In some parts of the country new patterns of community health services are needed to meet the needs of today and tomorrow, and the day after tomorrow. There is as yet no firm ground on which to base these patterns. This survey of present needs indicates possible approaches to the future.

THE DEVELOPMENT OF COMMUNITY HEALTH SERVICES

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Problem

TODAY'S PRACTICE of providing community health services through local units was developed nearly a half century ago. It was well suited to the most critical health problems of that time and has continuously proved its value in bringing public health to the people.

In recent years, however, there has been little extension of the traditional pattern of local health services. Many parts of the country still have no organized local health services. Other areas have services which are only fragmentary in nature. This may stem from the many changes in health problems which have occurred over the years. It may be that new and additional resources—such as voluntary health agencies, industrial health programs, insurance schemes, and other prepayment plans—are now providing, more acceptably, some services which in the past were supplied by the health department. Or perhaps the greater interest of private physicians in preventive medicine coupled with better methods of communication and transportation and increased public enlightenment regarding the individual's own responsibility for his personal health have reduced the need for organized health departments.

Whatever the cause might be—in view of the many changes which have occurred, both in health problems and in resources for meeting them—the entire concept and structure for the delivery of community health services should be reexamined.

Trends in Organization

Local health departments have flourished during the past half century. Recently, however, the extension of organized local health services to new areas appears to have reached a plateau. Since 1952, the number of counties so served has hovered around 2,200 and the percentage of population involved, from slightly under to slightly over 90. Today, 2,274 of the country's 3,067 counties are served by 1,435 full-time health organizations. This means that one-fourth of the counties—representing nearly 10 per cent of the total population of the country—still are uncovered by the familiar network of organized local health services.

When compared with the country as a whole, counties without full-time organized local health services are found to have the following characteristics:

They are sparsely populated.
They have a small total population.
The median age of the population is relatively high.
A high proportion of the population is employed in agriculture.
A very small proportion of the population is nonwhite.
They have a relatively high family income and educational level.
Their location is concentrated in the western Great Plains and Rocky Mountain sections of the country.

In developing new patterns of health services which might be more suitable for such areas, special attention should be given to their particular health problems and needs, to their history and methods of operation, the feelings and wishes of the people, and the adequacy of existing public health practices.

Deficiencies in Service

Measurement of the growth or status of local health services by geographic coverage alone can be very misleading. Staffing and financing patterns are more accurate indexes of the intensity of services, and program changes can indicate whether health departments are adapting their services to meet present-day needs.

The scope and intensity of services provided by existing local health departments varies tremendously. Because of limitations in staff and budgetary resources, the coverage is very thin in some areas. Particularly is this true of many state health districts where often as many as eight or 10 counties are served by a minimum staff of one physician, a sanitarian or two, and several nurses.

Staffing—During recent years there have been only slight gains in the total number of persons employed by state and local health agencies. The lack of progress in health department staffing is accentuated when related to growth of the country's population. Between 1951 and 1957, the population of the United States increased 11.5 per cent, whereas the total number of full-time personnel employed by state and local health departments increased only 7.5 per cent. Even this small amount of growth has lacked uniformity, both geographically and on the basis of professional categories in which the increases occurred.

Nurses and sanitarians accounted for the greater part of the increase. Indeed, there are actually fewer physicians, engineers, and laboratory personnel engaged full time in public health activities today than was the case six years ago. By 1957, 440 units—representing 31 per cent of the total number of local health organizations—were without a health officer, or were temporarily being served by a neighboring health officer.

Geographically speaking, personnel increases occurred in only about half the states and substantial growth was concentrated in only a few. Among the half of the states which lost personnel, five experienced reductions of more than 20 per cent.

The personnel-population ratio, or number of personnel per 100,000 population, is less favorable in 1957 than in 1951. This trend applies to all types of personnel in state and local health departments except nurses, for whom there was only a slight increase. The unfavorable trend is particularly striking in local health departments serving areas of less than 100,000 population. In these smaller areas even the nurse-population ratio—which, for the country as a whole, improved somewhat during the past six years—was lower in 1957 than in 1951. Since more than 75 per cent of all health departments in the country serve fewer than 100,000 people, the situation must be regarded with real concern.

