	50%
Not much	4%	13%	14%	20%
Not at all	2%	9%	8%	10%
Don't know (VOL)	1%	1%	2%	1%
Unweighted N=	1002	1001	1000	1001

	Newspapers, television, magazines, or radio	Internet websites or social media platforms	A community- or faith-based organization or public community center
A great deal	15%	10%	14%
A moderate amount	40%	25%	39%

Not much	26%	28%	26%
Not at all	18%	36%	19%
Don't know (VOL)	1%	2%	2%
Unweighted N=	1000	999	1002

DEMOGRAPHICS

We're almost finished. Now we just have some questions to help us understand our results.

QD7. To ensure we are reaching people of all ages, would you please tell me your age?

____ (ENTER AGE: 98=98+, 99 = REFUSED)

[IF Don't Know/REFUSED IN QD7, ASK:]

QD8 Would you be willing to tell us whether it's between...?

1 18 - 20
2 21 - 24
3 25 - 29
4 30 - 34
5 35 – 44
6 45 – 49
7 50 - 54
8 55 - 64
9 65 OR OVER
99 Refused (VOL)

[recoded]

18-34	27%
35-49	25%
50-64	27%
65+	21%
Unweighted N=	1001

QD6. What was the last grade in school you completed? **[CODE TO LIST]**

1. 8th Grade or Less

2. High School Incomplete (Grades 9, 10 and 11)
3. High School Complete (Grade 12)
4. Vocational/Technical School
5. Some College
6. Junior College Graduate (2 Year, Associates Degree)
7. 4 Year College Graduate (Bachelor's Degree)
8. Graduate Work (Masters, Law/Medical School, Etc.)
9. Refused (VOL)

8th grade or less	0%
HS incomplete	3%
HS complete	25%
Vo/tech school	7%
Some college	16%
Jr college grad	9%
4yr college grad	23%
Graduate work	17%
Unweighted N=	1003

[recoded]

HS or less	28%
Some coll	31%
Coll grad	23%
Grad work	17%
Unweighted N=	1003

QD17. Are you of Latino or Hispanic origin, such as Mexican, Puerto Rican, Cuban or some other Spanish background?

1. Yes
2. No
8. Don't know
9. Refused

Yes	18%
No	82%
Don't know	0%
Unweighted N=	989

QD18. Are you White, Black or of Asian origin, or are you some other race, or multi-racial?

1 White (includes Caucasian, European, Middle Eastern)
2 Black (includes African-American)
3 Asian (includes Asian-Indian, South Asian, East Asian, Chinese, Japanese)
4 Hispanic / Latino / Spanish (VOL)
5 OTHER, SPECIFY: _____
6 Multi-racial
8 Don't know (VOL)
9 Refused (VOL)

White	64%
Black	14%
Asian	6%
Hispanic/Latino/Spanish	7%
Other	0%
Multi-racial	9%
Don't know	0%
Unweighted N=	958

[recoded—combines results of QD17 and QD18]

White	58%
Black	13%
Hispanic/Latino/Spanish	18%
Other	12%
Unweighted N=	978

QD27. Do you describe yourself as a man, a woman, or in some other way?

1 Man
2 Woman
3 Some other way **[SPECIFY]**
9 Refused (VOL)

Man	48%
Woman	52%
Some other way	1%
Unweighted N=	1002

QD2. In politics today, do you consider yourself a Democrat, Republican, Independent, or something else?

1. Democrat
2. Republican
3. Independent
4. Something Else/Other
8. Don't know (VOL)
9. Refused (VOL)

Democrat	39%
Republican	20%
Independent	31%
Something else	8%
Don't know	2%
Unweighted N=	958

[recoded]

Democrat	39%
Independent	41%
Republican	20%
Unweighted N=	994

QD21. Last year, that is in 2020, what was your total family income from all sources, before taxes? Just stop me when I get to the right category. **[READ LIST]**

1. Less than $25,000
2. 25 to under $50,000
3. 50 to under $75,000
4. 75 to under $100,000
5. 100 to under $150,000
6. $150,000 or more
8. Don't know (VOL)
9. Refused (VOL)

<25K	13%
25K-<50K	20%
50K-<75K	19%
75K-<100K	13%
100K-<150K	17%
150K+	16%
Don't know	3%
Unweighted N=	919

[recoded]

<50K	33%
50K-<100K	33%
100K-<150K	17%
150K+	17%
Unweighted N=	893

HHA. Including, yourself, how many adults – that is, people 18 years or older – live in your household; that is, who live with you at least half the time?

____ **[ENTER NUMBER: 99= REFUSED]**

1	19%
2	44%
3	20%
4	12%
5+	5%
Unweighted N=	958

Closing and Additional Informed Consent Language

That completes our survey. Thank you very much for your time and cooperation. If you have any questions, you may contact Dr. Ashley Koning *(pronounced Cone-ing)* at 848-932-8940. If you have any questions about your rights as a research participant, you may contact the administrator of the Rutgers Institutional Review Board at 732-235-2866. Have a good day/evening.

Appendix B

SURVEY QUESTION CROSS TABULATIONS

HC1. In just a few words, what would you say is the top health-related issue facing your local community right now, aside from COVID-19? By health related issues, I do not necessarily mean specific diseases but rather issues or conditions that impact the overall health of your local community.

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Cold/flu	7%	3%	7%	5%	6%	6%	4%	9%	2%	6%	6%	6%	5%
COVID	6%	4%	8%	5%	5%	4%	7%	9%	2%	8%	7%	3%	2%
Health care access	15%	9%	5%	11%	9%	10%	15%	9%	5%	8%	7%	14%	11%
Obesity	5%	6%	9%	6%	5%	4%	4%	8%	12%	9%	7%	4%	3%
Mental health	6%	6%	5%	4%	8%	6%	7%	5%	8%	5%	8%	9%	2%
Food insecurity	3%	4%	0%	2%	4%	4%	2%	1%	5%	3%	3%	5%	1%
Cancer	2%	3%	1%	2%	3%	2%	2%	2%	2%	2%	2%	3%	2%
Environment	5%	3%	4%	4%	4%	4%	2%	5%	4%	4%	3%	5%	3%
Cost of living	3%	3%	1%	1%	3%	2%	6%	3%	2%	2%	3%	2%	2%
Addiction/drugs	4%	6%	5%	5%	6%	5%	2%	8%	4%	6%	8%	3%	3%
No issues	2%	3%	3%	4%	1%	3%	1%	3%	3%	2%	2%	2%	4%
Other	17%	21%	16%	20%	15%	19%	20%	15%	16%	18%	17%	19%	18%
Don't know (VOL)	26%	28%	37%	30%	29%	31%	27%	23%	34%	28%	27%	24%	44%
Unwt N=	376	392	180	473	520	587	143	127	107	253	257	268	210

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Cold/flu	7%	7%	4%	3%	5%	4%	9%	6%	8%	8%	4%	5%	4%
COVID	5%	6%	3%	7%	5%	5%	4%	6%	5%	5%	4%	9%	4%
Health care access	6%	12%	9%	13%	13%	11%	8%	5%	12%	4%	12%	11%	15%
Obesity	3%	5%	11%	9%	9%	5%	10%	2%	5%	2%	9%	7%	5%
Mental health	2%	8%	10%	5%	9%	6%	4%	6%	5%	4%	6%	7%	8%
Food insecurity	2%	3%	2%	7%	7%	2%	1%	4%	4%	3%	3%	2%	5%
Cancer	2%	2%	1%	3%	3%	2%	4%	1%	3%	2%	2%	3%	3%
Environment	6%	3%	3%	4%	5%	5%	4%	4%	2%	4%	5%	4%	4%
Cost of living	3%	2%	4%	1%	3%	2%	3%	2%	2%	1%	3%	2%	4%
Addiction/drugs	7%	6%	3%	3%	4%	3%	3%	8%	8%	5%	7%	4%	3%
No issues	3%	2%	2%	2%	3%	3%	2%	2%	3%	3%	1%	2%	4%
Other	19%	17%	17%	22%	19%	20%	19%	17%	14%	17%	17%	21%	16%
Don't know (VOL)	34%	27%	30%	21%	17%	32%	29%	38%	29%	42%	27%	24%	24%
Unwt N=	252	300	169	163	160	360	135	169	169	167	282	315	228

HC3. How much responsibility, if any, do you think each of the following has in making sure people lead healthy lives?

Individuals

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
A lot	71%	72%	77%	75%	70%	77%	63%	61%	70%	59%	82%	75%	74%
Some	17%	18%	8%	14%	18%	15%	17%	17%	21%	23%	11%	14%	16%
A little	9%	6%	10%	9%	7%	6%	12%	16%	5%	13%	5%	7%	7%
None	2%	3%	3%	2%	4%	1%	5%	4%	4%	5%	2%	2%	2%
DK (VOL)	1%	1%	1%	1%	2%	1%	3%	1%	0%	1%	0%	2%	1%
Unwt N=	380	398	180	477	526	591	146	128	108	257	258	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
A lot	62%	69%	86%	82%	75%	73%	81%	65%	69%	57%	76%	76%	85%
Some	21%	18%	9%	11%	15%	14%	13%	20%	18%	23%	12%	16%	11%
A little	14%	8%	4%	5%	8%	9%	2%	10%	10%	15%	8%	4%	2%
None	4%	3%	1%	1%	2%	3%	3%	3%	2%	4%	3%	2%	2%
DK (VOL)	0%	2%	0%	1%	0%	1%	1%	2%	0%	1%	1%	2%	1%
Unwt N=	255	305	170	164	163	361	138	172	169	168	284	317	232

Businesses and industries

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
A lot	40%	35%	24%	33%	35%	33%	38%	35%	39%	42%	29%	33%	33%
Some	38%	29%	32%	33%	33%	32%	32%	35%	36%	31%	36%	31%	36%
A little	13%	19%	23%	18%	17%	19%	17%	17%	7%	15%	19%	19%	16%
None	7%	16%	22%	15%	13%	14%	11%	13%	15%	11%	15%	16%	12%
DK (VOL)	2%	1%	0%	1%	2%	1%	2%	0%	3%	1%	2%	1%	3%
Unwt N=	380	398	180	477	526	591	146	128	108	257	258	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
A lot	34%	36%	29%	33%	44%	36%	27%	36%	25%	32%	37%	34%	33%
Some	33%	32%	39%	31%	32%	34%	37%	34%	29%	34%	32%	30%	37%
A little	20%	14%	21%	17%	13%	17%	20%	16%	21%	19%	16%	17%	17%
None	10%	17%	11%	19%	11%	12%	16%	12%	20%	12%	13%	18%	13%
DK (VOL)	2%	2%	1%	0%	0%	1%	0%	2%	4%	3%	2%	1%	0%
Unwt N=	255	305	170	164	163	361	138	172	169	168	284	317	232

State Government

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
A lot	47%	31%	29%	34%	39%	36%	50%	34%	35%	46%	33%	33%	36%
Some	32%	28%	25%	28%	29%	28%	24%	34%	27%	22%	31%	31%	29%
A little	15%	20%	22%	19%	18%	20%	15%	21%	12%	19%	21%	18%	15%
None	6%	18%	24%	18%	12%	15%	9%	10%	22%	11%	14%	15%	19%
DK (VOL)	0%	2%	0%	1%	2%	2%	2%	0%	4%	2%	1%	2%	2%
Unwt N=	377	397	180	476	523	589	146	126	108	253	258	268	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
A lot	39%	38%	35%	33%	45%	39%	29%	36%	32%	33%	40%	35%	41%
Some	27%	32%	28%	31%	30%	26%	32%	31%	27%	27%	26%	33%	30%
A little	21%	14%	24%	19%	20%	16%	17%	18%	24%	22%	17%	16%	16%
None	12%	15%	12%	18%	6%	18%	20%	13%	15%	16%	14%	14%	13%
DK (VOL)	1%	1%	1%	0%	0%	1%	3%	3%	3%	2%	3%	1%	0%
Unwt N=	252	303	170	164	162	359	138	171	169	167	282	316	232

Local Government

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
A lot	42%	27%	23%	30%	34%	29%	44%	35%	33%	40%	34%	27%	27%
Some	31%	33%	30%	31%	31%	31%	25%	36%	32%	31%	33%	31%	29%
A little	17%	19%	26%	21%	19%	22%	22%	19%	8%	14%	19%	25%	22%
None	8%	19%	19%	17%	12%	17%	6%	6%	22%	12%	14%	14%	19%
DK (VOL)	2%	2%	3%	1%	4%	2%	4%	4%	5%	3%	1%	3%	3%
Unwt N=	381	398	180	477	526	591	146	128	108	257	258	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
A lot	35%	35%	32%	26%	42%	35%	22%	33%	25%	30%	34%	34%	29%
Some	33%	32%	32%	29%	27%	30%	38%	33%	30%	29%	29%	32%	36%
A little	17%	18%	21%	24%	24%	16%	20%	15%	27%	19%	20%	20%	20%
None	11%	12%	15%	20%	7%	16%	18%	16%	14%	17%	13%	13%	15%
DK (VOL)	4%	2%	0%	1%	0%	3%	2%	4%	4%	5%	3%	1%	0%
Unwt N=	254	305	170	164	163	361	138	171	170	168	284	317	232

Community/Faith-Based Organizations

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
A lot	26%	20%	20%	18%	26%	19%	32%	23%	28%	25%	21%	20%	24%
Some	33%	31%	29%	30%	32%	31%	30%	28%	30%	30%	36%	27%	33%
A little	24%	27%	26%	30%	21%	27%	27%	26%	17%	25%	26%	29%	19%
None	13%	19%	25%	19%	17%	20%	9%	15%	22%	16%	13%	20%	23%
DK (VOL)	4%	4%	1%	3%	3%	3%	2%	8%	2%	5%	4%	3%	1%
Unwt N=	379	398	180	476	525	591	145	127	108	255	258	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
A lot	24%	24%	23%	15%	29%	19%	15%	29%	20%	24%	22%	21%	20%
Some	34%	29%	32%	29%	32%	33%	32%	31%	26%	27%	28%	35%	39%
A little	22%	26%	25%	33%	26%	25%	30%	19%	27%	22%	28%	24%	27%
None	15%	18%	17%	21%	11%	20%	21%	14%	24%	22%	17%	18%	14%
DK (VOL)	6%	2%	3%	1%	2%	3%	2%	7%	2%	6%	4%	1%	1%
Unwt N=	253	304	170	164	163	359	138	171	170	167	283	317	232

UPH1. In just a few words, how would you define the term "public health?" If you're not sure, just say so.

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Pop. Health	30%	26%	24%	29%	24%	28%	26%	28%	21%	30%	32%	29%	11%
Health services	8%	3%	4%	5%	5%	4%	8%	6%	4%	5%	3%	7%	6%
Govt response	5%	6%	3%	7%	3%	5%	4%	6%	3%	3%	3%	7%	7%
Health impact soc.	3%	5%	1%	2%	4%	3%	2%	4%	4%	3%	4%	4%	1%
Informing public	2%	2%	2%	1%	2%	2%	2%	1%	3%	0%	2%	4%	1%
Commty response	3%	4%	7%	4%	4%	5%	0%	2%	4%	6%	2%	4%	4%
All issues in society	2%	2%	1%	2%	2%	2%	0%	3%	1%	1%	2%	2%	2%
Science and health	2%	1%	0%	1%	1%	1%	0%	2%	0%	1%	2%	0%	1%
Indvl health/resp.	1%	4%	2%	4%	1%	3%	2%	1%	1%	3%	3%	2%	4%
General health resp.	3%	4%	2%	4%	3%	3%	6%	3%	2%	4%	2%	3%	4%
Other	11%	11%	10%	11%	11%	11%	16%	8%	8%	12%	13%	6%	15%
DK (VOL)	30%	34%	44%	31%	39%	32%	32%	37%	47%	33%	32%	32%	46%
Unwt N=	377	386	177	465	518	579	144	127	106	251	254	266	207

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Pop. Health	28%	24%	30%	32%	25%	28%	25%	27%	26%	19%	31%	27%	29%
Health services	3%	7%	5%	5%	9%	6%	3%	2%	5%	3%	6%	6%	7%
Govt response	1%	3%	6%	13%	6%	6%	6%	1%	5%	4%	2%	5%	13%
Health impact soc.	3%	3%	3%	4%	3%	2%	3%	7%	2%	1%	4%	3%	6%
Informing public	1%	2%	2%	2%	1%	2%	2%	1%	4%	0%	3%	1%	3%

Commty response	3%	4%	3%	4%	2%	3%	6%	3%	6%	3%	4%	5%	3%
All issues in society	1%	1%	3%	2%	3%	2%	0%	2%	2%	0%	1%	4%	3%
Science and health	1%	0%	1%	1%	4%	1%	0%	0%	0%	0%	1%	1%	3%
Indvl health/resp.	4%	1%	3%	2%	5%	3%	2%	0%	3%	3%	1%	4%	2%
General health resp.	1%	6%	2%	3%	3%	3%	5%	3%	2%	1%	3%	5%	5%
Other	14%	12%	9%	7%	13%	10%	12%	9%	13%	17%	7%	11%	9%
DK (VOL)	39%	35%	33%	24%	27%	35%	36%	45%	32%	51%	36%	28%	17%
Unwt N=	250	301	164	161	163	356	133	166	165	165	279	311	225

UPH2. If you read or hear somebody talking about "public health," how well do you feel that you understand what they mean by those two words – "*public health*"? Very well, somewhat well, not too well, or not at all?

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very well	39%	33%	29%	36%	34%	35%	46%	29%	33%	34%	38%	34%	33%
Smwht well	46%	41%	46%	43%	45%	44%	36%	49%	46%	46%	43%	45%	40%
Not too well	13%	18%	13%	15%	15%	15%	12%	14%	15%	13%	15%	17%	15%
Not at all	1%	5%	10%	5%	4%	4%	4%	6%	6%	5%	3%	1%	9%
DK (VOL)	1%	2%	2%	1%	2%	2%	2%	2%	1%	2%	0%	2%	2%
Unwt N=	381	395	179	475	524	589	146	128	107	255	258	268	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very well	31%	30%	43%	44%	40%	35%	37%	30%	34%	21%	35%	42%	49%
Smwht well	47%	48%	39%	39%	45%	43%	37%	49%	44%	49%	45%	41%	35%
Not too well	18%	14%	12%	13%	13%	17%	15%	13%	16%	20%	13%	13%	13%
Not at all	3%	8%	4%	2%	2%	4%	8%	5%	5%	8%	4%	3%	1%
DK (VOL)	2%	0%	3%	2%	1%	1%	3%	3%	2%	2%	2%	2%	2%
Unwt N=	255	305	168	163	162	361	136	171	169	168	284	314	231

DR1. How familiar are you with what your local public health department does? Are you very familiar, somewhat familiar, not too familiar, or not familiar at all with what it does?

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very familiar	14%	10%	14%	12%	13%	12%	17%	14%	12%	14%	13%	11%	12%
Smwht familiar	37%	35%	42%	36%	39%	39%	35%	34%	41%	33%	41%	39%	38%
Not too familiar	31%	31%	23%	30%	29%	30%	28%	31%	29%	32%	31%	29%	26%
Not familiar at all	15%	21%	21%	21%	16%	19%	19%	18%	17%	19%	13%	19%	24%
DK (VOL)	1%	2%	0%	1%	3%	1%	1%	3%	1%	3%	2%	2%	0%
Unwt N=	380	396	179	477	523	591	145	127	107	254	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very familiar	12%	11%	14%	16%	17%	13%	12%	9%	11%	7%	10%	17%	19%
Smwht familiar	35%	40%	35%	37%	40%	35%	39%	36%	41%	38%	37%	36%	41%
Not too familiar	35%	27%	34%	27%	31%	29%	26%	36%	27%	30%	32%	28%	26%
Not familiar at all	15%	21%	16%	18%	12%	21%	22%	15%	21%	21%	20%	17%	12%
DK (VOL)	3%	1%	1%	1%	0%	2%	0%	5%	0%	4%	1%	2%	1%
Unwt N=	252	305	169	164	163	359	138	170	170	167	283	316	232

DR2. Would you say your local public health department does too much, too little, or does the right amount to help people lead healthier lifestyles?

