

**A Case for Improving the  
MASSACHUSETTS  
LOCAL  
PUBLIC HEALTH  
INFRASTRUCTURE**

*Report Submitted by the  
Coalition for Local Public Health*

*Massachusetts Association of Health Boards  
Massachusetts Association of Public Health Nurses  
Massachusetts Environmental Health Association  
Massachusetts Health Officers Association  
Massachusetts Public Health Association*

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*“Every health department fully prepared;  
Every community better protected”*

— Centers for Disease Control and Prevention

# *Introduction*

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The Coalition for Local Public Health consists of five statewide public health organizations dedicated to promoting healthy communities in Massachusetts through strong boards of health and health departments. Our organizations represent over 3,000 citizens and health professionals interested in supporting the Commonwealth's local health infrastructure. We believe the Massachusetts local health infrastructure is insufficient as presently supported to adequately respond rapidly to both routine and acute health events.

The Constitution gives the states, not the federal government, primacy in exercising the police powers to protect the public's health. States, in return, operate under many organizational models in exercising their public health responsibilities. Local public health organizations carry out critical public health responsibilities that are embodied in state statutes and regulations and are authorized to pass local regulations and to meet other needs and expectations of their communities.

In Massachusetts, local governmental public health is a function of municipal government. This is not true in all states, which have four general forms of how they relate to their local health agencies created by state legislative action.

The first form is centralized, with the state health department providing the local health function. Rhode Island is an example. The second form is shared responsibility, such as in Connecticut, where the state has limited control over the Local Health Department (LHD) by approving the credentials of the local health officer and requiring the receipt of an annual report as a condition of receiving some state non-categorical funding. The third form is a mixed model, such as in Maine or New Hampshire, where the state provides local health functions for communities that do not have their own LHDs. The last and most common form is decentralized, with LHDs formed and managed by local government. In most states, this is done through a county system, but in Massachusetts it is done through individual cities and towns.

Massachusetts requires each municipality to have a Board of Health but also allows for a number of organizational models to exist at the discretion of the municipality. Boards of Health can be elected, appointed, regional, or advisory under a Health Commissioner model. Cape Cod has a county model, which does not replace local municipal Boards of Health but rather serves as a source of specialized support services to the local municipalities in Barnstable County. Board of Health staff may be paid full or part time, including Agents and Directors of Health with formal training in public health, or they may be voluntary, unpaid Board of Health members. Staff may also be shared with other municipalities.

Massachusetts has a strong tradition of local autonomy. The state does not provide incentives or staff support to assist municipalities to share resources as permitted under state law. As a result, most municipalities only cover their own jurisdiction with their local Board of Health. Massachusetts is 45<sup>th</sup> in land area of all the states but has more local health departments than any other state. Most municipalities have fewer than 10,000 residents and are too small to be able to afford a full range of professional public health services.

## *Local Public Health Overview*

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Public health works to promote and protect the health and safety of people in their homes, in their communities, in their schools and in their workplaces. The *public health infrastructure* is the system of governmental agencies, private providers and voluntary organizations, working together to protect the public's health by preventing epidemics and the spread of disease; responding to disasters and assisting communities in recovery; protecting against environmental hazards; preventing injuries; promoting and encouraging healthy behaviors; and assuring the quality and accessibility of health services (United States Public Health Service, 1994). Public health operates at the community level, and is rooted in *preventing* illnesses and injuries through health and safety promotion and protective regulatory activities.

A 2002 report issued by the Institute of Medicine (IOM), entitled *The Future of the Public's Health in the 21st Century*, points out that our national public health infrastructure is in disarray and is woefully under funded. It also recognizes that, if we invest in our public health system, we could make substantial differences in the health of our nation. The report states, in part:

“In the past two decades, there has been an increasing amount of research demonstrating that a variety of factors determine health, and health care is only one of these factors-- a relatively small one at that. Risky behaviors account for half of avoidable deaths. Environmental factors account for 20 percent. Other factors, such as socioeconomic status, race, social networks, and working conditions, are also very important to influencing health status.

Yet in the face of this mounting evidence, 95 percent of our health spending is targeted toward (expensive) individual health care delivery and biomedical research to treat illness after it occurs. Less than 1 percent of health dollars are spent on prevention. With our enormous resources, this is a very limited investment strategy, and it is likely a factor in our poor health outcomes.”