Any enrichment of the programs of official health agencies to meet the newer health problems will require either additional staff, a realignment of duties of personnel presently employed, or a change in the basic role of the health department in providing needed community health services.

Expenditures—Measures of growth based on expenditures are likely to be deceptive because of the changes in the value of the dollar. In addition, there have been varying estimates of the amount of money which will provide a minimal level of adequate public health services at any particular time. The amounts spent by local health departments are, on the average, below the lowest of the present estimates, which range from $2 to $3. In 1956 the expenditures of local health departments, as reported to the Public Health Service, equalled $1.08 per person in the United States as a whole and about $1.35 per person when only that part of the population living in areas served by full-time health units is considered.

The problem of financing local health services is considerably more acute in health departments serving populations of under 100,000 than in those serving more than this number of people.

The total expenditures for state and local health services vary from $3.30 per capita to less than $1. (These figures exclude the costs of construction and operation of hospitals.) When expenditures of state and local funds for public health services are related to state per capita income, it is found that the poorer states are spending a larger share of their available resources on health than are the wealthier states.

Although there has been a net increase of 61.2 million dollars (71.1 per cent) in state appropriations for public health since 1950, this increase has been concentrated largely in a few states. Two states—New York and Pennsylvania—accounted for 36 per cent of the increase and five states, for 51 per cent. In four states the percentage increase amounted to less than 10 per cent, and in one state, West Virginia, appropriations have been reduced since 1950.

Of that $61.2 million increase between 1950 and 1957, about $50 million was earmarked by state legislatures for some specialized type of public health programing such as tuberculosis control, mental health, water pollution control, etc. Hence most states have made relatively little provision for the growth of basic staff or organizational structures for the delivery of general community health services.

Local appropriations for public health increased between 1950 and 1957 by approximately $66 million (72.9 per cent). However, five states—New York, California, Ohio, New Jersey, and Pennsylvania—accounted for 57 per cent of the increase.

It is estimated that the costs of ongoing operations of state and local health departments have increased at least 50 per cent since 1950, as a result of salary increases and increased costs of supplies, equipment, travel expenses, etc. In view of these accelerated costs, only a few state and local health departments are able to provide substantially more service than they were furnishing in 1950. Although metropolitan areas have not fared so badly as more rural areas in maintaining stability of staff and financing, the rapidly changing needs for health services in such areas pose particular problems.

New Patterns of Community Health Services Needed

In looking to the future and the patterns of community health service which will best meet its needs, there are several vital points to be considered. Most important, perhaps, are:

Changes in the kinds of health problems which are of major concern.

The fact that health departments as we know them are not equipped to do the whole job.

Geographic and population bases on which many health units of the past have been established (75 per cent of all health departments serve fewer than 100,000 people) may not provide an adequate financial or technical base for the health services most needed today.

Health services are now being obtained from a variety of additional sources.

In some sections of the country there is strong resistance to provision, or use, of "public" (government-operated) services.

Individuals themselves must assume more responsibility for protection of their own health today than in the past.

Current Health Needs

The present structure of local health organization was developed for such basic public health activities as communicable disease control, general environmental sanitation, milk and food sanitation, etc. These activities are as important today as when they constituted the *total* public health program. However, our methods of attack—and reliance upon the health department exclusively—have changed even for these fundamental health problems.

Old Health Problems Require New Methods

Tuberculosis

Treatment can now be administered in large measure by a private physician to the patient at home, in his office, or a clinic.

Case-finding activities are more productive when carried out selectively than when extended on a community-wide basis.

Other Communicable Diseases

Intensive poliomyelitis vaccination programs have been carried out through school programs, in health department clinics, in the private offices of practicing physicians, or some combination of these methods. Despite these efforts, less than half the population under 40 have had the basic three injections and over a third have had no vaccine at all. Clearly, even greater effort is required to extend protection to this susceptible portion of the population. This may mean that new or different educational approaches will have to be used.

