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Proceedings of The National Conference on Local Health Units

THE UNIVERSITY OF MICHIGAN
SCHOOL OF PUBLIC HEALTH

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AMERICAN PUBLIC HEALTH ASSOCIATION
1790 BROADWAY NEW YORK 19, N. Y.

FOREWORD

Here is the substance out of which the health statesmanship of a democracy is built. First the concern of a profession that its nation was not equipped through government to apply the sciences of preventive medicine for the social ends of all the people. Then the study of each state and county to reveal present attainment of local government and project the desirable status of the future. Following this the printed record and a declaratory commitment to a policy of nation-wide scope, *Local Health Units for the Nation,* with more copies issued than there are counties in the nation.

Finally a rigorous testing of the profession's report in the crucible of free discussion by the very officers of state government upon whom the burden of achievement would fall. Do they agree with the facts? In what respects do their solutions match the proposals of the public health profession? What hindrances of law, tax moneys, or personnel prevent logical and prompt completion of the jobs? These and other questions received outspoken and unbiased consideration in a forum setting of academic halls and faculty participation.

Interest in the printed report far exceeded expectations. That this should be maintained and extended seemed both possible and desirable. A unique experiment was tried, single in purpose and novel in conception. Instead of having all state health officers assembled on official call to confer in the midst of political and financial pressures at the nation's capital, and at tax payers' expense, these officers together with their deputies in charge of local health administration were invited by the University of Michigan, the State and Territorial Health Officers Association and the American Public Health Association to gather in Ann Arbor in the halls of the School of Public Health for a week of uninterrupted presentation of facts and consideration of their implications. The expenses of travel and maintenance were met by a grant by the W. K. Kellogg Foundation to the University of Michigan for this particular experiment in self-education of the key men in public health administration.

The pattern of the days was simple; a morning devoted to scholarly, adequate dealing with four major topics by teachers and others of comparable ability; half the afternoon devoted to minute discussion of the morning subjects in conference groups, ending with a general assembly to hear and accept or reject summaries of opinions and recommendations.

Throughout the major purpose was kept in mind: "To consider the most effective way of getting complete coverage of the nation with efficient and economical local health service by whatever pattern seems best in each state."

There were guests from the federal and civilian health services and from the American Medical Association.

The proceedings as here presented are edited free of all but the hard core of facts and opinions. Formal papers are printed in full, but the committee in charge is responsible for all editorial corrections and omissions of irrelevant matter.

Paper shortage has necessitated rigorous cutting of discussions and the entire omission of the roll call by states carried out at the final afternoon session.

To judge by participants' comments, the conference was a serious success. The program committee's work was appreciated and cordially acknowledged. The host of the occasion was the School of Public Health and its Dean, who created an atmosphere of intellectual freedom and cordial acceptance of each helpful thought and sound point of fact or reasoning.

Absenteeism was all but nil: participation was practically universal by the members.

The purpose, the method, the results are worthy of a recall meeting in some other year and in similarly suitable surroundings.

The text herewith offered is worth more than casual reading by teachers, students, and practitioners of public health, and by those concerned with self government and its use as an instrument of applied medical science.

HAVEN EMERSON, M.D., *Chairman*
Subcommittee on Local Health Units
Committee on Administrative Practice
American Public Health Association

PUBLIC HEALTH CONFERENCE

The School of Public Health offers a series of Health Conferences of which this National Conference on Local Health Units is the twentieth. This conference is supported by a grant of funds from the W. K. Kellogg Foundation and is sponsored by the American Public Health Association and the Association of State and Territorial Health Officers.

PROGRAM

MONDAY, SEPTEMBER 9

General Session

Presiding: *Henry F. Vaughan, Dr.P.H.,* Dean, School of Public Health, University of Michigan

TUESDAY, SEPTEMBER 10

General Session

Presiding: *Clarence L. Scamman, M.D.,* The Commonwealth Fund.

WEDNESDAY, SEPTEMBER 11

General Session

THURSDAY, SEPTEMBER 12

General Session

FRIDAY, SEPTEMBER 13

General Session

Proceedings

Monday, September 9

General Session

Presiding: HENRY F. VAUGHAN, Dr.P.H., Dean, School of Public Health, University of Michigan

Dr. Vaughan: First of all, I want to thank you all for being here this morning, and in doing so I am speaking on behalf of the committee which has made this conference possible. The committee which is listed on the first page of your program includes representation of the American Public Health Association, the Association of State and Territorial Health Officers, and the School of Public Health. I think it is only fair to say, however, that the prime moving organization back of this conference is the Committee on Local Health Units, which is a subcommittee of the Committee on Administrative Practice of the American Public Health Association.

The committee's report, as you all know, has been published by the Commonwealth Fund, and is now in its third edition. The conference here is made possible through the support of the W. K. Kellogg Foundation, which is meeting the expenses.

Now, a word about the mechanics of the meeting itself. Your committee decided to hold general sessions in the morning, and in accordance with the program, the discussions will be postponed until the afternoon group meetings. There will be four group meetings each afternoon from 2–4. For example, this afternoon the leader for Group One will be Dr. Beelman, and his consultant will be Dr. Emerson. In each case the consultant is the person who has presented the paper in the morning. Dr. Beelman's obligation will be to lead the discussion based largely upon Dr. Emerson's paper. Then Dr. Beelman as discussion leader will report to the general session at 4 o'clock—as will each of the other group discussion leaders.

We have asked Dr. Emerson, who is the father of the report *Local Health Units for the Nation,* as prepared by the American Public Health Association and published by the Commonwealth Fund, to present the picture for the nation as a whole.

Local Health Units for the Nation

HAVEN EMERSON, M.D.

Chairman, Subcommittee on Local Health Units, American Public Health Association

To partake of the benefits of science is a privilege of society and an obligation of civil government.

Society has encouraged the development of professional bodies concerned with the advancement and application of the sciences, and has created instruments of education and service supported by tax resources and welded into the permanent structure of our local,

state, and federal governments. The American Public Health Association, with the concurrent participation of the Association of State and Territorial Health Officers, has accepted the invitation of this School of Public Health of the University of Michigan to spread before you, the officers of health of state government, the facts and opinions assembled by the Subcommittee on Local Health Units of the Committee on Administrative Practice, and to stimulate your active coöperation.

Our work began in August, 1942, and was outlined provisionally at the A.P.H.A. meeting in St. Louis in October of that year. Our formal report was published in March, 1945, and of this nearly 3,000 copies have been distributed, and a third printing has been ordered. The completion of our undertaking will be when health services are in fact provided in a professionally competent manner through local government for every person in our population and over every square mile of our national area, except for populations and areas specifically made the responsibility of the federal government. We have confidence that your presence here and the exercise of your influence in your respective states will in the early future achieve the goal which we as a committee propose.

Society and government have lagged behind the medical sciences until we appear indifferent and neglectful.

Rapid growth of a mass of intricate facts of the causes and prevention of disease, and of the truths of human biology has been accompanied by an effort to transfer the responsibilities for health from the individual, the family, the local community where they be'ong, to the slowly moving, ponderous, and more remote jurisdictions of federal and state authority.

The primary strength, the essential vigor of our form of representative government is local initiative, self-support, and responsibility. The least social unit demanding health protection and guidance is the mother and child. The family, the school, the shop, the trade group, the village, town, borough, township, city, and county are but composite and aggregate units made up of families. Public health is the sum of personal healths. The optimum in health cannot be achieved without interested, unanimous sharing in a way of life consistent with the lessons of nature.

For more than 40,000,000 of our people today health service is but a name, not a reality. They live where sanitary science has not yet touched them, where there is no board or officer of health, where no nurse penetrates the problems of their households, where only the record of births and deaths serves as a token that anyone is concerned with their existence.

Not only are these people biologically illiterate but their elected officers are indifferent to their obligation to provide the basic elementary services which only civil government can extend in the interest of their health. A department of public health is generally an authorized but not a required agency of local civil government.

In the three tables and attached pages of interpretation you will see the picture as it is today across the country.

Briefly: in Table 1 you will find the distribution by states of all counties in which all or any part of the population lives under the jurisdiction of full-time local health services, i.e., 1,322 of the 3,070 counties. In these 1,322 counties 1,110 local health units serve cities separately, city and county, single or multicounty populations.

In Table 2 you will see that only 85,558,300, or 65 per cent of our population, is served by these 1,110 existing units. In some states but a small fraction of the population is covered by full-time medically directed local health departments (Utah 2.9 per cent and

TABLE 1

Existing Full-time Local Health Units, Distribution by Type of Unit, Each State, June, 1946

State	Counties		Type of Unit								
							Multi-County				
	Total	Served [a]	Total	City	City-County	Single County	Total	Bi-County	Tri-County	Four-County	Five or More
Total	3,070	1,322—	1,110	270	111	475	254	151	71	26	6
Alabama	67	67	53	..	..	39	14	14	..	..	..
Arizona	14	6	6	..	2	4	..	..	..	..	..
Arkansas	75	65	26	1	3	5	17	1	10	5	1
California	58	29—	40	12	9	18	1	1	..	..	..
Colorado	63	6—	5	1	1	2	1	1	..	..	..
Connecticut	8	5—	13	13	..	..	..	..	..	..	..
Delaware	3	3	4	1	..	3	..	..	..	..	..
District of Columbia	..	..	1	1	..	..	..	..	..	..	..
Florida	67	43—	27	1	3	12	11	5	6	..	..
Georgia	159	63	46	1	4	29	12	6	6	..	..
Idaho	44	14	5	..	..	2	3	1	1	..	1
Illinois	102	19—	22	10 [b]	..	9	3	2	1	..	..
Indiana	92	3—	3	1	1	1	..	..	..	..	..
Iowa	99	3	3	..	3	..	..	..	..	..	..
Kansas	105	15	16	1	3	12	..	..	..	..	.
Kentucky	120	105	61	..	7	21	33	22	11	..	..
Louisiana	64	56	39	..	3	20	16	15	1	..	..
Maine	16	4—	5	5	..	..	..	..	..	..	..
Maryland [c]	23	23	24	1	..	23	..	..	..	..	..
Massachusetts	14	11—	54	52 [d]	..	2	..	..	..	..	..
Michigan	83	71—	56	11	3	29	13	6	3	4	..
Minnesota	87	4—	4	4	..	..	..	..	..	..	.
Mississippi	82	65	56	..	3	47	6	4	1	1	..
Missouri [c]	114	15—	18	3	..	15	..	..	..	..	..
Montana	56	5	5	..	4	1	..	..	..	..	..
Nebraska	93	13—	7	2	1	1	3	1	1	1	..
Nevada	17	2—	2	..	1	1	..	..	..	..	..
New Hampshire	10	4—	6	6	..	..	..	..	..	..	..
New Jersey	21	14—	53	53 [d]	..	..	..	..	..	..	..
New Mexico	31	31	10	..	..	..	10	2	5	3	..
New York	62	22—	21	14	1	5	1	..	..	..	1
North Carolina	100	93	66	5	4	36	21	12	8	1	..
North Dakota	53	11	3	1	..	..	2	..	..	1	1
Ohio	88	57—	66	18	18	26	4	4	..	..	..
Oklahoma	77	44—	28	2	2	13	11	7	3	..	1
Oregon	36	19	15	1	1	9	4	3	1	..	..
Pennsylvania	67	23—	15	4	1	3	7	4	3	..	..
Rhode Island	5	1—	2	2	..	..	..	..	..	..	..
South Carolina	46	46	34	3	1	18	12	10	1	1	..
South Dakota	69	1	1	..	1	..	..	..	..	..	..
Tennesse	95	53	38	2	5	17	14	11	3	..	..
Texas	254	62—	49	7	17	16	9	4	1	4	..
Utah	29	1	1	..	..	1	..	..	..	..	..
Vermont	14	..	..	..	..	..	..	..	..	..	..
Virginia [c]	100	51	42	14	2	11	15	9	4	2	.
Washington	39	23—	20	3	4	7	6	6	..	..	..
West Virginia	55	38—	24	3	1	15	5	..	1	3	1
Wisconsin	71	12—	14	11	1	2	..	..	..	..	..
Wyoming	23	1	1	..	1	..	..	..	..	..	..