Further, with security issues now at the forefront of the national agenda, public health needs to be at the heart of bioterrorism planning and response efforts. Contrary to our image of a sudden catastrophe, a bioterrorist action will almost certainly be gradual, taking hours or days before people begin appearing in hospital emergency rooms or in school nurses' offices. The outcome will be determined in large part by how quickly these cases are recognized, managed, and prevented.

When examining how the Commonwealth's public health infrastructure addresses these issues, it is important to understand that the Massachusetts Department of Public Health (MDPH) is a relatively strong and effective governmental agency, providing the bulk of public health services in the Commonwealth either through the direct provision of services and programs, or through contractual arrangements with private vendors.

But to understand the Commonwealth's public health infrastructure in its entirety, it is important to consider that in Massachusetts, every locality (city and town) is represented by its

own local board of health or health department, which bears the statutory responsibility for ensuring that the public health needs of its community is met. In addition to their ongoing regulatory and health promotion responsibilities, they are also charged with monitoring and investigating the rise of new infectious and food-borne diseases, as well as monitoring the continued proliferation of pollutants, and incidents that may constitute or appear to be bioterrorist threats.

These additional inescapable responsibilities threaten to overwhelm the local public health infrastructure of Massachusetts, which is already chronically under funded, understaffed, ill trained and ill equipped technologically to do the job they are expected to do. Too many health departments lack adequate staff or information and communication technologies. Many of them operate using volunteers who are not trained to address public health emergencies. In the face of these extant and newly emerging challenges arises an ominous message. The Commonwealth may be vulnerable to a naturally occurring epidemic or a possible bioterrorist attack, and we need to face up this reality.

Local, or municipal health departments perform a wide array of functions to keep communities healthy. For instance public health nurses provide rapid and efficient immunizations to populations at risk, they perform home visits to the infirm who might otherwise need institutional care, they provide youth educational programs on such topics as drug and pregnancy prevention, they organize preventive health screenings, they investigate communicable disease, and they provide information and referrals to citizens in need of health services.

Environmental health specialists also play a key public health role. They conduct housing and restaurant investigations to prevent possible lead poisoning and food-borne outbreaks, they identify environmental hazards that can contribute to clusters of acute and chronic illnesses, and they respond to indoor air quality problems in public schools and office buildings. They also inspect camps, pools, and all food establishments.

If an outbreak of meningitis or tuberculosis occurs at a school, our local public health officials respond. If a dead crow or raccoon is found in the street, they arrange to have them tested at the state laboratory to see if they are infected with West Nile Virus or rabies. And if a suspicious white powdery substance is discovered in a piece of mail, they are the first responders to contain the problem while communicating with and reassuring a terrified public. Public health officials work every day behind the scenes to keep our communities healthy and safe and protected.

At present a basic commitment is necessary by the state to assure that the local health boards or departments can carry out their vital functions and protect the citizenry of the Commonwealth. Currently, the state provides virtually no categorical support for public health departments, outside of the recently decimated tobacco control programs. Over the years, the state has required health departments to take on new and intensive regulatory activities without any additional compensation or support, such as extended camp inspections.

In addition, the Commonwealth in the past had strong regional health offices that were staffed to provide expertise and support to local health departments in their region. The legal

authority authorizing these offices still exists and the bioterrorism funds could provide the resource to restore their functions to meet the inter-municipal needs, which are currently not well addressed.

## *What Needs to be Done?*

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There is hardly a day that passes without a news media report on the hazards of chemicals and microbes in our environment producing a possible cornucopia of diseases ranging from cancer, reproductive disorders, failed pregnancies, birth defects, asthma, Lupus, Multiple Sclerosis, Lyme disease, and any number of other diseases causing premature death or chronic illness. Moreover, tobacco addiction and obesity, and other preventable conditions, are responsible for billions of dollars of needless health care costs in this state.

The rise of new infectious and food-borne diseases, the continued promulgation of toxic pollutants, the growth of certain populations in need of special health services, domestic and community violence, and the specter of bioterrorism are all local health problems which require local solutions. These problems will continue to be inadequately addressed as long as the local public health infrastructure is not buoyed with additional resources, such as increased staffing, technical assistance and continuing education opportunities. The state department of public health cannot address these emerging and evolving problems of disease prevention and health promotion effectively without the active partnership of local public health officials and professionals. Unfortunately, because of insufficient local health capacity, this partnership has been less than optimal.

