WHERE DO WE STAND
on local health units?

A FIVE-YEAR REPORT OF PROGRESS
in developing local responsibility
for community health services

WHERE DO WE STAND
on local health units?

National Advisory Committee
on Local Health Units
National Health Council

1790 Broadway **New York 19, N. Y.**

The time is now..

We are again in a war period with civilian defense a major home front problem. The National Security Resources Board has recommended to state governors that state health commissioners be made state civil defense health services directors and that local commissioners similarly be made local directors.

One of the purposes of a civil defense program has been defined as "the maintenance of a sufficient level of necessary services to our people so that they will have the strength and the heart to accomplish the tasks before them."

...."This means attention to such problems as adequate balanced nutrition to maintain health and prevent disease.

....It means availability of personal health services.

....It means control by minimizing the effects of disease and disability by rehabilitation, the bringing to bear of medical skill and judgment on the placement of both the handicapped and the older population, to the end that their productivity may be increased, both in amount and over a longer period of time."

...."Our responsibility as health personnel is to develop the best possible defenses against disease of whatever nature and from whatever source."

...."Our day-to-day sanitary practices will be our principal bulwark against induced disease."

There could be no better dramatization of the need for bringing to the 40,000,000 persons in the United States, who are now without such benefits, the basic local health services without which no community is fully protected.

Thomas D. Dublin, M.D.

Rehearsal For the Future..

It is now five years since "Local Health Units for the Nation"* was published. That report represented the culmination of a two year study supported by the Commonwealth Fund and inspired by the resolutions of two great professional bodies--the American Medical Association and the American Public Health Association.

The study was carried out by the Subcommittee on Local Health Units of the American Public Health Association and represents the first blueprint ever drawn up for an "umbrella" of local health protective services to cover every inhabitant of the United States.

Coming at a time when there were a variety of war pressures on civilian services as well as stirrings for adding to the responsibilities of local health officers in many directions, the main purpose of the study and the Committee's later program was to set up a workable administrative framework through which local health services could be provided. The basic traditional services of a health department are these: vital statistics, environmental sanitation, control of communicable diseases, public health laboratory services, maternity and child hygiene and public health education. Until these were provided it seemed useless to argue for the extension of the health officer's responsibilities into hospital administration, into medical care or any other area as long as there was no health officer or no provision for carrying out the indispensable basic functions in so many communities throughout the country.

In addition, the Committee felt it was important to have ready for the postwar period a rational plan for health departments that would stand the stresses of both the normal and the emergency periods.

The plan outlined by the Emerson report for providing these indispensable local health protective services might almost be said to constitute "the great rehearsal" for what in the five years since the report was published has come to be the pattern of the world. It is now a truism that both in peace and in war the peoples of the world must join together to do a great many things for themselves. With this in mind, the progress to be traced by this report and the further tasks that remain assume a new meaning to the reader.

*Local Health Units for the Nation, Haven Emerson, M.D., Commonwealth Fund, New York, 1945, 333 pp. $1.25.

The Unchallenged Definition

The local health units plan is a plan for communities to do jointly what many of them are unable to do alone. The Committee recommended that no unit of government smaller than a county organize its own health department, and that counties of less than 50,000 population join with one or more neighboring counties to organize a union health department serving a population of at least that size. A smaller population tax base can neither justify nor support a full time health officer and the necessary personnel for even basic minimum services.

As suggested by the Committee, approximately 1,200 health departments are required for the entire country.

As to personnel: the plan calls for a full time medical administrative officer of health for every health department with the necessary clinical medical assistance to meet the specialty needs in tuberculosis, venereal disease, maternity and child hygiene, and others.

It expects the environmental sanitation work of the department to be under the supervision of a public health engineer who will be backed up by sanitarians, at least to the extent of one per 15,000-25,000 population.

Public health nurses in the ratio of one per 5,000 population, clerks in the ratio of one per every three nurses, and additional personnel such as laboratory technicians, dentists and dental hygienists, statisticians, and health educators, as local conditions require.

It assumes that there will be supervisory and consultant service, probably on a regional basis, provided by the state health department.

In the years since these principles were outlined no serious challenge of their validity has been made by any professional or civic body. As to personnel, some of the professional groups, particularly engineers and dentists, have challenged the estimated needs as too low on a minimum basis even though the numbers suggested far exceed present availability.