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Too much	6%	5%	8%	7%	6%	7%	6%	6%	1%	9%	8%	4%	5%
Too little	42%	32%	33%	35%	36%	32%	45%	40%	32%	41%	35%	32%	34%
Right amt	33%	36%	36%	36%	34%	35%	31%	35%	43%	34%	33%	35%	38%
DK (VOL)	18%	27%	23%	22%	24%	26%	17%	19%	23%	16%	24%	29%	23%
Unwt N=	379	393	179	473	521	587	143	128	107	254	257	266	212

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Too much	6%	4%	13%	6%	7%	6%	5%	5%	10%	5%	6%	7%	8%
Too little	38%	42%	24%	33%	39%	35%	38%	27%	38%	36%	38%	33%	33%
Right amt	35%	34%	36%	35%	40%	35%	33%	36%	29%	35%	35%	34%	36%
DK (VOL)	21%	20%	27%	25%	14%	24%	23%	31%	23%	24%	21%	26%	22%
Unwt N=	254	303	168	163	161	360	138	168	167	165	284	314	229

RP1. Would you consider each of the following services to be one of the main responsibilities for local public health departments, or not? Just tell me yes or no for each. First:

Environmental health

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	81%	74%	74%	73%	79%	75%	80%	82%	75%	76%	77%	76%	79%
No	13%	19%	22%	21%	14%	18%	14%	15%	18%	15%	17%	19%	17%
DK (VOL)	6%	7%	5%	6%	7%	7%	7%	3%	6%	9%	6%	6%	4%
Unwt N=	381	395	179	474	525	588	147	126	108	254	258	268	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	74%	79%	79%	78%	76%	80%	75%	81%	66%	79%	76%	76%	75%
No	16%	17%	18%	15%	19%	14%	21%	11%	26%	13%	16%	20%	23%
DK (VOL)	10%	5%	3%	6%	5%	6%	4%	8%	8%	9%	8%	4%	2%
Unwt N=	254	303	169	164	162	358	138	172	169	168	281	316	232

Food safety inspection, education, and licensing

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	78%	79%	83%	78%	81%	79%	79%	86%	81%	79%	82%	85%	73%
No	16%	15%	13%	16%	13%	16%	14%	12%	11%	15%	13%	11%	21%
DK (VOL)	6%	6%	3%	6%	5%	6%	7%	2%	8%	6%	5%	4%	6%
Unwt N=	381	397	180	477	527	591	147	128	108	257	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	80%	78%	82%	83%	80%	79%	80%	82%	79%	78%	82%	81%	79%
No	14%	15%	15%	11%	13%	16%	17%	11%	14%	16%	12%	13%	18%
DK (VOL)	6%	7%	2%	6%	7%	5%	3%	7%	6%	6%	6%	6%	3%
Unwt N=	255	305	170	164	163	362	138	172	169	169	284	317	231

Emergency planning and preparedness

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	80%	82%	82%	78%	84%	81%	78%	86%	83%	79%	82%	84%	79%
No	15%	11%	11%	16%	9%	12%	15%	12%	11%	12%	13%	9%	16%
DK (VOL)	5%	7%	7%	6%	7%	7%	7%	2%	6%	9%	5%	7%	4%
Unwt N=	380	395	180	477	524	589	147	127	108	254	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	82%	76%	92%	80%	83%	80%	84%	79%	80%	80%	81%	81%	84%
No	10%	16%	7%	14%	13%	13%	12%	12%	11%	12%	12%	15%	11%
DK (VOL)	8%	7%	1%	7%	4%	6%	4%	9%	8%	9%	7%	4%	5%
Unwt N=	253	304	170	164	163	360	138	172	168	168	284	315	231

Maternal and child health

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	78%	69%	64%	66%	76%	68%	80%	77%	70%	75%	74%	69%	66%
No	13%	24%	29%	27%	16%	25%	10%	16%	18%	15%	19%	26%	25%
DK (VOL)	8%	7%	7%	7%	8%	7%	10%	7%	12%	10%	7%	5%	9%
Unwt N=	381	397	180	477	527	591	147	128	108	257	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	76%	72%	71%	66%	80%	71%	60%	75%	67%	71%	74%	68%	71%
No	14%	19%	26%	29%	13%	22%	35%	15%	24%	19%	18%	26%	24%
DK (VOL)	10%	9%	4%	6%	7%	7%	6%	10%	9%	10%	8%	6%	5%
Unwt N=	255	305	170	164	163	362	138	172	169	169	284	317	231

Animal control

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	60%	64%	62%	62%	63%	66%	56%	59%	62%	54%	59%	67%	70%
No	29%	27%	31%	31%	26%	26%	35%	30%	24%	32%	31%	23%	27%
DK (VOL)	11%	9%	7%	8%	11%	8%	9%	11%	14%	14%	10%	9%	3%
Unwt N=	380	397	180	476	527	591	147	127	108	256	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	60%	58%	67%	69%	63%	64%	68%	58%	58%	61%	57%	67%	68%
No	29%	31%	26%	25%	27%	28%	24%	28%	34%	28%	32%	25%	27%
DK (VOL)	11%	11%	7%	6%	10%	8%	9%	14%	8%	12%	11%	8%	5%
Unwt N=	255	304	170	164	162	362	138	172	169	169	283	317	231

Infectious disease prevention, monitoring, and reporting

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	91%	84%	86%	85%	89%	88%	85%	87%	90%	87%	86%	92%	82%
No	6%	12%	11%	11%	8%	9%	8%	10%	8%	8%	10%	5%	15%
DK (VOL)	3%	3%	4%	4%	3%	3%	7%	3%	2%	5%	3%	3%	3%
Unwt N=	381	396	180	476	526	590	147	128	107	256	258	268	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	89%	83%	90%	91%	89%	88%	83%	90%	84%	85%	86%	87%	93%
No	8%	10%	10%	9%	7%	9%	16%	7%	10%	10%	10%	9%	6%
DK (VOL)	3%	7%	1%	0%	4%	3%	1%	3%	6%	5%	4%	3%	0%
Unwt N=	255	305	169	164	163	360	138	172	169	169	283	317	231

Health and nutrition promotion and education

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	82%	72%	70%	71%	79%	75%	76%	78%	73%	75%	83%	74%	68%
No	12%	19%	25%	22%	14%	20%	14%	13%	17%	14%	12%	19%	26%
DK (VOL)	6%	9%	5%	7%	7%	5%	9%	9%	10%	11%	5%	6%	6%
Unwt N=	379	397	180	477	525	590	146	128	108	255	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	75%	75%	78%	69%	85%	74%	66%	77%	75%	69%	81%	72%	79%
No	14%	15%	19%	27%	12%	19%	29%	14%	17%	21%	11%	23%	17%
DK (VOL)	10%	9%	3%	4%	4%	8%	5%	9%	8%	10%	8%	5%	3%
Unwt N=	254	304	170	164	163	360	138	172	169	168	284	316	231

Clinical services like health screenings, counseling, and referrals

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	80%	74%	74%	71%	79%	77%	86%	70%	73%	74%	78%	75%	74%
No	16%	21%	22%	24%	15%	20%	10%	23%	18%	20%	17%	19%	22%
DK (VOL)	4%	5%	4%	5%	6%	4%	3%	6%	9%	5%	5%	6%	5%
Unwt N=	381	395	180	476	525	590	146	128	107	254	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	83%	74%	74%	72%	81%	77%	72%	75%	71%	75%	81%	70%	74%
No	13%	20%	22%	25%	18%	18%	25%	17%	22%	19%	14%	25%	22%
DK (VOL)	3%	6%	5%	2%	1%	5%	3%	8%	8%	7%	5%	5%	4%
Unwt N=	253	305	170	164	163	360	138	171	169	168	284	316	231

RP2. I am going to read you the same list of services that your local public health department provides. If you had to choose, which one do you think is the most important service that they provide? Is it:

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Envtl health	6%	4%	5%	5%	5%	5%	7%	5%	3%	5%	5%	4%	6%
Food	11%	14%	14%	17%	10%	13%	11%	12%	15%	13%	9%	16%	14%
Emergency P&P	8%	15%	20%	13%	15%	16%	6%	12%	15%	11%	15%	16%	13%
Mat./child health	4%	7%	4%	5%	5%	4%	6%	8%	7%	7%	6%	1%	6%
Animal control	2%	2%	1%	2%	1%	2%	1%	0%	2%	1%	1%	1%	4%
Disease	34%	25%	26%	28%	29%	32%	20%	25%	25%	25%	31%	32%	25%
Health and nutrition	11%	11%	9%	11%	11%	9%	12%	15%	11%	14%	11%	7%	9%
Clinical services	18%	16%	16%	14%	19%	16%	20%	18%	13%	16%	16%	19%	14%
Something else	2%	1%	1%	2%	1%	1%	6%	0%	0%	0%	1%	2%	3%
DK (VOL)	5%	5%	3%	3%	6%	3%	12%	4%	8%	8%	4%	2%	5%
Unwt N=	381	395	180	475	525	589	147	128	107	257	257	269	212

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Envtl health	3%	7%	3%	5%	5%	7%	3%	3%	4%	4%	5%	8%	3%
Food	10%	14%	15%	15%	10%	12%	12%	14%	18%	12%	12%	14%	13%
Emergency P&P	10%	15%	17%	18%	9%	17%	18%	11%	13%	15%	12%	16%	13%
Mat./child health	7%	4%	6%	2%	4%	6%	6%	6%	4%	5%	8%	3%	3%
Animal control	2%	2%	0%	2%	2%	1%	2%	2%	1%	2%	1%	2%	2%
Disease	28%	24%	28%	31%	31%	28%	32%	27%	24%	22%	31%	28%	36%
Health and nutrition	10%	13%	12%	10%	17%	9%	10%	9%	10%	13%	9%	9%	12%
Clinical services	21%	16%	12%	16%	12%	17%	14%	19%	21%	18%	18%	16%	13%
Something else	0%	3%	2%	1%	2%	0%	1%	3%	1%	3%	1%	1%	2%
DK (VOL)	8%	3%	4%	1%	8%	3%	3%	7%	4%	8%	4%	4%	2%
Unwt N=	254	305	169	164	162	362	137	171	168	166	284	317	230

RP3. I am going to once again read you that same list of services that your local public health department provides, and now I would like you to tell me whether or not each of these services has ever personally impacted you at some point in your life. First:

Environmental health

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	43%	40%	30%	37%	41%	36%	37%	47%	45%	48%	37%	36%	35%
No	47%	54%	65%	56%	51%	56%	54%	44%	52%	42%	55%	57%	61%
DK (VOL)	9%	6%	5%	7%	8%	7%	8%	9%	3%	10%	8%	8%	3%
Unwt N=	380	396	180	476	525	590	147	127	107	254	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	41%	40%	43%	36%	50%	36%	41%	37%	35%	32%	38%	44%	46%
No	48%	52%	55%	61%	43%	59%	52%	50%	58%	59%	52%	53%	48%
DK (VOL)	11%	8%	3%	4%	7%	5%	7%	13%	7%	8%	10%	3%	6%
Unwt N=	254	304	170	164	163	359	138	172	169	168	284	316	231

Food safety inspection, education, and licensing

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	46%	53%	49%	53%	45%	49%	38%	55%	53%	60%	48%	43%	44%
No	48%	42%	47%	44%	47%	45%	58%	39%	43%	34%	46%	50%	54%
DK (VOL)	6%	6%	4%	3%	8%	6%	4%	6%	4%	6%	7%	6%	2%
Unwt N=	380	397	180	477	525	591	147	127	107	256	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	49%	48%	55%	54%	56%	45%	54%	50%	46%	49%	46%	50%	52%
No	43%	47%	41%	42%	41%	51%	41%	40%	48%	45%	47%	48%	43%
DK (VOL)	8%	5%	5%	4%	3%	4%	5%	10%	7%	6%	7%	3%	5%
Unwt N=	255	304	170	164	163	360	138	172	169	169	283	317	231

Emergency planning and preparedness

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	48%	47%	48%	46%	49%	47%	47%	51%	42%	55%	47%	47%	38%
No	48%	47%	51%	50%	46%	48%	50%	45%	51%	36%	48%	51%	60%
DK (VOL)	4%	7%	1%	4%	5%	4%	4%	4%	7%	8%	5%	2%	2%
Unwt N=	380	397	180	477	525	590	147	128	107	255	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	46%	45%	52%	53%	54%	46%	47%	43%	47%	42%	46%	49%	56%
No	49%	48%	47%	45%	44%	51%	49%	49%	47%	53%	48%	49%	39%
DK (VOL)	5%	7%	1%	2%	2%	3%	4%	8%	7%	5%	6%	2%	5%
Unwt N=	255	305	170	163	163	361	138	172	168	169	284	316	231

Maternal and child health

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	37%	24%	26%	23%	35%	25%	35%	36%	37%	41%	34%	23%	18%
No	60%	68%	71%	71%	60%	69%	59%	60%	59%	50%	62%	73%	78%
DK (VOL)	3%	8%	3%	6%	4%	5%	6%	4%	5%	8%	5%	3%	4%
Unwt N=	380	396	180	477	524	591	147	126	107	254	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	36%	31%	30%	23%	36%	28%	24%	31%	29%	30%	34%	28%	22%
No	59%	62%	66%	75%	62%	67%	71%	62%	65%	63%	62%	67%	75%
DK (VOL)	5%	7%	3%	2%	3%	5%	5%	7%	6%	7%	4%	4%	4%
Unwt N=	254	305	170	164	163	360	137	172	169	168	283	317	231

Animal control

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	37%	41%	35%	41%	35%	40%	32%	38%	37%	39%	34%	43%	33%
No	59%	55%	59%	56%	59%	56%	66%	54%	57%	53%	59%	55%	65%
DK (VOL)	4%	5%	6%	3%	7%	4%	3%	8%	7%	8%	7%	2%	2%
Unwt N=	380	396	180	477	524	591	145	128	107	255	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	33%	39%	42%	41%	42%	35%	39%	38%	37%	38%	32%	39%	46%
No	61%	55%	57%	55%	53%	62%	55%	54%	57%	56%	62%	56%	50%
DK (VOL)	7%	6%	1%	4%	5%	3%	5%	8%	6%	6%	5%	4%	3%
Unwt N=	254	304	170	164	163	360	138	171	169	169	283	317	230

Infectious disease prevention, monitoring, and reporting

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	62%	52%	52%	55%	57%	55%	52%	57%	63%	62%	58%	56%	45%
No	35%	42%	46%	42%	38%	41%	44%	38%	33%	30%	37%	41%	54%
DK (VOL)	3%	6%	2%	3%	5%	4%	4%	5%	4%	8%	5%	3%	0%
Unwt N=	381	397	180	477	526	591	147	128	107	256	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	52%	55%	63%	57%	62%	55%	58%	53%	52%	46%	58%	62%	61%
No	41%	40%	36%	42%	36%	43%	38%	38%	43%	49%	37%	35%	37%
DK (VOL)	7%	5%	1%	0%	2%	2%	4%	9%	5%	5%	5%	3%	2%
Unwt N=	255	305	170	164	163	361	138	172	169	169	284	317	231

Health and nutrition promotion and education

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	44%	41%	36%	39%	43%	36%	42%	49%	55%	53%	47%	32%	32%
No	52%	53%	62%	58%	52%	60%	53%	46%	42%	38%	51%	65%	66%
DK (VOL)	4%	5%	2%	3%	5%	4%	5%	5%	3%	9%	2%	3%	1%
Unwt N=	380	396	180	475	525	591	147	126	107	254	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	47%	45%	37%	32%	49%	39%	36%	41%	41%	39%	44%	42%	38%
No	48%	50%	61%	66%	51%	58%	59%	51%	54%	56%	51%	55%	59%
DK (VOL)	5%	5%	2%	2%	1%	3%	5%	7%	5%	5%	5%	3%	2%
Unwt N=	255	303	170	164	162	360	138	171	169	167	283	317	231

Clinical services like health screenings, counseling, and referrals

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	52%	39%	40%	38%	49%	37%	54%	54%	55%	58%	47%	36%	34%
No	45%	57%	58%	59%	47%	60%	43%	44%	42%	38%	49%	60%	66%
DK (VOL)	3%	4%	2%	2%	4%	3%	4%	1%	3%	4%	4%	4%	0%
Unwt N=	380	395	180	475	525	590	146	127	107	253	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	52%	49%	41%	31%	56%	41%	35%	49%	40%	47%	46%	45%	36%
No	44%	46%	58%	68%	42%	56%	63%	45%	56%	50%	50%	53%	61%
DK (VOL)	4%	4%	2%	1%	2%	3%	2%	5%	4%	2%	4%	2%	3%
Unwt N=	255	303	170	163	163	359	138	172	168	168	284	315	231

E1. To the best of your recollection, have you ever engaged with, or received any information from, your local public health department? This may have been through a health fair or event, service or training, educational materials, or some other way. Again, this would be aside from anything related to COVID-19.

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Yes	53%	44%	48%	46%	49%	47%	56%	44%	54%	51%	52%	45%	42%
No	44%	48%	47%	49%	45%	48%	41%	47%	40%	42%	40%	50%	56%
DK (VOL)	3%	8%	5%	5%	6%	5%	4%	9%	6%	8%	7%	5%	1%
Unwt N=	380	395	180	477	523	589	146	128	107	253	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Yes	46%	51%	45%	52%	57%	48%	42%	47%	44%	40%	46%	53%	55%
No	48%	43%	49%	43%	40%	46%	53%	44%	52%	54%	46%	42%	41%
DK (VOL)	6%	6%	6%	4%	3%	7%	5%	9%	4%	6%	7%	5%	3%
Unwt N=	253	305	170	164	163	360	138	170	169	168	283	316	231

F1. How important do you think it is for the state of New Jersey to establish a source of stable, dedicated funding that can only be used for local public health services and programs – very important, somewhat important, not very important, or not at all important?

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	77%	51%	44%	50%	67%	54%	76%	66%	63%	64%	57%	58%	56%
Smwht	20%	31%	40%	33%	25%	32%	16%	25%	29%	26%	32%	29%	27%
Not very	1%	8%	7%	6%	4%	6%	3%	6%	3%	6%	5%	7%	3%
Not at all	2%	7%	8%	9%	2%	7%	3%	2%	3%	1%	4%	6%	11%
DK (VOL)	0%	2%	2%	2%	2%	2%	2%	2%	3%	3%	2%	1%	2%
Unwt N=	380	397	180	477	524	590	146	128	108	255	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	66%	62%	59%	53%	69%	57%	51%	64%	55%	63%	59%	53%	61%
Smwht	25%	27%	27%	32%	22%	32%	32%	28%	25%	25%	30%	32%	26%
Not very	5%	4%	7%	6%	5%	5%	5%	5%	7%	5%	3%	8%	5%
Not at all	2%	5%	6%	7%	3%	6%	10%	1%	8%	3%	6%	6%	7%
DK (VOL)	2%	2%	1%	1%	1%	1%	2%	2%	5%	3%	1%	2%	1%
Unwt N=	254	305	169	164	163	360	137	171	170	168	283	316	232

F2. Please tell me if you would strongly support, somewhat support, somewhat oppose, or strongly oppose each of the following proposals to create a dedicated and stable fund to support local public health services in New Jersey. First:

A small increase in your New Jersey income tax

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Strongly support	19%	10%	5%	10%	14%	8%	19%	21%	14%	18%	8%	12%	10%
Smwht support	30%	22%	14%	23%	23%	24%	22%	26%	20%	17%	26%	24%	27%
Smwht oppose	18%	19%	19%	17%	18%	17%	22%	19%	16%	28%	15%	16%	12%
Strongly oppose	31%	48%	60%	47%	43%	48%	35%	33%	48%	35%	49%	47%	49%
DK (VOL)	2%	2%	1%	2%	2%	2%	2%	1%	3%	3%	2%	2%	2%
Unwt N=	379	392	178	474	520	587	146	124	108	253	255	267	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Strongly support	13%	17%	8%	9%	18%	11%	11%	10%	11%	14%	12%	11%	11%
Smwht support	25%	20%	28%	26%	28%	26%	15%	22%	20%	20%	23%	24%	26%
Smwht oppose	21%	24%	10%	12%	20%	16%	19%	19%	17%	23%	16%	14%	19%
Strongly oppose	38%	37%	53%	53%	33%	45%	52%	46%	49%	40%	46%	51%	43%
DK (VOL)	4%	2%	0%	0%	1%	1%	3%	3%	3%	4%	2%	0%	0%
Unwt N=	249	303	169	164	161	358	137	170	168	166	279	315	231

A small increase in your local property tax

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Strongly support	13%	6%	8%	7%	11%	8%	10%	10%	9%	12%	7%	9%	8%
Smwht support	26%	21%	9%	20%	20%	17%	25%	29%	22%	25%	20%	17%	18%
Smwht oppose	16%	16%	14%	16%	15%	16%	13%	18%	13%	22%	13%	13%	14%
Strongly oppose	43%	55%	67%	56%	52%	58%	47%	41%	53%	38%	58%	59%	61%
DK (VOL)	3%	2%	2%	2%	2%	2%	4%	1%	3%	3%	2%	2%	0%
Unwt N=	380	393	178	474	523	588	146	124	109	254	257	267	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Strongly support	8%	11%	8%	7%	11%	11%	6%	5%	8%	12%	6%	9%	9%
Smwht support	19%	24%	22%	16%	30%	19%	17%	18%	15%	20%	19%	18%	24%
Smwht oppose	21%	14%	12%	14%	12%	16%	14%	19%	16%	18%	13%	17%	15%
Strongly oppose	47%	48%	58%	63%	47%	53%	60%	54%	58%	48%	59%	56%	51%
DK (VOL)	4%	3%	0%	0%	0%	1%	3%	4%	2%	3%	3%	1%	0%
Unwt N=	250	303	170	164	161	358	137	171	170	168	280	315	231

A small tax on unhealthy foods and sugary drinks

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Strongly support	41%	23%	17%	26%	30%	27%	31%	27%	39%	30%	29%	31%	20%
Smwht support	27%	27%	25%	25%	28%	24%	32%	27%	27%	30%	26%	24%	26%
Smwht oppose	12%	15%	14%	13%	14%	15%	9%	17%	9%	16%	15%	11%	12%
Strongly oppose	18%	32%	43%	35%	26%	33%	27%	27%	23%	22%	27%	32%	42%
DK (VOL)	2%	2%	1%	1%	2%	2%	1%	1%	3%	2%	2%	2%	0%
Unwt N=	379	396	179	476	523	590	144	126	109	255	257	268	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Strongly support	21%	31%	30%	35%	32%	30%	21%	29%	24%	24%	26%	30%	35%
Smwht support	25%	28%	26%	27%	28%	31%	22%	26%	20%	23%	27%	26%	31%
Smwht oppose	18%	13%	11%	10%	14%	11%	13%	23%	10%	17%	13%	12%	11%
Strongly oppose	32%	26%	32%	28%	26%	27%	41%	20%	43%	33%	32%	31%	22%
DK (VOL)	3%	2%	0%	1%	0%	1%	3%	3%	3%	3%	2%	1%	0%
Unwt N=	252	303	170	164	162	359	137	171	170	168	281	316	231

T1. People seek out information from various sources when they have a question or concern about public health issues. Please tell me how likely you would be to seek out information from each of the following if you had a question or concern about a public health issue. First, would you be very likely, somewhat likely, not very likely, or not likely at all to seek out information from [INSERT ITEM]? NEXT:

Family members, friends, and neighbors

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	32%	29%	30%	29%	31%	30%	34%	25%	30%	32%	29%	29%	29%
Smwht	42%	42%	43%	42%	43%	42%	40%	48%	43%	42%	48%	45%	34%
Not very	14%	11%	14%	12%	14%	13%	7%	17%	15%	13%	11%	13%	15%
Not at all	10%	14%	12%	15%	10%	13%	15%	8%	11%	9%	8%	12%	21%
Depends	2%	3%	2%	3%	2%	2%	3%	2%	1%	4%	3%	2%	0%
DK (VOL)	0%	1%	0%	0%	1%	0%	1%	0%	1%	1%	1%	0%	0%
Unwt N=	380	397	180	477	526	591	146	128	108	257	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	33%	31%	29%	29%	32%	30%	25%	36%	25%	39%	28%	29%	20%
Smwht	44%	38%	46%	42%	49%	39%	47%	40%	43%	35%	46%	41%	51%
Not very	10%	16%	12%	12%	11%	14%	13%	11%	14%	14%	9%	13%	16%
Not at all	10%	12%	10%	15%	6%	15%	12%	10%	15%	10%	14%	13%	11%
Depends	3%	2%	2%	2%	3%	2%	2%	2%	3%	1%	3%	3%	2%
DK (VOL)	0%	0%	0%	0%	0%	0%	0%	2%	0%	1%	0%	1%	0%
Unwt N=	254	305	170	164	162	362	138	172	169	169	283	317	231

Newspapers, television, magazines, or radio

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	32%	22%	21%	24%	26%	27%	26%	21%	23%	21%	20%	25%	36%
Smwht	35%	31%	31%	33%	31%	31%	33%	36%	37%	31%	34%	32%	32%
Not very	15%	21%	16%	20%	16%	17%	18%	21%	19%	21%	21%	19%	8%
Not at all	15%	23%	24%	21%	21%	22%	19%	14%	20%	20%	20%	19%	23%
Depends	3%	1%	5%	2%	3%	3%	3%	5%	1%	5%	4%	2%	0%
DK (VOL)	1%	2%	3%	1%	3%	2%	2%	3%	1%	2%	2%	3%	1%
Unwt N=	381	393	180	473	526	591	145	126	107	254	256	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	28%	27%	28%	16%	31%	28%	13%	30%	17%	29%	21%	23%	29%
Smwht	33%	34%	28%	36%	33%	32%	39%	26%	31%	23%	32%	37%	40%
Not very	13%	18%	15%	22%	16%	17%	19%	18%	18%	19%	18%	17%	15%
Not at all	19%	18%	23%	24%	16%	19%	25%	18%	28%	23%	23%	18%	15%
Depends	4%	2%	4%	2%	3%	1%	3%	4%	3%	3%	3%	3%	1%
DK (VOL)	4%	1%	2%	0%	0%	2%	1%	4%	2%	3%	2%	1%	1%
Unwt N=	253	303	170	164	162	359	138	171	169	169	283	315	230