[a] The minus (—) sign after the figure indicates that in some of the counties less than the entire area is covered by full-time local service.

[b] Two are multi-city units, 2 and 3 cities respectively.

[c] In addition to the counties covered, independent cities also have full-time local health officers apart from the county; one each in Maryland and Missouri, 14 in Virginia.

[d] Includes both cities and towns.

Iowa 6.3 per cent), in only five states (Alabama, Delaware, Maryland, South Carolina, New Mexico) and the District of Columbia, is all the population and area included.

In Table 3 you will find that in 225

TABLE 2

Existing Full-time Local Health Units by Population Groups and Population Served, Each State, June, 1946

State	Population Groups								Population Served	
	Total	Less than 10,000	10,000–25,000	25,000–40,000	40,000–50,000	50,000–100,000	100,000–500,000	500,000 and Over	Number (Thousands)	Per Cent
Total	1,110	30	227	292	145	275	126	15	85,558.3	65.0
Alabama	53	..	8	18	11	12	4	..	2,833.0	100.0
Arizona	6	1	2	1	..	1	1	..	341.2	68.3
Arkansas	26	..	..	2	5	19	..	..	1,770.2	90.8
California	40	..	4	8	2	12	11	3	6,265.0	90.7
Colorado	5	..	2	..	1	2	..	..	202.7	18.1
Connecticut	13	..	2	5	1	2	3	..	895.8	52.4
Delaware	4	..	..	1	..	2	1	..	266.5	100.0
District of Columbia	1	..	..	..	..	..	..	1	663.1	100.0
Florida	27	..	9	9	3	3	3	..	1,445.6	76.2
Georgia	46	2	13	16	5	7	3	..	2,016.7	64.5
Idaho	5	..	1	1	1	2	..	..	244.4	46.6
Illinois	22	..	2	5	4	6	4	1	4,873.8	61.7
Indiana	3	..	..	..	..	1	2	..	574.5	17.0
Iowa	3	..	1	1	..	..	1	..	160.5	6.3
Kansas	16	..	4	8	1	1	2	..	711.8	39.5
Kentucky	61	3	12	23	8	14	1	..	2,592.8	91.1
Louisiana	39	..	8	12	5	11	3	..	2,252.9	95.3
Maine	5	..	2	2	..	1	..	..	178.5	21.1
Maryland	24	..	11	5	..	6	1	1	1,821.3	100.0
Massachusetts	54	4	22	5	10	6	6	1	2,946.9	68.1
Michigan	56	..	9	20	6	15	5	1	4,555.8	86.7
Minnesota	4	..	..	1	..	..	3	..	907.5	32.5
Mississippi	56	..	22	23	4	6	1	..	1,836.9	84.1
Missouri	18	..	8	4	1	2	2	1	1,821.2	48.1
Montana	5	..	3	2	..	..	..	..	125.4	22.4
Nebraska	7	1	..	2	1	2	1	..	471.1	35.8
Nevada	2	..	2	..	..	..	..	..	27.6	25.0
New Hampshire	6	1	2	2	..	1	..	..	173.3	35.3
New Jersey	53	13	20	11	2	2	5	..	2,108.4	50.7
New Mexico	10	..	..	2	4	4	..	..	531.8	100.0
New York	21	..	..	2	2	7	8	2	10,496.7	77.9
North Carolina	66	..	5	14	16	28	3	..	3,453.0	96.7
North Dakota	3	..	..	2	..	1	..	..	118.9	18.5
Ohio	66	3	14	18	6	16	8	1	4,901.3	71.0
Oklahoma	28	..	2	7	4	12	3	..	1,677.9	71.8
Oregon	15	..	2	6	1	5	1	..	892.3	81.9
Pennsylvania	15	..	..	..	1	2	10	2	4,264.2	43.1
Rhode Island	2	..	..	..	1	..	1	..	302.8	42.4
South Carolina	34	..	4	12	5	8	5	..	1,899.8	100.0
South Dakota	1	..	..	..	..	1	..	..	57.7	9.0
Tennessee	38	..	6	11	4	13	4	..	2,280.0	78.2
Texas	49	..	9	11	7	10	12	..	3,552.5	55.4
Utah	1	..	1	..	..	..	..	..	15.8	2.9
Vermont	..	..	..	..	..	..	..	..	..	..
Virginia	42	2	9	7	10	11	3	..	1,975.1	74.0
Washington	20	..	3	3	6	4	4	..	1,448.7	83.4
West Virginia	24	..	2	5	1	15	1	..	1,398.1	73.5
Wisconsin	14	..	1	4	6	2	..	1	1,173.6	37.4
Wyoming	1	..	..	1	..	..	..	..	33.7	13.4

of the 1,110 units there is a vacancy in the position of full-time health officer. Furthermore it appears that three-fourths of the vacancies are in local health departments serving less than 50,000 people, and 60 per cent of the units with vacancies have populations of less than 40,000.

May I take it for granted that your professional curiosity and your official obligation to your state have caused each of you to read at least the first 24 and the last 4 pages of the report on *Local Health Units for the Nation,* Chapters I, II, III, and V, and at least the description and tables on the 3 or 4 pages dealing with your own state.

In simplest form the committee's sug-

TABLE 3

Existing Full-time Local Health Units, Existing Vacancies Among Health Officers, Each State, June, 1946

State	Total Full-time Units	Vacancy in Position of Full-time Health Officer				Position Full-time Health Officer Filled			Duplication [a]
		Acting Health Officer							
		Total	Medical	Non-medical	Not Filled	Total	Medical	Non-medical	
Total	1,110	225	78	15	132	885	773	112	24
Alabama	53	12	11	..	1	41	41	..	..
Arizona	6	4	1	..	3	2	2	..	..
Arkansas	26	16	..	..	16	10	10	..	..
California	40	..	..	..	..	40	37	3	..
Colorado	5	2	..	..	2	3	2	1	..
Connecticut	13	..	..	..	..	13	12	1	..
Delaware	4	2	..	..	2	2	2	..	..
District of Columbia	1	..	..	..	..	1	1	..	..
Florida	27	3	..	..	3	24	24	..	..
Georgia	46	20	..	..	20	26	26	..	..
Idaho	5	2	..	..	2	3	3	..	..
Illinois	22	3	1	..	2	19	19	..	..
Indiana	3	..	..	..	..	3	3	..	..
Iowa	3	1	..	..	1	2	2	..	..
Kansas	16	3	3	..	..	13	13	..	..
Kentucky	61	21	1	..	20	40	40	..	..
Louisiana	39	7	1	..	6	32	32	..	..
Maine	5	..	..	..	..	5	5	..	..
Maryland	24	3	3	..	..	21	21	..	3
Massachusetts	54	2	..	..	2	52	11	41	..
Michigan	56	7	3	4	..	49	49	..	..
Minnesota	4	..	..	..	..	4	4	..	..
Mississippi	56	20	20	..	..	36	36	..	17
Missouri	18	6	..	..	6	12	12	..	..
Montana	5	1	1	..	..	4	4	..	..
Nebraska	7	3	..	..	3	4	4	..	..
Nevada	2	..	..	..	..	2	2	..	..
New Hampshire	6	1	..	1	..	5	2	3	..
New Jersey	53	..	..	..	..	53	4	49	..
New Mexico	10	3	3	..	..	7	7	..	..
New York	21	..	..	..	..	21	21	..	..
North Carolina	66	17	10	..	7	49	49	..	1
North Dakota	3	..	..	..	..	3	3	..	..
Ohio	66	1	..	..	1	65	57	8	..
Oklahoma	28	6	3	..	3	22	22	..	..
Oregon	15	3	..	..	3	12	12	..	..
Pennsylvania	15	2	..	..	2	13	12	1	..
Rhode Island	2	..	..	..	..	2	2	..	..
South Carolina	34	2	..	..	2	32	30	2	..
South Dakota	1	..	..	..	..	1	1	..	..
Tennessee	38	12	1	..	11	26	26	..	..
Texas	49	15	6	9	..	34	33	1	3
Utah	1	..	..	..	..	1	1	..	..
Vermont	..	..	..	..	..	..	..	..	..
Virginia	42	12	4	1	7	30	30	..	..
Washington	20	..	..	..	..	20	20	..	..
West Virginia	24	12	6	..	6	12	12	..	..
Wisconsin	14	1	..	..	1	13	11	2	..
Wyoming	1	..	..	..	..	1	1	..	..

[a] Represents instances in which a health officer in one unit is acting health officer in another.

gestion is that about 1,200 units of local health jurisdiction would be sufficient to bring good local health service to the people of continental United States if at least one dollar per capita were provided from tax resources. We advise that only under exceptional circumstances of space and sparsity of

population should less than 50,000 of population be served by a single local health department. We consider that a local health organization for 50,000 people should include 16 persons: a full-time professionally trained and experienced physician for health officer, a professionally trained sanitary or public engineer and a non-professional assistant, 10 public health nurses of whom one should be of supervisory grade, and 3 persons in secretarial or clerical positions. Clinical medical services will be needed on a part-time basis.

It is not for me to deal with the problems and difficulties of political, financial, public relations, personnel and other varieties which demand concentrated attention and solution at other sessions.

Instead of the existing 18,000 local health jurisdictions, and to prevent a still greater catastrophe of 38,000 such jurisdictions, now actually authorized under existing state laws, we suggest 1,197.

The solution we propose cuts deeply into the traditional and now largely archaic structure of local government which suited an era of mule-back or buggy-riding transportation but can no longer serve the speed and convenience of modern conveyance.

A major problem is to blend the powers of federal, state, and local governments to assure a harmonious execution of a common purpose, and in so doing to increase the effectiveness of local government and reaffirm the basic principle of our democracy.

Our minor problem is the application of these principles to public health administration at the local level.

Federalism *and* democracy we are fortunately committed to. The balance between them is strained by the growth in the size and complexity of government. Coöperation between federal and local interests is not easy. The democratic process has started to bog down. The average citizen is befuddled and his natural inertia is increased by the complexity of current federal problems and programs. His share in his own local government has been whittled away by movement of power over functions and expenditures from local to the central governments. The vitality of citizen interest has been sapped and and yet upon this the whole structure of a democratic process ultimately depends.

Without hampering the development of a federal structure to deal with its own problems, we must retain or return the full capacity of the people for self-government at the local level especially in all matters so intimate and personal in character as those included within the six basic functions of public health.

Let me give you but one illustration of the complexity I have referred to. In one typical mid-western agricultural county of 36,000 persons there are not less than 298 governmental organizations. Of these, 155 are units of local government (county, 2 cities, 7 villages, 28 townships, and 122 school districts), each of which carries on independently of the other, levying its own taxes and planning its own activities. There are 105 state agencies and 38 federal operating in the county. In this county 56 cents per capita is spent for health promotion. The density of population is 48.9, close to that of the nation's 44.5. Politics is an established tradition. Social organization is highly developed. Ninety-two percent of children of 15 years of age are still in school attendance. The economic situation is excellent. Progress in self-government is bogged down by its complexity and lack of personal responsibility. A particular difficulty is the flow of federal grants through individual state departments instead of through the state's budgetary agency. Duplication is a major cause of extravagance in spending tax money.

Unplanned development of public health administration is the result as

well as the cause of such fantastic expressions of local, state, and federal incoördination.

At each level there is lacking a central tie-up of public health activities. There is only rudimentary organization at the local level. Local boards of health operate independently, and sometimes in conflict with each other. Local and state government has provided only a minimum of health services. Present arrangements do not favor intergovernmental coöperation or any attempt at a unified community health program. The total expenditures for health by all units located in the county amounted to $20,416.72, or 56 cents per capita.