Local medical societies as well as official and voluntary public health agencies, the pharmaceutical profession, and drug manufacturers were all intimately involved in planning for the widest possible protection of the population against Asian influenza.

Food and Milk Sanitation

New knowledge and the changing food processing industry require marked modifications in public health practices and relationships. In coping with problems of milk sanitation the approaches used by public health agencies are quite different from those employed a decade or more ago. But the main issues in planning for community health services of the future are for the relatively new areas of public health concern.

Meeting the Newer Health Problems

Prevention and Care of Long-Term Illness

Research to find preventive procedures for the chronic diseases is probably today's major health need. However, all that we now know is not being fully applied.

Positive community action will be required to supply the wide range of services necessary to prevent the occurrence or progression of chronic disease and disability. Diagnosis and medical supervision by the private physician are paramount, but services of the private physician must be supported by those of the laboratory, the hospital, the rehabilitation facility, and a number of

related services. Nursing care is needed in the hospital and in the home. Physical therapy, nutritional advice, medical social services, and a variety of others must be arranged for. These should be planned, integrated community services to aid and supplement the care of the patient by his physician.

Obtaining and Financing Medical Care

This is an integral part of the chronic disease picture, though not limited to it. In so far as possible, physicians in private practice should be relied upon to provide whatever curative medical services are needed, once the effectiveness and value of the method of treatment have been tested and accepted. In some communities, however, there are not enough physicians to meet the need for service, or some persons are deprived of care because of their inability to pay for it. Under these circumstances, clinics must be established or other appropriate arrangements made for delivery of service to the people requiring it.

Much more needs to be done in providing a wide array of services in the home for patients suffering from long-term illnesses. It has been demonstrated that, after intensive treatment in the hospital for a short period of time, it is possible to give equally satisfactory and much less expensive care at home for a number of conditions, including certain mental illnesses and tuberculosis. Such programs can also effectively reduce the load upon our hospitals and other medical services. Arrangements should be made for extending them to patients who can pay for the service as well as to the medically indigent group.

Mental Health

Much greater emphasis must be given to mental health. Experimentation with and evaluation of promising drugs for therapy of mental illness must continue. Concurrently, however, more guidance and counseling must be provided to school children to assist them in adjusting to the problems they meet. Programs for the prevention of alcoholism and drug addiction and for the rehabilitation of those under treatment should be expanded.

Dental Health

More effective health education and interpretation to the public of the value of good dental health should be among the major health goals of the present and the immediate future.

In order to bring the benefits of water fluoridation to the one-third of the population who are served by individual water supplies, it will be necessary to focus public and professional attention on the newer methods available for home fluoridation. Establishment of community service clinics and development of prepayment systems for dental care are other important aspects of a total community dental health program which must be arranged for.

Accident Prevention

Since accidents now rank fourth as an over-all cause of death and first among age groups from one to 35 years, study of the underlying causes of accidents and development of effective preventive and control measures are now among the major public health challenges.

Control of Water and Air Pollution

The nation is facing increasing problems of water and air pollution. Greater conservation of water resources through pollution control is growing more essential daily. There is growing public alarm about the problem of air pollution in metropolitan industrial areas. Expansion in the peacetime uses of nuclear energy adds new contaminants to air and water, further compounding the problems.

Major air pollution problems need to be pin-pointed more precisely through

field investigations. Little is known about the amounts and types of polluting materials being discharged into the air and about their reactions with each other to form new compounds. Health authorities and industrial groups must, together, devise plans for studying these problems and developing control measures. In water pollution control improvement of methods of treating industrial wastes and municipal sewage at lower cost is the key factor.

Radiation Protection

Sources of potential radiological hazards are steadily increasing. Safe and economical handling and disposal of radioactive wastes is becoming a most important health problem. Special laboratories will be needed for radiation assessment: proposed sites of atomic energy industries will have to be evaluated with respect to environmental health hazards; requirements and facilities for waste disposal must be determined.