Internet websites or social media platforms

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	28%	22%	24%	24%	26%	22%	32%	23%	34%	29%	28%	23%	18%
Smwht	26%	25%	31%	29%	24%	25%	25%	35%	26%	29%	32%	26%	18%
Not very	16%	17%	12%	17%	14%	15%	18%	17%	11%	17%	11%	18%	13%
Not at all	26%	33%	30%	28%	32%	35%	21%	21%	23%	19%	26%	29%	48%
Depends	2%	2%	3%	3%	2%	2%	4%	1%	2%	4%	2%	2%	1%
DK (VOL)	1%	1%	0%	0%	2%	1%	0%	1%	3%	1%	1%	1%	2%
Unwt N=	380	395	179	475	524	590	146	127	107	256	257	266	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	25%	26%	29%	23%	27%	26%	25%	28%	16%	23%	26%	26%	24%
Smwht	33%	27%	23%	27%	27%	26%	23%	35%	21%	28%	27%	28%	20%
Not very	13%	17%	15%	16%	19%	14%	18%	11%	15%	11%	14%	17%	22%
Not at all	24%	29%	30%	32%	24%	30%	31%	23%	41%	32%	30%	26%	31%
Depends	3%	2%	2%	2%	2%	2%	3%	2%	4%	3%	3%	2%	1%
DK (VOL)	1%	1%	1%	0%	0%	1%	0%	2%	3%	2%	1%	1%	1%
Unwt N=	254	303	169	164	163	359	138	170	169	167	281	317	231

A doctor or nurse

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	70%	64%	67%	65%	69%	71%	65%	55%	66%	56%	62%	74%	77%
Smwht	23%	24%	26%	25%	22%	22%	21%	30%	26%	25%	29%	19%	20%
Not very	4%	5%	4%	5%	4%	4%	5%	6%	4%	7%	5%	3%	2%
Not at all	3%	3%	1%	4%	3%	1%	7%	6%	3%	6%	2%	3%	1%
Depends	0%	3%	1%	2%	1%	2%	2%	1%	1%	3%	2%	1%	1%
DK (VOL)	0%	1%	0%	0%	1%	0%	1%	2%	0%	1%	0%	0%	0%
Unwt N=	381	396	180	477	526	591	146	128	108	256	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	61%	64%	71%	77%	73%	66%	75%	61%	63%	62%	69%	66%	73%
Smwht	28%	25%	21%	16%	20%	24%	19%	26%	27%	25%	23%	26%	19%
Not very	6%	4%	4%	4%	4%	5%	3%	7%	3%	5%	3%	5%	5%
Not at all	3%	4%	3%	2%	1%	3%	1%	4%	6%	5%	3%	2%	1%
Depends	1%	2%	1%	2%	1%	1%	1%	3%	2%	2%	3%	1%	1%
DK (VOL)	1%	1%	0%	0%	0%	1%	0%	0%	0%	1%	0%	0%	0%
Unwt N=	255	304	170	164	163	361	138	172	169	169	284	317	230

Your local public health department

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	41%	26%	25%	26%	37%	29%	42%	35%	34%	32%	34%	29%	35%
Smwht	36%	33%	33%	36%	32%	34%	33%	33%	38%	30%	41%	35%	27%
Not very	12%	17%	21%	18%	15%	18%	12%	17%	13%	20%	13%	20%	12%
Not at all	9%	18%	20%	18%	12%	17%	8%	12%	12%	12%	11%	13%	25%
Depends	1%	2%	1%	1%	3%	1%	2%	2%	2%	3%	2%	2%	0%
DK (VOL)	0%	3%	0%	1%	1%	1%	2%	1%	2%	3%	1%	0%	1%
Unwt N=	381	398	180	478	527	591	147	128	109	258	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	35%	33%	34%	21%	40%	33%	20%	33%	30%	32%	33%	30%	32%
Smwht	32%	36%	33%	34%	41%	32%	33%	36%	27%	30%	33%	35%	37%
Not very	13%	17%	15%	26%	12%	16%	23%	13%	20%	19%	16%	17%	14%
Not at all	15%	11%	16%	19%	6%	18%	19%	12%	17%	15%	15%	16%	14%
Depends	3%	2%	1%	0%	1%	1%	3%	3%	3%	2%	3%	2%	0%
DK (VOL)	2%	2%	1%	0%	1%	0%	1%	3%	3%	2%	1%	1%	2%
Unwt N=	255	305	170	164	163	362	138	172	170	169	284	317	232

The state health department

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	49%	29%	24%	34%	37%	33%	49%	36%	38%	37%	40%	37%	28%
Smwht	32%	33%	33%	31%	34%	33%	26%	36%	32%	33%	34%	31%	32%
Not very	10%	13%	19%	16%	11%	13%	14%	14%	10%	16%	10%	15%	12%
Not at all	7%	20%	21%	17%	13%	18%	7%	11%	15%	9%	13%	15%	26%
Depends	1%	3%	3%	1%	3%	2%	3%	2%	2%	4%	3%	2%	0%
DK (VOL)	0%	1%	0%	0%	1%	0%	0%	1%	4%	1%	1%	0%	2%
Unwt N=	381	396	180	476	526	591	147	127	108	256	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	41%	39%	37%	27%	49%	38%	23%	39%	26%	36%	36%	35%	39%
Smwht	31%	32%	33%	33%	31%	30%	41%	31%	33%	32%	32%	32%	34%
Not very	8%	13%	12%	21%	14%	15%	12%	11%	12%	13%	12%	14%	14%
Not at all	16%	14%	14%	17%	4%	15%	20%	15%	23%	17%	16%	15%	11%
Depends	4%	2%	3%	1%	2%	2%	4%	4%	2%	1%	4%	2%	2%
DK (VOL)	1%	0%	0%	0%	0%	1%	0%	1%	3%	1%	1%	1%	1%
Unwt N=	254	305	170	164	163	361	138	171	169	168	284	317	230

A community- or faith-based organization or public community center

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Very	21%	10%	16%	13%	17%	13%	29%	16%	14%	18%	15%	13%	17%
Smwht	31%	33%	28%	31%	32%	27%	37%	39%	32%	30%	31%	29%	37%
Not very	22%	22%	21%	23%	20%	24%	15%	23%	17%	19%	25%	25%	16%
Not at all	23%	31%	31%	30%	27%	32%	16%	19%	35%	28%	25%	30%	29%
Depends	2%	2%	2%	1%	2%	2%	3%	0%	0%	3%	2%	2%	0%
DK (VOL)	1%	2%	2%	1%	2%	1%	1%	3%	1%	3%	1%	2%	0%
Unwt N=	378	395	179	475	522	590	145	126	107	255	255	267	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Very	17%	19%	16%	12%	24%	18%	6%	14%	11%	15%	17%	15%	13%
Smwht	34%	31%	31%	23%	35%	33%	24%	31%	31%	36%	27%	33%	30%
Not very	18%	24%	23%	26%	18%	22%	25%	26%	15%	19%	22%	21%	26%
Not at all	26%	23%	26%	36%	21%	25%	40%	22%	38%	26%	29%	29%	29%
Depends	3%	1%	2%	2%	1%	1%	2%	5%	1%	3%	2%	1%	2%
DK (VOL)	3%	1%	0%	1%	0%	1%	2%	2%	3%	2%	3%	1%	0%
Unwt N=	253	302	169	164	162	359	138	170	168	166	280	317	231

T2. People trust some sources more than others when it comes to providing accurate public health information. Please tell me how much you trust each of the following. First, how much do you trust public health information provided by [INSERT ITEM] – a great deal, a moderate amount, not much, or not at all? First:

Family members, friends, and neighbors

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Great deal	24%	16%	20%	17%	21%	16%	21%	29%	20%	24%	20%	16%	15%
Moderate	49%	47%	55%	49%	50%	54%	48%	39%	42%	46%	49%	54%	49%
Not much	18%	23%	14%	23%	17%	18%	19%	22%	22%	22%	23%	19%	14%
Not at all	9%	12%	11%	11%	10%	10%	9%	10%	16%	7%	7%	9%	22%
DK (VOL)	1%	2%	0%	1%	2%	1%	2%	1%	1%	2%	2%	2%	0%
Unwt N=	380	396	180	477	524	590	146	127	108	255	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Great deal	27%	18%	17%	12%	21%	18%	16%	25%	16%	25%	18%	18%	13%
Moderate	48%	46%	55%	57%	53%	49%	49%	49%	49%	46%	49%	50%	55%
Not much	17%	24%	21%	16%	20%	20%	17%	16%	23%	17%	22%	19%	19%
Not at all	7%	11%	6%	13%	6%	11%	17%	8%	11%	10%	10%	11%	11%
DK (VOL)	1%	1%	1%	2%	0%	2%	0%	2%	2%	1%	1%	2%	2%
Unwt N=	253	305	170	164	163	360	138	171	169	168	283	316	231

Newspapers, television, magazines, or radio

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Great deal	22%	10%	12%	13%	17%	14%	19%	20%	12%	17%	10%	14%	18%
Moderate	45%	39%	35%	40%	39%	39%	49%	39%	39%	35%	42%	39%	44%
Not much	21%	30%	25%	26%	26%	26%	19%	25%	33%	30%	30%	26%	14%
Not at all	11%	20%	24%	21%	16%	20%	12%	15%	15%	14%	17%	19%	23%
DK (VOL)	0%	2%	3%	1%	2%	1%	2%	2%	2%	3%	1%	1%	1%
Unwt N=	380	395	180	474	526	589	146	128	108	256	256	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Great deal	18%	19%	11%	9%	15%	18%	7%	19%	10%	20%	13%	11%	17%
Moderate	40%	41%	40%	41%	51%	38%	37%	37%	36%	39%	34%	44%	46%
Not much	26%	25%	25%	26%	23%	24%	30%	23%	30%	21%	32%	24%	24%
Not at all	14%	14%	22%	23%	11%	17%	24%	19%	23%	19%	19%	21%	12%
DK (VOL)	2%	1%	2%	1%	0%	2%	2%	1%	2%	1%	2%	1%	1%
Unwt N=	254	305	170	164	163	360	138	170	169	167	284	317	229

Internet websites or social media platforms

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Great deal	12%	8%	9%	10%	9%	8%	12%	15%	11%	17%	10%	7%	3%
Moderate	25%	25%	27%	27%	23%	22%	37%	28%	23%	27%	25%	25%	22%
Not much	32%	26%	25%	26%	30%	26%	23%	30%	36%	29%	36%	26%	18%
Not at all	30%	39%	39%	36%	36%	43%	27%	24%	30%	24%	28%	41%	56%
DK (VOL)	1%	2%	1%	1%	2%	1%	1%	3%	0%	3%	1%	1%	1%
Unwt N=	381	395	179	476	524	589	146	128	108	255	257	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Great deal	12%	11%	8%	7%	14%	9%	7%	11%	7%	11%	8%	9%	11%
Moderate	29%	27%	24%	18%	19%	29%	26%	33%	14%	31%	21%	27%	19%
Not much	31%	27%	24%	29%	35%	25%	24%	30%	27%	21%	37%	25%	27%
Not at all	26%	32%	42%	45%	32%	36%	41%	25%	48%	36%	33%	37%	42%
DK (VOL)	1%	3%	1%	1%	0%	2%	2%	0%	3%	2%	1%	2%	1%
Unwt N=	254	303	170	164	163	362	138	168	169	167	283	316	231

A doctor or nurse

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Great deal	78%	63%	63%	69%	68%	71%	71%	66%	64%	58%	68%	74%	76%
Moderate	18%	28%	31%	24%	26%	25%	20%	24%	27%	29%	26%	21%	22%
Not much	3%	6%	4%	5%	4%	2%	4%	7%	7%	7%	5%	4%	1%
Not at all	1%	3%	2%	2%	2%	2%	4%	2%	2%	4%	1%	1%	1%
DK (VOL)	1%	1%	0%	0%	1%	0%	0%	1%	1%	2%	1%	0%	0%
Unwt N=	381	396	180	476	527	590	147	128	108	256	258	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Great deal	62%	70%	74%	78%	77%	67%	79%	60%	65%	60%	70%	69%	79%
Moderate	28%	24%	24%	16%	19%	28%	16%	29%	27%	29%	26%	23%	18%
Not much	7%	4%	2%	3%	2%	3%	4%	7%	6%	7%	2%	5%	3%
Not at all	3%	2%	0%	1%	2%	2%	1%	3%	2%	2%	2%	2%	0%
DK (VOL)	0%	1%	0%	1%	0%	1%	1%	1%	0%	1%	0%	1%	0%
Unwt N=	255	304	170	164	163	362	138	172	168	168	284	317	231

Your local public health department

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Great deal	50%	29%	27%	37%	37%	34%	42%	45%	36%	39%	38%	39%	31%
Moderate	35%	42%	40%	37%	41%	40%	43%	28%	46%	36%	40%	41%	38%
Not much	9%	18%	16%	15%	13%	15%	7%	16%	12%	15%	14%	12%	16%
Not at all	5%	8%	13%	9%	8%	10%	5%	7%	5%	6%	8%	7%	14%
DK (VOL)	1%	2%	3%	2%	2%	1%	3%	4%	1%	5%	1%	1%	1%
Unwt N=	381	397	180	477	525	591	147	128	107	257	257	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Great deal	38%	39%	35%	34%	47%	35%	32%	36%	34%	35%	35%	38%	41%
Moderate	40%	36%	41%	38%	40%	41%	36%	41%	34%	39%	38%	38%	40%
Not much	13%	13%	17%	17%	9%	13%	18%	15%	18%	16%	15%	14%	10%
Not at all	7%	9%	5%	10%	3%	9%	13%	4%	12%	9%	8%	9%	6%
DK (VOL)	2%	3%	2%	1%	1%	2%	1%	3%	2%	2%	3%	1%	2%
Unwt N=	255	305	170	164	163	362	138	171	168	167	284	317	231

The state health department

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Great deal	55%	30%	28%	37%	40%	36%	53%	39%	39%	38%	41%	40%	35%
Moderate	35%	42%	37%	37%	40%	39%	34%	39%	40%	37%	41%	41%	35%
Not much	6%	15%	17%	14%	11%	13%	6%	14%	12%	17%	9%	10%	14%
Not at all	3%	10%	19%	11%	8%	11%	6%	6%	7%	4%	9%	9%	16%
DK (VOL)	0%	3%	0%	1%	1%	1%	0%	3%	2%	4%	0%	0%	0%
Unwt N=	381	398	180	477	526	591	147	127	108	257	258	269	214

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Great deal	38%	41%	40%	37%	46%	39%	32%	40%	32%	33%	36%	42%	47%
Moderate	39%	38%	37%	37%	41%	41%	37%	38%	33%	40%	42%	32%	38%
Not much	13%	11%	12%	14%	8%	11%	16%	12%	19%	13%	13%	14%	9%
Not at all	9%	8%	11%	11%	5%	8%	15%	9%	13%	12%	8%	10%	5%
DK (VOL)	1%	2%	0%	1%	0%	1%	0%	2%	3%	2%	1%	1%	1%
Unwt N=	255	305	170	163	163	362	138	172	168	167	284	317	232

A community- or faith-based organization or public community center

	Party ID			Sex		Race or Ethnicity				Age			
	Dem	Ind	Rep	Male	Female	Wht	Blk	Hisp	Other	18-34	35-49	50-64	65+
Great deal	21%	9%	14%	14%	14%	10%	23%	23%	13%	20%	11%	14%	12%
Moderate	39%	41%	36%	39%	40%	39%	50%	39%	31%	36%	41%	36%	47%
Not much	24%	25%	29%	27%	24%	28%	15%	23%	27%	22%	28%	33%	17%
Not at all	14%	22%	19%	18%	19%	21%	8%	13%	25%	18%	17%	16%	24%
DK (VOL)	1%	3%	2%	2%	3%	2%	3%	2%	4%	4%	3%	2%	0%
Unwt N=	381	395	180	477	524	591	146	128	107	255	257	269	215

	Income				Region					Education			
	<$50K	$50K-<$100K	$100K-<$150K	$150K+	Urban	Suburb	Exurban	Phil/ South	Shore	HS or less	Some college	College grad	Grad work
Great deal	17%	18%	9%	9%	18%	16%	7%	17%	10%	16%	15%	13%	11%
Moderate	37%	39%	47%	38%	42%	40%	39%	39%	36%	39%	38%	39%	43%
Not much	24%	24%	27%	27%	29%	22%	28%	22%	31%	23%	26%	27%	27%
Not at all	19%	16%	15%	24%	8%	20%	24%	20%	20%	20%	18%	18%	16%
DK (VOL)	3%	2%	1%	2%	2%	2%	2%	3%	2%	2%	2%	2%	3%
Unwt N=	254	304	170	164	163	360	138	171	169	168	284	316	230

Appendix C

OPEN-ENDED VERBATIM RESPONSES

HC1 In just a few words, what would you say is the top health-related issue facing your local community right now, aside from COVID-19? By health related issues, I do not necessarily mean specific diseases but rather issues or conditions that impact the overall health of your local community.

A BIG PERCENT OF PEOPLE WITHOUT INSURANCE.

A LACK OF ABILITY TO GET FRESH LEAFY VEGETABLES.

A LOT OF PEOPLE NOT HAVING ACCESS TO AFFORDABLE HEALTH INSURANCE

A LOUSY GOVERNOR AND HIGH TAXES

A VIRUS GOING AROUND WITH THE KIDS

ACCESS HEALTH CARE

ACCESS TO AFFORDABLE CARE

ACCESS TO AFFORDABLE HEALTH CARE

ACCESS TO AFFORDABLE HEALTH CARE

ACCESS TO AFFORDABLE HEALTH CARE AND HOUSING.

ACCESS TO HAVING GOOD QUALITY HEALTH CARE

ACCESS TO HEALTH CARE

ACCESS TO HEALTH CARE (AFFORDABLE)

ACCESS TO HEALTH CARE. PRESCRIPTION MEDICATION IS VERY EXPENSIVE.

ACCESS TO PRIMARY HEALTH CARE.

ACCESSIBILITY AND COSTS. HEALTH CARE IS EXPENSIVE.

ACCESSIBILITY TO HEALTHY/AFFORDABLE FOOD. MY TOWN DOES NOT HAVE A LOCAL FOOD STORE.

ACCESSIBILITY TO SERVICES. POVERTY, SAFETY ISSUES AND GENERAL QUALITY OF LIFE.

ACTUALLY NOTHING. AIR QUALITY IN BERGEN COUNTY IS VERY GOOD.

ADEQUATE HEALTH CARE COVERAGE

ADEQUATE HEALTH CARE FOR UNDERSERVED POPULATION

AFFORDABILITY

AFFORDABILITY

AFFORDABILITY OF HEALTH CARE COVERAGE

AFFORDABILITY, ITS A GENERAL HEALTH CONCERN

AFFORDABLE HEALTH CARE

AFFORDABLE HEALTH CARE

AFFORDABLE HEALTH CARE

AFFORDABLE HEALTH CARE, AS PREMIUMS HAVE SKYROCKETED TO A POINT WHERE IT IS IMPOSSIBLE TO MAINTAIN, AND PLANS ARE COVERING LESS

AFFORDABLE HEALTH PLANS

AFFORDABLE MEDICATION

AIDS. IT'S STILL AN ISSUE. YOU STILL HAVE TO PROTECT YOURSELF.

AIR POLLUTION

AIR POLLUTION

ALL THE EMPLOYMENT THAT PEOPLE ARE NOT GOING TO GET JOBS. IT HAS GOTTEN SO BAD RIGHT NOW.

ALLERGIES

ALLERGIES

ALZHEIMER'S DEMENTIA

ANXIETY

ANXIETY AND DEPRESSION

ANYTHING WILL IMPACT THEM, THE COMMUNITY. I DON'T KNOW WHAT TO SAY

AS FAR AS I'M CONCERNED FOR RAMPS FOR SENIORS WITH WHEELCHAIRS TO GET AROUND MORE BECAUSE TO THEM ITS A LOT OF STEPS INVOLVED IN OUR COMMUNITY

ASIDE [from] COVID I CANNOT THINK OF ANY ISSUES

ASTHMA AND TASTING

ASTHMA, FEVER, COUGH

AUTOIMMUNE, DIET, DEPRESSION

BACK PAIN

BACK PROBLEMS...ADHD...DEPRESSION

BAD AIR QUALITY FRO POLLUTION

BAY CITY OVERINDULGING IN ALCOHOL

BECAUSE TAXES COST OF LIVING STRESS AND PROPER FUNDING FOR HEALTH CARE

BESIDE FROM COVID I CANT THINK OF ANYTHING ELSE THAT'S THE MAJOR HEALTH ISSUE

BLOOD PRESSURE AND STRESS.

BREATHING MY PROBLEMS

BUSINESSES COVID MANDATES MASK USAGE PEOPLE NOT VACCINATED

CAN'T THINK OF ANYTHING SPECIFIC

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER

CANCER AND DIABETES

CANCER, DIABETES, ANEMIA

CANCER, RARE DISEASES

CHILDHOOD NUTRIENT

CHRONIC DISEASES LIKE DIABETES AND HEART ISSUES.

CLEAR OUT RIVER

COLD AND FLU

COLD AND FLU SEASON, IMMUNE COMPROMISED ELDERLY

COMMON COLD

COMMON COLD AND FLU

CONGESTION OF TRAFFIC

CONSTRUCTION, TRAFFIC CONGESTION, NONE THE I KNOW ASIDE FROM COVID

COPD

CORONA VIRUS

COST AND ACCESS TO HEALTHY FOOD

COST OF CARE

COST OF DRUGS AND MEDICINE

COST OF HEALTH CARE

COST OF HEALTH CARE

COST OF HEALTH CARE

COST OF HEALTH CARE

COST OF INSURANCE

COST OF MEDICAL

COST OF MEDICAL COVERAGE

COST OF MEDICAL INSURANCE

COST OF MEDICATION

COST OF MEDICATIONS FOR OLDER PEOPLE

COST OF PRESCRIPTION DRUGS AND HEALTH CARE COVERAGE

COUNTY IS PRETTY GOOD

COVID 19

COVID 19

COVID HAS SOMEHOW INSTILLED FEAR AND ANXIETY IN MANY PEOPLE. PEOPLE HAVE BEEN FEARFUL OF RETURNING TO WORK AND NORMAL ACTIVITIES. ALSO, INFLATION HAS CREATED TENSIONS IN MANY GOOD FAMILIES IN OUR COMMUNITY

COVID MANDATES! THE MRNA VACCINES ARE NOT DURABLE AND SHOULD NOT BE MANDATED. WE NEED TO STOP PRETENDING THESE VACCINES WORK. WE NEED MORE THERAPEUTICS! EVENTUALLY A VACCINE THAT IS DURABLE AND STOPS THE SPREAD.

COVID SPREAD

COVID. BACTERIA FROM WASTE AFFECTING STOMACH

CRIME

CROWDED URGENT CARES WITH NOT ENOUGH STAFF. SHORT FOOD SUPPLIES

DELTA IS VERY DANGEROUS

DEMENTIA

DEPRESSION

DEPRESSION AND DRUG ADDICTION.