Shortage of staff and lack of coöperative planning for its use result in spotty and inefficient service to the community. Each unit under a part-time medical officer thinks only of its own assignments, even the county and school failing to pool their public health nurses as a single staff in the face of the present critical shortage of nurses.

Such is the kind of material used in creating an interest in the committee's objectives, in articles and lectures which have been called for all over the country. Miss Luginbuhl, the secretary of the committee, and I have prepared articles for many professional and other publications, the last two by Miss Luginbuhl being for *Hygiea* and *The Survey*.

I have spoken at the invitation of the state health officer or the state public health or medical association in 11 states, and Dr. Atwater and Dr. Buck in many more, to bring our report and proposal to wide public attention.

Particular attention should be called to the successful state-wide publicity and educational propaganda for local health units in Nebraska, North Dakota, Minnesota, Missouri, Illinois, Indiana, New York, and Michigan.

Never before has there been in this country so favorable a setting for the advance to a new level of national usefulness of publicly administered health services. The items of importance appear to me to be:

1. Unanimous professional approval of the objectives of the committee (A.M.A., A.P.H.A., State and Provincial Health Officers of North America, Association of State and Territorial Health Officers).

2. The acceptance in principle or in detail, or both, of the proposed 1,197 local health units by the state health officers.

3. The approval of officers of the U. S. Public Health Service in the content and publication of the report.

4. The support of the stage of exploration and collection of the facts, by two influential national foundations, the Commonwealth Fund and the W. K. Kellogg Foundation.

5. The absence of any personal, regional, state, or other opposition to our proposal.

6. While an optimum local health service cannot be had for the modest $1.00 per capita we suggest, the basic essentials of a good service can be.

7. Participation in the undertaking now before us for consideration has been accepted by faculties of schools of public health across the country.

You are gathered here under academic auspices so that rigorous critical consideration may be given to the proposals before you. Only intellectual, objective, impersonal, nonpolitical attitudes are permissible in the company of scholars that constitutes the academic collegium. We have ourselves taken part as students and teachers in university education.

Convictions in the scientific sense determine motives for social conduct.

The committee challenges you to detect and reveal flaws in our facts or argument, and welcomes the least and the most effective evidence as to the lack of logic in the position we maintain. Such conclusions as you may achieve, we believe, you must then devote to the practical conduct of public affairs with which you are entrusted.

The Committee comes to you in all humility as before the final court of

appeal. If you find our cause worthy we shall undertake whole-heartedly and unreservedly every useful measure of support of your action within your respective states so that local health services may become in fact what they have always been in theory; the very groundwork, foundation, background or landscape upon which state, federal, and international health performance and progress must be based.

The Committee is a reality of professional fellowship in this work and you will hear from several of the members during the week. They are not silent members.

We count on your answering some or all of the following questions during your stay with us.

1. How do you plan to complete the coverage of your state?
2. When do you plan to complete the coverage of your state?
3. What if any are present hindrances to such complete coverage?
4. How do you plan to remove these?
5. Have you at present or in prospect a state-wide official or voluntary organization devoted to getting complete coverage by local health units?

We have copies of a law suggested as suitable where state statutes do not yet authorize local health units as we suggest. In October this or a similar text will be acted on by the National Conference of Commissioners on Uniform State Laws.*

PUBLIC HEALTH ACT

AN ACT RELATING TO PUBLIC HEALTH

Be it enacted . . . . . .

SECTION 1. *Duties of (State Board of Health).* The (State Board of Health) (herein called the Board) shall:

(1) Establish a (Department of Public Health) with suitable offices, properly equipped;

(2) Make and may amend, after notice and hearing, necessary rules and regulations concerning matters of public health;

((3) Enforce this act and the regulations made pursuant thereto.)

SECTION 2. *Appointment of (Director); Qualifications; Compensation.* The (Board) shall appoint a (Director of Public Health), who shall be qualified (in accordance with standards of education and experience as the (Board) shall determine) (under civil service laws) and fix his compensation.

SECTION 3. *Duties of (Director).* The (Director), under the supervision of (the Board), shall have charge of the (Department of Public Health) and perform the duties prescribed by the (Board). He shall enforce this act and the regulations of the (Board) (and have supervisory power over all officers or employees of the (Department)). He shall submit to the (Board) (Legislature) (General Assembly) (Governor) an annual report of his administration.

SECTION 4. *Other Employees.* The (Director) shall appoint necessary subordinates and assistant personnel (who shall be qualified in accordance with standards of education and experience prescribed by the (Board) (under civil service laws) (under the merit system) (and fix their compensation).

SECTION 5. *(Public Health Districts).* The (Board) shall divide the state, from time to time, into (Local Health Districts), which shall conform to political subdivisions, or combinations thereof, or of parts thereof.

SECTION 6. *(Local Department of Public Health).* In each District the (local government) (or governments) shall (jointly) appoint a (Local Board of Health) (composed of persons professionally or otherwise qualified).

SECTION 7. *Duties of (Local Board of Health).* The (Local Board of Health) shall:

(1) Establish a (Local Department of Public Health) with suitable offices, properly equipped;

(2) Make and may amend, after notice and hearing, necessary rules and regulations concerning matters of public health not inconsistent with the rules and regulations of the (State Board of Health).

((3) Enforce this act and the regulations made pursuant thereto.)

SECTION 8. *Appointment of (Local Health Officer): Qualifications; Compensation.* The (Local Board of Health) shall appoint and

* This text was discussed and revised but not acted upon by the Annual Meeting in October of the Conference of Commissioners on Uniform State Laws. Final action will be taken at the 1947 annual meeting.

fix the compensation of a (Local Health Officer) who shall be qualified (in accordance with standards of education and experience) as the (State Board of Health) shall determine (under civil service laws) (under the merit system).

SECTION 9. *Duties of (Local Health Officer).* The (Local Health Officer) shall have charge of the (Local Department of Public Health) and perform the duties prescribed by the (Local Board). He shall enforce this act and the regulations of the (State) and (Local Board) (and have supervisory power over all officers or employees of the (Local Department)). He shall submit to the (Local Board) (Board of County Commissioners) (City Council) an annual report of the administration of his department.

SECTION 10. *Local Employees.* The (Local Health Officer) shall appoint all necessary subordinate personnel (who shall be qualified in accordance with standards of education and experience prescribed by the (Board)) (under civil service laws) (under the merit system) (and shall fix their compensation).

SECTION 11. *Publication and Effective Date of Regulations.* The regulations of the (State Board) and of the (Local Boards) shall be published and shall take effect 30 days after publication.

(SECTION 12. *Replacement of Existing Local Health Agencies.* When a District is established and a (Local Board of Health) is appointed, pursuant to the terms of this act, every other local, municipal or county health agency or department shall be abolished and the (Local Board of Health) shall have full control over all health matters in the District.)

(SECTION 13. *Creation of (Local Public Health Departments) by (Director) when Local Government fails to act.* If the Local Government in any District fails or refuses to create a (Local Board of Health) or (Local Department of Health), (Director) shall set up a (Local Health Department) for the District.)

SECTION 14. *Penalties.* Any person who knowingly violates any rule or regulation published by the (State Board) or the (Local Board) shall be (guilty of a misdemeanor and) fined (not more than ($100)).

SECTION 15. *Short Title.* This act may be cited as the "Public Health Act."

SECTION 16. *(Time of Taking Effect.)* This act shall take effect . . . . . .

Dr. Vaughan: Thank you, Haven. And, in keeping with our policy, we will have no discussion of the papers until the afternoon session.

Dr. Emerson has given us the keynote of this program and very concisely presented the problem.

Your committee thought it would be advisable to complement these erudite professionally trained speakers like Haven Emerson, with some practical men who really do know something about public health practice.

Dr. Van Volkenburgh is rich in the experience of the great State of New York, where recent legislation and planning have gone even beyond the minimum suggestions made by the Committee on Local Health Units. These suggestions of Dr. Emerson's and his committee are considered only as tentative, and minimal, and should not be considered final and fixed so far as suggested boundaries for districts and counties and local organizations are concerned. Please do not get the impression that the committee at any time thought its suggestions final. There will be geographic and political considerations and ethnological as well, which will modify the recommendations of the report. Dr. VanVolkenburgh will show you, I am sure, that already in the State of New York there has been deviation from the suggestion of the committee, and that is as it should be.

Local Health District Development in New York State

V. A. VAN VOLKENBURGH, M.D., DR.P.H.

Assistant Commissioner, Office of Local Health Administration, New York State Department of Health

Administrators responsible for the health of New York State citizens have long been aware of the inadequacy of the political structure of their state wherein primary responsibility for local health service was vested during the middle of the 19th century in the boards of health of the township, the village, and the city, on a mandatory basis. Relief for this anachronism was made possible by enactment of permissive legislation.

BACKGROUND OF LEGISLATIVE PROVISIONS

At least forty years ago the failure and inability of these basic units of government, usually too small in population and wealth to provide necessary health services, became apparent. The need was recognized for their enlargement and reorganization. In 1913 a state health commission sought to remedy the defect by obtaining authorization for the consolidation of adjacent towns and villages, with provision for a single representative board of health and part-time health officer. Provision was made also for more direct state supervision of local health services by authorizing the establishment of state sanitary districts in charge of a state sanitary supervisor to act as a liaison agent between the State Health Commissioner and local public health officials.

Such actions, while a step in the right direction, proved insufficient. In 1921 legislation was enacted authorizing the county board of supervisors on a permissive basis to establish a county or part-county health district. Provision was made for a county board of health and the appointment of a health officer who was required to devote full time to the duties of his office and possess qualifications approved by the State Public Health Council. Primarily to satisfy home rule principles, it was directed that all local health units contained in the county health district might continue to exist as subdivisions thereof. The board of health of each unit retained its powers and duties, including authority to appoint a local health officer to serve as a deputy of the county health officer. Each city was entitled to a representative on the county board of health. Townships and villages could obtain representation through the physician and supervisor appointees. The only restriction placed on the local boards was that their actions were subject to the rulings and ordinances of the county board of health.

At a later date, in 1929 to be exact, these home rule provisions were modified somewhat. Only cities and those townships and incorporated villages of 3,000 population or more were allowed the right to continue as subdivisions of the county health districts. All cities were granted the privilege of becoming a part of the county health district or of abstaining from joining. Any local unit having a right to continued existence under the law could be abolished through local action, whereupon the functions of the local board devolved upon the county board of health and the powers and duties of the local health officer upon the county health officer. In the interest of economy such abolish-

ment proved to be the rule, except for cities of 50,000 population or more having a full-time health officer.

Two other significant legislative acts should be mentioned. The first, enacted in 1921, authorized the county board of supervisors of a county not having a county tuberculosis hospital to employ and pay the necessary expenses of public health nurses. Later this was amended to apply to counties *not organized* as county health districts and authorization for the employment of dentists, dental hygienists, clinic physicians, milk inspectors and sanitary inspectors was added. Supervision was provided by a county public health committee, state department representatives, and the part-time local health officer of the basic health jurisdictions to which these individuals were assigned by the public health committee.

The second significant legislative act, effective in 1923, provided state financial aid to any county wherein the board of supervisors appropriated funds for public health work, whether said county was organized as a county health district or not. Reimbursement was granted in the amount of 50 per cent of the money so expended, subject to performance standards and limitations prescribed by the State Commissioner of Health. Each year the State Legislature makes an appropriation for this purpose based on estimated needs and the State Department's recommendation. Such action is taken independently of action on the budget of the State Department of Health.

BASIC PRINCIPLES ESTABLISHED

The foregoing legal provisions have been reviewed in a brief and incomplete fashion to establish the early background of administrative local health service provisions and to make the following points:

1. Recognition of the county as the most practical, efficient, and economical unit of local government to provide basic health services was obtained two and a half decades ago through authorization for the establishment of a county health department or for the employment of certain health service personnel by counties not organized as county health districts.

