Iowa Local Governmental Public Health System: Results of the 2024 Local Public Health Systems Survey

May 2025

Kelly Garcia
Director

Dr. Robert Kruse
State Medical Director and Division Director of Public Health

IOWA
Health and Human Services

Contents

Acknowledgements

Suggested Citation

Iowa Department of Health and Human Services, Division of Public Health. (2025, February). *Iowa's local governmental public health system: Results of the 2024 local public health systems survey*. Des Moines: Iowa Department of Health and Human Services. Published 2025. Web. http://hhs.iowa.gov/lphs

Governor: Kim Reynolds
Lieutenant Governor: Chris Cournoyer
Iowa HHS Director: Kelly Garcia
Iowa HHS State Medical Director & Division Director of Public Health: Dr. Robert Kruse

Report Contact Information

Marisa Roseberry, MPA
Chief, Performance and Operations Bureau
Division of Administration, Iowa Department of Health and Human Services
marisa.roseberry@hhs.iowa.gov

Jamila Yakubu, MPH
PHIG & HHS Systems Evaluator, Performance and Operations Bureau
Division of Administration, Iowa Department of Health and Human Services
jamila.yakubu@hhs.iowa.gov

The Iowa Department of Health and Human Services wishes to thank Iowa's Local Public Health Administrators and their staff for completing the 2024 Local Public Health Systems Survey.

Overview

This report provides an overview of Iowa's local public health system and the results of the data collected through the 2024 annual Local Public Health Systems Survey.

The results in this report can be used to provide a foundational understanding of the local governmental public health system in Iowa, identify needs and priorities for future public health planning and highlight trends over time. Iowa HHS intends to continue public health system assessment activities annually through data collection from local public health administrators and HHS program staff.

Survey Methodology

In the fall of 2024, HHS staff adapted the previously developed Local Public Health System Survey questionnaire to focus on the following areas:

- Local boards of health
  - Board membership
  - Board member background
  - Board service
- Local public health agencies
  - Infrastructure (workforce, revenue and expenses)
  - Service delivery

The questionnaire was emailed to all local public health agency administrators in October 2024. Survey responses were collected using Cognito Forms. Public health administrators clarified additional information through correspondence if needed. The response rate for the 2024 survey was 100% (n=99). However, the data collected on service delivery is not inclusive of all programming that takes place at the local level. The survey only collected data

from local public health administrators. Local boards of health and other public health staff were not surveyed.

For this report, unless otherwise noted, all data are for state fiscal year 2024 (SFY24: July 1, 2023-June 30, 2024).

Comparisons of statewide data collected by Iowa HHS Division of Public Health over the past four state fiscal years (SFY21, SFY22, SFY23, SFY24) has been included where appropriate. Some data was not available for each fiscal year as questions were revised or new questions were added with each survey iteration.

Iowa's Public Health System

Iowa's Governmental Public Health System

Iowa's governmental public health system consists of three main sets of partners:

The Iowa Department of Health and Human Services and the Council on Health and Human Services: The Council on Health and Human Services advises or makes recommendations to the Governor, General Assembly, and/or Director of the Department of Health and Human Services.

The State Hygienic Laboratory: The State Hygienic Laboratory serves all of Iowa's 99 counties through disease detection, environmental monitoring, and newborn and maternal screening.

Local Boards of Health and Recognized Local Public Health Agencies: The local governmental public health system consists of local boards of health (with assistance from local boards of supervisors) and recognized local public health agencies. As the groups that work most closely with people within their communities, these partners are typically front-line staff who provide services; advise policy development; enforce rules, regulations, or laws; or support and implement local public health efforts.

Local Boards of Health

Iowa is a decentralized, home rule state with 99 county boards of health (BOH), which means each local board of health has jurisdiction over the public health matters within its designated geographic area.

522

individuals served on their local board of health in SFY24

BOARD MEMBERSHIP, BACKGROUND AND SERVICE

Membership varies from board to board, however there are minimum requirements that each board must meet: at least five members including one member licensed to practice in the state of Iowa as a physician, physician assistant, advanced registered nurse practitioner or advanced practice registered nurse. All members of the local board of health are volunteers, appointed by the county board of supervisors.

Iowa Administrative Code 641.77.4(137) states that to be qualified for board membership, "members should have experience or education related to the core public health functions, essential public health services, public health, environmental health services, personal health services, population-based services, or community-based initiatives." In SFY24, slightly over half of Iowa's board of health members reported a Professional-Medical background (52.78%).

Members serve a three-year term, and the appointment of subsequent terms is at the discretion of the board of health (per board policies) and the local board of supervisors. In SFY24, 71% of local board of health members had served between 1-10 years, with an average of 6.87 years of service.

ORGANIZATION OF PUBLIC HEALTH AGENCIES

Due to the home rule nature of public health in Iowa, several factors play a role in how services are provided at the local level:

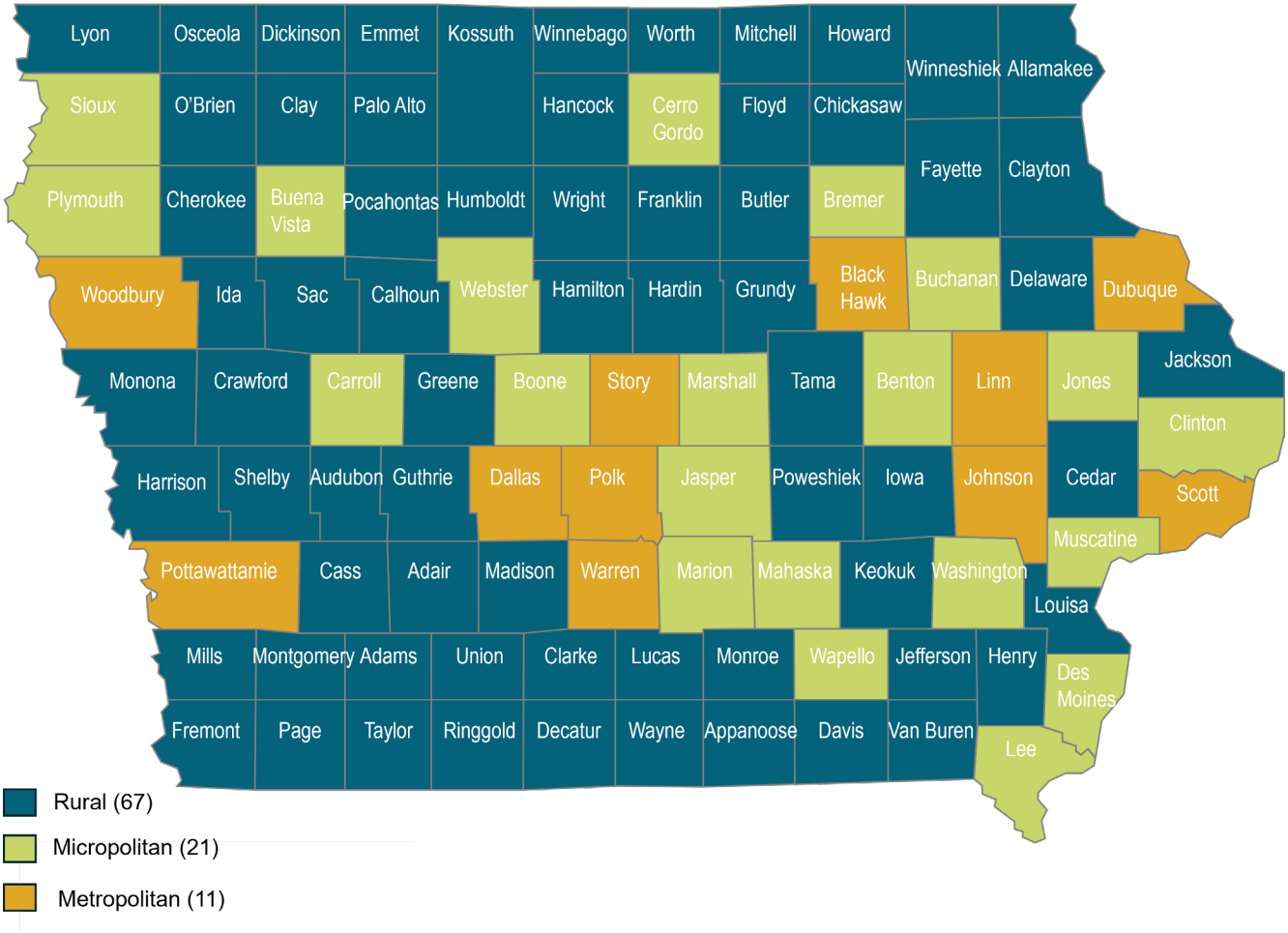
Population:

The number of residents in a county and the resources available to serve those individuals can impact the type and level of services needed. Based on their populations, counties can be classified into three categories:

- Rural county: defined as a population with fewer than 20,000 people
- Micropolitan: defined as a population between 20,000 to 49,999 people
- Metropolitan: defined as a population with more than 50,000 people

The following map provides a visual representation of the population classification for each county in the state.