DEPRESSION FOR SURE

DIABETES

DIABETES

DIABETES

DIABETES

DIABETES

DIABETES

DIABETES

DIABETES

DIABETES

DIABETES

DIABETES AND CANCER

DIABETES AND HEART

DIABETES I SEE A LOT OF PEOPLE WHO HAVE THAT

DIABETES, AGE,

DIABETES, HEART DISEASE, INFECTIOUS DISEASE

DIABETES, LACK OF GOOD FOOD CHOICES IN THE AREA.

DIET

DISPARITY AND HEALTH CARE BASED OFF COLOR AND ECONOMIC STATUS

DOCTOR NOW AND WHEN YOU DO THEY DON'T HAVE ANYONE WILLING TO WORK.

DRINKING WATER

DRUG ABUSE

DRUG ADDICTION

DRUG ADDICTION

DRUG ADDICTION

DRUG ADDICTION

DRUG ADDICTION

DRUG ADDICTION AND ABUSE.

DRUG ADDICTION AND MENTAL HEALTH

DRUG ADDICTION AND POVERTY.

DRUG ADDITIONS

DRUG OVERDOSE

DRUG USE

DRUG USE AMONG THE YOUNGER GENERATION IS GETTING CRAZY

DRUGS

DRUGS

DRUGS

DRUGS

DRUGS ADDICTION

DRUGS, FENTANYL

DRUGS, GUNS

EATING A LOT OF SWEETS AFFECTS THE BLOOD SUGAR LEVEL.

ECONOMY

ECONOMY, UNEMPLOYMENT, CLIMATE CHANGE

ELDER CARE WHEN THEY CAN'T TAKE CARE OF THEMSELVES ANYMORE

EMPLOYMENT

EMPLOYMENT, TROUBLE HIRING PEOPLE.

EMS RADIATION FROM CELL TOWERS AND SATELLITES

ENVIRONMENT ISSUES, ABANDONED BUILDING THE AMOUNT OF FAST FOODS IN MY COMMUNITY, THE AMOUNT MEDICAL FACILITY ARE DISAPPEARING

EQUITY, SAFETY OF CHILDREN FROM BULLYING

EVERYBODY IS PRETTY MUCH HEALTHY, OBESITY

EVERYBODY'S SICK AND NO ONE IS WEARING A MASK

EVERYONE MY AGE DOES NOT HAVE DENTAL INSURANCE AND I LOVE BIDEN, BUT HE SHOULD PASS A DENTAL PROVISION.

EXPENSIVE HEALTH CARE

FAIR AMOUNT LOWER INCOME PEOPLE LIVE HERE POOR DIET AND DIABETES, UNHEALTHY DIET

FAST FOOD

FEAR

FEAR

FEAR ANXIETY ANGER

FENTANYL

FINANCES AND JOBS

FINDING WELL PAYING JOBS IS HUGE IN MY COMMUNITY AND HURTING OUR OWN LITTLE ECOSYSTEM.

FLOODING HAS RESULTED IN HOMES LOST.

FLU

FLU

FLU

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FLU

FLU AND COLDS ARE STARING IN THIS PERIOD!

FLU AND PNEUMONIA

FLU, DIABETES AND HIGH BLOOD PRESSURE

FLU.

FOOD

FOOD

FOOD AND SECURITY SPECIALLY HUNGER IN OUR COMMUNITY.

FOOD AND THE LACK OF IT. I AM SURE THAT MANY PEOPLE IN MY NEIGHBORHOOD ARE SUFFERING FROM THE HIGH PRICES OF FOOD.

FOOD AVAILABILITY, NOT A LOT OF FOOD MARKETS IN WALKING DISTANCE

FOOD DESERTS AND AVAILABILITY OF HEALTHY EATING EDUCATION IN SCHOOLS

FOOD INSECURITY

FOOD INSECURITY.

GAS AND FOOD PRICES ARE SO HIGH

GENERAL HEALTH AND FITNESS

GENERAL HYGIENE, ESPECIALLY FOR CHILDREN, IS ONE OF THE MOST IMPORTANT PROBLEMS THAT SURROUND US.

GENERALLY THE [worry]ING ABOUT THE [length] OF THIS CONDITION

GETTING ACCESS TO HEALTH INSURANCE

GETTING HEALTH CARE DURING THIS TIME OF A PANDEMIC

GOOD AND HOUSING SECURITY

GOVERNMENT

GUN VIOLENCE

HARD TO FIND DOCTORS THAT ACCEPT CERTAIN INSURANCES AND GETTING APPOINTMENTS

HAVING A HEALTHY LIFE LIFESTYLE. INCREASE SMOKING

HEALTH AND WELLNESS

HEALTH CARE / RISING COST OF PRESCRIPTION DRUGS AND DOCTOR VISITS

HEALTH CARE ACCESSIBILITY

HEALTH CARE AND INSURANCE

HEALTH CARE AND SERVICES ARE NOT DELIVERED

HEALTH CARE SHOULD BE FREE FOR EVERYONE AND SHOULD HELP EVERYONE TAKE CARE OF WHATEVER HEALTH PROBLEMS THAT MAY ARISE. THE LACK OF UNIVERSAL HEALTH CARE IS A BLIGHT ON OUR WHOLE SOCIETY.

HEALTH CONDITION, INFLUENZA AND DANGEROUS DRIVING.

HEALTH COSTS

HEALTH INSURANCE

HEALTH INSURANCE AND DOCTORS

HEALTH INSURANCE COVERAGE

HEALTH INSURANCE STABILITY

HEALTH LITERACY

HEALTH PLANS AFFECTS MOST PEOPLE NEED BETTER HEALTH PLANS. OBESITY IN AMERICA

HEART

HEART CONDITIONS

HEART DECEASE

HEART DISEASE

HEART DISEASE

HEART DISEASE

HEART DISEASE

HEART DISEASE

HEART DISEASE

HEART DISEASE DIABETES

HEART ISSUES

HEART ISSUES AND BACK ISSUES

HEP C

HEROIN

HEROIN

HEROIN ADDICTION AND ADDICTION IN GENERAL

HIGH BLOOD PRESSURE

HIGH BLOOD PRESSURE HIGH CHOLESTEROL

HIGH BLOOD PRESSURE, DIABETES

HIGH CONCENTRATION OF CANCER AND AUTISM DIAGNOSIS

HIGH COST OF HEALTH CARE

HIGH DEDUCTIBLES ON A LOT OF POLICIES KEEPING PEOPLE FROM HAVING THINGS DONE DUE TO COST.

HIGH HEALTH CARE COST, AND NUTRITION

HIGH INSURANCE COSTS

HIGH TAXES

HIV

HIV

HOMELESS

HOMELESSNESS

HOMELESSNESS

HOMELESSNESS

HOMELESSNESS

HOMELESSNESS, POVERTY

HOSPITALS

HOW EXPENSIVE EVERYTHING COSTS

HUNGER

HUNGER AND HOMELESSNESS

HUNGER FOOD INSECURITY.

HYDRATION

I AM CONCERNED ABOUT FORCED VACCINATION FOR MINORS AND I FEEL IT IS DANGEROUS FOR CHILDREN AND I BELIEVE THERE IS A PUSH AND THEY ARE NOT [in] DANGER FROM THE VIRUS BUT MORE SO FROM THE VACCINE.

I AM NOT AWARE OF ANY

I AM SCARED THAT I WILL GET COVID OR ONE OF MY FAMILY MEMBERS

I BELIEVE IT'S ONLY COVID AND THE SPREAD OF IT AND LACK OF VACCINES

I BELIEVE IT'S THE CONFUSION OF WEARING MASK I THOUGHT THAT IF YOU WERE VACCINATED YOU WOULDN'T GET COVID-19 BUT IT JUST HELPS THE SYMPTOMS IN MY LOCAL COMMUNITY COVID IS DECREASING MORE PEOPLE ARE GETTING VACCINATED

I BELIEVE MY COMMUNITY IS PRETTY HEALTHY, I JUST WORRY ABOUT THE OPIOID CRISIS

I BELIEVE THAT SENIORS NEED TO HAVE REASONABLY ACCESSIBLE AND AFFORDABLE HEALTH CARE.

I DON'T HAVE ANY CONCERN

I DON'T HAVE ANY HEALTH-RELATED ISSUES AT THE MOMENT.

I DON'T KNOW BOUT ANYTHING

I DON'T KNOW IF ITS BOTHERING ANYONE, BUT THERE'S A LOT OF POLLUTION AROUND HERE FROM OLD PLANTS, AND THE WATER IS POISONED AS WELL

I DON'T KNOW OF ANY

I DON'T KNOW OF ANYTHING OF THAT MAJOR PROBLEM

I DON'T THINK THERE ARE ANY

I DON'T THINK THERE ARE ANY MAJOR HEALTH RELATED ISSUE BESIDE COVID

I GUESS AROUND HERE PEOPLE HERE THAT ARE STRUGGLING WITH GETTING FOOD, I THINK THERE'S ALSO PEOPLE WHO HAVE MENTAL HEALTH ISSUES THAT AREN'T GETTING THE HELP THEY NEED

I GUESS I WOULD THINK THE WATER IS THE MOST IMPORTANT THE WATER PURIFICATION

I GUESS IT WOULD MENTAL HEALTH

I GUESS THE AGING POPULATION

I GUESS THE FLU

I GUESS THE FLU

I HAVE ABSOLUTELY NO IDEA WHAT THIS WOULD BE

I JUST THINK RECYCLING

I LIVE IN A SMALL COMMUNITY THAT IS SO CAUGHT IN TRADITION THAT IT'S KEEPING THE COMMUNITY AND BUSINESS FROM PROGRESSING

I REALLY CANT SAY ANYTHING BESIDE COVID

I REALLY DON'T KNOW. I THINK EVERYONE HAS BEEN SO CONSUMED WITH MASKING AS FAR AS COVID I REALLY DON'T GIVE THAT MUCH CONSIDERATION. THERE'S MENTAL HEALTH AND PSYCHOLOGICAL HEALTH AS A SOCIAL WORKER I LOOK INTO EMOTION ASPECTS

I SAY AIR QUALITY

I THINK IT HAS TO DO WITH SIGHT. MANY PEOPLE NEED GLASSES OR CONTACT LENSES.

I THINK ITS MENTAL HEALTH

I THINK MOST PEOPLE IS OVERWEIGHT, WEIGHT ISSUE

I THINK NEW JERSEY HAS HIGHER RATE OF CANCER

I THINK POVERTY AND INJUSTICE IS A CURRENT ISSUE.

I THINK THAT HEART DISEASE IS PROBABLY THE BIGGEST ISSUE

I THINK THE INTERFACE BETWEEN VEHICLES AND PEOPLE IS A REAL PROBLEM

I THINK THE LOCAL COMMUNITY IS GOOD

I THINK THE TOP HEALTH RELATED ISSUE FACING MY LOCAL COMMUNITY RIGHT NOW ASIDE FROM COVID 19 IS THE HEALTH INSURANCE MANY PEOPLE CAN'T AFFORD ONE

I THINK THERE IS A SIGNIFICANT MENTAL HEALTH CRISIS IN OUR ENTIRE COUNTRY

I THINK TOO MANY PEOPLE ARE MAKING A BIGGER DEAL ABOUT THIS THAN THEY SHOULD.

I WILL SAY, HEALTH ISSUES DOWN HERE IS IN AN EXCELLENT CONDITION. COSTS ARE EXORBITANTLY HIGH THOUGH.

I WOULD HAVE NO IDEA. IT IS A VERY SMALL TOWN.

I WOULD HAVE TO SAY CATCHING A COLD

I WOULD HAVE TO SAY THE AFFECT FROM DRUG USE. SO MANY KIDS AND OLDER PEOPLE , MALE AND FEMALE ARE SUFFERING THE AFFECTS OF DRUGS AND DRUG WITHDRAWAL SYMPTOMS WITH NO END IN SITE. IT IS DEVASTATING.

I WOULD PROBABLY SAY WATER THE WATER IS FREE OF LEAD, THE HOUSING… WE HAVE HEARD OF BAD THINGS GETTING INTO THE DRINKING WATER.

I WOULD SAY ASTHMA AND HIGH BLOOD PRESSURE CAUSE OF THE ENVIRONMENT FOR ASTHMA AND HIGH BLOOD PRESSURE FOR POOR DIETS.

I WOULD SAY AVAILABILITY OF COMMUNICATION, HEALTH DEPARTMENT, GOOD INSURANCE PROGRAMS. THE AVAILABILITY OF HEALTH CARE FOR EVERYONE. I REALLY FEEL THAT IN OUR COUNTRY MEDICARE HAS BEEN GOOD TO ME AND MY EMPLOYERS. I'VE GOT A GREAT INSURANCE PROGRAM AND PRESCRIPTION PROGRAM AND IT CERTAINLY MAKES A DIFFERENCE.

I WOULD SAY GENERALLY OBESITY

I WOULD SAY HOUSING

I WOULD SAY IT WILL BE QUALIFICATIONS FOR THE STATE NEW JERSEY INSURANCE.

I WOULD SAY IT'S THE TAXES THAT AFFECT MY COMMUNITY THE MOST.

I WOULD SAY MENTAL HEALTH

I WOULD SAY MENTAL HEALTH

I WOULD SAY MENTAL HEALTH IS SOME THING THAT MY COMMUNITY IS STRUGGLING WITH AS A TIGHTKNIT COMMUNITY THAT HAD FELT MORE ISOLATED DURING COVID AS WELL AS THE IMPACT ON THE SCHOOL SYSTEM.

I WOULD SAY PEOPLE GETTING GOOD FOOD TO EAT EVERY DAY

I WOULD SAY PRETTY MUCH SEASONAL CALLS AND FLU IS THE PRIMARY ILLNESS THAT AFFECTS MY COMMUNITY

I WOULD SAY PROBABLY OBESITY.

I WOULD SAY SUBSTANCE ABUSE AND MENTAL HEALTH AND NOT TOO MUCH OF A SHOT OFF FROM COVID AND JUST A SIDE EFFECT OF HAVING TO BE IN YOUR HOUSE AND BE IN YOUR HOME. AND A LOT OF PEOPLE ARE AT HOME

I WOULD SAY THAT ITS RISKY TO DRIVE OTHER THAN THAT I DON'T KNOW.

I WOULD SAY THE LACK OF GOOD MEDICAL INFORMATION AND INSURANCE.

I WOULD SAY UNEQUIVOCALLY IF IT'S NOT COVID, THE DEGRADED INFRASTRUCTURE OF BERGEN COUNTY AND NEW JERSEY AND THE COUNTRY

I WOULD THINK BESIDES COVID IT IS AFFORDABLE HEALTH CARE FOR PEOPLE WHO ARE WORKING.

I'D PROBABLY SAY ISSUES RELATED TO SMOKING

I'D SAY DIABETICS IN MY AREA.

I'D SAY MENTAL HEALTH

I'M GOING TO SAY DIABETES BECAUSE IT SEEMS THAT EVERYONE I KNOW INCLUDING MYSELF HAS DIABETES

I'M UNSURE OF ANY, MY COMMUNITY HAS BEEN PRETTY GOOD ABOUT VACCINES AND REGULATIONS

IF THEY START TO INSTALL THE WIND TURBINES, IT WILL BE NOISE POLLUTION.

IM A REGISTERED NURSE, SO ITS JUST THE COVID

IM PRO CHOICE AND I THINK THAT'S THE MOST IMPORTANT HEALTH ISSUE

IN MY OPINION STRESS IS ONE OF THE BIGGEST ISSUES EFFECTING EVERYDAY HEALTH.

INACTIVITY

INCOME

INCOME/INSURANCE FOR HEALTH CARE

INFANT MORTALITY IN CAMDEN.

INFLUENZA

INFRASTRUCTURE

INSUFFICIENT NUTRITION

INSURANCE COVERAGE

ISOLATION

IT HAS IMPACTED ALL OF US. IT KEPT OUR PARENTS AND GRANDPARENTS INSIDE AND QUARANTINED EVERYONE FROM SEEING FAMILY. WE COULDN'T DO THE STUFF WE USED TO BECAUSE OF COVID.

ITS NOT COVID ITSELF, ITS THE LOCKDOWNS AND RESTRICTIONS. THEY JUST USE COVID AS AN EXCUSE.

JOB PROBLEMS , MONEY ISSUES, JOB ISSUES

JOBS, BEING HUNGRY, HOMELESS WOMEN BEING BEATEN.

JUST COVID

KILLINGS OF BLACK PEOPLE BY COPS

LACK OF AFFORDABLE HEALTH CARE

LACK OF AFFORDABLE HEALTH CARE

LACK OF AWARENESS OF MANY ABOUT THESE DISEASES

LACK OF COMMON SENSE

LACK OF HEALTH CARE

LACK OF HEALTH INSURANCE AND PRIMARY HEATH CARE

LACK OF HIGH QUALITY MEDICAL CARE

LACK OF IMMUNIZATION AND VACCINES AMONGST THE POPULATION

LACK OF IMMUNIZATIONS AMONG RELIGIOUS SECTORS

LACK OF KNOWLEDGE ABOUT HEALTH ISSUES

LACK OF MEDICAL INSURANCE.

LACK OF NUTRITIOUS, ORGANIC FOODS

LACK OF PROFESSIONAL SPECIALTIES

LACK OF PUBLIC MEDICINE

LACK OF SINGLE PAYER INS

LIKE DEMENTIA

LIMITED CAPACITY FOR HOSPITAL

LOCAL BUSINESS SUFFERING

LOT OF PEOPLE ARE DIABETIC AND THE FLU

LOW INCOME

LOW MORAL

LUNG ISSUES

MAIN ISSUES WELFARE FOR PROFIT MEDICAL INDUSTRY ESPECIALLY FOR PROFIT DRUGS DEMOCRATIC SOCIALISM, HEALTH CARE

MARIJUANA LEGALIZATION

MASKING UP AN VACCINES

MASS MANDATE

MASS OBESITY

MAYBE ANTICIPATING THE FLU

MAYBE JUST EATING HEALTHY AND WORKING OUT

MAYBE THE FLU OR OBESITY DIABETES I DON'T REALLY KNOW

MEALS HEALTHY EATING IN SCHOOLS

MEDICAID

MEDICAL PROTECTION AND MEDICAL INSURANCE

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH

MENTAL HEALTH - SUCH AS LEARNING DISORDERS AND DEPRESSION.

MENTAL HEALTH AND ACCESS TO AFFORDABLE HEALTH CARE

MENTAL HEALTH AND DIABETES

MENTAL HEALTH AND THE OPIOID EPIDEMIC

MENTAL HEALTH CRISIS

MENTAL HEALTH DECLINE

MENTAL HEALTH IN GENERAL AND ADDICTION

MENTAL HEALTH IS HUGE DUE TO RESTRICTIONS IN SOCIALIZATION

MENTAL HEALTH IS THE BIG THING. SO MANY PEOPLE ARE DEPRESSED FROM THE PANDEMIC.

MENTAL HEALTH ISSUES

MENTAL HEALTH ISSUES BECAUSE OF THE LOCKDOWNS. PEOPLE RUNNING OUT OF MONEY BEING ANGRY AND DEPRESSED

MENTAL HEALTH ISSUES NOT BEING ADDRESSED

MENTAL HEALTH LACK OF INCOME FEARS OF NOT BEING ABLE TO KEEP THE HOME FEED THE FAMILY HANDLE MEDICAL ISSUES

MENTAL HEALTH STRESS RELATED

MENTAL HEALTH. COPING

MENTAL ILLNESS

MENTAL ILLNESS

MENTAL ILLNESS

MENTAL ILLNESS HAVE INCREASED

MENTAL ILLNESS, AND MENTAL HEALTH ISSUES ARE THE SECOND GREATEST CONCERN IN MY COMMUNITY.

MENTALLY UNSTABLE PEOPLE

MIGRAINES, HEADACHES, FLU

MORE ON HEALTH INSURANCE NOT COVERING NEEDED SERVICES

MOSTLY CANCER AND HIV. AS WELL AS BLACK FUNGUS

MY ISSUES WITH THE DOCTORS THEY DON'T EXPLAIN WHAT'S GOING ON WITH YOU THEY JUST TELL YOU SO YOU [are] STILL FACING UNCERTAINTY

MY SKIN IS REALLY BAD

MY TOWN HAS BOTH YOUNG AND OLD. PROBABLY THINGS THAT HAPPEN WHEN YOU GET OLDER.

NARCOTICS

NEED FOR A CLOSER VA CLINIC FOR WHITING VETERANS

NO

NO

NO ISSUES.. ALL ARE TAKING COVID-19 PRECAUTIONS.

NO ONE THING

NO TOP-RATED HEALTH ISSUES IN MY COMMUNITY RIGHT NOW PLEASE

NO VACCINE MANDATE TO ENTER RESTAURANTS, ETC. AND NO USE OF MASK IN PUBLIC SPACES SUCH AS SUPERMARKETS

NONE

NONE

NONE

NONE I HAVE TO DO

NONE THAT I KNOW OF

NOT BEING ABLE TO GO TO THE GYM

NOT ENOUGH LOVE

NOT ENOUGH MEDICAL MARIJUANA FACILITIES IN THE AREA

NOT FAMILIAR WITH ANY PARTICULAR ONE, I DON'T KNOW WHAT TO TELL YA.

NOT HAVING INSURANCE TO TAKE CARE OF THEMSELVES. DENTAL VISION MEDICAL

NOT MANY PEOPLE ARE COMING OUT

NOT SURE

NOT TO WEAR MUZZLES PERMANENTLY AND CAREFUL PROMISE TO ADHERE TO QUARANTINE, SOCIAL SPACING AND POOR CHOICE OF FOOD AND NUTRITION

NOTHING

NOTHING

NOTHING IN MY LOCAL COMMUNITY

NOTHING THAT I CAN THINK OF

NOTHING. EVERYTHING IS WORKING SMOOTHLY HERE AND I DON'T NEED ANYTHING SPECIAL

OBESITY

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OBESITY

OBESITY BECAUSE EVERYONE IS LAZY

OBESITY AND OPIATES

OBESITY AND POOR NUTRITION CHOICES.

OBESITY ON YOUNG KIDS

OBESITY, ACCESS TO AFFORDABLE HEALTHY FOOD

OBESITY, ADDICTION, DIABETES

OBESITY, HEART DISEASE

OBESITY, LACK OF PHYSICAL ACTIVITY, AND THE DISGUSTING UNHEALTHFUL FOODS BEING SERVED IN SCHOOLS

OBESITY. ITS S HUGE PROBLEM BECAUSE OBESITY CAN LEAD TO DIABETES, HEART DISEASE AND OTHER HEALTH CONDITIONS.

ON THE JOB MARKET

OPEN SPACES, PARKS, ABILITY TO GO AND FIND OPEN SPACES WITHOUT TRAFFIC, CROWDS, AND HOUSES. PROBABLY BE RELATED TO MENTAL HEALTH.

OPIATE ABUSE

OPIOID ADDICTION

OPIOID ADDICTION AND HIGH LIVING PRICES. TAXES, UTILITIES, HOUSING PRICES.