2. The function of the state to act primarily as a supervisory agency rather than to provide direct local health services was recognized and authorization given to provide more direct state supervision of local health authorities through a state health district system.

3. The policy of state financial assistance for local health work was established by providing state aid reimbursement for the establishment and operation of county health departments or for counties not organized as a county health district but providing public health services on a county supported basis, primarily public health nursing.

4. The concept of home rule and democratic principles was preserved by prescribing regulations of a permissive rather than a mandatory character. Provision was made, if deemed desirable locally, for the continuance of the more populous local health units as subdivisions of a county health district, thereby assuring a reasonable degree of local autonomy.

PAST EFFORTS TO PROMOTE COUNTY HEALTH DEPARTMENTS

Considering the county as the local political unit of choice, it is evident from the foregoing that efforts to circumvent the inadequacies of health services by small political subdivisions permitted simultaneous development along two somewhat different lines. The method of choice was the promotion of county health departments which provide their own full-time planning, coördinating, directing, and advisory staff. The second and less suitable method was the promotion of county-employed health service personnel superimposed on the basic system of township, village, and city health service. The latter method does not provide coördination and direction of services by county officials other than that supplied by a county public health committee meeting once every two months.

Provision for state financial reimbursement was the same in either instance, except that a county of less than 150,000 population organized as a county health district and maintaining a county tuberculosis sanatorium received additional state aid reimbursement of 50 per cent of the operating deficit of such institution.

Since passage of permissive legislation in 1921, strong and continuous efforts have been made by the state to persuade counties to establish county health departments. At times, particularly during the first fifteen years, such efforts were intensive and broad in scope. However, no year has passed in which active promotion in several counties has not been undertaken. For example, during the last ten years specific promotional activities, some extending over several years, were made in 12 different counties. The fruit of these twenty-five years of labor has been the establishment of 6 county health departments out of a total of 57 upstate counties, upstate meaning exclusive of New York City.

Such conspicuous lack of success warrants analysis. It is generally agreed that many of the factors obstructing reorganization in New York State may be grouped under the following headings:

1. Traditional attachment to the township and village form of government inclusive of "laissez faire" attitudes.

2. Lack of understanding on the part of many citizens as to the needs and the benefits which would accrue.

3. Opposition of certain part-time local health officers because of fear that their jobs would be abolished and their prestige lowered.

4. Fear on the part of some elements of the medical profession that establishment of a county health department would result in state domination and direction of local health services and would constitute the initial step toward "state medicine."

5. Fear of future, if not immediate, increased local taxes.

6. Fear that the state legislature might not continue state aid appropriations for local health work.

That the state erred from time to time in its promotional activities is conceded. For example, when the first county health department was established in 1923, namely Cattaraugus County, it was organized on a study-demonstration basis. Private health agency funds and lay supervision supplemented state and local resources. Emphasis was placed on advanced public health activities to which the medical profession of the rural areas were unaccustomed. The project was widely publicized, which served to increase rather than decrease misunderstandings as to what might ordinarily be expected in the operation of a newly established county health department.

The reaction of many of the medical profession to the project was highly emotional. Their views permeated all areas of the state. Even today, physicians oppose the county health district system based on their remembrance of discussions concerning this study-demonstration project. It was not until five years later that a second county (Suffolk) was organized as a county health district. It was located in the corner of the state farthest away from Cattaraugus County. The remaining 4 counties were organized in 1929, 1930, 1933, and 1938 respectively.

EMPLOYMENT OF HEALTH PERSONNEL BY UNORGANIZED COUNTIES

However, the resistance to establishment of county health departments did not discourage the compromise method of promoting county employment of health service personnel to serve the rural areas. This development was pushed whether a county was organized as a county health district or not. By 1938 the number of public health nurses so employed totaled 147, or 2.6

nurses per upstate county. Eight years later, in 1946, the number had risen to 371, averaging 6.5 nurses per upstate county. This does not take into account the considerably larger number of nurses employed by city health departments, local boards of education, and the boards of health of townships, villages, and consolidated health districts.

The county employment of other types of health service personnel was similarly successful, particularly physicians on a part-time basis to staff various county diagnostic and preventive clinics, or, in the case of venereal disease, provide treatment services. For the year 1946, state aid amounting to $1,020,891 was approved for public health work for 48 counties exclusive of laboratory service and care of adult poliomyelitis. Approximately one-half of these funds was for the 6 counties maintaining county departments of health.

DEVELOPMENT OF STATE HEALTH DISTRICT SYSTEM

The weakness of lack of provision for a full-time planning, coördinating, directing, and advisory staff in unorganized counties employing health service personnel was satisfied, at least in part, by expanding the state sanitary district system to twenty such districts. At present no state health district covers more than 4 counties, the average being slightly less than 3. Substantial increases in the number of personnel assigned to the state districts were made. Moreover, the state abandoned somewhat its supervisory rôle and through legal provisions or otherwise engaged more actively in furnishing local health services.

The increased staff made it possible to study carefully the needs of each county, to provide plans and actively assist in satisfying such needs, to seek out local funds or state services to assure specialized personnel and equipment to service the local programs and to organize the health work of the county and its subdivisions to obtain the best degree of efficiency. Except in counties or cities served by a full-time local health officer, the state assumed the local responsibility for tuberculosis, venereal disease, and cancer control work, including the following-up of cases and contacts. Similarly the part-time local health officer was relieved of the inspection and permitting of farm labor camps, children's camps, summer camps and hotels, and pasteurizing plants. All communicable disease outbreaks were personally investigated by the district staff at the time of occurrence. Immediate supervision of public health nurses lacking local supervisory facilities was furnished. Close professional association with local part-time health officers and nurses permitted many supportive actions including in-service staff education.

The prediction of a special health commission, appointed by Governor Franklin D. Roosevelt in 1930, appears to have come true. It was stated "that unless a satisfactory unit of local health government is established throughout New York State it will be necessary for the state itself to conduct many health activities which otherwise could be considered local in character."

It may be of interest to list the staff of a typical state health district inclusive of state and local positions established by official agencies. Such a district containing no cities over 50,000 population or county health districts comprises 3 counties with a population of 148,367, and covers an area of 2,534 square miles. State health district positions consist of the full-time service of a district state health officer and an assistant district state health officer, four supervisory public health nurses, one orthopedic nurse, two sanitary engineers, one milk sanitarian and a clerical staff of seven. Specialty consultant

services are provided by the central office staff of the department. County, city, village, and township health jurisdictions employ thirty-six physicians as part-time local health officers, twenty public health nurses, one sanitary inspector, one veterinarian, and a clerical staff of three. In addition, physicians are employed on a fee-for-service basis to staff the various county and local clinics. Diagnostic laboratory services are available with state aid assistance. Diagnostic tuberculosis clinic service and hospitalization are cared for by the county sanatoria in 2 of the counties and by the state in the third. Medical rehabilitation clinics (formerly known as orthopedic clinics) and the care and hospitalization of such patients are the joint responsibility of state and local authorities. School health services are provided by the local school boards under the general supervision of the school superintendent and the State Department of Education. Local private health agencies also contribute to the general effort. For example, in one of the counties the Tuberculosis and Health Association in coöperation with the district state health officer is currently preparing a report on the local health facilities and services of the county as a part of a plan for promoting the establishment of a county health district.

Advantages and Disadvantages

From the standpoint of practice it is evident that in counties not organized as a county health district the district state health officer and his staff may be considered to function much the same as the comparable staff members of a local multi-county health district. In their work, the state employed staff assists and is assisted by the various public health personnel employed by the counties, small cities, villages, townships, and consolidated health districts. Such a method of functioning is facilitated by the fact that the Public Health Council of the State of New York has established a State Sanitary Code covering most phases of public health work. The provisions of this Code have the force and effect of law in all communities of the state except New York City. Accordingly, both state and local officials are guided by the same set of regulations. Although local boards of health may enact health regulations, such enactment shall not be inconsistent with the provisions of the State Code.

There can be no question that the state health district system for unorganized counties, as developed in New York State, has much to recommend it. In certain respects, it possesses advantages greater than those of the county health district plan, particularly freedom from local political interference and obstruction. A comprehensive review of these advantages was published in 1936 by Dr. E. S. Godfrey, Jr., Health Commissioner of the State of New York.*

Nonetheless, a state health district system possesses fundamental weaknesses. Some of these may be summarized as follows:

1. A state district system is a centralized system and therefore contrary to home rule and democratic processes as well as fundamental overall state policy.
2. Local initiative and responsibility are weakened, and state directional dependence fostered.
3. Unwarranted state domination of local health services is favored to a much greater degree than under the county health district system.
4. The state government is less favorably situated than the county, and would be unable to furnish complete health services for each and every county.
5. State personnel do not possess the necessary legal authority granted local health officers.

* Godfrey, Edward S., Jr., M.D. Comparative Value of State Districts and County Districts as the Basis of Local Health Organization. *A.J.P.H.*, 26, 5:465 (May), 1936.

The state health district system as developed in this state for supervising and supplementing local services has served a useful and necessary purpose. In final analysis, however, it must be considered as a transitional stage in attaining the main objective, namely, the establishment of county health departments. In an address before the Annual Conference of Health Officers and Public Health Nurses of New York State in 1944, Commissioner Godfrey stated "I look upon the existing state district system as a step in the evolution of whole-time county health service. It has taken thirty years to bring the existing districts to their present number and state of efficiency. Their better development has been halted by the war, but I look to the major part of their personnel being eventually absorbed into whole-time local autonomous districts. I think of them as training grounds and demonstrations of the worth-whileness of qualified personnel and whole-time service."

RENEWED EFFORTS TO PROMOTE COUNTY HEALTH DEPARTMENT ORGANIZATION

Amended Law Overcomes Objections

During the war years, it was obligatory for health agencies faced with the problem of personnel and material shortages to adopt a hold-the-line policy. It was necessary to apply priority ratings to the various health projects and even streamline individual projects to include only those activities of greatest comparative importance. Unfortunately, the problem of personnel and material shortages continues today. However, as was fitting, a critical appraisal and analysis of state and local health programs was undertaken following V-J day by a special health committee with the objective of strengthening the efficiency and productivity of public health services in the state. The committee's report was submitted to Governor Dewey in February, 1946, and specific proposals were made for the development of a comprehensive health program. These recommendations were enthusiastically endorsed by the Governor and the legislature.

Certain of these overall recommendations were concerned with stimulating further the development of adequate and efficiently operated local health services. Emphasis was placed on expansion of such services on a basis which would continue and strengthen local participation, local control, and local responsibility. Changes in the public health law were considered necessary to help achieve these objectives. These changes were made effective January 1, 1947.

The existing requirement abolishing local health districts of townships, villages, and consolidated health districts of less than 3,000 population, when a county establishes a county health department was stricken from the law. Decision is now left to the discretion of *all* local governing authorities whether or not the boards of health shall continue to exist and employ local health officers.

A provision in the new law relating to part-county health districts authorizes petitioning the county board of supervisors by the supervisors of the area lying *outside* of the cities of 50,000 population or more, to form a part-county unit. If not granted by the board of supervisors acting as a whole within a reasonable time, state aid for such cities may be jeopardized. This provision was desirable since in some instances failure to form a county unit has been due to the unwillingness of the supervisors of a dominant city to support such a measure even though it did not include the city and did not affect its taxes.

Conversely, opposition has come from supervisors outside of such large cities who were opposed to an organization

which included the cities. Some cities provide in their health budget for services for which the remainder of the county would have little use, and it was felt that the latter should not be expected to share the expense. In the amended law, the area outside of the cities of 50,000 population or more can now vote to exclude such cities from the county health district, if this is their determination. It is recommended, however, that such cities should be a part of the county health district to avoid conflicts and overlapping functions. In New York State, with few exceptions, from 50 to 80 per cent of the population living outside of cities having a population of 50,000 or more reside within ten miles of such city. Most of these people shop, work, and obtain much of their recreation within the city.