Graphic 1: The state has a majority of rural counties, based on population figures.



Public Health Service Provision:

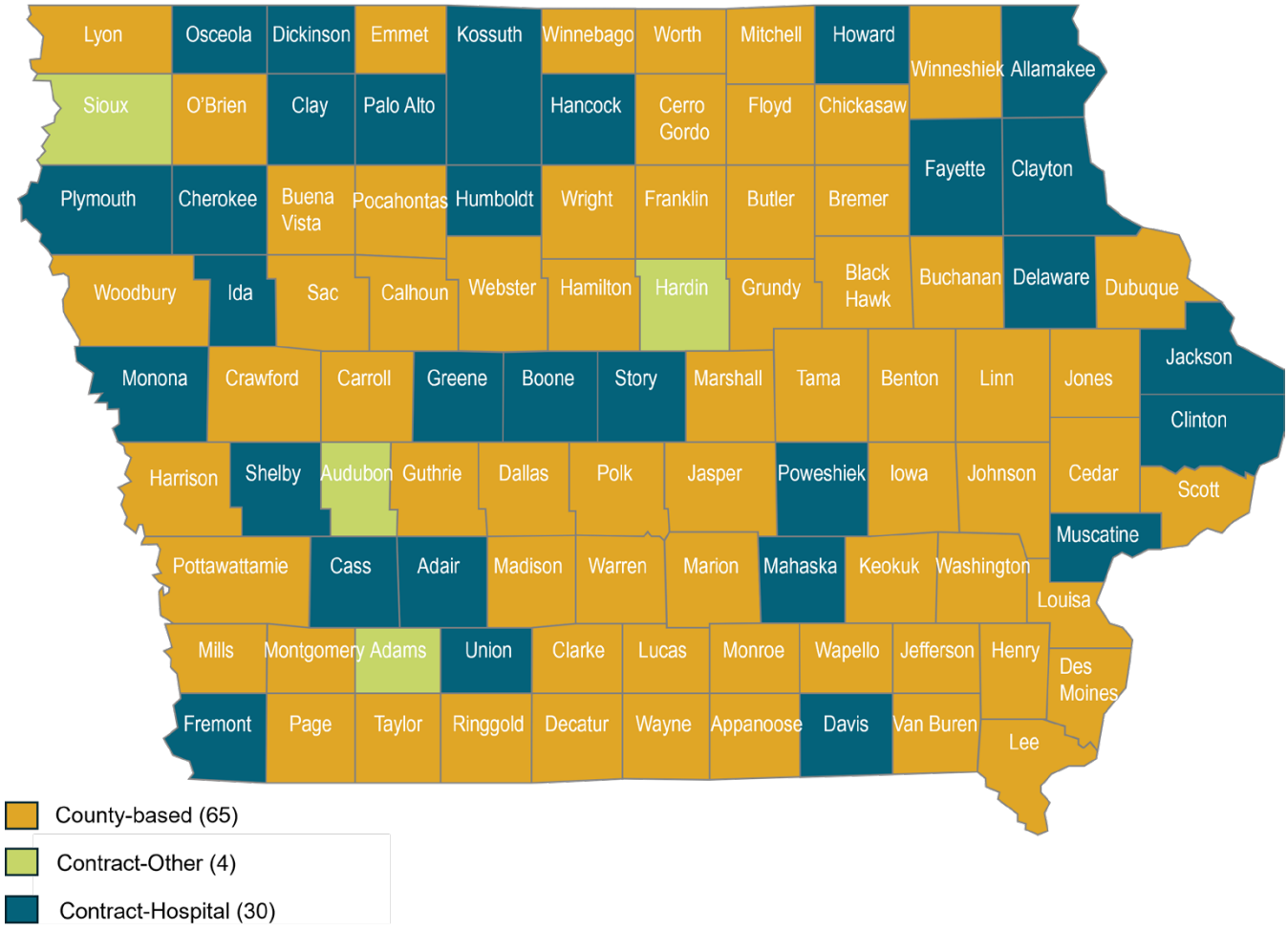
Iowa Code Chapter 137 allows boards of health to either directly employ staff or contract with outside agencies to provide personal and population-based public health services.

In SFY24, there were 65 counties in which the board of health directly employed staff to provide population-based services, personal health services, or both. When a board of health employs staff, they serve as the governing entity for the local public health agency and has oversight of agency operations. The agency is typically a department within the county's government structure. For this report, these counties are defined as a county-based system structure.

In counties where the board of health contracts with an outside agency for population-based services, personal health services or both, the board of health serves in an advisory capacity but remains the primary contractor for many state-issued grants. The outside agency's board of directors or board of trustees serve as the agency's governing body; they have oversight of the outside agency's operations. For SFY24, 30 boards of health contracted with hospital-based systems, defined as contract-hospital and four boards of health contracted with other entities, defined as contract-other.

Using the above definitions, the following map illustrates the public health service structure for each county.

Graphic 2: The majority of counties operate a county-based health structure.



Local Public Health Agencies

Administrators provided information about their agency business practices for infrastructure and service delivery. Results from these areas are described below. *Responses for counties which contract with another local public health agency were consolidated into a single agency response.*

Local Public Health Infrastructure

The workforce forms the foundation and heart of Iowa's public health system. Administrators were asked to report the total number of FTEs for their agency, including temporary and permanent full- and part-time staff.

WORKFORCE

Over the course of the fiscal year, 200 employees departed Local Public Health agencies. At the end of SFY24, there were 1,142 FTEs, a decrease of just one FTE from SFY23 (1,143). These FTEs translated to a total of 1,306 employees across all 97 agencies for the 99 counties. By comparison, the number of employees at the end of SFY23 was 1,290, demonstrating that replacement of departed staff within the public health agencies has increased slightly.