OPIOID CRISIS

OPIOIDS

OUTSIDE OF COVID I DON'T REALLY HAVE ONE. NOT REALLY

OVER-DEVELOPMENT... AS WELL AS AFFORDABLE, EFFECTIVE HEALTH INSURANCE. COST OF LIVING.

OVERDOSE ON PILLS OR DRUGS

OVERDOSES

OVERPOPULATION

OVERWEIGHT

PAID LEAVE TO TAKE CARE OF SICK FAMILY MEMBERS. THE PRICE OF HEALTH INSURANCE.

PARENTS SENDING THEIR CHILDREN TO SCHOOL SICK AND INFECTING OTHER STUDENTS AND SCHOOL STAFF

PAYING FOR HEALTH CARE

PEOPLE ARE GETTING TOO OLD

PEOPLE ARE MENTALLY AFFECTED AND THIS WILL AFFECT THEIR HEALTH

PEOPLE ARE STILL HAVING TROUBLE BEING ABLE TO AFFORD ADEQUATE HEALTH CARE.

PEOPLE CANNOT AFFORD TO LIVE

PEOPLE DON'T WANT TO GO BACK TO WORK. THE GOVERNMENT IS PAYING THEM TO STAY HOME.

PEOPLE NEEDING FOOD

PEOPLE NOT BEING VACCINATED

PEOPLE NOT FOLLOWING HEALTH PROTOCOLS LIKE WEARING MASKS FOR PROTECTION WHEN THEY ARE SICK AND OUT AND ABOUT. PEOPLE SNEEZING AND COUGHING AND NOT COVERING THEIR MOUTH WHICH IS DISGUSTING

PEOPLE NOT WANTING TO GET VACCINATED

PEOPLE NOT WEARING MASKS.

PEOPLE PUT OFF GOING TO THEIR DOCTORS FOR SO LONG THAT IT IS VIRTUALLY IMPOSSIBLE TO GET AN APPOINTMENT WITH ANY

PEOPLE REFUSING TO WEAR MASKS AND NOT COMPLYING WITH SOCIAL DISTANCING

PEOPLE STILL REFUSING TO WEAR MASKS. PARENTS SENDING STUDENTS TO SCHOOL SICK.

PEOPLE WORRYING ABOUT GETTING VACCINATED AS SOON AS POSSIBLE. TO PROTECT THEM SELVES AND OTHERS.

PEOPLE'S WEIGHT

PESTICIDES THAT ARE USED TO KILL MOSQUITOES.

POLICE ISSUES AND SHOOTINGS

POLICE REFORM

POLITICAL IGNORANCE

POLLUTED RIVER

POLLUTION

POLLUTION

POLLUTION

POLLUTION

POLLUTION

POLLUTION

POLLUTION

POLLUTION

POLLUTION

POLLUTION AND AIR

POLLUTION, BECAUSE WE LIVE DIRECTLY NEXT TO A DUPONT PLANT.

POOR HEALTH CARE AND HEALTH AWARENESS

POOR INFRASTRUCTURE, MAINLY SEWER AND CLEAN WATER.

POOR LIVING ENVIRONMENT

POOR NUTRITION

POOR NUTRITION POOR FOOD CHOICES

POVERTY

POVERTY

POVERTY AND MONEY

POVERTY INFLATION

POVERTY, FOOD SCARCITY

POVERTY, HOMELESSNESS IF WE ARE TALKING ABOUT THE ENTIRE COUNTY

PRESCRIPTION COSTS IS TOO HIGH

PRESCRIPTION MEDICINE

PRESCRIPTION PRICES, ACCESS TO GOOD CARE

PRESCRIPTIONS DRUGS AND COST OF THEM THE HIGH COST

PREVENTATIVE HEALTH

PRICE FOR HEALTH CARE

PRICE OF FOOD, GAS, UTILITIES, EVERYTHING IS GOING UP IN PRICE

PROBABLY DRINKING OR SMOKING

PROBABLY FLU

PROBABLY HIGH BLOOD PRESSURE

PROBABLY MENTAL HEALTH

PROBABLY MENTAL ILLNESS

PROBABLY NOT ENOUGH HEALTH CARE COVERAGE. YOU STILL HAVE TO PAY OUT OF POCKET FOR A LOT OF THINGS.

PROBABLY OBESITY AND OTHER ISSUES RELATED TO CONSUMING AN UNHEALTHY DIET.

PROBABLY OBESITY DUE [to] INCORRECT GOVERNMENT REGULATIONS

PROBABLY OBESITY OR OPIOID ADDICTION.

PROBABLY OBESITY. I SEE MANY OVERWEIGHT PEOPLE AND SOME OF THEM ARE VERY YOUNG. THIS NEEDS TO BE CORRECTED BEFORE THESE YOUNG PEOPLE GET OLDER AND THE WEIGHT & REALLY OUT OF HAND.

PROBABLY OF PREVENTATIVE MEDICINE

PROBABLY THE HEART.. HEART ATTACKS AND STUFF.

PROBABLY WOULD BE OBESITY

PROBLEMS IN HOSPITALS (ROBERT WOOD)

PROPER COVID AWARENESS

QUALITY OF FOOD

RACISM

RACISM

RACISM AND DISCRIMINATION

RAMPANT MARXISM REMOVING ALL RIGHTS FROM CITIZENS AND FORCING THEM TO LIVE UNDER TOTALITARIAN RULE.

REGULAR FLU SHOTS

RESEARCH INDICATES THAT STAYING PHYSICALLY ACTIVE CAN HELP PREVENT OR DELAY CERTAIN DISEASES, INCLUDING SOME CANCERS, HEART DISEASE AND DIABETES, AND ALSO RELIEVE DEPRESSION AND IMPROVE MOOD. INACTIVITY OFTEN ACCOMPANIES ADVANCING AGE, BUT IT DOESN'T HAVE TO. CHECK WITH YOUR LOCAL CHURCHES OR SYNAGOGUES,

SENIOR CENTERS, AND SHOPPING MALLS FOR EXERCISE AND WALKING PROGRAMS. LIKE EXERCISE, YOUR EATING HABITS ARE OFTEN NOT GOOD IF YOU LIVE AND EAT ALONE

RESPIRATORY ISSUES

RIGHT NOW NOTHING YET

RISKS OF ADDICTION AND OVERDOSE. WEALTH AND EQUALITY AND DISPARITY.

SAFETY

SAFETY

SERIOUS WATER PROBLEM

SHORTAGE OF SUPPLIES

SLEEP APNEA

SLIMMING DOWN

SMOKING AND WEED

SMOKING RELATED DISEASES AND DIABETES/WEIGHT RELATED DISEASES

SMOKING. A LOT OF SMOKING.

SOCIAL SECURITY BENEFITS

SOME PEOPLE DON'T HAVE PROPER HEALTH INSURANCE

SPECIAL NEEDS SERVICES

SPEEDING

SPIRITUAL IMPOVERISHMENT

STAYING PROTECTED FROM OTHERS

STDS

STORM WATER MANAGEMENT, OR THE LACK OF IT

STRESS AND ANXIETY

STRESS FORM TAXES

STRESS. STRESS HAS TAKEN A HUGE TOLL ON THE LOCAL COMMUNITY. THE ECONOMY IS NOT DOING WELL AND RENT/MORTGAGES HAVE BECOME ALMOST IMPOSSIBLE TO OBTAIN/PAY

STRESS/ANXIETY

STUPIDITY

SUBSTANCE ABUSE/ADDICTION

SUBSTANCES ABUSE

SUGAR ADDED IN ALMOST ALL PRODUCTS

SUICIDE

SUICIDE RATES DEPRESSION

SYSTEMIC RACISM

TAP WATER

TAXES

TAXES

TAXES

TAXES AND CRIME

TEENS SMOKING AND GETTING SICK

TERRIBLE SANITARY SEWER SYSTEM

THAT THE SOCIAL SECURITY BENEFITS NEED TO BE BETTER FOR OLDER PEOPLE.

THE AFGHANISTAN [refugees] LIVING IN THE MILITARY BASE I FREQUENTLY WALK THRU I LIVE THAT CLOSE. THEY HAD A MEASLES OUTBREAK

THE BIGGEST ISSUE IS NO ONE GETTING VACCINATED OR WEARING MASKS

THE BIGGEST ISSUE IS THE AFFORDABILITY OF HEALTH CARE.

THE COLD IS BRINGING SICKNESS TO EVERYONE AND ITS SPREADING

THE COMMON FLU AND OTHER ILLNESSES RELATED TO THE COLD WEATHER.

THE COMMUNITY OVERCROWDING, TO MANY PEOPLE IN A CONFINED AREA

THE COST INSURANCE

THE COST OF HEALTH CARE

THE COST OF HEALTH CARE AND A LACK OF MENTAL HEALTH INSTITUTIONS

THE COST OF HEALTH CARE PREMIUMS

THE COST OF PRESCRIPTIONS

THE CRIMINALS THAT ARE OUT. STEALING & KILLING INNOCENT PEOPLE

THE DIRECTION THAT THE COMMUNITY IS TAKING US TO

THE DISEASE OF KIDNEY WHICH PEOPLE ARE REALLY SUFFERING FROM IT WHICH IS ALSO CAUSE BY THE POOR NUTRITION AND EXCESSIVE ALCOHOL

THE ECONOMY, NOT ENOUGH PEOPLE WORKING, THE GROWING DIFFERENCE BETWEEN RICH AND POOR, INFLATION. THESE LEAD TO MENTAL HEALTH AND OTHER CONDITIONS IN LESS WEALTHY POPULATIONS. HIGHLY STRESSED PEOPLE ARE TYPICALLY MORE HIGH-STRUNG, LESS HAPPY, NOT AS NICE TO THEIR NEIGHBORS, AND MORE QUICKLY TO SNAP.

THE FACT THAT MOST PEOPLE IN MY AREA DON'T HAVE HEALTH INSURANCE AND THE COST OUT OF POCKET IS RIDICULOUS.

THE FACT THAT THEY ARE MANDATING VACCINES IS JUST PLAIN UN AMERICAN AND I FEEL LIKE THAT IS THE GREATEST HEALTH RISK

THE FEAR OF ANOTHER VIRUS TO COME AND PEOPLE NOT FEELING SAFE WITH OR WITHOUT A MASK.

THE FLU

THE FLU

THE FLU

THE FLU

THE FLU

THE FLU

THE FLU

THE FLU

THE FLU

THE FLU

THE FLU GOING AROUND AMONGST OTHER THINGS. I'M AFRAID TO EVEN GO OUT

THE FLU HAS BEEN GOING AROUND PRETTY FAST. PEOPLE STARTED STAYING HOME MORE.

THE FLU IS GOING AROUND BUT DEFINITELY COVID 19

THE FLU IS ONE OF THE OVERALL HEALTH ISSUES THAT PLAGUE MY COMMUNITY

THE FLU, A LOT OF PEOPLE HAVEN'T GOTTEN THEIR FLU SHOT. A LOT OF PEOPLE ARE WRAPPED UP ABOUT COVID-19

THE FLUE SEASON

THE GOVERNMENT FORCING US TO WEAR MASKS

THE GOVERNOR

THE GROSS OVERPRICING OF MEDICAL CARE AND PRESCRIPTIONS. PEOPLE ARE GOING WITHOUT MEDICAL CARE BECAUSE OF THE COST.

THE HEALTH CARE COST

THE HEALTH CARE SYSTEM, ITSELF, IS HORRIBLE; POOR CARE.

THE HIGH COST OF HEALTH CARE IN THE US, EVEN AMONG THE INSURED, AND SHOCKING RATE OF MEDICAL BANKRUPTCIES IN THE US (530,000 ANNUALLY) EVEN AMONG THE INSURED.

THE HIGH COST OF HEALTH INSURANCE.

THE LACK OF ANY MY TAXES GOING INTO SOCIAL INFRASTRUCTURE

THE LACK OF UNIVERSAL HEALTH CARE. BECAUSE THERE IS NO UNIVERSAL HEALTH CARE AND WITH PRICE OF PREMIUM HEALTH CARE IN THE UNITED STATES MAKE IT NON-AFFORDABLE. AND WITH THE PRICES OF EVERYTHING GOING UP IT WILL MAKE IT HARDER TO AFFORD IN THE FUTURE.

THE LOCAL HOSPITAL IS SUBSTANDARD

THE MAIN HEALTH ISSUES THE MOST IMPORTANT IS THE MENTAL HEALTH AND EARLY SCREENING

THE MOST IMPORTANT PROBLEM AS RELATED TO HEALTH AT THE PRESENT TIME IS THE LACK OF AWARENESS AMONG SOME PEOPLE AND THE LACK OF COMMITMENT TO WEARING A MASK AND MAINTAINING SOCIAL DISTANCING

THE OPIOID EPIDEMIC

THE PANDEMIC THAT WE ARE FACING IS SERIOUS DANGEROUS

THE POLITICAL DIVISION AND HOW IT AFFECTS JUST ABOUT EVERYTHING

THE PRICE OF MEDICINE

THE PSYCHOLOGICAL EFFECTS OF COVID

THE SEASONAL FLU.

THE SERVICE COMMUNITY HERE HAS MANY WORRIES AND CHARACTERISTICS AND… I RATHER GO SOMEWHERE ELSE AND DON'T WANT TO USE MEDICAL CARE AND FACILITIES HERE

THE SPIKE IN CARDIO WHATEVER

THE STUPIDITY OF THE PEOPLE HERE

THE TOP HEALTH RELATED ISSUE FACING MY LOCAL COMMUNITY RIGHT NOW IS THE FLU. IT'S EASY TO CATCH A COLD AND FOR IT TO TURN INTO THE FLU ESPECIALLY IN THIS COLD WEATHER

THE TOP HEALTH RELATED ISSUE IS ACCESS TO HIGH QUALITY HEALTH CARE

THE TOP HEALTH RELATED ISSUE IS NOT HAVING ENOUGH MONEY TO PAY FOR GOOD FOODS AND MEDICAL CARE AS WELL AS HAVING TO STRESS OVER LOW PAYING JOBS AND HAVING TO GO TO AN EARLY GRAVE

THE TOP HEALTH RELATED ISSUES IN MY COMMUNITY ARE OPIOID ADDICTIONS.

THE TOP HEALTH-RELATED ISSUE IS THE LACK OF MEDICAL RESOURCES THAT DON'T COST AN ARM AND A LEG. THE COMMUNITY SUFFERS WHEN PEOPLE CANNOT PAY THEIR DEDUCTIBLES, LET ALONE FOR A HOSPITAL STAY WHICH WE SAW WITH THE EMERGENCE OF COVID.

THE TOP ISSUE IS PEOPLE NOT WEARING THEIR MASKS. NOT ONLY THAT BUT THEY ALSO TOUCH EVERYTHING AND PUT IT BACK WITHOUT ACTUALLY CLEANING THEIR HANDS.

THE TOP ISSUE WOULD BE THE HOMELESS, THEY ARE SICK DON'T SHOWER AND HAVE MANY DISEASES

THE USE OF MASKING ITS HEALTHY PEOPLE LIVING IN A GROUND. THE COVID BROUGHT A MASK, MORE TOXINS IN OUR FOOD, UPSET LEARNING THAT FLUORIDE, [chem] TRAILS VERY BAD. FOOD PRODUCERS LIKE PEPSI AND GATORADE

THE VIRUS

THE VIRUS HAS CALMED DOWN A LOT

THE WATER

THE WEATHER IS CHANGING SO COLD AND FLU ARE ALWAYS PRESENT THIS TIME OF YEAR

THE WINDMILLS, AND FLOODING OF INFRASTRUCTURE.

THE WOKE CULTURE

THERE ARE A LOT OF ISSUES AROUND AGING

THERE ARE A LOT OF PEOPLE OUTSIDE I DON'T KNOW IF THERE ARE HOMELESS OR NOT

THERE ARE MANY PEOPLE WHO AROUND HERE WILL NOT TAKE THEIR SHOTS.

THERE IS A STOMACH AND COLD GOING AROUND THAT IS CONTAGIOUS. OTHER THAN A LACK OF HEALTH CARE, NOTHING ELSE.

THERE IS NOT A HUGE OUTBREAK BUT WE ALL STILL SHOULD WEAR MASK WHEN GOING PLACES AND STAY 6 FT AWAY FROM EACH OTHER

THERE REALLY ARE NONE. POSSIBLY THE START OF FLU SEASON.

THIS VACCINE MANDATE SHOULD BE MANDATORY SO WE CAN ALL LIVE

TOBACCO MENTAL HEALTH ACCESS TO HEALTH CARE SUBSTANCE ABUSE

TOO MANY FAST FOODS

TOO MANY PEOPLE RELY ON GOVERNMENT FOR THEIR HEALTH CARE.

TWO THINGS: EVERYBODY'S IN EVERYBODY ELSE'S BUSINESS AND DEPRESSION

UMM GEE THAT A TOUGH ONE. NUTRITION, EAT BETTER FEEL BETTER

UNDER STAFFING IN HOSPITALS, DUE TO INADEQUATE PAY AND LACK OF SUPPORT FOR STAFF SAFETY.

UNDIAGNOSED MENTAL HEALTH RELATED ISSUES.

UNSUPPORTED CHILDREN

VACCINATIONS

VACCINE MANDATES

VERY FEW. ITS NOT THAT MANY FACING OUR COMMUNITY. WE ARE PRETTY HEALTHY

VICTIM MENTALITY OR I CAN DO WHATEVER I WANT COUPLED WITH THE GOVERNMENT WILL TAKE CARE OF ME. LACK OF INDIVIDUAL RESPONSIBILITY AND ACCOUNTABILITY.

VIOLENCE

VIOLENCE

VIRUS

WATCH OUT FOR THIS PANDEMIC

WATER

WATER QUALITY

WATER QUALITY

WATER QUALITY

WATER QUALITY

WATER QUALITY

WE DON'T HAVE ANY.

WE HAVE A WATER ISSUE WITH CERTAIN TOXINS

WEARING MASKS AND BACTERIAL INFECTIONS RELATED TO CARBON DIOXIDE.

WELL COVID IS NUMBER 1 THAT'S NUMBER 1 IN MY OPINION.

WELL WATER QUALITY

WORK AND CARING FOR MY CHILDREN

WORRIED ABOUT THE NEW VARIANT THAT JUST CAME ABOUT.

WOULDN'T KNOW WHAT TO TELL YA

UPH1. In just a few words, how would you define the term "public health?" If you're not sure, just say so.

A DEPARTMENT THAT PERFORMS INSPECTIONS OF FOOD ESTABLISHMENTS

A GENERAL VIEWS OR CONCERN OF PHYSICAL CONDITIONS AND EMOTION STATE

A GOVERNMENTS RESPONSIBILITY TO MAKE THAT FOOD AND SAFETY REGULATIONS ARE ENFORCED.

A HEALTH ISSUE THAT EFFECTS THE WHOLE COMMUNITY, LIKE COVID

A HEALTHY DIET, ATTENTION TO BODY IMMUNITY, PREVENTION AND STAY AWAY FROM DISEASES

A JOKE

A POLICY THAT HAS ANY BEARING WELL-BEING OF THE COMMUNITY OR ITS MEMBERS

ABOUT THE HEALTH OF THE COMMUNITY

ABSENCE OF TREATMENT OF EPIDEMICS

ACCESS IN MEDICAL CARE

ACCESS TO AFFORDABLE MEDICAL CARE FOR EVERYBODY

ACCESS TO HEALTH CARE, PRENATAL CARE, THAT'S WHAT I WOULD SAY.

ACCESS TO PARKS AND OTHER PUBLIC RECREATIONAL AREAS, HEALTHFUL FOODS FOR STUDENTS, EDUCATION ABOUT RESOURCES IN THE COMMUNITY

ACTIVITIES ORGANIZED BY PUBLIC ADMINISTRATIONS TO PREVENT DISEASE AS WELL AS TO PROTECT, PROMOTE AND RECOVER THE HEALTH OF THE PEOPLE IN THE COMMUNITY

ACTIVITIES THAT PERTAIN TO KEEPING THE COMMUNITY AND MONITORING ITS HEALTH.

ADVOCATING EQUAL HEALTH AND WELL-BEING

ALL OF THE ACTIVITIES THAT GO INTO SECURING THE HEALTH OF A "COMMUNITY"

ALL PEOPLE AND THEIR PHYSICAL MENTAL WELL-BEING.

ANYONE CAN GET HELP FROM THE PUBLIC

ANYONE HAS ABILITY TO RECEIVE HEALTH CARE

ANYTHING CONCERNING THE PREVENTION, TREATMENT, AND CURE OF DISEASES AND DISORDERS

ANYTHING THAT AFFECTS THE WELFARE LIFESPAN ETC. OF THE WHOLE COMMUNITY

ANYTHING THAT CAN BE TRANSMITTED OR SPREAD BY CASUAL CONTACT. AND IF IT IS ISOLATED TO A CERTAIN AREA

ANYTHING THAT EFFECTS THE WHOLE PUBLIC AS A WHOLE

ANYTHING THAT IMPACTS THE GREATER POPULATION

ANYTHING THAT IMPACTS THE WHOLE COMMUNITY IN TERMS OF HEALTH

ANYTHING THAT IS GOING TO AFFECT THE COMMUNITY

ANYTHING THAT WOULD HAVE AN IMPACT ON THE HEALTH OF INDIVIDUAL MEMBERS OF A COMMUNITY.

ANYTHING TO DO WITH ASSISTANCE OR IMPROVEMENT OF A COMMUNITY HEALTH

AS BEING THE LEVEL OF BEING FREE FROM CONCERN AND DISEASE FROM THE MENTAL AND PHYSICAL

AS IT RELATES TO THE OVERALL COMMUNITY AND THEIR HEALTH

AS THE ACCESSIBILITY TO LITTLE OR LOW-COST HEALTH CARE

AS THE OVERALL HEALTH OF PEOPLE WITHIN THE COMMUNITY AND HOW IT IMPACTS EACH OTHER

ATTENTION TO THINGS THAT AFFECT THE COMMUNITY WHETHER IN DISEASES OR WATER AND AIR POLLUTION

AVAILABILITY AND INFORMATION REGARDING HEALTH.

AVAILABLE HEALTH CARE

AVERAGE MORTALITY AND MORBIDITY ACROSS A GIVEN POPULATION

BASICALLY THE GOVERNMENT AND INDIVIDUALS ARE RESPONSIBLE FOR HEALTH FOR EXAMPLE MENTAL AND PHYSICAL HEALTH

BEING SOCIAL

BEING SURE THAT DISEASES CONTROLLED AND PEOPLE ARE HEALTHY

BEING THE COUNTY OR WHATEVER SUBSIDIARY THAT I LIVE IN, WHO IS PRESIDING THAT SECTION ANNOUNCING THE HISTORY HEALTH OF THE COMMUNITY AND BASICALLY LETTING US KNOW WHAT IS HAPPENING IN THE ZIP CODE BEING CONCERNED

CAN BE ASSURING THE SAFETY OF CITIZENS

CHAIR WARMERS WHO DO MORE HARM THAN GOOD, E.G. FAUCI APPROVED FUNDING FOR WUHAN LAB WHICH KILLED 6 MILLION PEOPLE AND COUNTING.