State Aid Increased

Excepting projects for which other state aid provisions are made, the amended law increases the amount of state aid for county and part-county health departments to 75 per cent on the first $100,000 expended for public health work. Expenditures above $100,000 are reimbursable on a 50 per cent basis. State aid for county health work in counties not organized as a county health district is continued on the same 50 per cent basis as heretofore. For the first time in the history of the state, the establishment and maintenance of a county health department has received state aid consideration more favorable than that allowed to unorganized counties.

Another radical change in the state aid law is provision for 50 per cent in state aid for public health work undertaken by health departments of cities of 50,000 population or more. It is the intention that such grants be utilized to expand local health services and correct existing inadequacies rather than reduce local taxes. Preliminary reports would indicate that this principle will be followed. District state health officers have already discussed with local authorities of these cities the detail of a three year line item budget plan acceptable to the state for providing minimum city health services as a part of the overall plan to include such cities in a county health district.

State Health Department Reorganized

Perhaps even more important than the foregoing changes in the law which becomes effective January 1, 1947, is a statement of organizational change affecting the functions of the State Department of Health staff. Notice has been given of the decision to divide the state into six supervisory state health regions and, as county health departments are established, the existing smaller state health districts will correspondingly be decreased in number and eventually become extinct. During the transitional period the state districts will be under the supervision of the regional offices as local service units. The regional staff * will consist of a regional health director in charge, assisted by qualified professional personnel in the fields of tuberculosis, maternity and child hygiene, cancer, nutrition, venereal disease, health education, public health nursing, environmental sanitation, medical social work, and office and record system management. The duties of the staff in Commissioner Godfrey's words "will be advisory and observational; to assist in local planning; to note deficiencies and exceptional accomplishments; to visit the central office frequently and keep it closely in touch with conditions in the field and keep the field in close touch with the State Health Department's objectives."

Administratively, the regional health director and, through him, his staff will

* The regional office covering New York City is excepted.

be a part of the staff of the central office division of local health services. In technical matters, the regional specialty personnel will be responsible to the appropriate specialty divisions of the central office. Under the existing central office organization, the divisions of local health services, environmental sanitation, and public health nursing, with their various bureaus are responsible to the Assistant Commissioner for Local Health Administration as operations officer. The area covered by each of these regional offices will be coterminous with the hospital health service regions established under the impetus of the federal Hill-Burton Act and each of the regional offices will be located in the city of the respective regional hospital teaching center, thereby permitting close coördination among all phases of health services. The population covered by each of the five upstate regional offices varies from one to one and one half million.

Minimum Personnel Standards Established

With the foregoing legislative and organizational changes under way, attention was directed toward defining what might be considered by the state as acceptable minimum standards for the number and type of personnel to be employed by county and large city health departments in order that state aid requirements would be reasonably satisfied. Such provisions should help to establish the scope of the health program, the availability of sufficient personnel to effectuate the program and, through salary provisions, the quality of the personnel employed. To avoid possible hardship, it was decided that, if necessary, a three year period would be allowed for health departments to attain such objectives.

The minimum standards to be used as an overall guide in determining the needs of a specific health department were decided upon after conferneces with staff members of the department. Due to the advantageous economic status of most counties and large cities, the generous state aid provisions allowed and the fact that public health practices are generally more advanced in New York State than in some states, it was felt that such standards should be higher in most instances than those established by the Subcommittee on Local Health Units of the Committee on Administrative Practice of the American Public Health Association. Briefly, the decisions of the conference group were as follows, the listing being given by descriptive titles:

1. Health Officer. A full-time physician experienced in general public health practice and administration to be in charge of each county, part-county, or large city health district.
2. Other Medical Officers. One for each 35,000 unit of population above the first 35,000 with provision for the fractional equivalent of such service for interim populations. The qualifications of such personnel and status as to full-time or part-time to be dependent on the size of the population served and the needs of the district. Where warranted, at least one of the "other medical officers" should be a full-time deputy with public health experience.
3. Public Health Nurses.
   (a) A supervisor or director of nursing for each district; additional supervising nurses on the basis of one for each eight staff nurses or major fraction thereof.
   (b) One staff public health nurse for each 5,000 unit of population; if school health nursing service or bedside care on a visit basis is contemplated, one nurse for 2,500 population.
   (c) One orthopedic nurse for each 100,000 unit of population with provision for the fractional equivalent of such service for interim populations.
4. Environmental Sanitation Personnel.
   (a) One sanitary engineer for each district having a population of 33,500 or more; one additional sanitary engineer for each 70,000 unit of population or major fraction thereof above the first 70,000.

(b) One sanitary inspector for each 35,000 unit of population or major fraction thereof.

(c) One milk sanitarian for each district having a population of 25,000 or more; one additional milk sanitarian for each 70,000 unit of population or major fraction thereof above the first 70,000.

(d) One veterinarian for each population unit of 100,000 with provision for the fractional equivalent of such service for interim populations.

5. Dental personnel.

(a) One dentist for each 90,000 population unit with provision for the fractional equivalent of such service for interim populations; one of the dentists to serve as supervising dentist for each unit of 4 dentists.

(b) One dental hygienist for each 15,000 unit of population or major fraction thereof; one of the hygienists to serve as supervising hygienist for each unit of 15 dental hygienists.

6. Health Educator.

(a) One for each district having a population of 25,000 or more; one additional health educator for each 100,000 unit of population above the first 35,000.

7. Clerical and other office personnel.

(a) An office manager for each district; an assistant office manager in districts employing 40 or more clerical staff; a head clerk in districts employing 20 to approximately 40 clerical personnel.

(b) One stenographer or clerk for each 2.6 full-time professional worker. This ratio is based on existing practices in the state.

(c) One statistician for each 300,000 population unit.

8. Maintenance and operation. Twenty per cent of the total budget. The amount proposed is based on existing state practices and includes the average number of autos exchanged annually, building rentals, medical and office supplies, attendance at meetings, publications. etc.

Single County Health Districts Recommended

As is apparent, from the foregoing standards, the custom of employing a population unit of 50,000 as the most practical minimum population for support of a county health district has not been followed. An explanation should be given. The population of upstate counties based on July 1, 1946 estimates falls into the following pattern: 30 counties have a population of more than 50,000; in 16 counties the population varies from 33,500 to 50,000; in 11 counties the population is less than 30,000. Since 10 of the counties in the 33,500 to 50,000 group have populations of 40,000 or more and in only 2 counties does the population approach the 33,500 level, one of which having been established and continuously operated as a county health department since 1929, it would appear that these 16 counties in the 33,500 to 50,000 population group would not be materially out of line to support and provide efficient local health services with state aid subsidy as single county health districts.

Considering the 11 counties of less than 30,000 population: 7 have populations ranging from 21,000 to 29,500; 2 have population of 16,500; in 1 the population is 13,000, and in the remaining county, our only orphan, the population is estimated at approximately 3,500. Having little faith in the lasting qualities of locally staffed and operated multi-county or two and three piece county health departments, ways were sought to justify the individual employment of a full-time county health officer and staff by each of at least 10 of these 11 counties.

One method is establishment of a county general hospital with state and federal subsidy which would also house the county health department and county laboratory facilities, the health officer to serve in a dual capacity as superintendent of the hospital with the aid of an assistant superintendent. Such an arrangement should provide desired coördination between preventive and curative services in the county. At least 8 of these counties lack satisfactory hospital bed facilities. For 1 of these counties, a plan complete in all

details has been prepared in accordance with the above suggestion. Another method is combining the school medical inspection and nursing service with the work of the county health department. School services in this state are provided by local school boards through contract with local physicians and school nurse teachers. Such contracts could be made with the county health department. Still another method is intensification and more universal provision of public health services. It has been our experience that these small population rural counties have greater need of public health services and require more personal attention than do more populous and prosperous counties.

It is believed that in New York State every effort should be made to develop single county health districts and avoid multi-county units. The economic factor has been largely removed by state aid since such counties can now be reimbursed 75 cents for each dollar expended on health work. If more financial aid is necessary, it is possible to supplement further with federal funds granted to the state.

Utilizing the suggested minimum personnel standards previously mentioned, work sheets were prepared for each of the upstate counties inclusive of all cities, setting forth the personnel required in the different categories and the cost. These work sheets were supplied to the district state officers and adjusted by them to meet local conditions. Considering each of the 56 counties * as a whole, inclusive of all cities, calculations show that the cost † of establishing and operating an efficient county health department for general public health services would be less than $100,000 in 33 counties. In 7 it would range from a little over $100,000 to $125,000. In 6 it would range from over $125,000 to $200,000, and would amount to over $200,000 in the remaining 10, 7 of which are counties containing a city or cities of more than 50,000 population. The cost on a per capita basis, using the average for all 56 counties, is only $1.52 per annum. Using the average cost, in a county expending $100,000, the *local* per capita cost under state aid would amount to 38 cents per annum. There would seem to be no question of the ability of each one of the 56 upstate counties to afford such a health service under the new state aid provisions.

Publicity

With the foregoing preparatory steps taken and the amendments to the public health law passed and signed by Governor Dewey in April of this year, the next problem for consideration was public promotion. It was decided that such efforts must be limited at this time, due to the serious lack of public health physicians and public health nurses. War conditions had retarded and finally stopped our pre-service training program which normally supplies almost wholly the needs of state and local services. Several city health officers were retiring. The state's field staff of 45 district health officers had been reduced to 26. Vacancies in local and state public health nursing positions were approximately 10 per cent and 20 per cent respectively. Efforts to obtain qualified replacements and a reserve for new positions met with insignificant success. However, a revived campaign for pre-service training started last winter, assures us of 8 health officers and 50 public health nurses possessing the necessary qualifications by next spring,

* Hamilton County with a population of 3,433 has been omitted.

† Excludes public health laboratory service, tuberculosis hospitalization and medical rehabilitation hospital, clinic and appliance costs for which separate state aid provision is made. Also: industrial hygiene services, mental hygiene clinics and hospitalization, and school medical inspection and nursing service in all but 10 counties of less than 30,000 population wherein it would seem practical for the school boards to contract with the health department for such services; these services are the responsibility of other governmental agencies in New York State.

with more to follow at a later date. It was considered unwise to put on an all-out campaign for county health department organization until the personnel situation had improved.

Steps taken to date of a public promotional nature may be summarized briefly as follows:

1. General and local publicity has been given to the new provisions of the law. Both central office and district staff have utilized every opportunity to discuss effective local units for health services before professional and lay groups and obtained good publicity.

2. The district staff have worked with local authorities and key individuals explaining the legal provisions and the opportunites offered. They have taken up with them the detail of the staff needed and the cost to the county. Service rather than cost has been emphasized. Special efforts have been made in certain of the more promising counties.

3. The State Medical Society in 1946 passed a resolution recognizing the limitations of health services provided by small governmental units and urged the voluntary establishment of county health departments.

4. Plans are being perfected to staff an all-out campaign for county health department promotion. Such a campaign will utilize the best advertising techniques and organizational work. Materials used will cover the full range of publicity facilities. Available qualified personnel will govern commencement of the campaign.

Results to date.

Results from efforts made to date appear encouraging. Although county boards of supervisors will not act on budgetary matters of this nature until fall, two counties passed resolutions in August establishing county health departments. One of them is a county of 122,000 population and contains a city of 70,000. The other is a county of 21,000 population which plans a combined county health department, county general hospital and laboratory type of service. There is good reason to believe that at least four additional counties will establish county districts this year. If so, as much progress will have been made in 1946 as in the previous twenty-five years. It must be understood, however, that cumulative efforts over the years deserve much of the credit, particularly the demonstration of the worthwhileness of qualified personnel and whole-time service afforded under the state health district system.