FTEs reported for an agency

- Total: 1,142
- Minimum: 1.0
- Maximum: 63.8

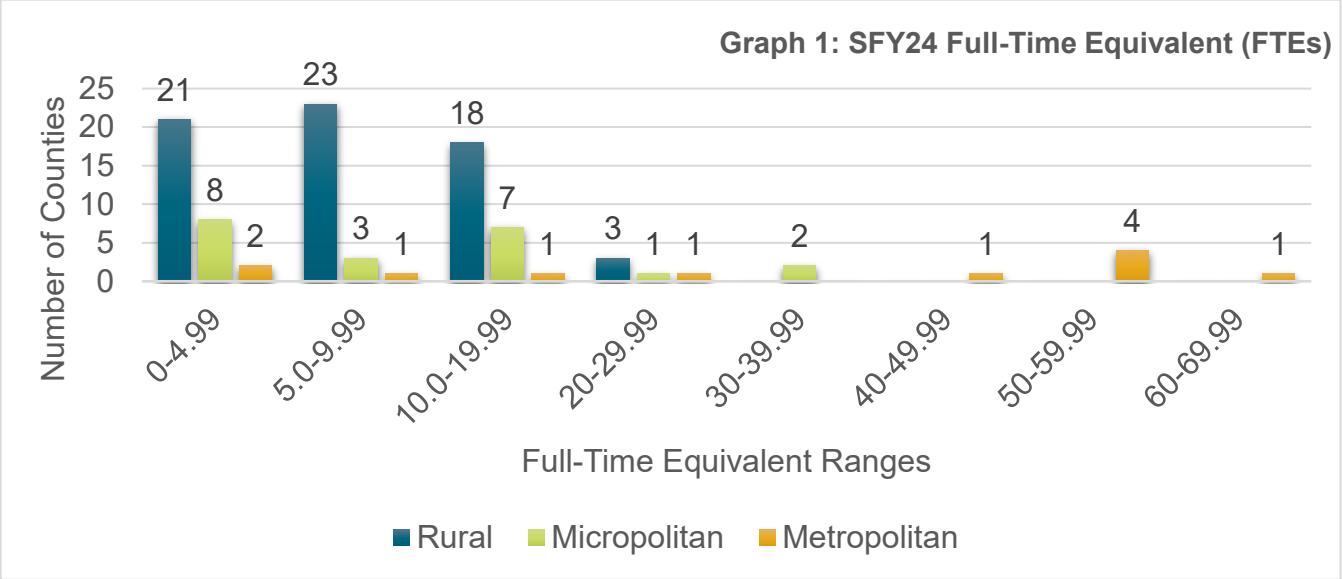
The table below provides information about FTEs as they relate to county classification based on population. Population size is not a factor for determining the number of FTEs for an agency. The average number of FTEs has decreased for rural and micropolitan counties, while increasing for metropolitan, as seen in Table 1.

Table 1: Agency workforce data from SFY20 to SFY24 shows changes in average number of FTEs across county classifications

Fiscal Year	Average Number of FTEs		
	Rural (n=67)	Micropolitan (n=21)	Metropolitan (n=11)
SFY20	8.9	15.0	32.4
SFY21	9.1	14.7	37.6
SFY22	8.2	11.6	33.1
SFY23	8.2	11.6	33.1
SFY24	8.1	11.3	34.5

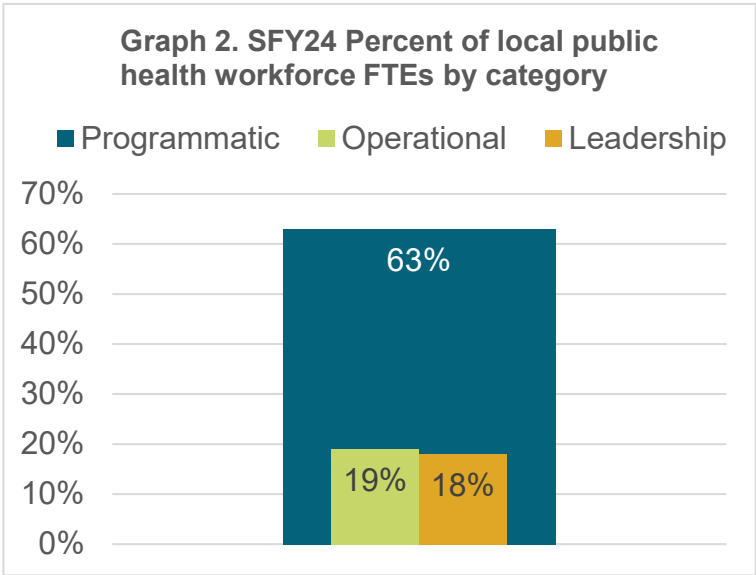
As demonstrated in the graph below, there is great variability in the number of FTEs in agencies across the state. Sixty-two rural counties employ less than 20 FTEs, which indicates a minimum capacity for serving their populations. There are five metropolitan counties with more than 50 FTEs, which is on trend from SFY23 data.

In SFY24, across all county population classifications, most agencies employed less than 20 FTEs, as shown below in Graph 1.



Administrators also reported a breakdown of the different roles across agency FTEs. The majority of roles were programmatic (63%), as show in Graph 2. Roles were assigned to one of three categories:

- Leadership: agency administrator and other agency leadership
- Operational: business functions, finance, information technology, administrative staff and public information professionals
- Programmatic: staff across a wide range of areas providing activities and services to Iowans, such as environmental health workers, epidemiologists, licensed nurses, health educators and nursing/home health aides



Agency Administration

In SFY24, there were 96 local public health administrators serving Iowa's 99 counties. Three of the 96 administrators provide administrative services for another county through a contractual agreement. Local public health administrators are responsible for the daily operations of their agencies and work closely with their boards of health to identify and meet the needs of residents. An administrator may have several responsibilities, depending on the size and structure of the local public health agency including:

- Shaping and implementing the strategic vision for public health in their county,
- Supervising and evaluating the work of staff,
- Developing annual budgets and monitoring revenue and expenses,

- Establishing and maintaining relationships with county officials and public health partners, and
- Evaluating agency and administrative services.

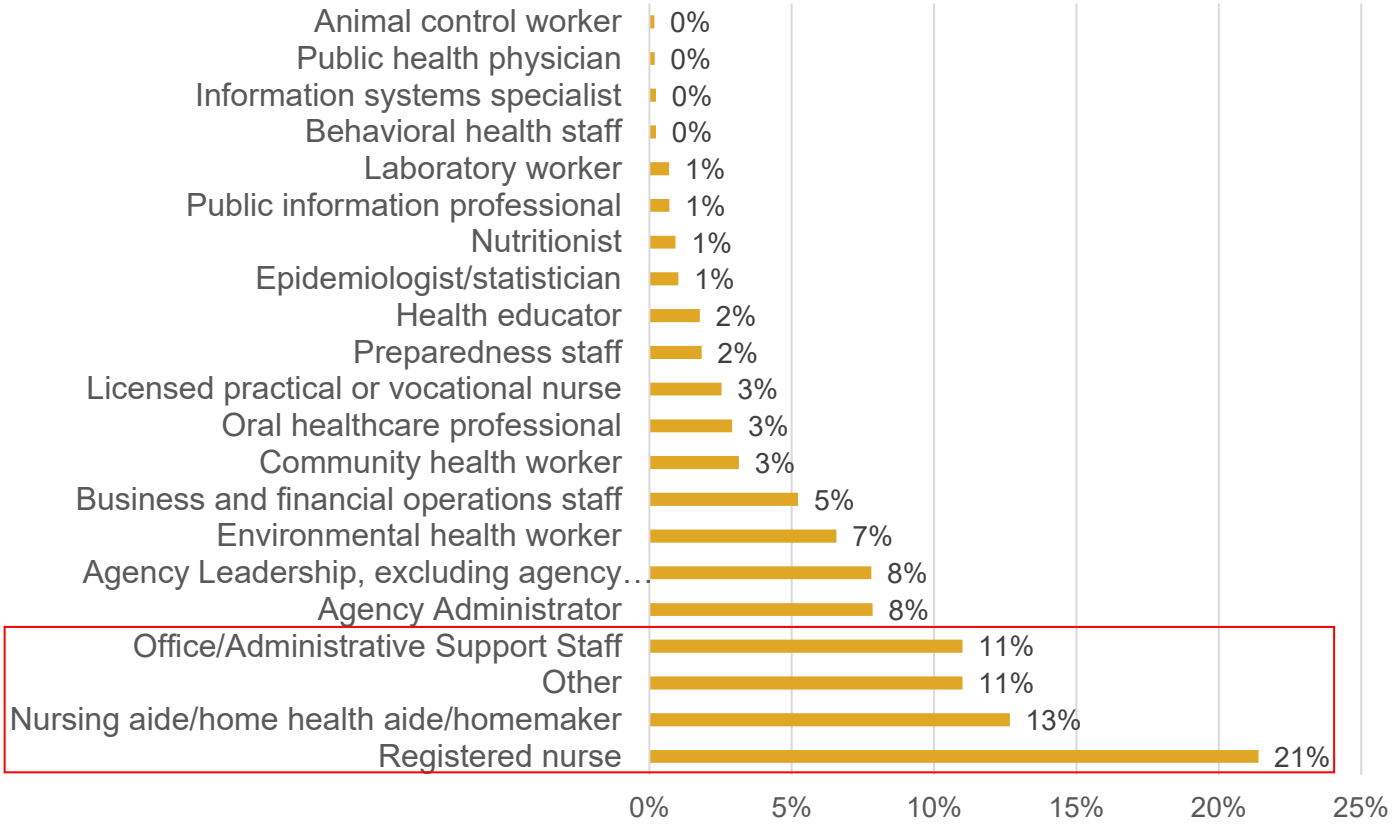
Local Public Health Staff

Local public health staff are key players in the delivery of public health activities and services at the local level. The 10 Essential Public Health Services serves as a primary framework in guiding the work of local public health and includes:

- Assess and monitor population health status, factors that influence health, and community needs and assets,
- Investigate, diagnose, and address health problems and hazards affecting the population,
- Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it,
- Strengthen, support, and mobilize communities and partnerships to improve health,
- Create, champion, and implement policies, plans, and laws that impact health,
- Utilize legal and regulatory actions designed to improve and protect the public's health,
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy,
- Build and support a diverse and skilled public health workforce,
- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement, and
- Build and maintain a strong organizational infrastructure for public health.

Titles and classifications vary by agency, although roles are usually the same across the state. As seen in Graph 3 below, registered nurses represent 21% of the workforce across all workforce FTEs, followed by nursing aides/home health aides/homemakers at 13%, office/administrative support staff and the "other" category at 11%. The "other" category primarily included roles such as social workers, parent educators, family support workers and program/project coordinators.

Graph 3: SFY24 Percentage of FTEs by role



Ensuring there is sufficient workforce capacity to provide services is critical, however local public health agency administrators may find it challenging to fill certain roles due to a variety of factors (salary, qualifications, location etc.). In SFY24, administrators were asked to identify the positions most difficult to fill. The top roles reported were: registered nurses, nursing aide/aide/homemakers, office and administrative support staff and agency leadership (including administrators).

Succession planning is a “deliberate and systematic effort by an organization to ensure leadership continuity in key positions, retain and develop intellectual capital for the future, and encourage individual advancement” (Rothwell, 2010, p. 6). In addition to data on their hiring challenges, administrators also reported on their agency’s progress to implement three specific components of succession planning:

1. Identifying high potential employees (defined as someone with the ability, engagement and aspiration to rise and succeed in more senior, critical positions)
   - 32% of administrators reported having fully identified high potential employees, *a decrease from the 37% reported in SFY23*
2. Developing high potential employees
   - 11% of administrators reported having fully developed high potential employees, *a decrease from the 16% reported in SFY23*
3. Developing written documentation describing work critical to the agency
   - 11% of administrators reported having fully developed written documentation describing work of critical importance to the agency; this is a *decrease from the 18% reported in SFY23*

REVENUE AND EXPENSES

Financial management is complex and varies across local public health agencies. Revenue and expenses reflect a wide variety of sources and broad range of expenditures and as a result, budgets across public health agencies are difficult to compare.

Revenue:

Revenue sources to support public health activities and services at the local level include, but are not limited to:

- County tax dollars; designated by the county Board of Supervisors (BOS)
- Federal grants or programs
- State grants or programs
- Foundations or private grant opportunities
- Public health insurance (Medicare or Medicaid)
- Private health insurance
- Fees for services

Revenue for local public health agencies varies by county and is based on the level of activities and services provided, the county health system structure, and financial investment by county board of supervisors, among other factors.

Local public health agencies that offer a wide range of public health services and activities typically have larger revenues due to the volume of grants and other resources they pursue to meet community needs. Agencies providing certified home health services generate higher revenue compared to those who provide decertified home health services, as they are able to provide home care to a greater number of clients and can bill both public and private insurance. Additionally, local public health agencies that serve as the lead contractor for a multi-county service area (such as WIC, Maternal, Child and Adolescent Services, or Public Health Emergency Preparedness) may generate higher revenue; however, these funds may not be solely allocated to services and activities within the lead county. For example, the lead entity for a multi-county service area receives the funding to oversee the contract and deliverables but may subcontract a significant portion of that funding out to other public health partners to provide public health activities and services. This would then appear as both revenue and expenditure on the agency financial reports.

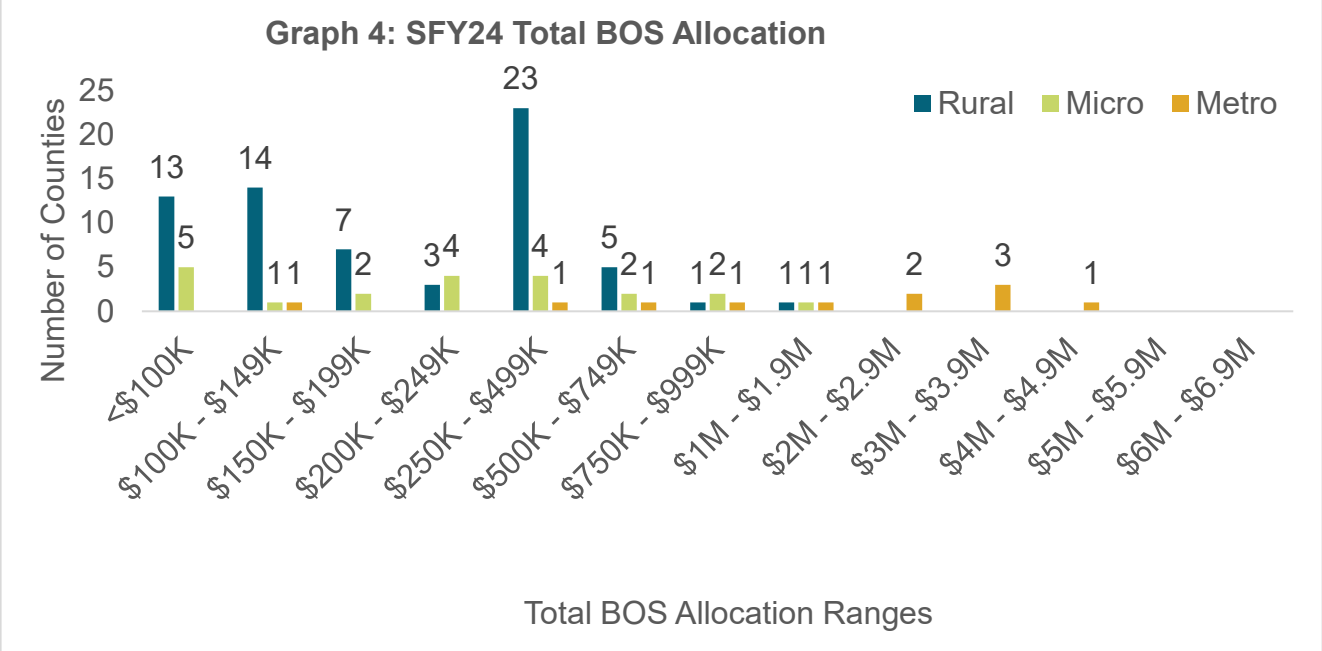
Boards of Supervisors Allocation

Boards of supervisors (BOS) engage in annual discussions with boards of health and local public health agencies to address county funding needs. The amount of county tax dollars invested in public health varies by county. Some counties receive the amount of funds needed to cover predicted shortfalls between anticipated revenue and expenses for the fiscal year, while others receive a fixed amount each year.

Approximately **$40 million** was invested in public health by Iowa's Boards of Supervisors in SFY24.