This enumeration of today's leading health problems is far from exhaustive. Yet it is quite clear that they require a wider range of professional competence and more complex facilities and services than did the primary health problems of earlier days.

Health Department Resources Too Limited

Many local health organizations as they are now constituted find it difficult to fit these newer programs, so essential to reducing the nation's total disability burden, into their traditional pattern of operation. For example, the majority of health departments have neither the kind nor the number of personnel to cope with the long-term illnesses—particularly with their early detection and treatment and with the rehabilitation and retraining of patients after they have been stabilized. They also lack the needed physical facilities. Far more community cooperation, far more joint planning by public health personnel and the private practitioners of medicine, far more individual understanding are required than for any of the earlier health programs. In dealing with the newer environmental health problems arising from progress in industrial technology, special training must be provided for personnel presently employed. Close cooperative work with industry will also be required.

Obviously, the geographic and population bases on which many health units of the past have been established do not provide an adequate financial foundation for the health services most needed today. There is need for redefinition of functional areas most suitable as a geographic base for planning health programs. This is a particular problem in the growing suburban areas extending beyond the corporate limits of urban centers—areas in which public health problems multiply more rapidly than governmental organization and administration can be adapted to cope with them. In some places the suburban fringes of several separate cities have extended until they touch, and are separated only by artificial political boundaries which bear little or no relationship to existing demographic conditions. Common health needs of the continuous strip must be approached through a bureaucratic maze engendered by the number of governmental jurisdictions involved. Moreover, some of these have totally inadequate resources to meet the burden of public service which they have suddenly inherited.

Through broader regional planning the interdependence of areas with higher resources and those with lesser resources can receive full consideration.

If we are to develop adequate public health programs to meet current needs, the resources and services of community

groups—social, economic, and educational—must be welded into a smoothly functioning whole for maximum continuity of service to the greatest number of people possible. The exact nature and role of the official health agency which can function best in this broader concept of community health services are yet to be determined. Unknown, too, is the extent to which generally uniform patterns for the delivery of health services will be feasible—or even desirable. It has been suggested that a public health agency might most profitably serve as a community catalyst—a central "coordinator" and "obtainer" of the necessary services, providing as many as it is equipped to do. This suggestion assumes, of course, that needed services are available from some other source in the community, which may or may not be the case.

Health Services from Other Sources

The fact that nearly 70 per cent of our total population now have voluntary insurance against some part of the costs of medical care is extremely significant in considering a community's health needs and resources. The movement for development of industrial health plans which may be sponsored by employees, unions, employers, or a combination of these has been growing at an amazing rate. Coverage of these plans ranges from hospital or medical care insurance for the employee only to complete preventive health service and medical care for the worker and his entire family. There is little evidence, however, that services available under these plans are coordinated in any way with health services of the official health agency or with community health services provided under any other auspices. Thus there is duplication of some types of service and wide gaps with respect to others.

Participation by the General Consumer Public

We are moving into an era of public health in which individuals themselves must assume more and more responsibility for protection of their own health. To a large extent the effectiveness of community public health programs of the present and the future will depend upon their taking into account the history and methods of operation of the community, the feelings and wishes of the people, as well as specific knowledge of the existing health problems and available technical medical knowledge.

More information is needed regarding the attitudes toward health and health services of different ethnic and occupational groups, educational and income levels, in different geographic locations, and the bearing these factors may have on the way health services should be organized and delivered in a community. There is a strong indication that professional health workers may place very different priorities on the need for various types of health services and the way they should be provided than does the general public.

Research in Public Health Practice Needed

The foregoing discussion leads to two major conclusions:

1. The need for new patterns of community health services is well established.
2. There is a dearth of specific knowledge as to what those patterns should be.