Dr. Vaughan: Now we turn back to the academic field. We had hoped this morning to be honored by the presence of Dr. Allen Freeman, who, as you know, would probably have been the best man whom any committee could select in the United States to talk on this subject of the basic principles involved in the legal aspects of planning for local health units, but Dr. Mustard, in spite of the fact that he is also on the program tomorrow morning, has agreed to pinch hit for Dr. Freeman.

Legal Aspects of Planning for Local Health Units

HARRY S. MUSTARD, M.D.

Dean, School of Public Health, Columbia University

I have no hesitancy, no embarrassment at all in appearing here as a second choice for Allen Freeman. As a matter of fact, I was one of those who felt that it would give a flavor and a perspective, otherwise not obtainable, if we could get Freeman. We could not, but what I did undertake to do was to get a paper along the lines of this subject, a paper which he read some 26 years ago, and I shall

read to you an abstract from that paper and comment upon it. My comments will not be in legal phraseology, nor shall I attempt to tabulate for you the limitations, the provisions, the prohibitions, and the laws of each of the several states as they relate to local health units, but I shall rather attempt on the basis of Freeman's paper to present certain matters which we would want to provide from a legal standpoint if we are to reach the goal which Freeman visualizes in his paper, and which has been set forth here today.

Now, please bear in mind that what I am reading was written—presented as a De Lamar lecture at the School of Hygiene and Public Health at Johns Hopkins in 1920. I think you will agree with me that Dr. Freeman had an amazing gift not only of prophecy, but of summarizing as of that date a situation which to a considerable extent we face today. And, until I tell you differently I am reading from Dr. Freeman's paper.*

"Every thoughtful sanitarian has in his mind the picture of that ideal system of health administration which would be founded on scientific principles, organized on the basis of administrative efficiency, and manned by a staff of trained workers filled with the spirit of public service. This ideal organization would have behind it a volume of law which, while fully recognizing the principle of individual liberty, would permit no man to offend against the health of his neighbor. It would be so financed that every dollar would go for effective service, and no fruitful work would go undone for lack of funds. Its program would be so broad and elastic and its personnel so versatile that every significant addition to our knowledge of disease prevention and health promotion would be, at once, translated into actual operation for the benefit of the public it served. It would utilize all existing knowledge of hygiene and preventive medicine and would constantly strive to add to the sum of that knowledge.

"To conceive such an ideal is a fascinating study. To create it at once an impossibility. Governmental systems of administration in any line of public effort are always combinations of hoary tradition, medieval precedent, and modern makeshift and compromise. However thoughtfully a proposed measure may be prepared by its framers, it has by the time it is enacted into law usually been so altered by ill-considered, hasty or prejudiced amendment as to have lost all semblance of its original form. Governmental finance is never conducted on a broad, well considered plan, by which the various functions of the government are appraised as to their relative value and adequate provision made for developing each in its logical and proper relation to the public welfare. Each administrative officer asks for what he wants and takes whatever he can convince the appropriating body, in the few minutes alloted to him for a hearing, that he must have. Governmental personnel, hampered by inadequate salaries, political influence, uncertain tenure or too rigid civil service restriction, can be kept at a high point of efficiency and enthusiasm only by unremitting effort. In the face of these obstacles, therefore, we progress towards our ideal only by slow and uncertain stages, taking advantage of each favoring change in the public mind to go forward and consolidating the ground so won into a starting point for the next advance.

"The policy of opportunism, however necessary it may be under present conditions, does not make for either efficiency or economy. The development of a logical, well balanced and forward looking organization under such conditions can take place only when the administrative officer has constantly before

* Public Health Administration in Ohio by Allen W. Freeman, M.D., Commissioner of Health.

him the ideal towards which he is working, and points each step, however short, in the direction of that ideal.

" The growth of public health organizations in the United States within recent years has, however, been so rapid that from the numerous experiments attempted and the varied methods proposed, certain administrative principles and types of organization have been evolved, which give promise of leading within a comparatively few years to the development of a logical and fairly uniform system of health administration in the several states. It is the purpose of this paper to discuss these principles and systems, particularly as they have been developed in Ohio, in the light of our ideal organization.

"For convenience of consideration, we may divide the manifold questions involved in planning a state system of health administration into five essential features as follows:

" 1. The size and character of the local unit of administration

" 2. The relation between state and local units

" 3. The method of finance, state and local

" 4. The character and method of selection of personnel

" 5. The programme to be undertaken

THE LOCAL UNIT

" The size and character of the local unit of administration constitutes the most important single factor in a state health system. When a satisfactory local unit of administration has been developed, the creation of sufficient such units to cover a state is purely an administrative procedure.

" The ideal unit of local health administration would be a territory of such size and density of population as would justify the whole-time employment of a properly trained sanitarian as administrative officer, with such a staff of inspectors, nurses, and other assistants as to give adequate service to the population of the territory.

" Practically, of course, it is impossible to divide a state arbitrarily into such units. A local unit of health administration must have a system of finance including machinery for the preparation and review of a budget, for levying and collecting taxes, for disbursing and auditing expenses, must have a legal adviser and easily defined limits of jurisdiction, and must be able to integrate effectively with other activities of government affecting the public health. Unless the overhead expense of health administration is to be prohibitively great, the fiscal and legal machinery of existing governmental units must be utilized to the fullest extent.

" In effect, therefore, our unit of local organization must correspond to that existing unit of government, or practicable combination of such units, which in average size and density of population most nearly approaches the ideal unit as we have defined it.

" At this point we are confronted with the fact that there is in the United States no standard form of local government. In some states the division is between city, town, and country, each sovereign in its territory and with little or no overlapping of authority. In other states, cities, villages, and townships have limited jurisdiction, with the county exercising concurrent jurisdiction over all. In some states, cities and towns are sovereign units and the county as a unit is practically a negligible factor in the equation. It is quite evident, therefore, that in any discussion of local organization we can discuss the practical application of general principles only as they affect a single type of organization, and in detail only as they affect a single state.

RELATION BETWEEN STATE AND LOCAL UNITS

" While theoretically the relation between the federal and state governments is defined by the federal constitution,

and the relation between state and local government in any state is defined by the constitution of the state, practically the past few years have witnessed a process, enormously accelerated during the war, of shifting administrative responsibility from the local to the state government and from the state to the federal government. The reasons for this shift towards centralized government lie buried deep in the popular consciousness. In part it is due to the fact that federal and state taxes are largely indirect and are not so heavily felt by the average citizen as are local and direct taxes. For this reason increased expenditures are not so vigorously supervised or so keenly felt as is the case with local expenditures. A second reason is the popular feeling based largely on the operation of large industrial corporations that large administrative units are in general more efficient than smaller ones. A third reason is based on the very prevalent lack of respect for a law in which the person affected has had too direct a part in the making. In general we find in America that a city or county ordinance is harder of enforcement than a state law, while a state law is harder of enforcement than a federal statute. The power to make and enforce laws in America, to be reasonably effective, must be somewhat removed from the personal and political influence of the person affected.

"In planning a state system of public health administration, therefore, we must decide as between a highly centralized system on the one hand and a policy of complete independence by local units on the other, or must determine as accurately as possible just what division of authority there should be as between the state and the local unit.

"The idea of a single health service, covering an entire state, controlled, officered, and financed by state authority, has certain features of great attractiveness. Under such a system a logical and well balanced scheme could be developed, with a central administrative authority, appropriate supervisory divisions, and standard local units of administration. Personnel could be obtained and handled without regard to local prejudices. By proper selection of personnel, a valuable esprit de corps could be developed. The poor and backward parts of a state could be developed as well as the richer and more advanced. In cases of emergency the entire force would be available for duty wherever and whenever needed. Standard methods of operations could be devised and enforced. Reports could be made uniform. A single health tax could be levied for the entire state, collected by the state fiscal system, and disbursed and audited by existing efficient agencies. Under ideal conditions the system could function as efficiently and accurately as the sales department of a large corporation.

"Over against these obvious and it must be confessed enticing features of a centralized state system, there must be set its dangers and disadvantages. The great fundamental objection to such a system is that it is undemocratic and not in accord with the spirit of government in the United States. The powers granted to the health authorities are broad and in some cases arbitrary. Only in exceptional cases do the courts attempt to limit or control them. They can be exercised rightly only when the health officer feels in full measure his responsibility to those over whom he exercises them. The danger of autocratic use of health powers under a highly centralized and inevitably bureaucratic system is very real and very great. The health officer must, it is true, be above

partisan or personal influence, but he must never let himself forget that his power comes only through the common consent of the people over whom it is exercised.

"The second great danger in a highly centralized system of control is that of its use for partisan political purposes. The personnel of a good health organization is on the average more highly paid than that of almost any other branch of government. A state-wide organization, offering the possibility of rewarding political favors with well paid positions in considerable numbers offers a tempting bait to party organizations. The health system's freedom from partisan politics, where such freedom exists, is frequently the result only of inconspicuousness. The larger the organization which is developed the greater the danger becomes.

"Another danger of such a highly centralized system would be in its inadaptability and inflexibility. The operation of standard units over a large territory simplifies administration and makes for economy and efficiency, but standardization and progressiveness are not always synonomous. Conditions in different communities, even adjoining communities in the same state, vary enormously. These variations are sometimes recognizable only by the man immediately on the ground, and cannot be appreciated by a distant central authority. Standard forms and procedures seldom apply accurately to any particular district. They tend to hamper individual initiative and obstruct advance. In a highly centralized system, therefore, changes to meet changing conditions can be made only with difficulty. Useless procedures, for which personnel has been engaged, can be abandoned only for imperative reasons. In a small unit an unprofitable piece of work can be dropped and forgotten without difficulty. In a large unit, particularly in governmental affairs, such a procedure is difficult or impossible.

"In the matter of finance, though a state-wide health tax offers striking advantages, it likewise offers striking disadvantages. It is ideal for maintaining existing work, but not for undertaking new work. In a large state system, involving a hundred or more local units, even a small addition to the force of each local unit runs into hundreds of thousands of dollars. Tax levying bodies will properly scrutinize such large sums with the greatest care and allow them only upon strong and prolonged pressure.

"Health administration under present conditions must be a flexible and adaptable organization. There is so much that we do not know, and so much of what we do know may not be true, that open-mindedness is the most necessary of all virtues. Individual initiative, investigation, and experiment must be encouraged in every way possible. Such results are more probable where local enthusiasm, interest, and energy are given full swing than where a too rigid standardization is insisted on.

"Another obstacle in the way of the development of a highly centralized state system is to be found in the powers already granted to the larger municipalities under the so-called home rule charters. These powers could not now be reserved again to the state, even were it advisable, and were it possible, it would not, in our opinion, be advisable. The people of a municipality of any considerable size can and of right should exercise a substantially complete authority over their own health administration. Municipal government is in many cases much more efficient and responsible than state government. To withdraw from it the power to control

its health organization would be a real disservice.

"The efficiency of larger units of organization, therefore, is within certain limits undeniable. Beyond the point where the principal administrative officer can have real knowledge of the operations of his organization, his chief functions are in the choice of his principal subordinates and the determination of general policies. These functions are not incompatible with a very considerable degree of decentralization.

"The policy of complete autonomy of units of local health administration, on the other hand, is admittedly inefficient and wasteful. There is no local problem of disease prevention. The whole citizenship of a state has a vital and real interest in the proper conduct of health work in every part of the state. The inefficiency or negligence of a single unit may imperil the success of well conducted work in any other unit. Some form of state control to insure at least a minimum of performance by the local unit is essential.

"The success of detailed health work, however, depends upon the popular recognition of the fact that the work is necessary for the protection of the people themselves, that it is a service worth the expenditures made for it, and that it is performed in a spirit of service rather than of arbitrary coercion. This state of the popular mind cannot be achieved by a distant authority, over which the people of a district have no control and in the conduct of whose work they have no part. It can be had only when the people recognize that their own funds are being expended, under their own direction and for purposes which they consider right and proper. The local unit of administration, therefore, must be as completely under local control as efficiency permits.