In SFY24, 43 counties reported receiving county tax dollars to support local public health efforts equaling $200,000 or less. The majority of rural counties (23) reported receiving between $250,000 and $499,000. Two counties reported receiving no support from their county board of supervisors. Additionally,

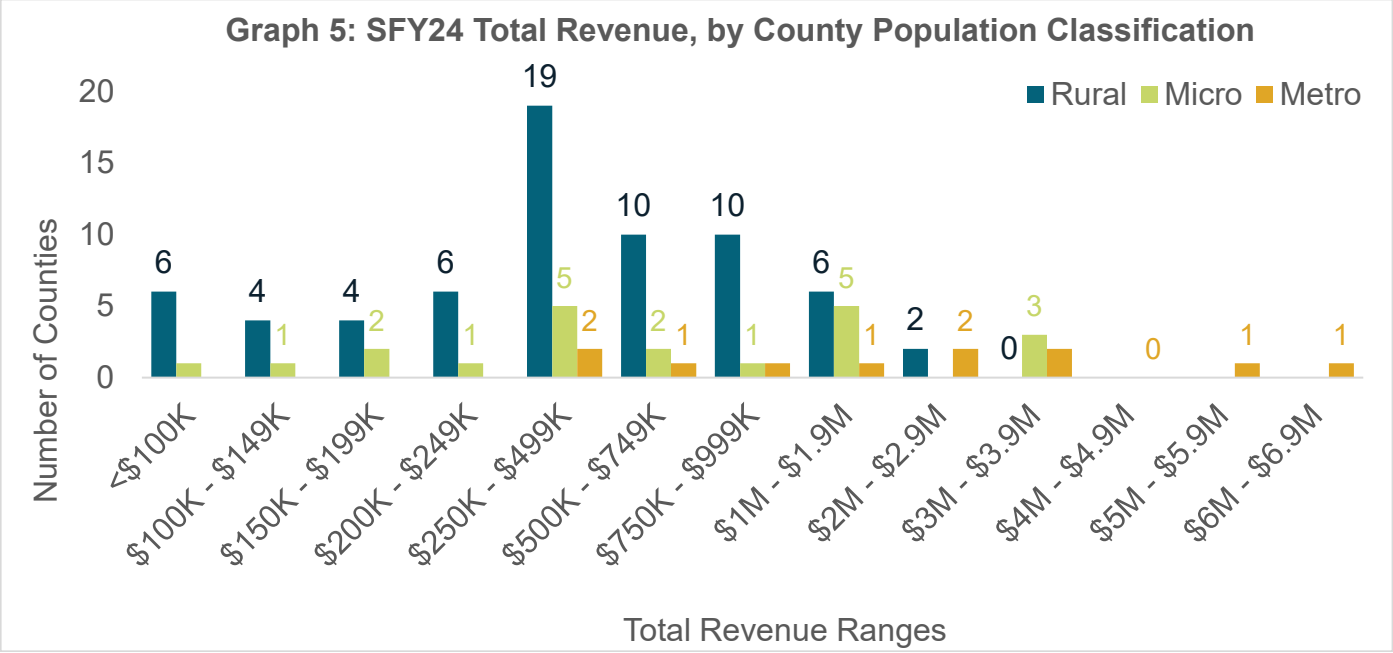
nine counties, including seven metropolitan counties, reported receiving over $1 million in county tax dollars. Graph 4 breaks down the BOS allocation by county population classifications (rural, micropolitan, metropolitan).



Total Revenue

Total revenue data found that counties received total revenue of $86,351,014 across all sources, averaging $478,285; however, this figure is heavily skewed by 19 rural counties reporting total revenue between $250,000 and $499,000. The breakdown by county classification is described below and in graph 5:

- Rural counties reported a total revenue of $35,101,301
- Micropolitan counties reported a total revenue of $23,427,976
- Metropolitan counties reported a total revenue of $27,821,737