In order to meet the need of public health preparedness in our state, there are four general areas of local health that need to be addressed:

- 1. Organizational Capacity:** The local health departments need to be regarded as equal partners with the state public health department to provide the essential services of public health. They need the equipment and staffing infrastructure to accomplish this goal.
- 2. Workforce Standards and Competency:** Every health department needs to be able to employ trained public health professionals to carry out their duties. A volunteer or jury-rigged workforce won't do. Minimum performance standards of service and mechanisms of accountability must be promulgated.
- 3. Information, Communication and Data Systems:** Biological and chemical weapons, with their potential for massive death and destruction, necessitate local health departments and boards to have access to robust information and communication systems that monitor disease, access critical information, and enable rapid, confidential and seamless communication among federal, state and local agencies as well as public and private health organizations, the media and the public.
- 4. Resources:** Dramatic cuts in state funding for Massachusetts Department of Public Health (MDPH) programs over the past three years, including virtual elimination of the tobacco control

program, have had devastating consequences for local health boards and departments. Local public health programs have also suffered disproportionate impacts due to reduced state aide to cities and towns and resulting municipal budget cuts. Vital programs have been severely reduced or eliminated, and staff have been terminated in many communities. New federal funding for emergency preparedness offers an important potential resource for strengthening local public health infrastructure, but the levels of state funding cuts far exceed the amount of new funds available from federal sources. It is essential for the administration and the legislature to stop disproportionate funding cuts to public health, compared to other departments of state government, and to restore funds required for programs that benefit all communities in the Commonwealth.

None of these recommendations can be executed without a functional Office of Local Health, which deals with collecting basic information the MDPH needs to support the CDC Bioterrorism work plan. At this time, the Department is missing any information on local staffing, budgets, a capacity analysis, updated communication information, or a mechanism to keep whatever information is collected current.

There are statutes still on the books (Chapter 111, section 4 and Chapter 111, section 18) that would allow the implementation of regional MDPH offices that could consolidate the CDC work plan with a strategy to strengthen the local public health infrastructure using the spirit, as well as the intent, of these federal resources.

The implementation of a strong regional service to provide expertise and support to local health departments is possible within a short timeframe. Attempting to organize regional local health departments is a very difficult task that would take years and some form of state tax support, as is done in Connecticut, to succeed. There is insufficient motivation for most local governments to consider joining a regional structure or even to supply mutual aid to each other. A successful model already exists for a strong regional state office in the Western Regional Health Office. This model has shown how these offices can work, even with limited resources. This, combined with a new communication system granted to local health departments, would allow the CDC work plan to go forward in a timely and efficient manner.

In this report, we see an opportunity to dramatically improve the public health system of the Commonwealth, particularly given the new federal resources that are available for these purposes. We see a specific weakness in the lack of direct state support for the infrastructure and core functions of local public health. We also recognize that there are opportunities for local public health programs to organize themselves more efficiently and effectively through an improved system of sharing of resources and programs.

To correct the deficiencies we have outlined, we call for improvements in the public health infrastructure through the state's Department of Public Health. The MDPH should be authorized and funded to give direct support to local boards of health, not just for categorical programs, but also for support of basic infrastructure and emergency preparedness.

## *Recommendations*

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The Coalition for Local Public Health recommends the following actions be supported as a means of improving local public health capacity to face a world of new threats and reemerging threats of infectious disease. These recommendations, if implemented, would strengthen relations between local public health providers and the MDPH and provide a roadmap for future efforts to improve the public health infrastructure:

1. **Develop minimum standards for essential public health services** in every community, that identify an adequate infrastructure needed to conduct prevention-oriented programs and emergency preparedness at the local level. We recommend that they include, at a minimum, a public health nurse and a health inspector available to every community.
2. **Increase personnel, equipment, technology, and data resources** available to boards of health departments so they can respond more rapidly to disease outbreaks, biosecurity, and health promotion activities.
3. **Strengthen workforce development and competency** through increased training opportunities for local boards of health and staff, and through the development of minimum educational levels and credentialing for certain positions.
4. **Collaborate with localities, explore mechanisms for alternative service delivery** including greater municipal and/or regional collaboration that do not usurp, preempt, or limit the authority of local Boards of Health.
5. **Reinstate a Local Health Services Office** at the MDPH, with increased staffing, training and technical assistance provided at regional offices for area cities and towns. Epidemiologists must also be made available to conduct community-based health surveillance activities and research.
6. **Establish a Director of Public Health Nursing position** at the MDPH to provide technical assistance and ensure communication at the local level and address public health nursing shortages by supporting increased public health nursing workforce development initiatives.
7. **Consult with local public health providers through the Coalition for Local Public Health** in planning and response efforts related to bioterrorism and emergency preparedness.
8. **Adequately fund** local public health departments, boards and Coalition for Local Public Health member organizations to implement newly promulgated state regulations, mandates, or requirements involving enforcement activities, program initiatives, and collaborative planning.
9. **Institutionalize dedicated funding mechanisms** to be reallocated or developed to adequately support disease and injury prevention and health promotion at the local level. Tobacco tax revenues approved by the voters for tobacco control, for instance, should be allocated as intended. CDC emergency preparedness funds awarded to strengthen local public health infrastructure should be allocated as proposed as quickly as possible.