"It is quite evident, therefore, that an effective state system of health administration can be founded neither on complete centralization of authority in the state organization, nor upon complete autonomy of local organizations. There must be division of authority and responsibility between them. Here again the wide differences in the constitutions, customs, and governmental habits of the various states render impossible too narrow a definition of this division of authority. Only general principles can be formulated."

Dr. Freeman then lists two or three more objections to a centralized state system, and then he goes to the matter of county systems:

"The state should likewise assist materially in the training of personnel. While the health officer should be well trained before undertaking the duties of his office, the actual situation does not always conform to this ideal. Even if well trained before appointment the local health officer needs the stimulation of new information and contacts. The state organization should conduct conferences and schools for the benefit of health officers and other employees of local organizations, and should keep each health officer informed of all happenings in health matters both inside and outside the state in which he is working. Supervising agents of state health organizations should consider their duties as primarily educational.

"Research in sanitary problems should be a constant feature of the activity of a well developed state health organization. In very few states are the laboratories supplied with the equipment or personnel suitable for research involving any but the simplest of laboratory procedures, and the burden of routine procedure prevents the conduct of any prolonged research work. These limitations do not apply, however, to field investigations. The epidemiologist of a state department of health is almost in daily contact with interesting problems. The amount and character of material which passes in review be-

fore him would permit, if carefully studied, the drawing of accurate conclusions regarding many doubtful points in sanitary science. The state health organization should promote this kind of studies by every means possible.

"The state organization should constantly seek through experiments and demonstrations to develop new methods of work by local organizations, and stimulate the undertaking in backward local organizations of methods of operation already in successful use elsewhere. It should conduct a continuous propaganda for the education of the public as to the necessity for supporting local organizations and for enlarging the field of their activities.

"With a sound system of local organization, a state department carrying out the general procedures outlined above, and at the same time performing the functions properly devolving upon it as the primary authority for the enforcement of state health laws, will find its time well filled without trespassing upon the proper territory of local units.

"Upon the local unit on the other hand should devolve the conduct of all direct health activities except those conducted by units of the state organization for purposes of experiment or demonstration. The choice of personnel, under the limitations to be discussed later, the program of work, the amount and distribution of expenditures, and the actual direction of all preventive work should be under the control of the local health officer.

"The state health organizations should have power to prescribe standard forms of records and reports and to compel the keeping of suitable records and the rendering of regular and satisfactory reports by all local units. It should, of course, keep prompt and accurate reports of reportable diseases and of births and deaths and should compile and study these reports and publish them for the benefit of all concerned.

METHODS OF FINANCE

"The finance of health organizations, state and local, should conform to the recognized principles of public finance. Estimates of appropriations deemed necessary should be prepared in advance of the meeting of the appropriation body, reviewed by some competent authority outside the organization proposing to expend the money, and incorporated into a budget for presentation to the appropriating body. All receipts from licenses and special fees should be paid into the general revenue fund and all appropriations for a health organization should be made from general funds as are other legitimate expenditures of government. All expenditures of health organizations should be audited and disbursed by an agency outside the health department.

"The practice of financing health organizations or any of its special activities from fees, licenses, or special funds of one sort or another has been much practised in the past and if one holds that unconscious tax paying is the proper method has much to commend it. If health work is to take its proper place as one of the major functions of government, however, it must be financed as are other major forms of government by appropriations from the general tax levies. Special health levies are made in a few states, and in most municipalities. There is no objection to this if the funds so provided are appropriated on budget as are other public funds. Any form of finance that separates health expenditure from the usual expenses of government will in the long run be a limiting, rather than a helping factor.

"In general, therefore, it may be said that funds for health expenses of government should be raised, appropriated,

and expended just as any other regular expense of government.

CHOICE AND CHARACTER OF PERSONNEL

"Securing, training and retaining a proper personnel is much more difficult in any government undertaking than in a private enterprise of the same magnitude. The administrative health officer is usually beset either by political influence on the one hand, or by overrigid civil service restrictions on the other. He has only nominal control over compensation, and is usually without power either to reward good service or penalize poor service. And yet all other factors in securing efficient administration machinery are subordinate to the question of proper personnel.

"For ideal results, of course, the personnel should be properly trained before appointment, should be selected for reasons of fitness only, should practically without exception be on a whole-time basis, should receive adequate compensation, be assured of tenure during satisfactory service, and have reasonable opportunity for promotion.

"The qualifications for the administrative officer of a local unit of administration vary with the size and character of the local unit. In smaller units, where the health officer must be a man of all work it is almost essential that he possess the training of a physician. In larger units where the duties are principally administrative and where there are medical officers on the staff, an engineer or a biologist may make an admirable executive. In general, however, a physician with executive experience in sanitation will be able to secure more satisfactory coöperation from the physicians in his district to exercise better control over his medical and nursing personnel than even the best trained engineers. Appointment of health officers by local authorities without restriction frequently results in securing persons without any qualifications except the possession of a right to practise medicine. To cure this condition, such appointments should be limited to persons possessing prescribed qualifications as determined by some impartial body. The examinations to determine these facts may be conducted by the state organization, by the state civil service commission, or, where there is a central board of licensure, by such board. With such limitation on appointments the question of tenure is not of great importance. If appointments are made for a stated tenure, the time should not be less than four years.

"All subordinate personnel should, of course, be chosen by and be responsible to the administrative officer. Under existing circumstances, this constitutes one of the most difficult of his duties. If his employees are not subject to a really rigid civil service restriction, he is frequently exposed to almost irresistible pressure to appoint this or that person by reason of political influence. If his appointments are subject to civil service control, he is limited to the names submitted on the list of eligibles, and once appointed the employees are practically beyond his control. Of the two methods, civil service is to be preferred. A rigid civil service restriction on appointments with freedom to dismiss at will for unsatisfactory service offers probably the best solution of the difficulty.

THE PROGRAM TO BE UNDERTAKEN

"While in the broadest sense any influence affecting the physical welfare of human beings may come within the scope of activity of a health organization, in practice our field of activity is considerably limited. The traditional function of a health department is to control communicable disease and to prevent and abate nuisances. There are, of course, advanced thinkers in public health who take these primary functions as facts accomplished and would press on immediately to newer

and more spectacular fields of endeavor. Viewing the health problem of any state as a whole, however, we must confess that outside the larger cities, these kindergarten tasks (preventing communicable disease and abating nuisances) are seldom done efficiently and frequently not done at all. In our opinion, therefore, the first task of a state-wide health organization should be to put into effect, in rural district, town, and city alike, efficient communicable disease control. This task is in itself well worth the doing, and once well done, will form the basis for our claims for popular support in doing other things. In those units where this is well done, we may at once begin more advanced work, but where it is not done, it should be begun before other work is undertaken.

"Nuisance control is the *bête noire* of the health officer. Our conception of the importance of decaying vegetable and animal matter and of noxious odors and vapors has changed mightily since Murchison, but the school of Murchison fastened nuisance control on the health organization and until some other agency can be found to carry on the work the health officer will have to do it. If done at all, it should be done as accurately and completely as possible.

"The next task in magnitude and promise of fruitful result is that of the health of the school child. This work has already developed a tremendous popular appeal, can usually be started with a small personnel and gives promise of almost unlimited development. The relation between health authorities and school authorities in this matter has as yet to be settled definitely, but in almost every case some sort of a working agreement can be established. Until the school recognizes its full responsibility to the physical well-being of the child, the health authority must continue to invade the schoolhouse.

"Next in order, perhaps, should come the work of maternity and infant welfare. Here again the popular appeal has developed very rapidly, striking and valuable results may be obtained easily and quickly, and the work is capable of almost unlimited extension.

"Beyond this point, no one can at present predict what will be the future of the efficient and energetic local health organization. The end is not apparent.

"In planning our work, therefore, we must dream dreams and see visions, for as yet we are only in the beginnings. The former estrangement between preventive and curative medicine is rapidly passing; health insurance, socialized medicine, and we know not what else is just over the hill. It appears that the health officer of the future will be an exceedingly busy man, and we must, in laying our foundations lay them broad enough and deep enough to carry a structure far exceeding any that we can at present visualize."

We come then, Gentlemen, to the end of that part of Dr. Freeman's paper which I wished to read to you. I think that it raises certain questions, or makes certain suggestions that we might follow somewhat further. I shall, therefore, take a few more minutes for such a discussion.

Dr. Freeman expresses a conviction that the ideal health organization would have behind it a volume of law. That volume of law, I should say, must be either federal, state, or local law. And I think that what existed in a given state would vary considerably because we are concerned with 48 separate states, 49 if we include the District of Columbia. Not only must these laws vary as regard state laws, but I think that the legal terms under which local health jurisdictions operate in a given state may vary to some extent. Out of those considerations then I think we may evolve a further consideration; that is, in our planning for local health units over the nation we would do well to

bear in mind that each governmental health agency, regardless of the area or level of government in which it is located must function within the framework of legal authority and responsibility of the government of which it forms a part. I think that it is a fundamental concept in any of our planning that our local health unit has a framework and it cannot grow too big for its pants—it must not. If we use that as a starting point then, where will these laws come from?—the volume of law for which Freeman calls? In this connection may I reread to you a commentary of Dr. Freeman's. He says that "While theoretically the relation between the federal and state governments is defined by the federal constitution, and the relation between state and local government in any state is defined by the constitution of the state, practically the past few years have witnessed a process, enormously accelerated during the war, of shifting administrative responsibility from the local to the state government and from the state to the federal government."

As I say, that observation was made in 1920 at the end of World War I. I think reality forces us to recognize the fact that that process has been even more accelerated in the past 25 years. I say that, not in commendation, not in condemnation, it is a fact that the larger units of government have tended to impose themselves, shall we say, upon the smaller units of government. An un-reconstructed rebel from South Carolina might get his back up about that, but at the same time the common sense within him tells him that great benefits have accrued from it.

So, you can approach it unemotionally and approve or disapprove, or you can approach it practically and thank heaven you are getting some more money that you would not otherwise have had. The point that I wish to make is this: legally, of course, the federal government cannot formally pass legislation that would directly force local health units all over the United States and each state. However, we do know that there are more ways of killing a cat than choking him to death with butter, and I think we must recognize that even though the conduct of ordinary health affairs in a state is a state matter, such conduct is indirectly being markedly influenced by federal legislation, for good or ill. The federal government, for instance, may not say that a state must have a civil service. They cannot put that in their legislation, but they can say that those states that do have civil service will get a certain amount of federal money. Now, when somebody says that, and reflects in deep tones the power of anywhere from ten to twenty-five million dollars it is pretty persuasive.

Now, I am not criticising, I am not commending, I am simply saying that, while from a legal standpoint we may not expect direct federal action in relation to our development of local health units, we can expect indirect aid on the one hand and perhaps indirect influence, which you may like or not, on the other. That is a possibility with our broad social legislation under the general welfare provision. If the federal government cannot, and is not going to do this job completely, what is the state situation? How do we stand as regards a volume of law for the institution of local health units in each of the 48 states? I think that here we may say that with few exceptions the states have delegated to one type of local governmental jurisdiction or another the authority and responsibility for conducting public health work. I know that that does not apply in all states, but I think that we have enough and certainly the majority of states, with such provisions to feel that there is legally a basis for continuing on this plan of local health units for the nation.

Now, I have almost finished because time is short. I may say that if there is this basic provision, or if such a basic provision is to be attempted in states that do not now have it, the following essentials should be considered as necessities to be legally provided for reasonably effective public health administration. These necessities I should list as follows:

1. That this volume of law should provide assurance that there is a proper balance between local autonomy and state supervision.

2. That this volume of law should provide insurance that where a local unit of government is too small for effective public health administration, combinations of local jurisdictions may be made.

3. Insurance that health work locally will not be scattered among different elements of the local government. There is but little use in having a local health unit if every Tom, Dick, and Harry in the local community is going to be running a separate and competing show.

4. Insurance that budgets for local health units be sufficient to meet at least a minimum in terms of funds, and to meet standards as to personnel.