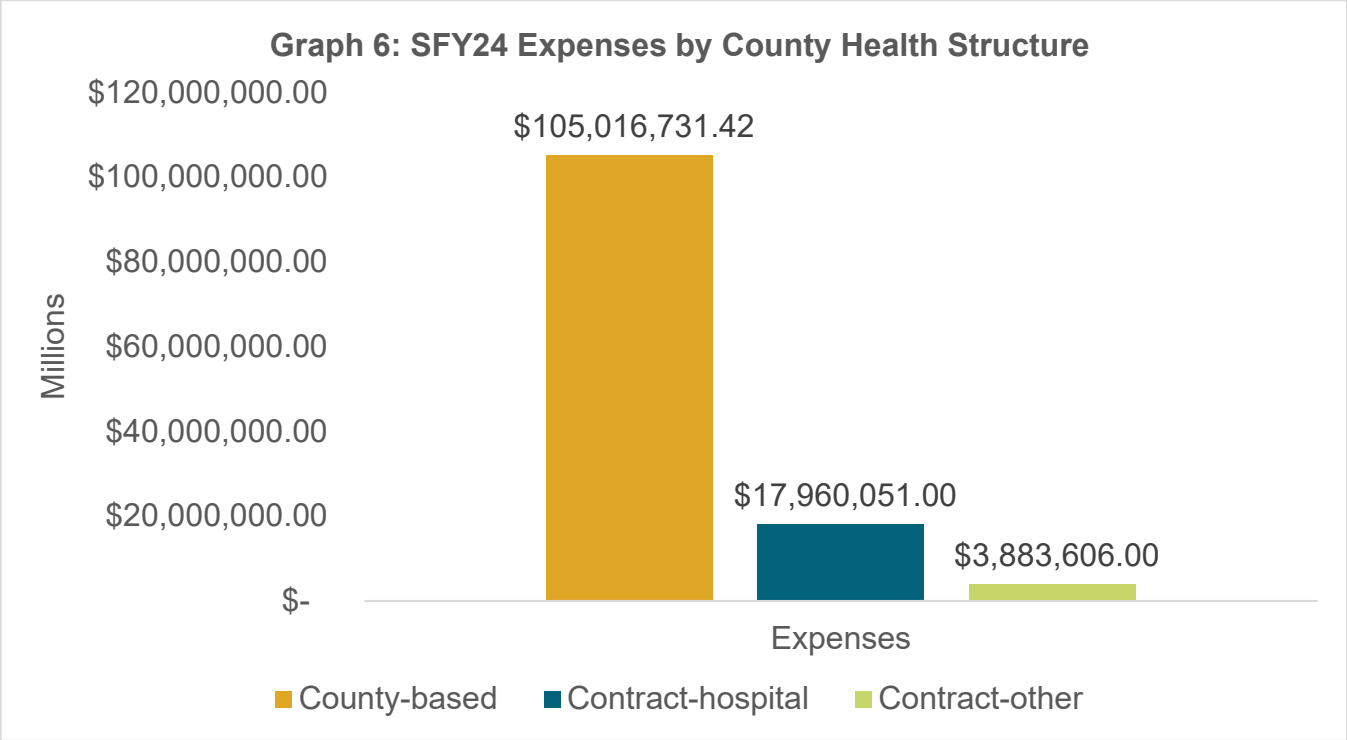


Expenses

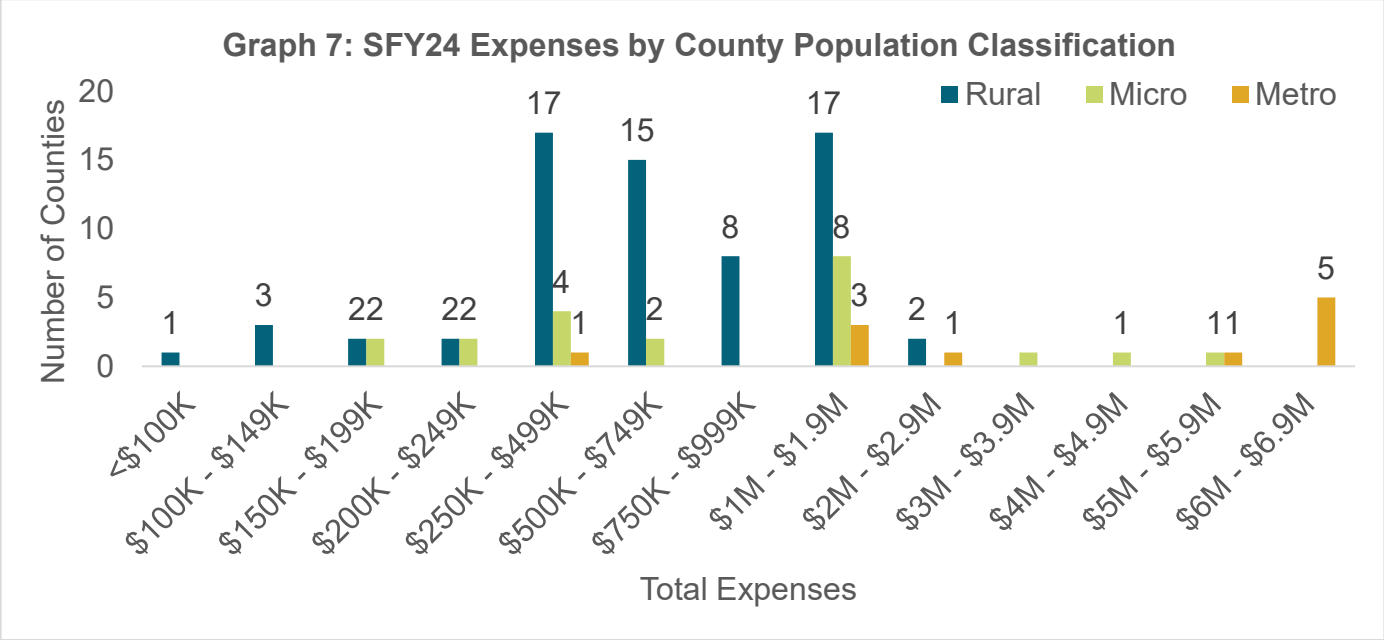
Administrators were asked to provide their total expenses for SFY24. Although most expenses for a local public health agency come from salaries and fringe, there are several other necessary expenses over the course of a fiscal year, including:

- travel and training,
- equipment and supplies,
- operational overhead,
- dues and fees,
- subcontracts, or
- contracted providers (including internal operations support such as human resources and IT and external services such as physical therapy (PT), occupational therapy (OT), or speech therapy).

Additionally, expenses can vary widely based on many factors including the level of services provided, staffing levels and county health structure (county-based, hospital-based or contract-based). Total expenses for all agencies in SFY24 totaled $126,860,388, a slight increase from SFY23 by $1,525,396 (1.2%). The highest expenditures were reported by counties with a county-based health structure, as seen in Graph 6.



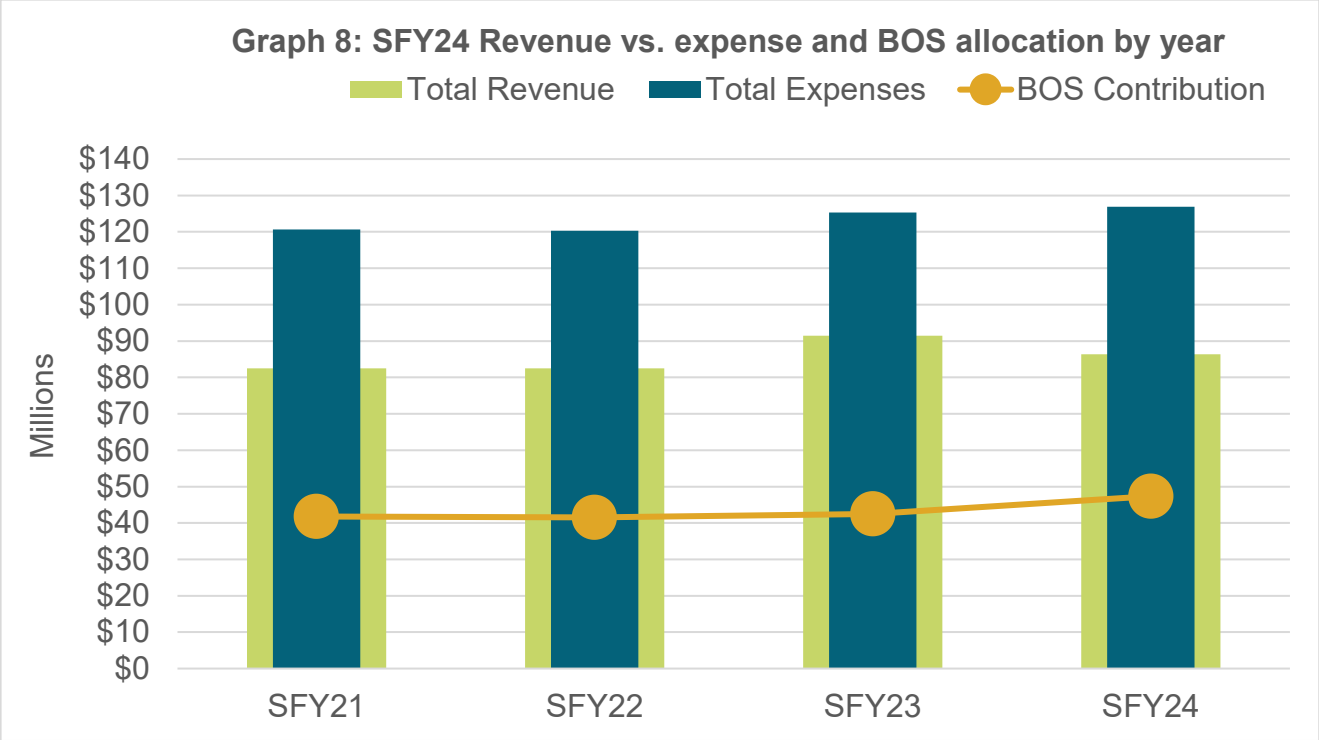
Graph 7 below shows that Iowa counties reported an average of $1,281,418 in expenditures. Half of the rural counties (34 of the 67, or 50.7%) fall into two expense ranges: $250,000 - $499,000 and $1 million - $1.9 million. Five metropolitan counties spent between $6 million - $6.9 million, driving up the average for all counties.



Key Findings

Revenue and Expenses: Trends

A comparison of annual revenue, expenses and boards of supervisors (BOS) allocations for the past four fiscal years, seen below in Graph 8, reveals a decline in revenue from SFY23 to SFY24. This decrease can be attributed to the full utilization of COVID relief funds in SFY23, which supported the unprecedented response to the COVID-19 pandemic and are no longer available. While expenses have increased over time, BOS allocations have remained relatively stable.