## APPENDIX

### REQUIRED DUTIES OF LOCAL BOARDS OF HEALTH IN MASSACHUSETTS

Local boards of health in Massachusetts are required by state statutes and regulations to perform many important and crucial duties relative to the protection of public health, the control of disease, the promotion of sanitary living conditions, and the protection of the environment from damage and pollution. These requirements reflect the legislature's understanding that many critical health problems are best handled by the involvement of local community officials familiar with local conditions.

The following is a list of duties and responsibilities of local boards of health in Massachusetts. Each item includes a citation to the statute or regulation, which imposes the duty or responsibility. The items have been grouped under general subject categories.

Following this listing of Required Duties is a list of Additional Powers of local boards of health, which extend the local board's authority over the broad range of health, sanitation and environmental problems.

A. Records, Record keeping and Reports:

1. In cities, submit an annual report to the city council concerning the board's activities during the preceding year and concerning the sanitary condition of the city. M.G.L. c.111, s.28.
2. Maintain numerous records and retain them for required minimum retention periods. (A list of approximately three dozen categories of board of health records and their retention periods will be found in the Guidebook for Massachusetts Boards of Health published by the Massachusetts Association of Health Boards.
3. Process numerous types of reports of cases of diseases. These reports are detailed in Food Borne Illness Investigation and Control Reference Manual, and MAHB Guide book.
4. Process of death certificates. M.G.L. c.46, s.11.

B. Health Care and Disease Control:

1. Upon request, telephone to a gas and electric utility company and certify in writing within seven (7) days of said telephone call that there is a serious illness in a residence such that no gas or electric company shall shut off or fail to restore gas or electric service in any residence during such time as there is a serious illness. M.G.L. c.164, s.124A; 220 CMR 25.03(2).
2. Receive reports of cases of disease dangerous to public health. Keep records of these reports and also forward copies of these reports to the local school committee, and to other local boards in whose jurisdiction the patient resides, or may have contracted the disease, or may have exposed others. M.G.L. c.111, s.111. See 105 CMR 300.100 for list of diseases required to be reported.
3. Report cases of dangerous diseases to the Department of Public Health within twenty-four hours. M.G.L. c.111, s.112. See 105 CMR 300.100 for a list of diseases required to be reported.

4. Consult with the Department of Public Health regarding the prevention of dangerous diseases. M.G.L. c.111,s.7.
5. Send to the Department of Public Health weekly reports of deaths due to dangerous diseases. M.G.L. c.111 s.29.
6. Receive notices of school children sent home because of dangerous disease. M.G.L. c.71, s.55A. See the School Health Manual.
7. Report to the Department of Public Health cases of a certain contagious disease occurring at dairy farms. See 105 CMR 310.100-110 for list of such diseases required to be reported.
8. Receive reports of any inflammation, swelling, redness or unnatural discharge from the eyes of an infant less than two weeks old, and take immediate action to prevent blindness. M.G.L. c.111, s.110.
9. Receive reports of persons afflicted with cerebral palsy, and submit an annual report of these cases to the Department of Public Health. M.G.L. c.111, s.111A.
10. Provide anti-rabic vaccine and treatment. M.G.L. c.140, s.145A, 105 CMR 335.
11. Supervise or carry out the disinfection of dwellings which have housed a person who has suffered from or died of a disease dangerous to the public health. M.G.L. c.111, s.109.
12. Receive reports of food poisoning and send these reports to the State Department of Public Health, 105 CMR 300.000.
13. Receive notices from inspectors of the Division of Occupational Safety regarding violations of health laws or nuisances in industrial establishments, investigate these reports, and enforce appropriate laws. M.G.L. c.149, s.136.