COLLECTIVE WELL-BEING IN OUR SOCIETY

COMMON HEALTH ISSUES THAT AFFECT THE ENTIRE COMMUNITY.

COMMON POLICY ON ENCOURAGING HEALTHY LIFE

COMMUNITY BASED TO HELP PEOPLE WITH VARIOUS ISSUES THAT MAY ARISE

COMMUNITY ENSURING LOW TRANSMISSION OF DISEASES

COMMUNITY HEALTH

COMMUNITY STANDARDS, ANYTHING THAT HAS TO DO WITH THE PUBLIC AS A WHOLE LIKE DISEASE MITIGATION AND HYGIENE

COMMUNITY WELFARE

COMMUNITY WIDE HEALTH

COMMUNITY WORKING TOGETHER FOR THE GOOD OF THE CITIZENS

COMPARING IT WITH OTHER COUNTRIES AND WHAT WE HAVE IS VERY BAD. I AM AFRAID TO...

CONCERN FOR THE GENERAL WELFARE, HEALTH OF THE GENERAL COMMUNITY… ADVERTISEMENT OF THE COVID PROGRAM

CONCERNS THAT AFFECT THE PHYSICAL AND EMOTIONAL WELL- BEING OF ALL PEOPLE.

CONDITION OF THE GENERAL PUBLIC

CONDITIONS THAT AFFECT THE ENTIRE COMMUNITY

CONDITIONS THAT AFFECT THE HEALTH OF GROUPS OF INDIVIDUALS IN OUR SOCIETY

CONTROL OF WATER, AIR

COUNTY TOWN STATE HEALTH WORKERS

DEFINES AS HAVING A PORTABLE HEALTH AND HAVING LIKE HEALTHIER

DEPENDS ON CONTEXT. PHYSICAL HEALTH OR HEALTH OF SOCIETY. BASED OTHER QUESTIONS...HOW WELL THE SOCIETY FUNCTIONS FOR THE WELL-BEING OF ALL WITH LITTLE TO NO OVERSIGHT BY THE GOVERNMENT.

DESCRIBING THE CONDITIONS THAT AS MEASURED BY POPULATIONS EXPERIENCES RATHER THAN INDIVIDUALS.

DETERIORATING OR GOING DOWN

DISEASES AFFECTING THE PUBLIC AT LARGE

DISEASES THAT ARE COMMUNICABLE THROUGH CARELESS AND IRRESPONSIBLE PEOPLE

DIVIDE SERVICES AND MAKE IT EASIER TO BE HEALTHY

DOING WHAT'S RIGHT NOT JUST FOR YOURSELF BUT ALSO FOR THE PEOPLE AROUND YOU

EACH PERSON INDIVIDUALLY IS RESPONSIBLE FOR THEIR OWN HEALTH AND WELL-BEING

EASY ACCESS TO HEALTH CARE, AFFORDABLE HEALTH CARE

EDUCATION DISTRIBUTION AND HEALTH SERVICES LIKE CLINIC AND HOSPITAL CAPACITY

ENSURING SAFETY FOR THE PUBLIC. AS WELL AS INDIVIDUAL RESPONSIBILITY FOR SELF AND OTHERS

ENTIRE WELL-BEING OF THE COMMUNITY OR LIFE EXPECTANCY

EVERYBODY BEING RESPONSIBLE FOR THEMSELVES SO YOU HAVE A HEALTHY PUBLIC

EVERYBODY'S HEALTH

EVERYBODY'S HEALTH

EVERYBODY’S HEALTH

EVERYBODY’S HEALTHY

EVERYONE CARING ABOUT EVERYONE

EVERYONE HAS A RIGHT TO GO TO THE HOSPITAL AND BE TAKEN CARE OF, WHETHER THEY HAVE INSURANCE OR NOT

EVERYONE LIVING IN OR AROUND THE COMMUNITY

EVERYONE SHOULD HAVE HEALTH CARE EQUALLY

EVERYONE TAKING THE TIME TO MAKE SURE ONE'S COMMUNITY AND BEING HEALTH CONSCIOUS OF OTHERS AND BEING VERY CAUTIOUS WITH SHARING GERMS TO ONE ANOTHER.

EVERYONE THAT WORKS A NON-GOVERNMENT JOB

EVERYONE'S HEALTH

EVERYONE'S HEALTH

EVERYONE'S HEALTH

EVERYONE'S HEALTH

EVERYONE'S HEALTH AND SAFETY

EVERYONE'S HEALTH MATTERS. EVERYONE WHO IS IN THE OUTSIDE AND INSIDE

EVERYTHING OCCURRING IN YOUR COMMUNITY THAT CAN AFFECT YOUR LIFE

FEDERAL GUIDELINES

FINANCED BY THE LOCAL AND STATE GOVERNMENT

FOR ALL THE PEOPLE

FREE HEALTH CARE

FREE HEALTH FOR EVERYBODY, AT LEAST THE BASICS

FREE INSURANCE

FREE SERVICES ARE BEING PROVIDED THE GOVERNMENT

GENERAL ENVIRONMENT

GENERAL HEALTH AND WELL-BEING OF THE PUBLIC.

GENERAL HEALTH ISSUES AFFECTING PUBLIC

GENERAL HEALTH OF THE COMMUNITY OF PEOPLE

GENERAL HEALTH OF THE PUBLIC

GENERAL HEALTH, WELL-BEING OF THE GENERAL POPULATION.

GENERAL PHYSICALITY AND AVERAGE LIFE SPAN OF THE COMMUNITY AND QUALITY OF LIFE

GENERAL PUBLIC HEALTH

GENERAL PUBLIC SANITATION, SUCH AS TRASH, WATER SANITATION, SEWERAGE TREATMENT.

GENERAL WELL-BEING OF PEOPLE

GENERAL WELL-BEING OF THE COMMUNITY

GENERAL WELL-BEING OF YOUR COMMUNITY

GETTING INFO OUT FROM THE PEOPLE ABOUT HOW TO STAY HEALTH AND HOW TO LOWER THEIR COST OF DRUGS

GOOD HYGIENE, WEIGHT

GOOD MEDICAL FACILITIES

GOVERNMENT

GOVERNMENT BASED HEALTH CARE AND SOCIAL SERVICES.

GOVERNMENT DETERMINES HEALTH

GOVERNMENT FUNDED MEDICAL SERVICES

GOVERNMENT INVOLVEMENT AND HAVING INSTITUTIONS AND SYSTEMS IN PLACE THAT ALLOW THE PUBLIC EQUAL ACCESS TO BASIC HEALTH CARE OR PROGRAMS

GOVERNMENT MUST ENSURE A FAIR STANDARD AND EQUITABLE RULES APPLIED EQUALLY TO ALL, NO EXCEPTIONS.(INDIVIDUAL, PUBLIC AND PRIVATE ORGANIZATION), EXAMPLE, NO ONE SHOULD BE ALLOWED TO DUMP POISON INTO PUBLIC DRINKING SOURCES

HAS TO DO WITH ADDRESSING ANY ISSUE OR CONCERN ABOUT PUBLIC HEALTH LIKE MENTAL, PHYSICAL HEALTH

HAVEN'T THOUGHT ABOUT IT MUCH. HEALTH OF GENERAL POPULATION ALL OF THE PEOPLE

HEALTH AND WELL-BEING OF THE GENERAL POPULATION

HEALTH AWARENESS AMONG DISEASE- FREE PEOPLE

HEALTH CARE AND KEEPING THE GENERAL PUBLIC SAFE

HEALTH CARE AVAILABILITY

HEALTH CARE AVAILABLE TO THE PUBLIC

HEALTH CARE FOR EVERYONE

HEALTH EDUCATION, ENCOURAGING PHYSICIAN ACTIVITIES, HOLDING EVENTS FOR EVENTS SUCH AS MARATHONS

HEALTH FOR EVERYONE

HEALTH FOR EVERYONE IN THE AREA

HEALTH FOR THE PUBLIC

HEALTH HAZARDS THAT EFFECT NOT JUST ONE PERSON BUT THE PUBLIC AS A WHOLE

HEALTH IN THE NEIGHBORHOOD

HEALTH IN THE OVERALL COMMUNITY THE WHOLE NATIONALITY OF PEOPLE

HEALTH IN THE PUBLIC

HEALTH INSURANCE

HEALTH ISSUES AFFECTING THE ENTIRE PUBLIC

HEALTH ISSUES THAT AFFECT A WHOLE COMMUNITY NOT JUST AN INDIVIDUAL

HEALTH ISSUES THAT EFFECT EVERYONE IN A COMMUNITY

HEALTH ISSUES THAT IMPACT OR DEFINE HEALTH CARE OPTIONS AND EFFECTIVENESS FOR EVERY CITIZEN OF THE STATE

HEALTH ISSUES THAT PERTAIN TO THE POPULATION

HEALTH ISSUES THAT PERTAIN TO THE PUBLIC

HEALTH OF A PERSON IN AN PUBLIC AREA

HEALTH OF ALL OVERALL

HEALTH OF EVERYONE IN THE COMMUNITY

HEALTH OF EVERYONE IN THIS WORLD.

HEALTH OF LOCALS

HEALTH OF PEOPLE

HEALTH OF PEOPLE IN THE COMMUNITY

HEALTH OF PUBLIC

HEALTH OF THE COMMUNITY

HEALTH OF THE COMMUNITY

HEALTH OF THE COMMUNITY AS A WHOLE

HEALTH OF THE COMMUNITY AS A WHOLE.

HEALTH OF THE COMMUNITY...

HEALTH OF THE GENERAL COMMUNITY

HEALTH OF THE GENERAL PUBLIC

HEALTH OF THE PUBLIC

HEALTH OF THE PUBLIC

HEALTH OF THE PUBLIC

HEALTH OF THE PUBLIC, THE PEOPLE HEALTH PUBLIC HEALTH

HEALTH PROVIDED BY THE GOVERNMENT

HEALTH RELATED ISSUES THAT CAN BE PASSED FROM PERSON TO PERSON... A COMMUNICABLE DISEASE

HEALTH SITUATION THAT AFFECTS A LARGE NUMBER OF PEOPLE IN THE COMMUNITY AND WHERE THE GOVERNMENT RESPONSE WOULD HAVE AN EFFECT ON A LARGE PORTION OF THIS COMMUNITY

HEALTH STANDARDS FOR EVERYONE'S BENEFIT

HEALTH THAT AFFECTS THE POPULATION AS A WHOLE

HEALTH THAT CONCERNS ALL PEOPLE AND AFFECT THE WHOLE COMMUNITY

HEALTH THAT IMPACTS THE COMMUNITY AND BY THAT I MEAN HEALTH CARE, AFFORDABLE HEALTH CARE AND PROVIDERS

HEALTH THAT IS FUNDED BY THE PUBLIC AND SEPARATED FROM THE GOVERNMENT.

HEALTH THAT LOOKS OUT FOR THE WELFARE OF ALL PEOPLE FROM ALL BACKGROUNDS ALL OF THEM

HEALTH THAT WOULD AFFECT A LARGE GROUP OF THE POPULATION

HEALTH-RELATED ISSUES THAT CAN AFFECT ALL HABITANTS

HEALTHY

HEALTHY PERSON

HELPING PEOPLE HAVE GOOD HEALTH AS A COMMUNITY

HELPING THE PUBLIC WITH HEALTH CONCERNS

HOLISTIC CARE AND COMMUNITY BUILDING

HOSPITAL

HOW ARE THE STATE OF YOUR PEOPLE MENTALLY AND PHYSICALLY

HOW HEALTHY OR UNHEALTHY INDIVIDUALS IN A COMMUNITY ARE

HOW HEALTHY PEOPLE ARE AS A WHOLE

HOW HEALTHY THE COMMUNITY IS

HOW HEALTHY THE GENERAL POPULATION IS

HOW PEOPLE AROUND YOU CAN STAY HEALTHY

HOW THE COMMUNITY ITSELF IS AND GETS SUPPORT IT NEEDS

HOW THE GENERAL OVERALL HEALTH OF AN AREA IS

HOW THE PEOPLE IN YOUR COMMUNITY AND SURROUNDING IT ARE AFFECTED IN THEIR IMMUNE SYSTEM AND MIND/BODY

HOW THE PUBLIC IS CARED FOR REGARDLESS OF ABILITY TO PAY.

HOW YOUR HEALTH IS IN THE PUBLIC

HYGIENE

I ASSUME IT HAS TO DO WITH LOCAL COMMON COMMUNITY

I DEFINE IT AS A GENERAL OVERALL HEALTH OF A SPECIFIC POPULATION IN SPECIFIC AREAS.

I DON'T BELIEVE THE TERM PUBLIC HEALTH IS A VIABLE TERM

I GUESS HOW MUCH ACCESS PEOPLE HAVE A LEADING HEALTHY LIVES

I GUESS IT'S MEDICAL.

I GUESS JUST THE WELL-BEING OF THE COMMUNITY INCLUDING THE MENTAL HEALTH AND PHYSICAL HEALTH

I GUESS OVERALL WELL-BEING OF A PERSON.

I GUESS PUBLIC HOSPITALS CONTROLLED BY THE GOVERNMENT, STATE OR LOCAL GOVERNMENT

I GUESS THE REGULATORY AGENCIES LOOKING OUT FOR THE PROPER TREATMENT OF MEDICINE AND DRUGS THAT ARE DISTRIBUTED.

I HAVE NO IDEA HOW I WOULD DEFINE IT

I REJECT THE CONCEPT OF "PUBLIC HEALTH" GENERALLY, ASIDE FROM CERTAIN EXTRAORDINARY EVENTS SUCH AS AN EMERGENT OUTBREAK SUCH AS COVID, WHERE THE INTERACTION OF THE PUBLIC WITH EACH OTHER CAN IMPACT THE WHOLE OR MASS EXPOSURE TO AN ENVIRONMENTAL TOXIN IMPACTING VERY LARGE NUMBERS AT ONE TIME. THE STATUS OF INDIVIDUAL'S HEALTH IS NOT SOMETHING THAT CONCERNS THE PUBLIC. I

BELIEVE THE GOVERNMENT WANTS TO MAKE IT SO, BUT IT'S ALL A CONSTRUCT THEY CREATE. I AM NOT AN ANTI-GOVERNMENT NUT BUT I ALSO DO

I SAID FAIR

I THINK IF YOUR TOWN OR COUNTY OFFER PLACES TO GET THE SHOTS. LIKE --- HAD PLACES TO GET THE SHOTS LONG BEFORE THE PANDEMIC. LIKE THE PNEUMONIA, THE USUAL SHOT. THEY PROVIDE THEM USUALLY.

I THINK IT IS EDUCATING THE PUBLIC— ENVIRONMENTAL, VACCINATION, CHECKING THE PEOPLE OR THE ENVIRONMENT.

I THINK IT MATTERS WHAT YOU ARE EATING AND IF YOU'RE NOT PAYING ATTENTION TO IT, IT CAN RUIN YOUR HEALTH IN THE LONG RUN.

I THINK IT'S A MEANINGLESS TERM. I THINK IT'S AN OXY MORON.

I THINK PUBLIC HEALTH IS ABOUT PROTECTING THE HEALTH OF OTHERS AND PROTECTING YOUR FAMILY AND YOURSELF BUT NOT SACRIFICING THE HEALTH OF OTHERS.

I THINK PUBLIC HEALTH IS LOOKING A HEALTH-RELATED ISSUES OF MASS CONCERN AND INDIVIDUAL CONCERN

I THINK PUBLIC HEALTH MEANS PREVENTING DISEASE OR HEALTH ISSUES IN A POPULATION. I ALSO THINK THAT IT MEANS MAINTAINING THE MENTAL HEALTH OF A COMMUNITY THROUGH TRANSPARENCY, POLICIES, AND EDUCATING PEOPLE.

I THINK THEY TRY, BUT SOMETIMES THEY CAN DO MORE

I WOULD DEFINE AS THE HEALTH OF COMMUNITY OR THE POPULATION IN THE AREA

I WOULD DEFINE AS THE LOCAL STATE/ GOVERNMENT ADHERING TO MEDICAL HEALTH SERVICES AVAILABLE

I WOULD DEFINE PUBLIC HEALTH AS EVERYTHING THAT IS BEING DONE TO PROTECT THE HEALTH OF THE GENERAL PUBLIC INCLUDING CLEAN WATER, SANITATION SYSTEMS.

I WOULD DEFINE PUBLIC HEALTH AS THE HEALTH OF THE POPULATION AS A WHOLE.

I WOULD DEFINE PUBLIC HEALTH THAT THE COMMUNITY NEEDS A POPULATION, MENTAL HEALTH NEEDS, PUBLIC SUPPORT

I WOULD RELATE IT TO ACCESSIBILITY TO HEALTH CARE AND INSURANCE FOR ALL PEOPLE

I WOULD SAY EVERYONE HOW THE VAST MAJORITY OF THE PUBLIC STAYS HEALTHY

I WOULD SAY FOR PUBLIC HEALTH, PEOPLE'S HEALTH IN GENERAL

I WOULD SAY INSURANCE COST

I WOULD SAY IT IS KIND OF A FREE FOR ALL RIGHT NOW

I WOULD SAY IT'S THE POLICIES AND PRACTICES THAT ARE IN PLACE TO ENSURE THE PUBLIC IS HEALTHY.

I WOULD SAY MAKING SURE THE POPULATION IS LIVING HEALTHIER LIVES I GUESS.

I WOULD SAY PUBLIC HEALTH A GENERAL STATE OF HOW A CONDITION IN OUR STATE HAS BEEN.. HOW MANY PEOPLE ILL ASIDE OF COVID-19. SMOKING INCREASING HEART ATTACKS, RESPIRATORY/HEART CONDITIONS IN UNITED STATES

I WOULD SAY PUBLIC HEALTH HAS TO DO WITH THE INFRASTRUCTURE OF SERVICES THAT ARE AVAILABLE TO THE COMMUNITY. LOCAL REGULATIONS [on] TOXIC WASTE

I WOULD SAY PUBLIC HEALTH IS DEFINITELY DEFINED AS A COMMUNITY THE WAY A COMMUNITY LOOKS AT THE HEALTH OF THAT COMMUNITY: ACCESSIBILITY, DISEASE PREVENTION, THOSE KIND OF THINGS.

I WOULD SAY PUBLIC HEALTH IS THE HEALTH AND WELL-BEING OF THE PUBLIC AT LARGE

I WOULD SAY PUBLIC HEALTH IS VERY IMPORTANT MATTER IN THE COMMUNITY. IT CAN TAKE CARE OF THE ELDERLY DOWN TO CHILDREN

I WOULD SAY THE WELL-BEING OF OUR COMMUNITY, AND THE ISSUES THAT IMPACT IT.

I'M FAMILIAR WITH OUR HEALTH DEPARTMENT. THEY HAVE CLINICALS FOR PEOPLE WHO ARE DISADVANTAGED AND THEY MAKE CHILDREN ARE TAKEN CARE OF. WELL-CARE, CLINIC IN HAMILTON. PEOPLE CAN COME IN DURING THE DAY AND THEY DO HAVE CLINICALS AND INFORMATION OF SERVICES. FOR ALZHEIMER'S, THEY HAVE FLU CLINICS EVERY YEAR THAT WE CAN COUNT ON.

I'M NOT SURE, BUT I THINK PUBLIC HEALTH REFERS TO HEALTH AND ENVIRONMENTAL ISSUES THAT AFFECT MOST MEMBERS IN THE COMMUNITY OR GENERAL POPULATION.

I'D SAY IT'S GENERALLY GOOD PUBLIC HEALTH.

IN A TERMS OF POPULATION, EVERYTHING INVOLVE KEEPING PEOPLE HEALTHY IN GOVERNMENTAL ISSUES, BUSINESS LEVEL.

IN MY TERMS IN MEANS HEALTH IN YOUR COMMUNITY

IN OTHER WORDS, I DEFINE IT AS SOCIALISM

IN REGARDS TO THE PUBLIC ARE WE ABLE TO GET HEALTHY AND MAINTAIN THAT STATE

INDIVIDUAL CHOICE

INDIVIDUAL FREEDOM, LIBERTY.

INDIVIDUAL WELL-BEING

INSURANCE AND WELFARE FOR ALL

IS A RESPONSIBLE FOR PEOPLE. PUBLIC HEALTH IS THE RESPONSIBILITIES OF THE PEOPLE

IS ACTUAL HANDS-ON THINGS THAT MUNICIPAL COUNTY, STATE LEVEL. SMOKING, DIABETES, NUTRITIONAL STANDARDS, NOT HAVING JUNK FOOD VENDING MACHINE IN SCHOOLS. MOSTLY INFORMATION AND HANDS-ON THINGS

IS FOR EXAMPLE MAKING VACCINATIONS MANDATORY AND SCHOOL NURSES DO HEALTH CHECKS IN SCHOOL

IS RESPONSIBLE FOR THE HEALTH OF LARGE GROUPS

IS TAKING CARE OF THE PUBLIC'S HEALTH; OFFER INSTRUCTIONS AS TO WHAT TO EAT AND EXERCISE

IS THE ACT OF EVERYONE WHETHER LOCAL, STATE OR FEDERAL LEVEL WORKING TOGETHER FOR EVERYBODY’S SAFETY

IS THE GENERAL HEALTH OF THE PEOPLE IN THE COMMUNITY

IS THE HEALTH FOR ALL PEOPLE

IS THE HEALTH OF THE POPULATION AS A WHOLE

IS THE LOCAL STATE AND FEDERAL GOVERNMENT ALL COMBINING THEIR RESOURCES TO TRY TO ENSURE THAT LOCAL CITIZENS HAVE GOOD HEALTH CARE AND THEY MAINTAIN IT

IS THE RESPONSIBILITY OF THE LOCAL GOVERMENT TO MAKE SURE PEOPLE ARE SAFE, AND THAT THERE IS THE RIGHT AMOUNT OF PEOPLE TO FIX IT.

IS THE WELL-BEING OF THE PEOPLE IN THE COMMUNITY

IS WHEN PEOPLE MAKING THEM AWARE OF WHAT'S NOT GOOD FOR THEM ITS MANDATED BY THE STATE

ISSUES THAT AFFECT ALL OF US.

ISSUES THAT AFFECT THE FUNCTIONING OF THE COMMUNITY

ISSUES THAT CONCERN THE PUBLIC WITH HEALTH AND ENVIRONMENT

ISSUES THAT LARGELY AFFECTS THE COMMUNITY AS A WHOLE

IT ALL DEPENDS ON THE PUBLIC HEALTH. I DON'T STRUGGLE WITH PUBLIC HEALTH SO I DON'T STRUGGLE

IT DEPENDS ON THE CONTACTS

IT IS THE WELL-BEING OF THE GENERAL POPULATION

IT MEANS TO ME THE AVAILABILITY OF QUALITY FOOD.

IT SHOULD BE BETTER

IT SHOULD BE IMPORTANT TO EVERYONE

IT SHOULD BE IN ALL AREAS FROM THE SCHOOL TO THE WORKPLACE TO PUBLIC PLACE. ALL OVER SHOULD BE A CONSIDERATION FOR HEALTH.

IT THE SCIENCE OF DEALING WITH HEALTH ISSUES

IT WOULD MEAN THE GOVERNMENT IS RESPONSIBLE FOR KEEPING ITS CITIZENS STAY HEALTHY INCLUDING WHAT THEY ALLOW TO BE SOLD TO THE PUBLIC.