Variations on the Original Plan

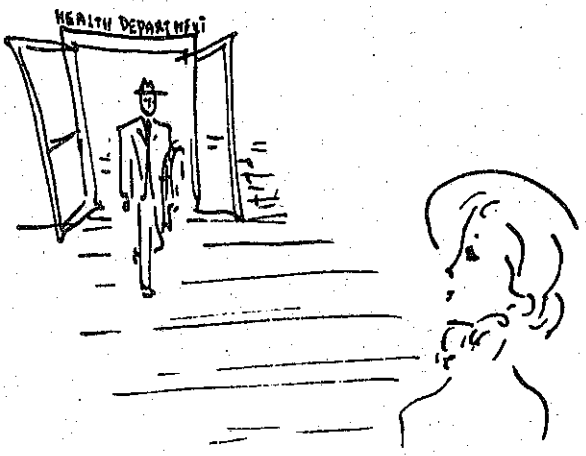
The principle of city-county and district health units is practically universally accepted today. It is the basis on which state plans are being worked out as well as the basis for permissive health district legislation being introduced in the few remaining states that do not already have it.

As anticipated by the Committee and as might be expected in a dynamic program, current planning includes numerous changes in the particular districting of states originally suggested in the report by agreement with the state health officers.

....Idaho and Texas, for example, are using the actual districting suggested in the report;

....Georgia's present plan, on the one hand, calls for 55 units instead of the 45 agreed upon earlier;

....Ohio's plan, on the other hand, now calls for only 37 districts, none with a population of less than 68,000, while in 1945 no agreement could be reached with the state health officer for fewer than 53 districts.



A Record of Growth..

What has been the growth in local health services since, and perhaps in part growing out of, the Committee's report?

The number of persons not previously served who have been brought under the umbrella of an administrative setup able to give minimum health protective services is between 15 and 20 million.

The percentage of population served by full time local health units has gone up from about 62 to 71 percent.

Because there have been such marked changes in population, one can not speak with any exactness either as to total numbers or percentage increases until the details of the 1950 census are available. Much more exact are figures for the number of counties in which there is full time local health organization.

At the time of the study there were 1,220 such organized counties. Today there are 1,546 or more than one-half of the counties in the 48 states. This increase in the number of counties came about with an increase of only 136 in the total of local health departments. In the past year alone, more than 50 counties have been added to those organized for delivering health protective services but the total of departments has increased by only 8.

Through Consolidation, Joint Action -

How has this come about? Through the slow but steady extension of city health services to the entire county; or through consolidation of the services of cities and county.

Numerous examples of this process have taken place across the country in the last five years. Fresno City-County, Palo Alto-Santa Clara County, and Riverside City-County in California; Seattle-King County and Tacoma-Pierce County in Washington; Tulsa City-County in Oklahoma; Wichita-Sedgwick County and Leavenworth City-County in Kansas; Joliet-Will County in Illinois; Bay City-County, Battle Creek-Calhoun County, Kalamazoo City-County, and Lansing-Ingham County in Michigan; Charleston-Kanawha County and Huntington-Cabell County in West Virginia; High Point-Greensboro-Guilford County and Winston Salem-Forsyth County in North Carolina; Buffalo-Erie County, Albany City-County, and Troy-Rensselaer-Rensselaer County in New York -- to mention a number that come quickly to mind.

Secondly, this has come about through joint action by two or more counties to provide a combined or common local health service for their citizens. This process is perhaps older in states such as Mississippi, the Carolinas, Kentucky and Tennessee where income must stretch as far as possible and where there has been a good deal of Foundation help and influence.

In the past five years this has spread to other states. Illinois' Searcy-Clabaugh law provides for multi-county units and a number have been organized there. Indiana, Kansas, and Missouri have each had their first multi-county organizations within the past year. Michigan has extended the number of such joint departments as have nearly all the southern states except Alabama and Louisiana.

West Virginia has a number of joint departments, having begun with its capital city and largest county a few years ago. Virginia, without a specific law authorizing county consolidations, has gone on apace with such consolidations, a number of which also include some of the independent cities of that state. North Dakota has just completed the organization of a four county department.

In Massachusetts, the 20 year old Nashoba Associated Boards of Health has had a post war rebirth and has added to the number of towns included. Colorado has been adding to its coverage, chiefly through setting up multi-county departments.

Coverage in the States..