C. Housing and Dwellings:

1. Enforce Chapter II of the State Sanitary Code: Minimum Standards of Fitness for Human Habitation, M.G.L. c.111, ss.127A and 127B: 105 CMR 410.000. enforcement of Chapter II includes inspecting dwellings (upon request or upon the board's initiative) for compliance with the minimum standards, certifying violations, issuing orders, holding hearings, granting variances and instituting court proceedings if necessary to enforce such orders.
2. Enforce the State Lead Poisoning Prevention regulations. M.G.L. c.111, s.198; 105 CMR 460.000. Enforcement of these regulations includes inspecting dwellings (upon request or upon the board's initiative) for lead paint, issuing orders for removal of lead paint, and instituting court proceedings to enforce such orders if necessary.
3. Review and approve or disapprove preliminary and definitive plans for the subdivision of land. M.G.L. c.41, ss.81S-81V.
4. Inspect and certify public lodging houses for waterclosets, urinals, ventilation and cleaning. M.G.L. c.140, s.36.

D. Hazardous Wastes:

1. Assign the site for a hazardous waste disposal facility as follows (M.G.L. c.111, s.150B):
  - a. Notify the Department of Environmental Protection (DEP) of the receipt of an application to assign a site.
  - b. Assess significance and degree of danger to public health and consider and evaluate any evidence submitted.
  - c. Give public notice and hold a public hearing.
  - d. Every decision of the board in assigning or refusing to assign a site must be in writing and include a statement of reasons and facts relied on.
2. Chairperson of board serves on the local assessment committee, established whenever a developer seeks to construct and operate a hazardous waste facility within the city or town. Committee has certain duties including negotiating with the developer, entering a contract, and adopting necessary rules and procedures. M.G.L. c.21D, s.5.
3. Notify the mayor and city council or board of selectmen of the following (M.G.L. c.21C, s.4):
  - a. Pending applications for licenses for the collection, storage, treatment, or disposal of hazardous waste, upon notification from DEP.
  - b. Information supplied annually by DEP identifying types and quantities of hazardous waste generated, stored, treated or disposed of within the city or town.

E. Solid Waste:

1. Assign sites of sanitary landfills, refuse incinerators, waste storage or treatment plants, and refuse transfer stations, after a public hearing. Ensure that these do not present a danger to public health. M.G.L. c.111, s.150A.
2. Consider and act on applications for permits for the disposal of special wastes. 310 CMR 19.16.
3. Consider and act on applications for special permits for salvaging or recycling materials from sanitary landfill sites or refuse transfer stations. 310 CMR 19.18; 18.15(1).
4. Periodically inspect sanitary landfill sites, and provide written notice of deficiencies. 310 CMR 19.25.
5. Periodically examine and evaluate refuse transfer stations. 310 CMR 18.00.

6. Inspect and verify satisfactory completion of all corrective work to sanitary landfill projects. 310 CMR 19.26(3).
7. Handle requests for variances of regulations governing sanitary landfills and refuse transfer stations (forward these to DEP); keep notices of the grants of these variances 310 CMR 19.32; 18.27.
8. Keep on file an emergency plan governing emergencies occurring at a refuse transfer station. 310 CMR 18.21.

F. Septage and Garbage

1. Enforce Title V of the State Environmental Code; Minimum Requirements for the Subsurface disposal Sewage, 310.CMR 15.00.
2. Make rules and regulations for the removal, transportation and disposal of garbage, offal and other offensive substances. M.G.L. c.111, s.31B.
3. Issue permits for the removal or transportation of garbage, offal or offensive substances when such refuse has been collected in the city or town. Keep registry of all transporters of refuse through the city or town, and enforce local rules and regulations regarding such transport. M.G.L. c.111, s.31A.

G. Nuisances:

1. Investigate nuisances which in the board's opinion may be injurious to health. The board shall destroy, prevent or remove such nuisances, and shall make regulations relative to nuisances. M.G.L. c.111, s.122.
2. License noisome trades M.G.L. c.111, s.151.
3. Assign location for slaughter houses or other noxious or offensive trade. M.G.L. c.111, s.143.

H. Food:

1. Issue permits for all food service establishments, including restaurants and food service facilities in stores, recreational camps for children, family style campgrounds, institutions, hotels, motels, schools, retail food store, mobile food units and pushcarts, etc., 105 CMR 590.052.
2. Enforce Chapter X of the State Sanitary Code: Minimum Sanitation Standards for Food Establishments, 105 CMR 590.000. Enforcement includes conducting inspections, issuing orders, suspending or revoking permits where necessary.
3. Issue permits for plants which break and can eggs. M.G.L. c.94, s.89.
4. License milk pasteurization plants. M.G.L. c.94, s.48A.