Extensive research is needed to find answers to the many questions regarding the development of effective community health services, including the concepts and principles which govern the present structure of health services in this country. This involves, among other areas, experimentation with new or alternative methods for the delivery of

community health services, including the provision of medical care by private practitioners, as well as proprietary, voluntary, and governmental agencies. What type of research or study projects could lead us to knowledge of what the new patterns of community services should be? A few possibilities are cited:

1. Research in the use of new types of personnel.
2. Research in ways of organizing community resources (official, voluntary, and private) and of delineating responsibilities and relationships for most effectively meeting the current and future health needs of the public.
3. Research in the application of improved administrative technics and procedures to state and local health department operations.
4. Research in the establishment of different types of jurisdictional boundaries (regionalization of services). For example, what type of organization is practical for counties of less than 10,000 population?
5. Research in ways of obtaining, retaining, and more effectively training competent health personnel.
6. Research in more satisfactory methods of financing community health services.
7. Research in broad, over-all community planning and design for maximum health protection of all population groups.

The Public Health Service has initiated a modest program of community research for the purpose of developing and scientifically testing new, more effective, and acceptable ways of meeting health needs—as seen by the general public, by community leaders, and by professional health workers. Over a period of years, the program will be extended to different types of geographic areas of widely varying characteristics. As a first step of this continuing program, a pilot study is now being carried out in Kit Carson County, Colo., to acquire experience in the use of interdisciplinary public health and social science methods for obtaining information regarding health needs and the feasibility of various ways of meeting selected needs. Analysis of field data collected is now in progress.

Recognizing that much, much more research in public health practice is needed, the Public Health Service, through its research grants program, is strengthening its support of investigations by state and local health departments and universities dealing with problems related to the development, operation, and evaluation of health services for communities as a whole—or of segments of the total population. The Public Health Research Study Section has been reconstituted, with wider representation from the field of public health administration and education. This change is designed to insure the best possible competence for review of applications for grants to assist in carrying out public health research.

Wide interest has been expressed in this underdeveloped area by a number of groups and individuals in leadership positions. This augurs well for the development of a greatly expanded program of research in public health practice during the next few years. Hopefully, the findings will give us a more scientific basis than we have had in the past for the establishment of new patterns of community health services.

In the meantime, scattered experimentation with different patterns for the provision of community health services is already in progress. Unfortunately, too little information regarding these varied efforts is available for the guidance of others. Careful documentation of action taken *and results obtained* would be extremely useful.

Several of the better known efforts to tailor the community's pattern of health services to particular local conditions and situations are summarized below:

Examples of Varied Patterns of Community Health Services

Health Services for Sparsely Populated Rural Areas

California[1]—In 1953, there were 15 counties in California, with a total popu-

lation of around 200,000, without any organized local health protection and without much prospect of obtaining it through purely local efforts. Although the resident population of these counties is small and their financial resources are meager, there is a large temporary population in which "normal" health problems are accentuated.

Following surveys of major health needs in several typically rural counties of northern California—which were conducted by a team of consultants of the State Department of Public Health with assistance from interested community groups and individuals—nine counties have elected to contract with the State Department of Public Health for selected services rather than to establish and operate the usual type of local health department.

This program differs significantly from the "state district plan" in that the State Department of Public Health participates in the provision of public health services in these areas as a partner of local government. Thus the people feel that the program is their own.

There is no "standard" contract and no stereotyped program. An individualized contract is entered into by the state health agency with each separate board of supervisors. The contract seeks to embody the ideas and wishes of the board of supervisors and of the community as to their public health problems and needs and the program priorities and emphasis which they believe are needed to meet them.

Typically, the local staff consists of a part-time health officer, a clerk, and one or more nurses and sanitarians. Local funds are generally used for the part-time health officer and clerk, for the provision of office quarters and the purchase of supplies. The state employs nurses and sanitarians and assigns them to the county. The locally assigned state personnel live in the areas in which they work and receive their day-to-day instructions from the local health officer.

Health Services Radiate from a Hospital

Hunterdon County, N. J.—Immediately following World War II the people of Hunterdon County—a small, semi-rural county (estimated population—then 38,000; now 43,000)—began to attack a number of long-time community problems. With the interest of a wide diversity of groups and organizations centered on improvement of health and medical services, the need for a county hospital appeared to be foremost. However, the people wanted more information before a definite decision was reached. An experienced consultant was employed to study Hunterdon's health, hospital, and medical problems and to work with a county-wide citizens' committee in developing suggestions for their solution.