And what have been the results? States with complete coverage number six: Maryland, which has the longest history of service in every county; Delaware, with its three counties and a total population equalling a moderate size city; New Mexico, where the only mandatory state districting law is in operation; North Carolina, which added its final county recently; South Carolina, and Alabama.

In the latter state there are relatively few county consolidations and the traditional limited "four piece health department" still prevails in large measure. But a number of other states have service virtually in the entire state: California, except in a few sparsely settled counties; Michigan, Mississippi, Florida, and Virginia. Kentucky, Louisiana, and Tennessee each have an organization for nearly every county but have so many health officer vacancies that much of the coverage is in theory rather than practice.

Indiana, Missouri, Arkansas, Colorado, Montana and Washington each have enacted permissive health unit legislation. Eight states are without the necessary legislation to authorize county or district health units, and a number of other states need amendments to permissive laws to make them workable. Massachusetts has a health union act which becomes mandatory within ten years if voluntary unions have not been formed. New Jersey has a Governor's Commission studying local health services and writing a health unit bill.

Even in Pennsylvania, where the local health services map has remained unchanged for many years, citizens' committees are active in publicizing a recent study of health services in the state, made at the Governor's request by the American Public Health Association, with a view to carrying out the recommendations of the study. In Colorado and in Wisconsin, state health councils are active in building citizen support for local health departments. In New York State, the State Committee on Tuberculosis and Health has a 1951 program to foster development of county health departments. In 44 of the 57 upstate counties of this state there is no locally operated full time health service in rural areas and in many smaller cities.

The growth in number of reported full time local health departments and the number of counties and percentage of population served is summarized below for the United States for a number of years. The minus sign (-) in the third column indicates that, in some instances, less than the entire county is included in the coverage.

Year	Local health departments	Counties Served	Percent of population served
1942	1,084	1,220-	62.2
1947	1,172	1,372-	66.6
1948	1,201	1,431-	67.8
1949	1,212	1,492-	69.9
1950	1,220	1,546-	70.8

Leadership and Progressive Steps

Funds From Kellogg--

What have been some of the forces at work during this period to aid in this development? Perhaps foremost is the W. K. Kellogg Foundation, whose knowledge of public health needs in the country and leadership in local health administration has led it to pioneer in many directions. It provided the funds whereby first the American Public Health Association and later the National Health Council might carry on a nation-wide educational campaign on the importance of public health services as a function of local government, both in peace times and, even more, in war or other emergency periods.

Ann Arbor Conference - 1946

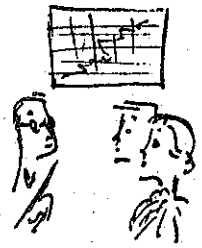
In 1946 the Ann Arbor Conference on Local Health Units opened this campaign. Here, for a week, state health officers and directors of local health administration explored the legal, financial, personnel, and community means by which their states could have the benefit of at least a minimum of local health protective services. In workshop sessions, everyone had a chance to explore his own problems against the backdrop of similar problems elsewhere. The Proceedings of this Conference constitute the bible, as it were, of planning for the extension of local health services.

Princeton Conference — 1947

A year later, the Princeton Conference on Local Health Units was held. This time the emphasis was on citizen involvement. Hence, the invited group was made up of representatives of national agencies with broad lay membership. About 100 persons representing some 65 agencies laid the groundwork for involving their state and local affiliates and their vast membership in a program to get local health protective services to every community and every inhabitant. Again, in a workshop session, panel and discussion leaders were drawn from such diverse groups as the American Farm Bureau Federation, state health councils, the General Federation of Women's Clubs, the Congress of Industrial Organizations, the National Congress of Parents and Teachers, the National Tuberculosis Association, as well as a sprinkling of local health officers.

National Advisory Committee — 1948

Out of this Conference was born the National Advisory Committee on Local Health Units. Made up of representatives selected by the "Princeton agencies", this Committee was organized in January, 1948, under the auspices of the American Public Health Association. At this time the new Committee and the Association jointly requested the National Health Council to provide professional leadership and staff and office space for the Committee's activities.



Progress Through Regional Conferences..

Then things began to happen. In the spring of 1948 a first five-state regional conference on local health units was held in Indiana, involving Indiana, Kentucky, Michigan, Ohio, and Wisconsin. Here was a "little Princeton", but now a representative list of the state counterparts of the "Princeton agencies" came together to share their common problems and to make state plans for their respective states.