5. City health departments shall have milk inspectors. Town boards may appoint milk inspector. Inspectors must inspect and license milk producers and dealers. M.G.L. c.94, s.33 and s.40.
6. Issue permits for plants that bottle carbonated non-alcoholic beverages. M.G.L. c.94, s.10A; inspect such plants, and revoke permits where plants are found to be unsanitary or otherwise in violation of public health rules and regulations, M.G.L. 94 s.10C; 105 CMR 570 et. Seq. Send to the Department of Public Health copies of all licenses, applications and half the license fees, 105 CMR 570.002. Notify each owner prior to the expiration date of each permit and close plants that fail to renew such permits, 105 CMR 570.002. M.G.L. c.94, s.10C.
7. Register and inspect bakeries and enforce State Bakery Regulations. M.G.L. c.94, s.94F; 105 CMR 550.000; 105 CMR 551.000. Furnish MDPH with monthly reports of inspections, 105 CMR 550.001.
8. License plants that manufacture frozen desserts, M.G.L. c.94, s.65H; 105 CMR 561.000.
9. Inspect cold storage and refrigerated warehouses, M.G.L. c.94, s.67.
10. Enforce M.G.L. c.130, s.81 which prohibits importation of shellfish which have not been certified by a United States or foreign shellfish regulating agency.
11. Enforce statutes and regulations relative to the adulteration and misbranding of food. M.G.L. c.94, ss.186-195.

I. Pools and Beaches:

1. Enforcement Chapter V of the State Sanitary Code: Minimum Standards for Swimming Pools, 105 CMR 435.000. Enforcement includes issuing annual permits, conducting examinations, issuing orders, holding hearings, granting variances, taking water samples.
2. Enforce Chapter VII of the State Sanitary Code: Minimum Standards for Bathing Beaches, 105 CMR 445.000. Enforcement includes issuing annual licenses, approving plans for new or altered beaches, issuing orders, holding hearings, granting variances, receiving reports of accidents, taking water samples.
3. Prohibit swimming in water that fails to meet proscribed standards for bathing, 105 CMR 445.10 (-3).
4. Review plans for new or altered bathing beaches, 105 CMR 445.16.

J. Camps, Motels and Mobile Home Parks:

1. Inspect all recreational camps for children and family style campgrounds, motels, mobile home parks and cabins; and annually issue licenses for these facilities,

M.G.L. c.140, ss.32B and 32C. Send copies of family style campground permits to the Department of Environmental Protection.

2. Enforce Chapter VI of the State Sanitary Code: Minimum Standards for Developed Family type Campgrounds, 105 CMR 440.000. Enforcement includes conducting examination; issuing orders; issuing, suspending and revoking licenses; holding hearings; granting variances.
3. Enforce Chapter IV of the State Sanitary Code: Sanitary Standards for Recreational Camps for Children, 105 CMR 430.000. Enforcement includes inspection, issuing orders and licenses, conducting hearings, granting variances.

**K. Miscellaneous:**

1. Pesticides

- a) Local boards may make reasonable health regulations regarding pesticides provided such regulations are not inconsistent with the Massachusetts Pesticide Control Act, M.G.L. c.132B or state regulations, 333 CMR 2.00. Wendell v. Attorney General, 476 NE 2<sup>nd</sup> 585, 394 Mass 518 (1985). For example, a city or town may want to give its board of health an opportunity to determine whether the proposed application of pesticides in particular locations would be consistent with the products labeling or other restrictions imposed by the Department, Wendell v. Attorney General, supra, 394 Mass at 528.
  - b) Receive public notice of the application of herbicides from applicants that intend to maintain a right of way by the application of herbicides. 333 CMR 11.07.
2. Nominate animal inspectors, M.G.L. c.129, s.15.
  3. License massage parlors, M.G.L. c.140, s.51.
  4. Issue burial permits, M.G.L. c.14, s.45.
  5. License and if necessary revoke licenses for funeral directors. Transmit to the board of registration in embalming names and addresses of all licensees, M.G.L. c.114, s.49.
  6. Approve location of cemeteries, M.G.L. c.114. s.34.
  7. Retain charge of any case arising under M.G.L. c.111 in which the board has acted. M.G.L. c.111, s.32.
  8. Enforce all local health regulations promulgated pursuant to M.G.L. c.111, s.31.

**J. Smoking**

1. Receive written complaints regarding the willful failure or refusal to comply with the Indoor Clean Air Act regarding restaurants, supermarkets or retail food outlets. M.G.L. c.270 s.22.