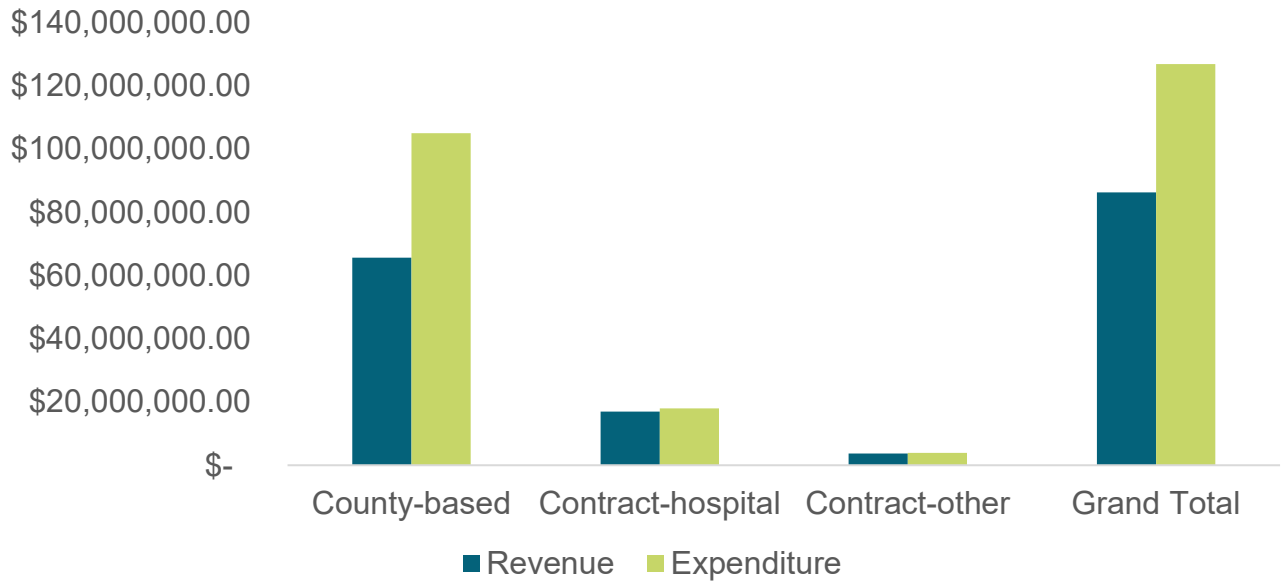
Graph 9 below compares revenue and expenditures by public health system structure. County-based structures had the highest revenue and expenditure ($65,655,179 and $105,016,731 respectively), followed by contract-hospital ($16,951,596 and $17,960,051 respectively). Contract-other structures, with the least number of counties (n=4) had the lowest revenue and expenditures ($3,744,238 and $3,883,606, respectively).

Across all three structures, there is a trend of higher expenditures compared to revenue received, with the difference more pronounced in county-based structures, which are often subsidized by local county tax dollars, and typically operate with a deficit budget. This process is referred to as being deficit funded. When the difference between anticipated revenue and anticipated expense demonstrates a shortfall of funds, the amount of money that is not available (the deficit) is covered by other sources such as local county tax dollars contributed by the BOS.

Contract-hospital and contract-other health structures are typically able to trend closely to the projected budget and expenditure because they are not deficit funded by the BOH and/or

BOS. Instead, they have an established subcontract with the BOH and/or BOS for a set amount of funds which inhibits incurring a deficit.

Graph 9: SFY24 Revenue and Expenditure by Health Structure



Using the data reported by administrators, per capita figures were calculated to determine spending on population health services per person in the state. Overall, counties budgeted a sum of $2,462 and received a sum of $1,960 per capita, resulting in a total shortfall of $502 per person for SFY24. This translated into a per capita budget average of $24.87 with $19.80 received, a difference of $5.07 per person. The per capita budget median was $18.13 with $16.13 received, a difference of $2.00 per person.

Per capita averages (Table 2) and per capita medians (Table 3) across all county classifications and health structures showed that counties received less than they planned for, pointing to a gap in budget planning between agencies and BOS, underscored by low overall health spending per person in the state.

Table 2: Per capita averages budgeted and received for SFY24, by county population and health structure classifications

	County Population Classification			County Health Structure		
	Rural	Micropolitan	Metropolitan	County-based	Contract-other	Contract-hospital
Budgeted	$29.75	$15.10	$13.78	$31.29	$23.35	$11.17
Received	$23.43	$11.71	$13.12	$24.03	$19.00	$10.74

Table 3: Per capita medians budgeted and received for SFY24, by county population and health structure classifications

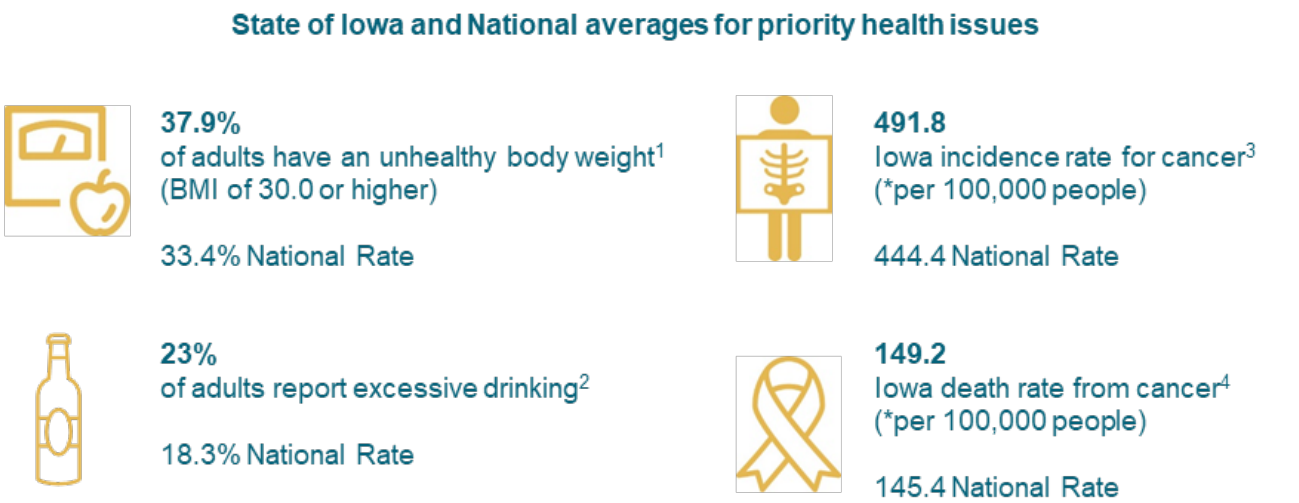
	County Population Classification			County Health Structure		
	Rural	Micropolitan	Metropolitan	County-based	Contract-other	Contract-hospital
Budgeted	$28.91	$8.11	$9.86	$29.01	$23.98	$9.54
Received	$19.74	$7.10	$11.22	$22.19	$16.35	$9.33

Service Gaps

The 2021-2022 State Health Assessment (SHA) identified mental health disorders, healthy eating and active living, substance abuse and cancer as top health issues with significant disparities, particularly among those with disabilities and living in rural areas of the state. The findings from the assessment contributed to the development of the 2023-2027 State Health Improvement Plan (SHIP) to support counties and their organizational partners to focus on two key areas: behavioral health and healthy eating & active living.

The Community Health Assessments and Improvement Planning (CHA CHIP) conducted by local public health agencies with their communities to identify the most important health issues and develop strategies to address them similarly identified behavioral health, including substance abuse and nutrition, physical activity and obesity as key issues, along with cancer.

Graphic 3: The state rates for cancer incidence, cancer deaths, obesity and excessive drinking are higher than national averages, highlighting the urgent need for increased efforts and resources to address them



1. Centers for Disease Control and Prevention, BRFSS, 2022 (State and U.S. median); Centers for Disease Control and Prevention. PLACES: Local Data for Better Health, 2022 (Counties). https://www.cdc.gov/places
2. Centers for Disease Control and Prevention, BRFSS, 2022 (State and U.S. median); Centers for Disease Control and Prevention. PLACES: Local Data for Better Health, 2022 (Counties). https://www.cdc.gov/places
3. Age-Adjusted Incidence Rate: cases per 100,000: 2017-2021, U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. CDC and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.
4. Age-Adjusted Death Rate: deaths per 100,000: 2018-2022, U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. CDC and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2024.