IT'S A POLICY ISSUE

IT'S ABOUT MAKING SURE YOU, YOUR FRIENDS AND NEIGHBORS, AND EVERYONE ELSE AROUND YOU IS HEALTHY AND CLEAN.

IT'S ESSENTIAL

IT'S FOR ALL OF US, PERTAINING TO THE UNITED STATES, EACH STATE AND THE PEOPLE HAVE TO HAVE A PART IN IT. THE PEOPLE WE VOTE FOR IN THE LEADERSHIP POSITIONS.

IT'S THE HEALTH OF THE PEOPLE IN THE SOCIETY IN THE REGION

IT'S THE HEALTH OF THE PUBLIC

IT'S THE MENTAL AND PHYSICAL HEALTH THEY GO TOGETHER

IT'S THE SERVICE GIVE INTEGRATED HEALTH SERVICE TO PUBLIC

IT'S TO PREVENT DISEASES WHERE THEY STUDY IT FIRST.

ITS A COMBINATION OF THE POPULATION WE SHOULD HAVE FREE HEALTH CARE

ITS CREATING POLICIES THAT PROMOTE THE GENERAL HEALTH OF POPULATIONS

ITS THE OVERALL HEALTH OF THE PUBLIC OR WELL-BEING.

ITS WHAT AFFECTS THE PUBLIC IN GENERAL

KEEPING THE LOCAL ENVIRONMENT HEALTHY. CLEANING UP TOWNS, SAFE WATER & AIR

LET'S JUST SAY NOT SURE

LIKE ANY CONTAGIOUS DISEASES.

LOCAL AND STATE COMMUNITY SUPPORT FOR HEALTH-RELATED DISEASES AND CONDITIONS

LOOKING OUT FOR EACH OTHER

MAINTAINING A SAFE STANDARD FOR HEALTH AND PHYSICAL ACTIVITY

MAINTAINING THE WELL-BEING IN INDIVIDUALS INTERACTING IN A PLACE DAILY

MAKING AVAILABLE OPTIONS TO FIGHT DISEASE AND SICKNESS.

MAKING PEOPLE AWARE OF ISSUE AND UNSAFE WATER ISSUES AND DOING SOMETHING ABOUT IT

MAKING SURE INDIVIDUAL IN THE COMMUNITY ARE HEALTHY NOT IN AN INSTITUTION

MAKING SURE PEOPLE ARE LEADING SAFE LIVES AND HOW TO BE HEALTHY.

MAKING SURE THAT PEOPLE ARE INFORMED ON WHAT STEPS THEY NEED TO BE HEALTHY.

MAKING SURE THAT PEOPLE ARE PROTECTED AGAINST COMMUNICABLE DISEASES.

MAKING SURE THE PUBLIC IS HEALTHY

MAKING SURE WE WOULD HAVE CORRECT INFORMATION, NOT THE MEDIA PROPAGANDA.

MAKING THERE IS ENVIRONMENT FOR PEOPLE TO LIVE SAFELY

MANAGE OR KEEP IN CHECK THE CONDITIONS AND WELL-BEING OF THE PEOPLE

MANY PEOPLE, A SOCIAL AREA AND THE HEALTH OF THOSE WITHIN AND SURROUNDING THE AREA.

MATTERS THAT IMPACT GROUPS OF PEOPLE, INCLUDING CONTAGIOUS DISEASES

MEANS GENERAL WELL-BEING OF THE COMMUNITY. ACCESS TO GET MEDICAL SERVICES.

MEANS GOOD SANITATION, GOOD HEALTH RESPONSIBILITIES BY THE PEOPLE

MEDIAN LEVEL OF HEALTH IN THE COMMUNITY; TYPICAL LEVEL OF HEALTH

MEDICAL AND MENTAL HEALTH

MEDICAL CONDITIONS OF PEOPLE IN OUR COMMUNITY

MEDICAL HELP FROM THE GOVERNMENT

MEDICAL MARIJUANA FOR EVERYONE

MEDICARE

MENTAL HEALTH AND SOCIAL JUSTICE AND COMMUNITY HELP

MONITORING AND NAVIGATION OF ILLNESS SO THAT PEOPLE CAN FIRST BECOME AWARE OF IT, AND KNOW RESOURCES, AND ARE ABLE TO GET SOME SERVICES TO PROMOTE THEIR HEALING AND PREVENTION

MONITORING/MANAGING HEALTH CARE DELIVERY AND DISEASES

MONITORS, REGULATES AND ADMINISTERS POLICIES THAT HELP AND PROTECT THE CITIZENS

MONOPOLY

MOST PEOPLE ARE HEALTHY

MOSTLY HEALTHY WATER HEALTHY AIR CONTROLLING COMMUNITY DISEASES ETC.

MY VIEW IS IT IS A COMBINATION OF PUBLIC HEALTH RESPONSIBILITY, INDIVIDUAL, COMMUNITY, BUSINESS AND ORGANIZATION, STATE AND FEDERAL

NONE I HAVE UNFORTUNATELY

NOT SAFE AT ALL

NOT SURE

NOT SURE

NOT SURE

NOT SURE

NOT SURE AS FAR AS PUBLIC HEALTH IS CONCERNED

NOT TAKING ACCOUNT OF INDIVIDUALS

NURSES, COMMUNITIES, SET UP FLU CLINICS, BLOOD PRESSURE SCREENING, FOR PEOPLE WHO CANNOT AFFORD TO GO TO THE DOCTOR

OF OR RELATED TO THE OVERALL WELL-BEING OF THE COMMUNITY.

OFFERING SERVICES TO INDIVIDUALS TO THE BEST THEIR ABILITIES.

OTHER PEOPLE MAKING SURE THEIR COMMUNITIES ARE LIVING HEALTHY LIVES

OUR COMMUNITY

OUR PUBLIC HEALTH IN GENERAL

OVERALL COMMUNITY HEALTH AND ACCESS TO HEALTH CARE/HEALTH CHOICES

OVERALL COMMUNITY HEALTH ISSUES

OVERALL CULTURAL PRIORITIES AND PRICE POINTS/ACCESS TO NUTRITIOUS FOOD

OVERALL HEALTH AND SAFETY OF A COMMUNITY

OVERALL HEALTH AND WELL-BEING OF THE CITIZENS.

OVERALL HEALTH OF A COMMUNITY

OVERALL HEALTH OF A PARTICULAR COMMUNITY

OVERALL HEALTH OF ALL PEOPLE

OVERALL HEALTH OF AN AREA OR A REGION

OVERALL HEALTH OF COMMUNITIES

OVERALL HEALTH OF EVERYONE

OVERALL HEALTH OF OUR COMMUNITY

OVERALL HEALTH OF THE COMMUNITY

OVERALL HEALTH OF THE POPULATION

OVERALL HEALTH OF THE PUBLIC. SORRY I CAN'T THINK OF ANY WORDS RIGHT NOW. THE COLLECTIVE STATE OF HEALTH FOR A HUGE SET OF PEOPLE IN THE STATE.

OVERALL PHYSICAL AND MENTAL WELLNESS OF THE COMMUNITY

OVERALL PLAN FOR THE COMMUNITY FOR THE NATION. PLAN TO HAVE AN OVERALL VIEWPOINT ON KEEP EVERYTHING HEALTHY.

OVERALL SYSTEM WHERE HEALTH CARE AND RESOURCES AND AVAILABLE FOR A REASONABLE PRICE

OVERALL WELL-BEING OF THE COMMUNITY

OVERALL WELL-BEING OF THE COMMUNITY

OVERALL WELL-BEING OF THE POPULATION WHICH INCLUDES PHYSICAL AND MENTAL HEALTH

OVERALL WELLNESS AND AWARENESS OF HEALTH-RELATED TOPICS AMONGST A COMMUNITY.

OVERALL WELLNESS OF COMMUNITY NATIONAL WELLNESS OF ALL INDIVIDUALS

OVERALL, THE PEOPLE IN THE COMMUNITY AND THEIR HEALTH

PEOPLE SHOULD GET VACCINATED.

PEOPLE, BUT MANY.

PEOPLE's OVERALL PHYSICAL CONDITION

PHYSICAL AND MENTAL HEALTH COMBINED

PHYSICAL HEALTH, MENTAL HEALTH

POLICIES RELATED TO THE GENERAL PHYSICAL AND MENTAL WELL-BEING OF THE CITIZENRY

POLICIES THAT ARE ENACTED BY VARIOUS GOVERNMENTAL AGENCIES THAT ARE DESIGNED TO ENSURE THE BEST POSSIBLE HEALTH OF ALL ITS CITIZENS

POLICY, MONEY AND INFRASTRUCTURE TO SUPPORT

POOR

POOR

POOR

POOR DIET, UNHEALTHY

PROMOTES HEALTH

PROTECTING AND IMPROVING THE LIVES OF PEOPLE FROM VARIOUS THINGS THAT WOULD IMPACT THEIR HEALTH.

PROTECTING THE PUBLIC AS A MASS PUBLIC

PROTECTS THE HEALTH OF THE COMMUNITY...DOCTORS THAT PROTECTS THE HEALTH OF PEOPLE IN THE COMMUNITY. IT'S A SCIENCE THAT PREVENTS DISEASES AND MAKES EFFORTS TO HELP PEOPLE AND TRY TO PREVENT DISEASES.

PROVIDING OUTREACH PROGRAMS AND CLINICS

PUBLIC EVERYBODY, NOT JUST THE ONES WITH GOOD INSURANCE, SHOULD BE FOR EVERYBODY. EVERYBODY SHOULD BE TREATED EQUALLY

PUBLIC HEALTH

PUBLIC HEALTH

PUBLIC HEALTH A LARGE MASS OF PEOPLE FOR PUBLIC HEALTH

PUBLIC HEALTH AFFECTS OTHERS, WE ALL HAVE RESPONSIBILITY TO MAKE SURE COMMUNITY IS SAFE

PUBLIC HEALTH AND SAFETY

PUBLIC HEALTH CAN BE DEFINED AS PEOPLE IN A COMMUNITY THAT ARE PART OF PUBLIC HEALTH.

PUBLIC HEALTH DEALS WITH HEALTH STATUS OF THE COMMUNITY

PUBLIC HEALTH DEALS WITH OVERALL WELL-BEING OF THE COMMUNITY THAT YOU LIVE. MAKING SURE THAT UNDERPRIVILEGED PEOPLE ARE GETTING INFORMATION AND OUTREACH.

PUBLIC HEALTH DEFINES ISSUES THAT AFFECT OUR COMMUNITIES

PUBLIC HEALTH ENTAILS THE SYSTEMIC COVERAGE AND CARE OF THE PUBLIC. ENSURING ACCESS TO CARE, RESOURCES, AND HEALTH-BASED INFORMATION ACROSS COMMUNITIES.

PUBLIC HEALTH GOES BEHIND HEALTH CARE. IT IS OVERALL THE HEALTH OF THE PUBLIC IN TERMS OF ACCESS TO NUTRITIOUS FOOD, CLEAN WATER, NON-TOXIC ENVIRONMENT, LESS POLLUTION OVERALL.

PUBLIC HEALTH HAS BEEN DEFINED AS THE SCIENCE AND ART OF PREVENTING DISEASE.

PUBLIC HEALTH HAS TO DO WITH EVERYONE

PUBLIC HEALTH HAS TO DO WITH FOOD CHOICES

PUBLIC HEALTH HAS TO DO WITH ISSUES THAT AFFECT THE LARGER POPULATION AND THEY INCLUDE SANITATION OF FOOD, CLIMATE CHANGE

PUBLIC HEALTH HAS TO DO WITH THE LIFESTYLE OF INDIVIDUALS

PUBLIC HEALTH I WOULD SAY ITS TALKS SAFETY, MENTAL AND PHYSICAL, EMOTIONAL THAT SOMEONE'S HEALTH GLOBALLY OR COUNTY.

PUBLIC HEALTH INCLUDES A COMMUNITIES MENTAL, EMOTIONAL, PHYSICAL, AND FINANCIAL WELL-BEING. FINANCIAL WELL-BEING INCLUDES ACCESSIBILITY TO SUFFICIENT HOUSING, EDUCATION, TRANSPORTATION, HEALTHY MEALS, HEALTH CARE, ETC.

PUBLIC HEALTH INVOLVES HAVING A HEALTHY ENVIRONMENT IN THE GENERAL HEALTH AS OPPOSED TO JUST MAKING SURE YOU CAN GET YOUR PRESCRIPTION DRUGS

PUBLIC HEALTH IS A QUESTION OF ENSURING THE COMMUNITY IS PROPERLY PROTECTED FROM HEALTH EMERGENCIES AND SANITARY CONDITIONS IN PUBLIC. LIKE LOCAL FACILITIES AND SANITATION CENTERS.

PUBLIC HEALTH IS A RESPONSIBILITY SHARED BETWEEN LOCAL GOVERNMENT FOR EACH STATE AND INDIVIDUALS

PUBLIC HEALTH IS A WELLNESS OF THE POPULATION AND HOW IT IS AFFECTED BY REGULATION IN LEGISLATION

PUBLIC HEALTH IS EVERYTHING

PUBLIC HEALTH IS FOR EVERYBODY TO WASH THEIR HANDS, DON'T COUGH ON ME, BE CONSIDERATE OF OTHERS

PUBLIC HEALTH IS FOR THE PUBLIC, LIKE IT'S AVAILABLE FOR EVERYBODY

PUBLIC HEALTH IS FRAUDULENT. PUBLIC HEALTH IS NOT CARING FOR HEALTH.

PUBLIC HEALTH IS HOW A COMMUNITY/GOVERNMENT IS OPERATING TO HELP PEOPLE FEEL THE BEST ABOUT THEMSELVES

PUBLIC HEALTH IS HOW HEALTHY A PUBLIC COMMUNITY IS

PUBLIC HEALTH IS HOW THE GOVERNMENT ASSIST THE PEOPLE IN BEING HEALTHY

PUBLIC HEALTH IS I GUESS DOCTOR'S STUFF

PUBLIC HEALTH IS IMPORTANT. I WOULD DEFINE AS MAKING SURE THAT THERE IS PROPER SEWAGE, CLEAN WATER, AND THAT EVERYTHING IS NOT PESTICIZED AND HARM NO PEOPLE.

PUBLIC HEALTH IS IN A DECLINE AT THE RISE OF THE COST OF LIVING… MENTALLY, PHYSICALLY PUBLIC HEALTH IS GOING TO DECLINE.

PUBLIC HEALTH IS MEDICAL INFORMATION PROVIDED TO A COMMUNITY AS OPPOSED TO JUST AN INDIVIDUAL IT RATES HOW WE ARE DOING AS A COMMUNITY IN REGARDS TO HEALTH ISSUES. IT ALSO GIVES INFORMATION THAT A COMMUNITY WOULD NEED

PUBLIC HEALTH IS NOT GOOD

PUBLIC HEALTH IS NURSING AND PEOPLE THAT GO INTO THE COMMUNITY AND EDUCATE THE POPULATION ABOUT CERTAIN DISEASES.

PUBLIC HEALTH IS PREVENTING SICKNESS TO LIVE LONGER LIVES AND IMPROVE YOUR KINDS OF LIVES AND IT IS VERY RELATED TO YOUR COMMUNITY

PUBLIC HEALTH IS SOMETHING THAT THE COUNTRY IS TAKING CARE OF. THE UNITED STATES SHOULD BE CONCERNED [about] THEIR CITIZENS.

PUBLIC HEALTH IS TAKING CARE OF YOUR COMMUNITY AS A WHOLE AND MAKING SURE THEY ARE AWARE OF HOW TO TAKE CARE OF THEMSELVES AS WELL AS TAKING CARE OF YOURSELF

PUBLIC HEALTH IS TAKING CARE OF YOUR COMMUNITY RECYCLING, AND TAKING CARE OF YOUR COMMUNITY

PUBLIC HEALTH IS THE ART AND SCIENCE OF PREVENTING DISEASE

PUBLIC HEALTH IS THE COMBINATION OF DIFFERENT DISEASES AND ENVIRONMENTAL FACTORS THAT NEGATIVELY IMPACT SOCIETY

PUBLIC HEALTH IS THE CONDITION OF THE AGGREGATE

PUBLIC HEALTH IS THE GENERAL CONDITION OF THE POPULATION THAT WOULD BE MENTAL AND PHYSICAL CONDITIONS

PUBLIC HEALTH IS THE GOVERNMENT MAKING SURE THAT INDIVIDUALS ARE DOING THE RIGHT THING FOR THEIR HEALTH AND WELL-BEING

PUBLIC HEALTH IS THE HEALTH AND WELL-BEING OF A CERTAIN GEOGRAPHIC AREA

PUBLIC HEALTH IS THE HEALTH IF THE PUBLIC PEOPLE, WHETHER WE KNOW THEM PERSONALLY OR NOT.

PUBLIC HEALTH IS THE HEALTH OF EVERY INDIVIDUAL IN THE UNITED STATES OF AMERICA. YOUR FAMILY, YOUR COMMUNITY, YOUR TOWN, YOUR STATE, THE UNITED STATES, AND OUR BRETHREN IN THE WORLD.

PUBLIC HEALTH IS THE HEALTH OF EVERYONE, NOT JUST INDIVIDUALS

PUBLIC HEALTH IS THE HEALTH OF INDIVIDUALS AROUND THE WORLD. WE NEED TO TRY TO IMPROVE AND FIX THE WAY PUBLIC HEALTH.

PUBLIC HEALTH IS THE HEALTH OF MULTIPLE PEOPLE THAT INTERACT IN A PUBLIC SPACE

PUBLIC HEALTH IS THE MEASURES AND REGULATIONS THE GOVERNMENT PUTS ON THE COMMUNITY TO MAKE SURE EVERYONE IS SAFE

PUBLIC HEALTH IS THE OVERALL HEALTH OF A COMMUNITY, HEALTH OUTCOMES, AND HOW PEOPLE AND INSTITUTIONS AFFECT

PUBLIC HEALTH IS THE OVERALL WELL-BEING PHYSICAL AND MENTALLY OF THE POPULATION AS A WHOLE

PUBLIC HEALTH IS THE RESPONSIBILITY OF GOVERNMENT AT ALL LEVELS TO PROVIDE A SAFE ENVIRONMENT, SUCH AS CLEAN WATER, CLEAN AIR, AND STORM WATER MANAGEMENT.

PUBLIC HEALTH IS THE SCIENCE OF PROTECTING AND IMPROVING THE HEALTH OF PEOPLE AND THEIR COMMUNITIES

PUBLIC HEALTH IS THE STATE OF HEALTH OF THE MASS.

PUBLIC HEALTH IS THE WHOLE OF THE LIVES OF THE PEOPLE, INCLUDING SAFETY OF THE FAMILY AND SOCIAL JUSTICE. IT INVOLVES THE FOOD ON THE TABLE AND THE AVAILABILITY OF QUALITY DOCTORS AND INSURANCE PROVIDERS. IT ALSO INCLUDES THE HOPE THAT THINGS CAN GET BETTER. JESUS OR WHATEVER GOD YOU BELIEVE IN.

PUBLIC HEALTH IS THERE TO HELP THOSE THAT NEED IT. THOSE EXPOSED TO DISEASE NOTIFY OTHERS AND, YA KNOW, EDUCATION AND RESPONSIBILITY TO MAKE SURE PEOPLE ARE AWARE.

PUBLIC HEALTH IS VERY IMPORTANT TO EVERY COMMUNITY AND EVERY INDIVIDUAL

PUBLIC HEALTH IS YA KNOW ANYTHING THAT IS OUTSIDE OF YOUR CONTROL, LIKE AIR QUALITY, WATER QUALITY, GENERALLY THE STANDARDS THAT WE SET AS SOCIETY.

PUBLIC HEALTH IS YOUR HEALTH AND THOSE AROUND YOU

PUBLIC HEALTH MAKES ME THINK OF COMMUNITY-BASED HEALTH SUPPORT AND INFECTIOUS DISEASE RESOLUTION.

PUBLIC HEALTH MEANING COMMUNITY NEEDS AFFORDABLE HEALTH CARE

PUBLIC HEALTH MEANS - HEALTH CARE FOR ALL OF THOSE WHO WANT TO BE HEALTHY, INCLUDING DOCTORS, MEDICINES, AND FREE CARE. WITHOUT WORRYING ABOUT THE COST.

PUBLIC HEALTH MEANS AFFECTING EVERYONE OUTSIDE OF YOU SAFE DEALING WITH THE VACCINE

PUBLIC HEALTH MEANS ANY LIVING PERSON.

PUBLIC HEALTH MEANS I BELIEVE THE HEALTH OF THE PUBLIC IN THE AREA THAT YOU ARE LIVING IN OR DOES BEING SPOKEN OF

PUBLIC HEALTH MEANS PREVENTING DISEASES AND RAISING THE LEVEL OF HEALTH THROUGH THE EFFORTS OF ORGANIZATIONS

PUBLIC HEALTH MEASURE TO KEEP THE PUBLIC SAFE

PUBLIC HEALTH PROMOTES AND PROTECTS THE HEALTH OF PEOPLE AND THE COMMUNITIES WHERE THEY LIVE, LEARN, WORK AND PLAY.

PUBLIC HEALTH REFERS TO OVERALL GENERAL PEOPLES GOOD HEALTH CONDITIONS.

PUBLIC HEALTH REFERS TO THE STATUS AND OVERALL WELL-BEING OF A GIVEN POPULATION. IT'S A TERM THAT ENCOMPASSES BOTH THE PHYSICAL AND THE MENTAL ASPECTS OF HEALTH.

PUBLIC HEALTH REFERS TO THE WELL-BEING OF THE COMMUNITY

PUBLIC HEALTH TO ME IS MORE LIKE SOMETHING THAT'S CONTAMINATING A LOCAL AREA

PUBLIC HEALTH WOULD BE ACCESS TO HEALTH CARE ALSO SAFETY MEASURE TO KEEP PEOPLE HEALTHY AND SAFE

PUBLIC HEALTH WOULD BE GENERAL HEALTH OF THE COMMUNITY

PUBLIC HEALTH WOULD BE PEOPLE WHO LIVES THERE

PUBLIC HEALTH WOULD BE THE OVERALL HEALTH OF THE COMMUNITY. THAT STEMS FROM MORE THAN PHYSICAL HEALTH BUT PUBLIC HEALTH ENCOMPASSES MENTAL, FINICAL AND SOCIAL HEALTH

PUBLIC HEALTH WOULD BE VERY CONFUSING BECAUSE OF HEALTH INSURANCE.

PUBLIC HEALTH WOULD REFERENCE HEALTH ISSUES THAT AFFECT A COMMUNITY OR STATE. IT DOESN'T ONLY AFFECT A FEW

PUBLIC HEALTH-THE MEDICAL SAFETY OF LARGE GROUPS OF PEOPLE SUCH AS NEIGHBORHOODS AND STATES

PUBLIC HEALTH, MEANING WHEN BE CLEAN AND HEALTHY.