2. Inspect the area described in the complaint and enforce no-smoking laws. M.G.L. c.270 s.22.
3. Provide written response to complainant within 15 days and send copies of the complaint and response to MDPH. M.G.L. c.270 s.22.

### **ADDITIONAL POWERS AND AUTHORITY OF LOCAL BOARDS OF HEALTH IN MASSACHUSETTS**

Local boards of health in Massachusetts have historically played a crucial role in the protection of public health, promotion of sanitary living conditions and protection of the environment. In recognition of the importance of local leadership and action in these areas, the legislature has enacted over the years numerous statutes which authorize and thereby encourage local boards to be responsible for dealing with the broad range of health, sanitation and environmental problems at the local community level.

The following is a list of statutes which grant additional powers and authority to local boards of health. Each time includes a citation to the appropriate statute. The items have been grouped under general subject categories which parallel, where possible, the categories in the prior lists of required local activities.

#### **A. General Health Protection and Regulation:**

1. Adopt and enforce any reasonable health regulations. M.G.L. c.111, s.31.
2. Issue an order reciting the existence of an emergency and requiring that such action be taken as the board deems necessary to meet the emergency. State Sanitary Code, Chapter 1, 105 CMR 400.200(B), pursuant to M.G.L. c.111, s.127A; and State Environmental Code, Title I, 310 CMR 11.05(1).

#### **B. Health Care and Disease Control:**

1. Direct the operation of and adopt rules for city and town medical dental and health clinics, M.G.L. c.111, s.50 and hospitals, M.G.L. c.111, s.92.
2. Require vaccination of inhabitants of the city or town. M.G.L. c.111, s.181.
3. Order the fluoridation of public water supplies. (This order may be overturned by a referendum vote.) M.G.L. c.111, s.8C.
4. Appoint school physicians. M.G.L. c.71, s.53.
5. In cities, and in towns with a population greater than ten thousand, establish public sanitary stations. M.G.L. c.111, s.33.

6. Isolation and quarantine of individuals and property relative to communicable disease Chapter 111 sections 92-121A

**C. Housing and Dwellings:**

1. Condemn a dwelling which is unfit for human habitation, order the occupants to vacate, order the owner to clean the dwelling or tear it down (or the board may itself clean or tear down). M.G.L. c.111, s.127B.

**D. Nuisances:**

1. Condemn all nuisances; clean or tear down a nuisance. M.G.L. c.111, s.128.

**E. Food:**

1. Inspect and condemn all unfit meat, fish vegetables, produce, fruit or provisions of any kind. M.G.L.. c.94, s.146; 105 CMR 590.059.
2. Adopt and enforce regulations relative to the keeping and exposure of food for sale. M.G.L. c.94, 2.146.
3. Adopt and enforce regulations for bakeries and close bakeries found unfit for the production of handling of food or dangerous to the health of its employees. M.G.L. c.94 s.9D-9M, 105 CMR 550.14.
4. In towns, appoint milk inspectors. (City boards of health are required to appoint milk inspectors.) M.G.L. c.94, s.33.
5. Adopt bacterial standards for milk which are stricter than the standards adopted by the Department of Public Health M.G.L. c.94, s.13E.
6. Upon determination that drinking water in a dwelling or food service establishment is unsafe, order discontinuance of use or order provisions of a new source. M.G.L. c.111, s.122A.

**F. Miscellaneous:**

1. Adopt and enforce regulations to control air pollution. M.G.L. c.111, s.31C.

**INSPECTION TIMETABLE FOR BOARDS OF HEALTH**

The following list describes the majority of inspections Boards of Health are required to perform. It is not intended to be a comprehensive formal listing of all inspection requirements.

- 1) Food Establishments 105 CMR 590.000, State Sanitary Code Chapter X
  - Inspect food establishments every six months.
- 2) Bathing Beaches 105 CMR 445.000, State Sanitary Code Chapter VII
  - Inspect accredited bathing beaches twice during operating season.