Nearly all public health agencies reported delivering services in four essential areas, demonstrating widespread engagement across the system:

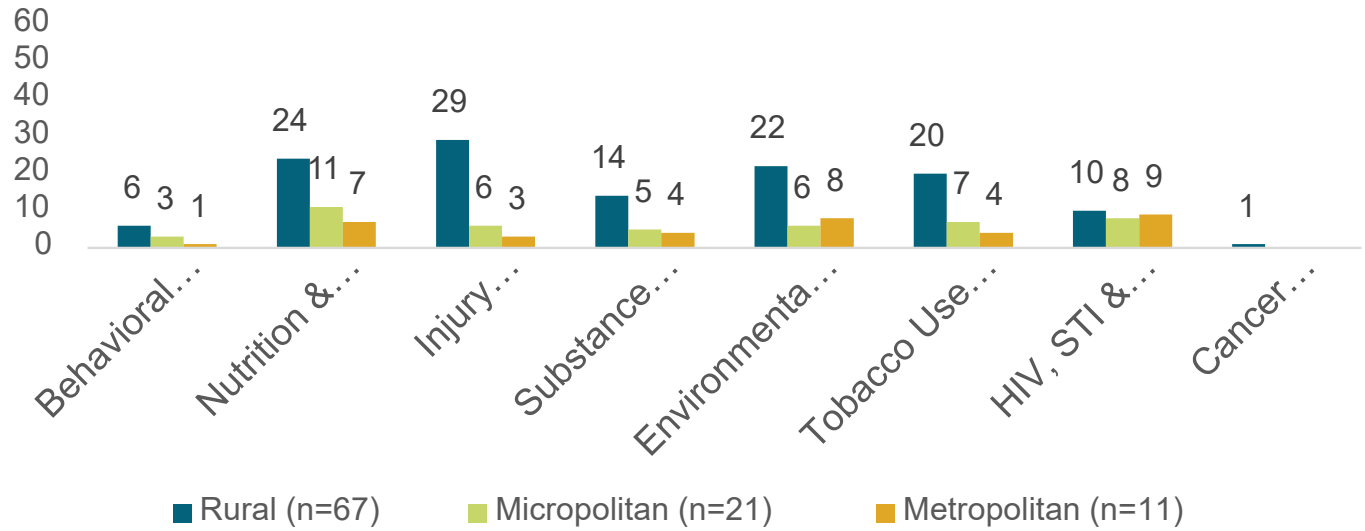
- Emergency preparedness (100%)
- Disease follow-up, surveillance and control (99%)
- Immunization & tuberculosis (97%)
- Public information, health education and community engagement (97%)

By comparison, less than 50% reported providing the following prevention and early intervention services:

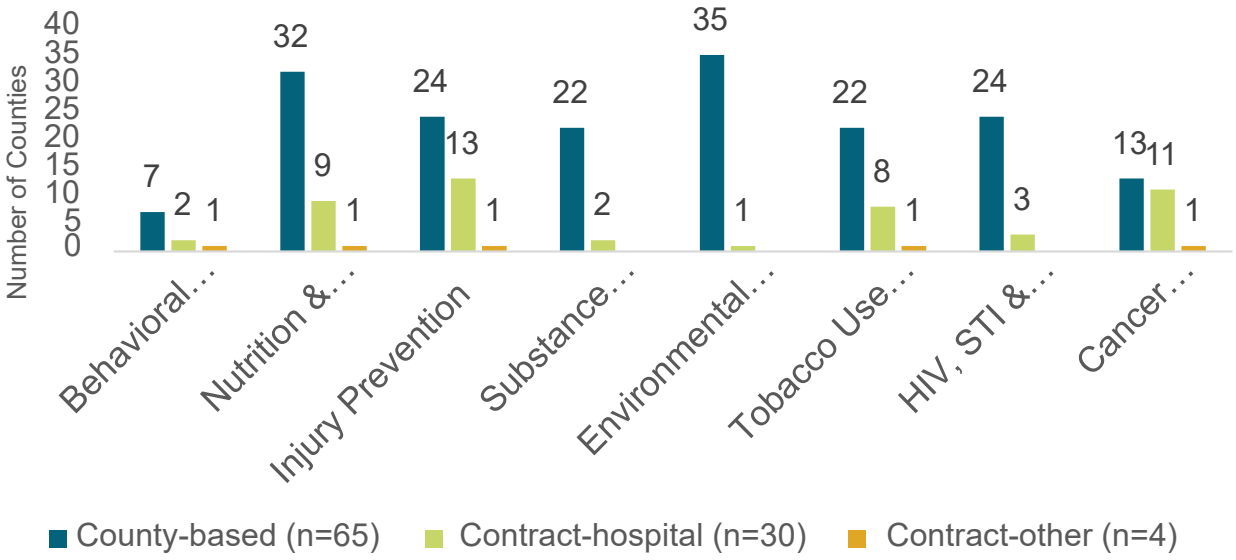
- Behavioral Health
- Nutrition & Physical Activity
- Injury Prevention
- Substance Use Disorder Prevention
- Environmental Health
- Tobacco Use, Prevention & Control
- HIV, STI and Hepatitis Prevention & Control

The graphs below shows the number of counties which reported providing prevention and early intervention services, including those relevant to the state health priorities (behavioral health, nutrition & physical activity, substance use disorder prevention and cancer screening), broken out by county population classification (Graph 10) and county health structure (Graph 11).

Graph 10: SFY24 Service Delivery by County Population Classification



Graph 11: SFY24 Service Delivery by County Health Structure



Gaps Between Identified Health Concerns and Provided Activities/Services:

Iowa's public health system continues to address a range of complex health issues, with three areas emerging as the most pressing statewide concerns: behavioral health, chronic disease (including cancer), and obesity. The SFY24 data reveals notable disparities between the number of counties identifying major health concerns and those actively providing related services or activities. While many counties recognize critical issues such as behavioral health, chronic disease (including cancer), and obesity, far fewer are equipped to address them through programming or interventions.

- **Behavioral Health** was identified as a leading concern by **93 counties**, yet only **9 counties** reported providing behavioral health activities or services—highlighting a significant service gap in one of the state's most pressing health areas.
- **Chronic Disease (including cancer)** was recognized by **51 counties**, and encouragingly, nearly all—**49 counties**—are offering relevant programs or services, indicating strong alignment between need and response.
- **Obesity** was reported as a major concern in **76 counties**, but only **42 counties** provide nutrition and physical activity programs aimed at addressing this issue, suggesting that more than a third of counties face resource or capacity challenges in combating obesity.

This mismatch between identified needs and service availability—especially for behavioral health—underscores the importance of increased support, funding, and infrastructure development to ensure that public health efforts effectively meet community priorities.

Next Steps

The next survey will be conducted in the fall of 2025, collecting data for state fiscal year 2025 (SFY25: July 1, 2024-June 30, 2025).

References

Centers for Disease Control and Prevention. (1994). *Original essential public health services framework.* https://www.cdc.gov/publichealthgateway/publichealthservices/originalessentialhealthservices.html

Institute of Medicine. (1988). *The future of public health*. The National Academies Press. https://doi.org/10.17226/1091

Iowa Department of Health and Human Services. 2021-2022 State Health Assessment (SHA). Healthy Iowans: Iowa State Health Assessment June 2022

Iowa Department of Health and Human Services. 2023-2027 State Health Improvement Plan (SHIP). Iowa's 2023-2027 State Health Improvement Plan Final.pdf

Iowa Department of Health and Human Services. Community Health Assessments and Improvement Planning (CHA CHIP). https://hhs.iowa.gov/lphs/cha-chip

Local Boards of Health, Iowa Code § 137 (1967 & rev. 2022). https://www.legis.iowa.gov/docs/code/137.pdf

Local Boards of Health, Iowa Administrative Code 641.77 (1967 & rev. 2017). https://www.legis.iowa.gov/docs/iac/chapter/641.77.pdf

National Association of County and City Health Officials. (n.d.). *Public health finance.* https://www.naccho.org/programs/public-health-infrastructure/public-health-finance

National Association of County and City Health Officials. (n.d.). *Public health infrastructure and systems*. https://www.naccho.org/programs/public-health-infrastructure

National Association of County and City Health Officials. (n.d.). *The role of local health departments* [Fact sheet]. https://www.naccho.org/uploads/downloadable-resources/Fact_Sheet_2.doc

Rothwell, W. J. (2010). *Effective succession planning: Ensuring leadership continuity and building talent from within* (4th ed.). AMACOM - American Management Association.