Three additional "little Princetons" have been held, one in September, 1948, in Salt Lake City for 5 Mountain states and two in April, 1949, in Kansas City and Omaha. Each of the latter involved five of the Great Plains States. Thus 20 states have been covered in these regional workshops in each of which have been involved from 60 to 100 representative citizens with the opportunity for leadership in their communities.

State health councils have in some instances been organized by the nucleus of persons attending one of these conferences. Sometimes these councils grew out of state conferences following the same general plan and involving a larger number of citizens. Everywhere there has been more discussion, more understanding of local health services, more citizen participation. The advances already mentioned in Idaho, Indiana, Kansas, Missouri, and Ohio can certainly in part be credited to the influence growing out of these conferences.

Further Fields for Action..

There are still two or three areas in which a regional conference might serve a useful purpose. Chief among these is New England. with the passage of the town union acts of Massachusetts and New Hampshire, three of the New England states now have authorization for consolidated health districts made up of groups of towns. New Jersey has taken the lead in organizing a 5-state Eastern conference in January, 1951. This will cover the host state as well as Delaware, Massachusetts, New York, and Pennsylvania. Such a conference might add useful fuel to the fire of change that appears to be smoldering in the last named state.

A number of the southern states might be brought together for such a conference, particularly to share experiences in consolidating small and inadequate health units and in solving the problems of personnel recruitment so acute in that region. Florida and Mississippi have successful and growing experience in consolidation; Alabama and Louisiana, much less. As to recruitment, salaries are a deterrent practically throughout the South except in Florida which is meeting competition with the North and West.

Health Councils Have Helped..

The accelerated growth in the number of health councils in the past several years has been both cause and effect of the local health units interest. Out of the regional conferences in several instances have grown state health councils or their equivalent under another name. And out of the growth of health councils has come a better understanding of the need for local health services. In the National Health Council these two movements have converged in two of its activities, the National Advisory Committee on Local Health Units and its program of promoting community health planning councils. For the first time a national directory of such councils has been compiled and is available to anyone interested in community organization for health. State councils were found in 31 states; and 1,190 local councils in all but one of the 48 states as well as in the District of Columbia, Alaska, and Hawaii.

Legislation - a cheerful Prospect

A still further interest of the National Advisory Committee on Local Health Units has been the proposal for federal aid to local communities in establishing and maintaining local health services. In the 80th Congress a bipartisan Local Health Units Bill, sponsored by the National Congress of Parents and Teachers, passed the House by a substantial majority but failed to reach the Senate floor before adjournment. In the 81st Congress, with bipartisan introduction by 10 Senators, this legislation was adopted without opposition in the Senate.

By the time the House reached it, however, the Korean war broke out and war matters took almost the exclusive attention of Representatives. Nevertheless, the logic of federal aid for local health departments is firmly established. Already the federal government appropriates substantial sums for such special services as cancer, tuberculosis, heart disease, venereal diseases, and mental health. The local health department is a "must" in the effective and economical administration of the appropriations already provided by federal law. Nor can the health services of a community civil defense program be carried out effectively without a properly functioning local health department.

The bill's provision for an overall state plan and for stimulating and maintaining local responsibility and expenditures made it popular among groups with widely differing viewpoints. Many national voluntary health agencies and citizen groups, as well as many state and local agencies, are on record in support of the bill. The development of

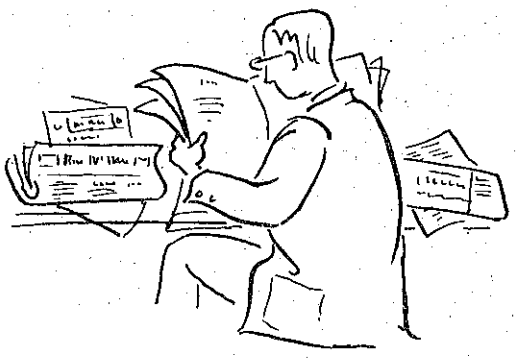
local health departments is one plank in the American Medical Association's 12-point national health program. Furthermore, the importance of a local health department in a civilian defense program increases the bill's urgency. Many states and communities are geared to implementing carefully planned programs and are awaiting only the necessary financial assistance which the bill is designed to provide. There is a good prospect that it will be passed in the final days of the 81st Congress. If not it will certainly be reintroduced in the 82nd Congress.