PUBLIC HEALTH, THE ART AND SCIENCE OF PREVENTING DISEASE, PROLONGING LIFE, AND PROMOTING PHYSICAL AND MENTAL HEALTH, SANITATION, PERSONAL HYGIENE, CONTROL OF INFECTIOUS DISEASES, AND ORGANIZATION OF HEALTH SERVICES

PUBLIC IS MAKING SURE OVERALL THAT EVERYONE HAS THE ABILITY TO TAKE HEALTH CARE NEEDS AND LEAD HEALTHY LIVES

PUBLIC USUALLY MEANS ALL TYPE OF PEOPLE HEALTH! THE PUBLIC HEALTH GROUP NEEDS TO BE AWARE OF POSSIBLE TYPES OF SICKNESS GOING ON AND ALERT THE PUBLIC [and collect] SUGGESTIONS TO HOW TO ADDRESS THE ISSUES

PUBLIC WELL-BEING AND AWARENESS OF THINGS THAT MIGHT HARM THEM

REFERS TO HEALTH OF ENTIRE COMMUNITY

REGARDING PRESENT SITUATION IT'S FINE.

RELIABLE TREATMENT WHEN IT IS NECESSARY

RESPONSIBILITY OF EACH INDIVIDUAL

RESPONSIBILITY OF EVERYBODY AND HAVE ACCESS TO HEALTHY FOOD AND EXERCISE

RESPONSIBILITY OF THE FEDERAL GOVERNMENT

RESPONSIBILITY TO PROVIDE INFORMATION THAT IS ACCURATE

RULES OR REGULATIONS THAT AFFECT ALL OF US AS FAR AS STAYING HEALTHY

SAFETY

SAFETY AND PROTECTION OF ALL CITIZENS. IMPROVE HEALTH CARE,

SAFETY AND WELL-BEING OF PEOPLE

SAFETY FOR THE PUBLIC

SAFETY OF THE COMMUNITY

SAFETY WELL-BEING OF THE EVERYONE IN THE COMMUNITY

SCARY

SCIENCE OF PREVENTING DISEASE, PROLONGING LIFE AND PROMOTING HEALTH THROUGH THE ORGANIZED EFFORTS OF SOCIETY

SELF-COMMITMENT AND COLLABORATION

SHOULD BE A PRIVATE ENTERPRISE BETWEEN AN INDIVIDUAL AND HOW THEY LIVE.

SO AMAZING AND FINANCIAL

SOME TOTAL OR AVERAGE OR WELL-BEING OF A PARTICULAR COMMUNITY

SOMETHING I DON'T THINK I HAVE LOOKED IN THE DICTIONARY A VERY GENERAL STATEMENT THE OVERALL HEALTH AND WELL-BEING OF PEOPLE IN SOCIETY

SOMETIMES UNFAIR BUT SAVES THE COMMUNITIES FROM ILLNESS AND DISEASE.

STATE GOVERNMENT SHOULD OVERSEE OPIOID EPIDEMIC

STATE OF HEALTH ACROSS GEOGRAPHIC

STAY HEALTHY

SUPPLY INFORMATION FOR PEOPLE TO MAKE GOOD DECISIONS

SUPPORTING THE HEALTH OF INDIVIDUALS THROUGH POLICY AND DECISION MAKING, SUPPORTING WELL-BEING INSTEAD OF JUST TREATING DISEASES/ILLNESS

TAKING A STAND ON HOW TO HANDLE A PANDEMIC. TAKING PRECAUTIONS AND SAFETY MEASURES. IMPLEMENTING RULES FOR MASK

TAKING CARE OF CONSTITUENTS

TAKING CARE OF OTHERS

TAKING CARE OF PEOPLE MAKING SURE THEY HAVE THE TRUE INFORMATION ON ALL SIDES, NOT JUST BIG PHARMA OR WHAT THEY WANT PEOPLE TO HEAR

TAKING CARE OF THE PUBLIC HEALTH

TAKING CARE OF THEMSELVES

TAKING OF INDIVIDUALS OF ALL NEEDS

TELL US WHAT IS GOOD FOR THE OVERALL HEALTH OF THE CITIZENS, GUIDANCE

THAT PEOPLE TAKE THEIR PUBLIC HEALTH SERIOUSLY

THAT THINGS ARE BEING DONE TO MAKE SURE THERE ARE NO DISEASES; PEOPLE EATING PROPERLY, ENVIRONMENT IS CLEAN

THAT WOULD BE PEOPLE LIVING DISEASE FREE LIVES. HAPPY, DISEASE-FREE, FEELING WELL THROUGH GOOD FOOD

THAT'S A CHALLENGE AND A LOT OF RESPONSIBILITIES TO MAKE SURE THAT THERE ARE THERE'S SOME KIND OF CONTACT AVAILABLE, SOME PLACE THAT YOU COULD GO TO IF YOU NEED HELP.

THAT'S EVERYTHING, BECAUSE IF YOU DON'T HAVE THAT YOU DON'T HAVE ANYTHING

THE ABILITY TO WORK PEOPLE WORK NORMALLY WITHOUT NATURE PROBLEMS

THE ATTENTION RELATED TO PUBLIC INFECTION AND GENERAL HEALTH

THE AVERAGE OF COMMUNITY HEALTHINESS.

THE AVERAGE STATE OF HEALTH OF A COUNTRY.

THE COLLECTIVE HEALTH OF THE POPULATION

THE COMMUNITIES' HEALTH OVERALL

THE COMMUNITY AS A WHOLE

THE COMMUNITY OF BUSINESS, GOVERNMENT, PEOPLE, TAKING CARE OF EACH OTHER TO BE WELL

THE COMMUNITY UNDERSTANDING THAT WE ARE INDIVIDUALLY RESPONSIBLE FOR OUR OWN HEALTH BUT WE ALSO MUST PRACTICE DUE DILIGENCE TO PROTECT OTHERS WHILE PROTECTING OURSELVES

THE COMMUNITY'S STATE OF OVERALL WELL-BEING.

THE CONDITION OF HEALTH THE PUBLIC AS A SOCIETY IS IN

THE CONDITION OF THE HEALTH OF PEOPLE IN THE PUBLIC

THE CONDITIONS OF A COMMUNITY OR GROUP. THIS CAN INCLUDE ENVIRONMENTAL HEALTH, PHYSICAL HEALTH, OR ECONOMIC HEALTH.

THE CONSTELLATION OF ISSUES THAT EITHER CONTRIBUTE TO WELLNESS OR CREATE AND PERPETUATE ILLNESS. IT IS REALLY FROM A GOVERNMENT PERSPECTIVE

THE ENVIRONMENT WHERE EVERYONE CAN LIVE HEALTHILY.

THE FACILITY IS WORKING ON THE HEALTH OF THE CITIZENS

THE GENERAL CONDITION OF THE PEOPLE.

THE GENERAL HEALTH OF A GIVEN COMMUNITY

THE GENERAL HEALTH OF THE MAJORITY OF PEOPLE.

THE GENERAL HEALTH OF THE POPULATION

THE GENERAL HEALTH OF THE PUBLIC.

THE GENERAL OF YOUR POPULATION

THE GENERAL OVERALL HEALTH CONDITIONS OF PEOPLE COLLECTIVELY

THE GENERAL WELL-BEING OF THE COMMUNITY AT LARGE

THE GENERAL WELL-BEING OF THE ENTIRE POPULATION.

THE GENERAL WELL-BEING OF THE PEOPLE AT LARGE, THAT WOULD ENCOMPASS MENTAL HEALTH, PHYSICAL HEALTH AND SOCIAL HEALTH

THE GENERAL WELL-BEING OF THE POPULATION IN ANY GIVEN AREA.

THE GENERAL WELL-BEING OF THE PUBLIC

THE GENERAL WELLNESS OF THE COMMUNITY AS A WHOLE.

THE GOVERNMENT HAS STEPPED IN DURING COVID, BUT I THINK IT IS THE FAMILY'S RESPONSIBILITY TO PROTECT ITSELF

THE GOVERNMENT SHOULD BE THERE TO HELP WITH THE WHEN THEY NEEDED

THE GOVERNMENT'S ASSURING THAT THE POPULATION IS SAFE AND UNDERSTANDS THE PUBLIC HEALTH THAT PEOPLE UNDERSTAND NUTRITION AND THE GOVERNMENT SHOULD IMPROVE HEALTHY LIFESTYLES.

THE GREATER COMMUNITY AS IT RELATES TO A GEOGRAPHIC AREA

THE HEALTH AND GROWTH OF A COMMUNITY

THE HEALTH AND SAFETY OF ALL PEOPLE

THE HEALTH AND SAFETY OF THE SOCIETY, BOTH LOCAL AND NATIONAL

THE HEALTH AND WELL-BEING OF THE OVERALL PUBLIC- WE ARE A SOCIETY AND IT IS OUR RESPONSIBILITY TO ENSURE THAT THOSE WITHOUT MEANS ARE TAKEN CARE OF

THE HEALTH AS A WHOLE

THE HEALTH CARE OF A COMMUNITY

THE HEALTH CARE OF THE PUBLIC, SO IT CAN VARY. IT'S EVERYTHING FROM ENVIRONMENTAL TO MEDICAL TO POLITICAL, THE EVERYTHING

THE HEALTH FOR EVERYONE

THE HEALTH OF A COMMUNITY

THE HEALTH OF A COMMUNITY

THE HEALTH OF A GROUP OF PEOPLE LINK BY A COMMON CHARACTERISTIC.

THE HEALTH OF A POPULATION

THE HEALTH OF A POPULATION AS A WHOLE

THE HEALTH OF A POPULATION AS WHOLE

THE HEALTH OF A WHOLE POPULATION

THE HEALTH OF ALL COMMUNITIES

THE HEALTH OF ALL INDIVIDUALS

THE HEALTH OF AN ENTIRE MAJORITY. NUTRIENTS AND SUCH AS A WHOLE.

THE HEALTH OF CITIZENS

THE HEALTH OF EACH INDIVIDUAL PERSON THAT IS OUT IN PUBLIC AREAS

THE HEALTH OF EVERYBODY.

THE HEALTH OF EVERYONE

THE HEALTH OF EVERYONE

THE HEALTH OF EVERYONE IN A CERTAIN COMMUNITY

THE HEALTH OF INDIVIDUALS.

THE HEALTH OF LARGE GROUPS OF PEOPLE. PROTECTING INDIVIDUALS FROM DISEASES THAT ARE EASILY SPREAD.

THE HEALTH OF MY NEIGHBORS AND FRIENDS AND FAMILY.

THE HEALTH OF PEOPLE IN A COMMUNITY

THE HEALTH OF PEOPLE IN GENERAL

THE HEALTH OF SOCIETY AS A WHOLE

THE HEALTH OF SOCIETY AS A WHOLE, KEEPING IT ON THE BETTER END OF THE SPECTRUM

THE HEALTH OF SOCIETY AT LARGE.

THE HEALTH OF THE CITIZENRY

THE HEALTH OF THE COMMUNITY

THE HEALTH OF THE COMMUNITY

THE HEALTH OF THE COMMUNITY

THE HEALTH OF THE COMMUNITY AND PEOPLE IN IT

THE HEALTH OF THE COMMUNITY AS A WHOLE

THE HEALTH OF THE COMMUNITY AS A WHOLE.

THE HEALTH OF THE COMMUNITY BOTH MENTALLY AND PHYSICALLY

THE HEALTH OF THE COMMUNITY INDIVIDUALLY AND AS A WHOLE

THE HEALTH OF THE COMMUNITY MEMBERS AND THE PROGRAMS THE LOCAL GOVERNMENT DOES TO HELP.

THE HEALTH OF THE COMMUNITY SOMEONE LIVES OR WORKS IN.

THE HEALTH OF THE ENTIRE PUBLIC/COMMUNITY

THE HEALTH OF THE GENERAL POPULOUS

THE HEALTH OF THE INDIVIDUALS WHO LIVE IN A TOWNSHIP/CITY.

THE HEALTH OF THE PEOPLE IN A COMMUNITY RESPECTIVELY AS A WHOLE.

THE HEALTH OF THE PEOPLE IN YOUR COMMUNITY

THE HEALTH OF THE POPULACE.

THE HEALTH OF THE POPULATION

THE HEALTH OF THE POPULATION AS A WHOLE

THE HEALTH OF THE POPULATION AS A WHOLE

THE HEALTH OF THE POPULATION AS A WHOLE ESPECIALLY AS THE SUBJECT OF GOVERNMENT REGULATION

THE HEALTH OF THE POPULATION AS A WHOLE, ESPECIALLY AS THE SUBJECT OF GOVERNMENT REGULATION AND SUPPORT.

THE HEALTH OF THE POPULATION IN GENERAL

THE HEALTH OF THE POPULATION. PROMOTING HEALTH THROUGH SCIENCE AND MEDICINE.

THE HEALTH OF THE PUBLIC

THE HEALTH OF THE PUBLIC

THE HEALTH OF THE PUBLIC

THE HEALTH OF THE PUBLIC

THE HEALTH OF THE PUBLIC AS A WHOLE

THE HEALTH OF THE PUBLIC WHAT KIND OF CONDITION THEY ARE IN

THE HEALTH OF THE PUBLIC. THE OVERALL HEALTH OF THE COMMUNITY

THE HEALTH REGARDING COMMUNITY AND ITS RESIDENTS AND IT'S RESIDENTS AND WHETHER OR NOT IT'S CONTAGIOUS

THE HEALTH SAFETY AND WELFARE OF EVERYONE IN THE COUNTRY

THE HEALTH-RELATED ISSUES THAT IMPACT EVERYONE IN THE COMMUNITY

THE IDEA THAT THE GENERAL POPULATION IS SOMEWHAT HEALTHY AND FREE OF DISEASE.

THE IMPACT PUT ON THE LOCAL TOWN OR CITY

THE INTERACTION BETWEEN INDIVIDUALS AND GOVERNMENT

THE LEVEL OF WELLNESS OR DISEASE IN A POPULATION / COMMUNITY.

THE LOCAL COMMUNITY WANTS TO HELP YOU, LIKE A SENIOR CITIZEN ORGANIZATION

THE LOCAL MEDICAL AUTHORITY OF COUNTY OR CITY

THE MAJORITY OF PEOPLE WITH RELATIVELY FEW HEALTH ISSUES

THE MANAGEMENT OF HEALTH ISSUES OF A COMMUNITY AS A WHOLE

THE NUMBER OF PEOPLE INFECTED WITH THIS CONDITION

THE OVERALL HEALTH AND WELFARE OF THE PUBLIC.

THE OVERALL HEALTH AND WELL-BEING OF THE GENERAL POPULACE

THE OVERALL HEALTH AND WELL-BEING OF THE PUBLIC.

THE OVERALL HEALTH OF A COMMUNITY

THE OVERALL HEALTH OF A COMMUNITY OR GROUP OF PEOPLE.

THE OVERALL HEALTH OF A COMMUNITY, WITH AN EMPHASIS ON THE COMMUNITY'S GOVERNMENT NEEDING TO TAKE RESPONSIBILITY IN ADDRESSING IT.

THE OVERALL HEALTH OF AMERICANS.

THE OVERALL HEALTH OF CITIZENS IN GENERAL.

THE OVERALL HEALTH OF PEOPLE IN A COMMUNITY

THE OVERALL HEALTH OF SOCIETY

THE OVERALL HEALTH OF THE COMMUNITY.

THE OVERALL HEALTH OF THE COMMUNITY. ISSUES WOULD BE THINGS THAT AFFECT EVERYONE

THE OVERALL HEALTH OF THE GENERAL POPULATION

THE OVERALL HEALTH OF THE PEOPLE WHO LIVE IN THE COMMUNITY

THE OVERALL HEALTH OF THE POPULATION

THE OVERALL HEALTH OF THE PUBLIC

THE OVERALL HEALTH OF THE PUBLIC AS A WHOLE

THE OVERALL HEALTH OF THE PUBLIC, DEALING WITH DISEASES AND COMMON PROBLEMS.

THE OVERALL HEALTH OR WELL-BEING, WHETHER PHYSICAL, MENTAL, EMOTIONAL, OR SPIRITUAL OF A GROUP OF PEOPLE LIVING IN A CERTAIN ENVIRONMENT.

THE OVERALL STATE OF THE HEALTH OF THE PEOPLE OF AN AREA

THE OVERALL THE ABILITY OF SOCIETY TO FUNCTION ON AN ANATOMICAL BASES TO CARRY OUT WHAT THEY DO IN SOCIETY

THE OVERALL WELL-BEING AND QUALITY OF LIFE IN A COMMUNITY.

THE OVERALL WELL-BEING OF A COMMUNITY

THE OVERALL WELL-BEING OF A COMMUNITY OF PEOPLE THAT LIVE IN CLOSE PROXIMITY

THE OVERALL WELLNESS OF INDIVIDUALS IN THE COMMUNITY.

THE OVERALL WELLNESS OF THE GENERAL POPULATION

THE PEOPLE IN YOU COMMUNITY AND WHO AFFECTED HOW YOU EAT

THE PERCENTAGE IN THE PUBLIC WITH SIMILAR DISEASE

THE PHYSICAL AND MENTAL AND QUALITY OF LIFE AND A COMMUNITY AT LARGE

THE PHYSICAL AND MENTAL WELL-BEING OF THE PEOPLE WITHIN A COMMUNITY.

THE PORTION OF THE LOCAL GOVERNMENT TO SPREAD GENERAL HEALTH INITIATIVES

THE PRACTICE OF GOVERNMENT TO ENACT HEALTH-RELATED INITIATIVES INTENDED TO HELP THE AVERAGE CITIZEN.

THE PROCESS OF PROTECTING AND IMPROVING THE HEALTH OF THE COMMUNITY

THE PROGRAMS THAT ARE OFFERED FOR PUBLIC HEALTH. LIKE VACCINES FOOD BANKS OR IS THAT RESOURCES

THE PUBLIC BEING HEALTHY

THE PUBLIC HEALTH WOULD BE ANYTHING THAT AFFECT THE WELL-BEING OF THE SOCIETY THAT WE ARE IN

THE PUBLIC'S HEALTH

THE PUBLIC'S HEATH LIKE THE COMMONERS AS SUCH AS MYSELF

THE QUALITY OF ONE'S LIFE.

THE SAFETY AND HEALTH OF THE GENERAL POPULATION

THE SAFETY OF THE PUBLIC

THE SCIENCE AND ART OF PREVENTING DISEASE WITH COMPLETE TRANSPARENCY! CURRENTLY OUR PUBLIC HEALTH IS A DISGRACE.

THE SCIENCE AND ART OF PREVENTING DISEASE, PROLONGING LIFE AND PROMOTING HEALTH

THE SCIENCE OF PREVENTING DISEASES, PROLONGING LIFE AND QUALITY OF LIFE THROUGH ORGANIZED EFFORTS. INFORMED CHOICES OF INDIVIDUALS, SOCIETY, ORGANIZATIONS, CORPORATIONS, AND COMMUNITIES.

THE STANDARD OF HEALTH LIKE A MINIMUM STANDARD OF HEALTH FOR ALL THE COMMUNITY

THE STATE OF HEALTH FOR THE GENERAL PUBLIC

THE STATE OF THE COMMUNITY AS FAR AS HEALTHY VERSUS AFFLICTED PEOPLE AND THE STATUS OF THE CLEANLINESS OF THE MUNICIPALITIES

THE STUDY AND ADMINISTRATION OF HEALTH ACROSS COMMUNITIES TO PROVIDE SERVICES.

THE SURROUNDING COMMUNITIES

THE WAY HEALTH ISSUES THAT CAN AFFECT THE WHOLE COMMUNITY

THE WAY OUR WORLD WORKS

THE WAY WE INTERACT IN PUBLIC SETTINGS WITH EACH OTHER ESPECIALLY WHEN WE ARE SICK OR NOT FEELING WELL

THE WELFARE OF EVERYONE IN THAT STATE

THE WELFARE OF THE ENTIRE COMMUNITY.

THE WELFARE, WELL-BEING AND OVERALL HEALTH CARE OF THE COMMUNITY

THE WELL-BEING AND HEALTH OF THE PUBLIC AND MAKE SURE THEY AREN'T I'LL

THE WELL-BEING OF CITIZENS.

THE WELL-BEING OF EVERYONE IN YOUR COMMUNITY.

THE WELL-BEING OF INDIVIDUALS AROUND EACH OTHER IN OPEN PLACES.

THE WELL-BEING OF PEOPLE IN THE COMMUNITY

THE WELL-BEING OF THE PUBLIC

THE WELLNESS OF YOUR COMMUNITY

THE WHOLE COMMUNITY REGARDING HEALTH CARE

THERE'S A LOT PEOPLE NOT DOING THEIR PART

THEY ARE DOING A GREAT JOB DURING COVID TIMES

THEY ARE THE AVERAGE HEALTH OF THE COMMUNITY.

THEY'RE TRYING TO TELL EVERYBODY, THEY ALWAYS GIVE THE FLU SHOT, THE MANDATES THE SHOT THAT TYPE OF STUFF.

THINK HEALTH

TO DO WITH THE GOVERNMENT SUPPOSED TO PROVIDE FOR THE PEOPLE, UNIVERSAL CARE.

TO MAKE SURE EVERYTHING IN YOUR BODY STAYS SAFE

TO MEAN THE OVERALL HEALTH OF THE GENERAL PUBLIC

TO WHAT THE GOVERNMENT IS DOING TO PROMOTE GOOD HEALTHY LIVES FOR EVERYONE

TOTALLY MESSED UP COVID ROLL-OUT STRUCTURE AND FEDERAL GOVERNMENT STRUCTURE

UMM IN MY OWN WORDS PROGRAMS AND POLICIES TO HELP EVERYBODY ON BETTER HEALTH

UNDERLYING SYSTEMIC CIRCUMSTANCES THAT EFFECT PEOPLES WELL-BEING

VACCINE NATIONS

VACCINES AND PUBLIC DISEASES

WASHING HANDS, SANITIZING

WELFARE

WELL BING OF COMMUNITY

WELL I WOULD SAY THAT'S MULTIFACETED... IN THE AREA ITS THE FACILITIES THE HEALTH CARE FACILITY ARE IMPORTANT IN THE AREA, HOSPITALS MOSTLY… IT'S THE INDIVIDUALS.

WELL-BEING OF EACH INDIVIDUAL

WELL-BEING OF EVERYONE

WELL-BEING OF SOCIETY

WHAT KIND OF HEALTH SERVICES IS AVAILABLE FOR THE COMMUNITY

WHAT THE GOV PROVIDES TO KEEP PEOPLE HEALTHY

WHAT'S BEST FOR THE INDIVIDUAL AND COMMUNITY

WHAT'S GOOD FOR A MAJORITY OF PEOPLE

WHEN PEOPLE COME TOGETHER OUTSIDE OF THE HOME

WORKING TOGETHER TO KEEP EACH OTHER HEALTHY

WORLDWIDE HEALTH STANCE

WOULD BE ANY TYPE OF DISEASE THAT AFFECTS PEOPLE

WOULD ESSENTIALLY MEAN BEING RESPONSIBLE FOR THE HEALTH OF THE COMMUNITY

WOULD INCLUDE SAFETY & PROVIDING OPPORTUNITY FOR ADEQUATE HEALTH CARE FOR THE COMMUNITY

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