- Take water samples twice monthly from accredited bathing beaches during bathing season.
  - Periodically inspect no accredited beaches to determine compliance with physical and bacteriological water quality standards.
- 3) Swimming Pools 105 CMR 435.000, State Sanitary Code Chapter V
- -Inspect periodically and before issuing annual permit.
  - -Take samples of swimming, wading or special purpose pool water for bacteriological analysis prior to its opening.
- 4) Family Type Campgrounds 105 CMR 440.000, State Sanitary Code Chapter VI
- Inspect periodically with the exception of those operated by the Commonwealth.
  - Renew license annually if inspection reveals compliance with the provisions of the code.
- 5) Recreational Camps for Children 105 CMR 430.000, State Sanitary Code Chapter IV
- Inspect yearly and issue license annually if found to be in compliance with requirements of the code. Other town inspectors also must approve for license.
  - Board of Health may also inspect at any time if there is reason to believe that a violation or violations of this chapter exist or upon request or complaint for any reason.
- 6) Subsurface Disposal of Sanitary Sewage 105 CMR 15.00, State Environmental Code Title 5,
- Inspect the installation of all sewage disposal systems.
  - Witness percolation tests, deep observation holes, and perform site examinations for each system.
- 7) Housing (Human Habitation) 105 CMR 410.000, State Sanitary Code Chapter II
- Inspect a dwelling or dwelling unit upon receipt of a written, oral or telephone request. Refer to code for specific timetable requirements.
- 8) Cabins, Motels and Mobile Home Parks M.G.L. Chapter 140, Section 32B, 32C
- Inspect periodically and renew licenses annually, if inspection reveals compliance with applicable regulations.
- 9) Disposal of Solid Waste by Landfill 310 CMR 19.00, State Environmental Code
- Periodically examine and evaluate sanitary landfills.

**STATE REGULATIONS COMMONLY USED BY LOCAL BOARDS OF HEALTH**  
**MASS. DEPT. OF PUBLIC HEALTH: THE STATE SANITARY CODE**

105 CMR 300.00	Reportable Diseases and Isolation and Quarantine Requirements
105 CMR 400.000	General Administrative Procedures
105 CMR 410.000	Minimum Standards of Fitness for Human Habitation

105 CMR 430.000	Minimum Sanitation and Safety Standards for Recreational Camps for Children
105 CMR 435.000 *(310 CMR 12.00)	Minimum Standards for Swimming Pools
105 CMR 440.000 *(310 CMR 14.00)	Minimum Standards for Developed Family type Camp Grounds
105 CMR 445.000 *(310 CMR 17.00)	Minimum Standard for Bathing Beaches
105 CMR 460.000	Regulations for Lead Poisoning Prevention and Control
105 CMR 590.000	Minimum Sanitation Standards For Food Establishments

\*Regulations which were previously available under asterisked D.E.P. CMR numbers.  
(State Legislature transferred to MDPH FY87)

310 CMR 15.00	Title 5 Minimum Requirements for Subsurface Disposal of Sanitary Sewage
310 CMR 19.00	Disposal of Solid Waste by Sanitary Landfill

**PRICE LIST**

105 CMR 400.000 through 419.000 (in one publication)	\$	plus postage
105 CMR 420.000 through 499.000 (in one publication)	\$	plus postage
105 CMR 590.000 through 595.000	\$	plus postage
310 CMR 11.00 through 17.00	\$	plus postage
310 CMR 18.00 through 21.00	\$	plus postage

NOTE: Any single regulation may be purchased separately.

**ABOVE ARE AVAILABLE FROM:** Secretary of State Bookstore at these locations:

State House  
First Floor, Room 116  
Boston, MA 02133  
1-617-727-2834

State House West  
436 Dwight Street  
Springfield, MA 01103  
413-784-1376 check number

THIS IS A GUIDE ONLY...

Update: Mar. 2003,  
Charlie Kaniecki, M.D.P.H. District Health Officer

**MASSACHUSETTS GENERAL LAWS FREQUENTLY USED  
BY LOCAL HEALTH OFFICIALS**

The following are cited in the Manual of Laws Relating to Public Health:

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40	54	Restrictions on Issuance of building Permits Availability of Water Supply	347
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79A	13	Enforcement of state sanitary code; displacement of persons; moving expenses; state financial assistance; reports	507
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111	127B	Dwellings unfit for human habitation; order to vacate or to abate nuisance; removal of occupants; demolition expense, lien; inspection reports, code violations; notices, enforcement proceedings, jurisdiction; appeal	951
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111	141	Application to county commissioners from refusal or neglect of board to abate nuisance; hearing notice	966
111	188	Disposition of fines and forfeitures	993n
129	14B	Feeding garbage to swine; definitions; permit; application; revocation; processing of garbage; inspection of premises; entry; record	1315
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148	25B	Buildings used for human habitation; use of space heaters occupied for dwelling or residential purposes; criminal penalties; civil remedies; jurisdiction; sections applicable to acts of reprisal, waiver in leases or rental agreements prohibited.	1481
218	26	District Courts – Criminal Jurisdiction (General Provisions)	1576