Based on the survey findings, the community decided to establish a Medical Center which would pioneer in bringing to a rural area the best medical care and health services available. This meant that the Center would be affiliated with a university medical school and hospital; that it would concern itself not only with the cure but also with the prevention of disease—through early diagnosis and care. Incorporated in the Medical Center would be a Health Center where the health and welfare organizations of the county could carry out their work with the cooperation of the Medical Center staff and make use of its equipment and research. The Center was envisioned as a community resource around which many services in the public health field would be clustered, i.e., a combined central public health laboratory and clinical site, with possibly the same person serving as county health officer and hospital administrator.

Public response to the drive for construction funds was enthusiastic, a mil-

lion dollars being contributed by citizens of the community. Such wholehearted support has been attributed to careful planning based upon specific community needs, as revealed by the survey.

The Hunterdon Medical Center—consisting of a 120-bed hospital and space for a diagnostic center and other services for ambulatory patients, a community auditorium, and public health offices—began operation in July, 1953.

The following positive features are among those cited by Trussell[2] in his analysis of the successes and failures of the first two years of operation:

Development of Lay Initiative and Responsibility

"The Medical Center originated through citizen action and has been carried to its present stage of achievement by citizen leadership coupled with consultation with experts and cooperation from the medical profession."

Increase in Local Medical Resources

"The Center has done much to improve the quantity and the quality of local medical care through a variety of methods."

Integration of General and Specialized Medicine

"A group of full-time and part-time salaried specialists supplemented by a visiting consultant staff now make available to the local citizen a spectrum of medical services for which he previously traveled some distance and at considerable expense. . . . The family physicians practicing in the county have become an integral part of the Center. They have been greatly aided in the care of their patients by the diagnostic, consulting, and rehabilitation facilities now available to them locally. New general practitioners have moved into the county. . . . This has done much to alleviate the shortage of locally available physicians."

Improvement of Patient Care

"The care of indigent and medically indigent individuals has been put on the same level in Hunterdon as that of the persons fortunate enough to be able to pay for the full cost of services."

Cooperation with Existing Services

"To a considerable degree, the Center has coordinated its activities on a sound and friendly basis with official and voluntary services throughout the county and State. In some instances, this integration could proceed further and no doubt will."

On the other side of the ledger, planning for the Center has failed in the creation of a county health department. Neither a county health officer nor department has come into being. Local communities and townships remain autonomous.

This does not mean that the original plan to emphasize preventive as well as curative medicine in the Center has been abandoned. Close cooperation is maintained with the State Health Department, which participated in a major way in the county's recent chronic disease survey; has provided a wide variety of equipment to facilitate the Center's diagnostic and screening programs; has contracted with the Center to furnish special services; and encouraged local public health nurses to integrate their program activities with those of the Center. Voluntary health agencies concerned with services for tuberculosis, cancer, poliomyelitis, dental, and cardiovascular patients have also, in large measure, integrated their programs with those of the Center.

Nearly half of the county's population has had some contact with the Center, as it continues to move toward its long-range goals—the direction of school and preschool health, premarital counseling, accident prevention, rehabilitation, and mental health.[3]

Perhaps the most impressive characteristic of the development of the Hunterdon Medical Center is the extensive citizen involvement in its origination, its

planning, and its day-to-day services. Although the Center has no formal auxiliary organization, more than 300 workers put in some 40,000 hours during 1954.[3]

Leadership of a Large Industry for Integrated Community Health Services

Richland, Wash.[4]—This community of 24,000 persons—the "Atomic City"—is unique in that its municipal functions are managed by a large industrial organization, the General Electric Company for the United States Atomic Energy Commission. Nevertheless, its integrated program of public health, a community hospital center, industrial medicine, and private medical practice might hold suggestions for any American community.