Health Units in the Public Press —

The program for organizing adequate local health services is reaching the man in the street. When the Saturday Evening Post takes note of it, there is no doubt of a wide and varied reader interest. And the Saturday Evening Post has done just that in "Public Health Doctor," one of a series on "Men at Work" by Richard Thruelsen. This appeared in the May 13, 1950, issue with interesting color photography. It is the story of an actual three-parish health unit in Louisiana. Arrangements for reprints, in the original colors, have been made for wide distribution by the Public Health Service.

In addition, "Today's Health" of August, 1950, has an article by Dr. Haven Emerson on "Your Health Department" in which he summarizes where we are and what is still to be done. In the October, 1950, The Lion Magazine of Lions International, Dr. Lee A. Rademaker discusses "Local Health Units-Three Years of Progress." These, together with Dr. Rademaker's earlier series of articles in "The Lion" and the widely distributed "Shame of Our Local Health Departments" in Collier's Magazine, as well as articles in "Hygeia" and the Junior League Magazine, constitute an impressive index of citizen interest.

Latest in this type of citizen education is the broadcast in October over a nationwide radio hookup of an interview on civil defense, the feature of which was the importance of the local health unit as the first bastion in a community civil defense program. The commentator interviewed the Surgeon General of the Public Health Service and the State Health Commissioners of New York and California.

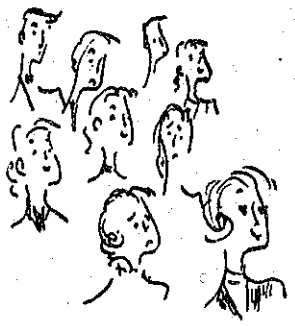


The "danger" Element

A third of our people still lack basic local health services. Many more have services which need to be stepped up both as to quantity and quality. With present personnel shortages, which may become more acute if the medical needs of the armed forces continue to expand, there is real danger that quality will be sacrificed and that communities will be satisfied with makeshift or inexpert service. Or perhaps worse still, they will reject the makeshift service with the thought: "If this is public health service, we will have none of it." Then the job of educating the community must begin all over again, this time with the handicap of having to explain away a full time health department that never got beyond the paper stage.

The Time is Now, Indeed!

Is it possible that we will waste the effort of the past five years? Can we ignore the need to follow through on the investment of time, money, work, especially in view of today's more critical need? Or will we see the five year period that has passed for what it is: not a period of isolated endeavor, but part of a living thread of human striving to reach a reasonable level of individual and group health for every community? If the latter, then we will all put our shoulder to the wheel-- public health workers, legislators, and even more important every man and woman in the community who stands to gain or lose according to the success or failure of our work. And the answer lies in your hands.



This report has been prepared jointly by Yolande Lyon, Public Information Director of the National Health Council, and Martha Luginbuhl, Secretary of its National Advisory Committee on Local Health Units.

The National Advisory Committee on Local Health Units

Alpha Kappa Alpha, National Health Program
Altrusa International
American Academy of Pediatrics
American Association for Health, Physical Education and Recreation
American Association of Medical Social Workers
American Association of University Women
American Cancer Society
American Dental Association
American Diabetes Association
American Federation of Labor
American Federation of Soroptimist Clubs
American Heart Association
American Home Economics Association
American Hospital Association
American Library Association
American Medical Association
American Medical Association, Woman's Auxiliary
American National Red Cross
American Nurses Association
American Pharmaceutical Association
American Physical Therapy Association
American Public Health Association
American Public Welfare Association
American School Health Association
American Social Hygiene Association
American Veterans Committee
Association of American Medical Colleges
Association of Junior Leagues of America
Association of State and Territorial Health Officers
Community Chests and Councils
Conference for Health Council Work
Conference of Municipal Public Health Engineers
Congress of Industrial Organizations
Farmers' Educational and Cooperative Union
Federal Council of the Churches of Christ in America
General Federation of Women's Clubs
Lions International
National Association of Negro Business and Professional Women's Clubs
National Association for Mental Health
National Congress of Colored Parents and Teachers
National Congress of Parents and Teachers
National Council of Negro Women
National Epilepsy League

National Federation of Business and Professional Women's Clubs
National Foundation for Infantile Paralysis
National Grange
National Health Council
National Multiple Sclerosis Society
National Organization for Public Health Nursing
National Safety Council
National Sanitation Foundation
National Social Welfare Assembly
National Society for Crippled Children and Adults
National Society for the Prevention of Blindness
National Tuberculosis Association
National Urban League
Spokesmen For Children
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