Complete, integrated medical services have been made available by the industry that has operated the plant and the community for the government for a period of nine years. These services consisted of public health, industrial medicine, hospital, and—for the first six years—general patient care. With all facilities closely grouped and with activities coordinated, the community medical center idea has been a reality.

Richland's public health program includes the "six basic functions," plus bedside nursing, school nursing, mosquito control, and welfare services—dealing primarily in the areas of family service, child welfare, and medical social work.

The industrial medical program is designed to materially reduce: occupational disease, accident frequency, personal illness, absenteeism, compensation costs and labor turnover. The program is carried out through medical activities that concern the individual employee and combined medical and engineering activities that concern the working environment.

A 106-bed hospital is the center of medical activities. Industrial medical services, including examinations and dispensary services, are administered in one section of the hospital. The public health building and the clinics for private medical specialists and dentists are located in close proximity to the hospital. X-ray facilities and laboratory services are available for industrial medicine, public health, hospital patients, and outpatients. The industrial medical dispensary serves as the emergency admitting center for the hospital. The public health chief, in addition to his usual duties, assists in planning hospital expansion and health education for employees, as well as for the general public.

Public Health Nursing Service Revamped for State-wide Coverage

Vermont[5]—Prior to 1951, public health nursing services in Vermont were unevenly distributed. Although there were no full-time city, county, or district health units, about a third of the state was extremely well covered as far as public health nursing service was concerned. Seven of the larger cities had nursing services supplied by private and publicly supported Visiting Nurse Associations; about twice that number of smaller communities supported one-nurse services through private and public funds; and school boards of a dozen or so communities employed school nurses, or helped pay for the services of the one community nurse in order to secure nursing services in their schools. But the rest of the state—the greater portion of the rural area—was totally dependent upon the nursing resources of the State Health Department.

In order to give state-wide coverage of generalized nursing service, the entire public health nursing staff of the State Health Department was redistributed. Currently, 34 staff nurses are stationed in 12 offices throughout the state and six nursing supervisors supervise these areas. Each nursing office has a dicta-

phone and other up-to-date equipment designed to minimize the time the nurses must spend on routine office duties.

Legal responsibility for the control of communicable disease throughout the state is delegated to the State Health Department. In areas having locally employed public health and school nurses, state nurses plan and work jointly with them in order to avoid duplication and to use these existing nursing services to their maximum capacity.

Through state supplementation of local nursing resources, Vermont has been able to recruit well qualified nurses and to strengthen services throughout the state.

A City Combines Nursing Services of the Department of Public Health and the Instructive Visiting Nurse Association

Richmond, Va.[6] — The Community Nursing Service of Richmond—representing a combination nursing service of the Department of Public Health and the Instructive Visiting Nurse Association—began operation in 1953. Purpose of the merger was to offer a more effective service providing for continuity of care, with less duplication of effort and confusion to families.

The combination service operates under the director of public health, who is legally responsible for the public health program. The nursing director is the administrator of the service and is responsible both to the city health director and the Board of Trustees of the Visiting Nurse Association.

The Board of Trustees of the Instructive Visiting Nursing Association has retained its incorporated status with all standing and special committees continuing to function. In addition, it serves in an advisory capacity to the Department of Public Health in relation to the public health nursing program. A Medical Advisory Committee of the Richmond Academy of Medicine provides consultation with respect to the total program.

Each agency controls and maintains separately its own budget, including income, personnel, and general expense items, the city assuming 60 per cent of the general expenses of the service.

Services offered are those previously provided by the separate agencies before the combination took place. Included are nursing care and health guidance to individuals and families in the home and clinics; assistance in the maintenance of environmental hygiene and in making epidemiological studies; and—under the direction of the physician giving medical care—nursing care to the acutely and chronically ill in the home. The nurses participate in maternal and child health, chest, immunization, and venereal disease clinics.

In addition to providing more satisfactory service, the combination service has been found to be more economical and to give a greater degree of job satisfaction to nurses working in the program.

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Prepared by the Division of General Health Services, Bureau of State Services, Public Health Service, for the 1958 Annual Meeting of the National Advisory Committee on Local Health Departments.