5. Further, insurance or assurance that should be provided, I think, legally is that no local jurisdiction will remain in want of health service, merely because of unfavorable financial position locally.

6. Supplementary to this insurance that even the poor areas will be included, there should be insurance that there will be adequate state aid.

7. Insurance that the whole state system of local health units will not be jeopardized by local option. Now, we may assure that the system will not be jeopardized by local option in two ways. One is by such a tide of persuasion, such a peak of salesmanship that every local government concerned in the area will be panting as it were to get in under the system. The other way, of course, is by mandatory legislation. Now, I am not going to argue the details of that here because I have never seen anyone who was convinced in one direction have his mind changed by wanting another. I am further quite willing to admit that it is much easier to sit in the ivory tower of an academic position and talk about something like that than it is to get right out under the gun and get mandatory legislation put in. I do believe, however, that for the parmanent and final stabilization of our health services we shall have to create some sort of a situation where the local health officer, even where he is on the job, and where his appropriation for this year is made on the first of July, does not have to start out on the second of July and give the major part of his time to building up assurances that he will get the appropriation on the following next July. I think that it is rather a serious thing and a potential weakness of our systems that we are not, in public health, in a position comparable to education. I say that is a debatable point.

Now, the last thing I submit for consideration by this committee is that if we are to get an improvement in the legal terms under which we do health work I believe we will need a procedure somewhat like that which was carried out in relation to the administration of vital statistics. I do not mean that some gifted and voluble power, as it were, write a document, an act, for every state and expect every state to swallow it whole. I do recommend, however, that such an act, as a proposed model act, be written and that in each state, depending upon how much the state health officer needs it and how much he wants it, he plan his campaign on the basis of having brought about, in the United States, as complete an adoption of an effective legal instrument for public work as was adopted universely for effective administrative work in vital statistics.

Dr. Vaughan: Thank you, Dr. Mustard, and I think we all agree, much as we missed having Dr. Freeman here, that you have covered the subject that Dr. Freeman would have presented to us in a masterly fashion.

Dr. Boyd and Dr. Cross have gone through the organizational struggle in developing their health units—district health units and local health units in Illinois. Dr. Boyd can speak feelingly and effectively of the work that has been done in his own state and relate it to the problems of the nation as a whole.

Legal Aspects from the Viewpoint of a State Health Department

RICHARD F. BOYD, M.D.

Chief, Division of Local Health Administration, Illinois Department of Public Health

Since my experience with legislation relating to the development of full-time local health departments has been acquired in large measure in the State of Illinois, it will be necessary that I speak rather generally in terms of the situation in this state. An attempt shall be made, however, to indicate desirable principles which should be included in such legislation and to point out certain strengths as well as weaknesses in the legislation presently existing in Illinois.

In order that there may be a better understanding of the existing legislation in Illinois, a bit of historical background is necessary.

The first legislation permitting the establishment of local health departments was placed on the statute books in Illinois in 1872. This was legislation contained in the Cities and Villages Act, which enabled these urban governmental units to provide public health protection for their citizens. This legislation, although rather nonspecific in character, has enabled a few of the cities in our state to develop full-time health departments. Unfortunately, provision is not made in this act for a board of health. As a result, one city has found it desirable to obtain a special act of the legislature in order that this city might have a health department which would be less easily dominated by political influence.

It is worthy of note that although the Cities and Villages Act has permitted the establishment of full-time urban health departments for almost three-quarters of a century, only 6 full-time health departments have come into existence as a result of this law. It would seem that more specific legislation relative to whole-time health departments was needed.

Interestingly enough, the law permitting cities and villages to provide public health services for their peoples anticipated by almost thirty years the law enacted in 1901 providing for township boards of health in those counties having this type of government and for county boards of health in counties having the commission form of government. This legislation provides for a board of health consisting of the supervisor, clerk, and assessor in each township in counties having the township type of organization, and a board of health consisting of the three commissioners in a county having the commission type of government. Since townships in Illinois are in general not sufficiently populous to warrant the services of a full-time health department, and, further, since there is no provision for a special tax for the support of a health department organized under this Act, this law has produced no full-time health departments.

The need for health departments staffed by trained professional personnel was recognized in Illinois as early as 1917, as evidenced by the enactment of the Coleman Act in that year. The

Coleman Act provides that a township, or several adjacent townships, may by referendum establish a full-time health department, levy a tax for the support of this department, and employ a full-time health officer and a staff of trained professional public health workers.

Due to the difficulties in bringing about the consolidation of a sufficient number of townships to make possible a health department serving a population of sufficient size to make economy of operation possible, the Act has been utilized in the establishment of only 5 health departments.

It was long recognized that the county or a group of adjacent counties was the logical local area for which to establish full-time health departments. This is indicated by the fact that as early as 1924 attempts were made to obtain legislation permitting the establishment of such health departments. However, for one reason or another, all attempts met with failure.

Because of the lack of legislation permitting the establishment and maintenance of county and multiple county health departments, the enactment of the Social Security Act by the federal Congress in 1935, necessitated the establishment of state district health departments in Illinois. These districts grew to 21 in number, and included from 4 to 7 counties each. This gave a complete, but very thin, coverage to the entire state with the services of trained public health personnel.

Such was the situation which prevailed in Illinois in 1941, at which time a survey of the Illinois Department of Public Health was made by the American Public Health Association. Out of this survey came a strong recommendation that another attempt be made to secure legislation providing for county health departments. It was further recommended that a State-wide Public Health Committee be developed to assist in strengthening the public health organization in Illinois by aiding the Illinois Department of Public Health in implementing this recommendation. This committee was formed, and now consists of several thousand interested and influential citizens from all parts of the state. The committee took as its first goal the enactment of legislation permitting counties to establish and maintain health departments. This proposed legislation was written after consultation with the Illinois Legislative Reference Bureau; the field staff of the American Public Health Association; the councils of the Illinois Public Health Association, the State Medical and Dental Societies, and other organizations having an interest in public health work. This law, which is commonly known as the Searcy-Clabaugh County Health Department Law, was passed without a dissenting vote in both houses of the legislature and was signed by the Governor on July 9, 1943. Through the efforts of the State-wide Public Health Committee, many organizations placed their stamp of approval on the bill during the time that it was pending in the general assembly. These and other efforts of the State-wide Public Health Committee undoubtedly were responsible in a large measure for the favorable action of the legislature.

The Subcommittee on Local Health Units of the American Public Health Association has set forth eight principles which it suggests should be incorporated in legislation of this type. An attempt will be made to take up these principles one by one, and to indicate the degree to which the County Health Department Law in Illinois measures up to each of these.

The *first* of these *principles* simply states that each state should enact leg-

islation providing for the organization of local health units. The law just mentioned meets this requirement, of course.

The *second principle* states that the authority to approve the organization of local health units should rest with the State Department of Public Health. The only reference to this principle in the Illinois law is the provision that 4 or more counties must obtain the permission of the Director of the Illinois Department of Public Health before they may establish a multiple county health department. Experience thus far indicates the need for an expansion of this requirement, since there is a tendency for too sparsely populated counties to attempt to set up single county health departments. A requirement that such counties join with adjacent counties to form multiple county health departments is probably indicated, rather than the present provision, which merely permits such consolidation.

The *third principle* has been partially covered in the discussion of the second, since it states that provision should be made for the consolidation of adjacent governmental units into multiple county health departments. The Illinois law provides for such consolidation, either by resolution of the respective boards of supervisors, or by a referendum in these counties. Our law also wisely provides that any city or village within a county establishing a health department under the law may abandon its health department and join with the county. It is hoped that this provision will be generally invoked so that uniformity of health jurisdiction within counties will be obtained.

The *fourth principle* set forth by the committee states that the state department of public health should be empowered to require that the six minimum essential public health functions should be carried out by the local health departments. This is not definitely covered by the Illinois law. There is, however, a requirement that all rules and regulations of the Illinois Department of Public Health be enforced by the county board of health. Possibly the rules and regulations of the department could be broadened to require the provision of minimum public health service by local health departments organized under the statute. This possibility has not been explored, since each health department presently operating under the law is providing these services.

The *fifth principle* states that each health department should be administered by a full-time medical health officer, appointed locally. This principle is definitely covered by the law in Illinois, which requires that the county board of health shall appoint a full-time medical health officer as the executive officer of the county health department, and states further that this person must have minimum qualifications of training and experience as set forth by the Illinois Department of Public Health.

The *sixth principle* provides that the personnel of the local health department shall meet standards established by the state health department. This is adequately covered in the Illinois law, which requires that all professional personnel employed by the county health department shall meet minimum qualifications of experience and training as established by the Illinois Department of Public Health. Although this requirement is necessary if local health departments are to be efficiently staffed, it is interesting that this provision is quite frequently seized upon by persons opposing the establishment of county health departments. These persons argue that this provision is con-

trary to the principle of local autonomy. I believe we will all agree, however, that this argument is not valid if we give consideration to certain precedents in situations in which local autonomy is well recognized to exist. For example, a person must obtain a teaching certificate in order to be employed in this capacity by a local board of education. These certificates in Illinois are issued by the State Department of Public Instruction, and there is no criticism of this procedure on the ground that it usurps local prerogatives.

The *seventh principle,* which states that the discharge of personnel in local health departments shall be in accordance with the rules and regulations of the state health department, is not adequately covered in our law. This law specifically provides that the local board of health shall have exclusive right to discharge its personnel. Since the county boards of health are nonpartisan and consist of three professional persons and four other public spirited citizens, it is not anticipated that employees of local health departments will be discharged without cause.

The *eighth principle,* relative to the financing of local health departments through local tax funds, state and federal subsidies, grants from individuals and organizations, fees, etc., is very well covered in the Illinois law. The Searcy-Clabaugh Law makes possible a tax not to exceed ½ mill on the dollar, which in approximately 85 per cent of the counties in Illinois will provide at least $1 per capita. The law further provides for the receipt of contributions of real and personal property, which is considered sufficiently broad to enable county health departments to receive subsidy from state and federal funds, collect fees, and receive financial assistance from other sources.

In addition to the strengths of the Searcy-Clabaugh County Health Department Law as mentioned in the discussion of the eight broad principles, there are certain other provisions which are thought to be helpful. The first of these is the provision that in counties in which health departments exist under the provisions of this law, county boards of supervisors or commissioners, as the case may be, may enact such rules and regulations as may be necessary for the promotion of health and the supression of disease. Since the local board of health is required by the County Health Department Law to enforce all rules and regulations of the Illinois Department of Public Health, the regulations enacted by the county government must be more stringent than those of the State Health Department. The power to make such regulations is in accord with the principle of local autonomy, and further enables a county more completely to provide adequate public health protection for its citizens. For example, we do not have a sanitary code in Illinois. This provision of the law would enable a county to adopt such a group of rules and regulations relative to sanitation.

Another provision of the law which is believed to be helpful is the proviso that the county board of health has jurisdiction throughout the entire county, except in cities and villages having full-time health departments. This makes it possible for a full-time county health department to bring to the cities and villages of the county having less adequate health departments the services and protection provided by a staff of full-time trained professional public health workers.

Still another provision which is believed to be desirable is the requirement that a county health department may be abandoned only by the means by

which it was established. Since most county health departments will be established by referendum, it will be necessary that the electorate vote on a proposal to dissolve the health department. It is believed that this makes for permanency, since this provision protects the health departments against the whims of local politicians.

In general, it is believed that the Searcy-Clabaugh Law in Illinois conforms rather closely to the basic principles outlined by the Subcommittee on Local Health Units. We believe, therefore, that with this legislation, plus the intensive program of health education which is being carried out by the Illinois State-wide Public Health Committee and the Illinois Department of Public Health, county health departments will come into existence as rapidly as qualified personnel may be obtained with whom the departments must be staffed if they are to operate successfully.

Dr. Vaughan: Thank you, Dr. Boyd, for that very complete report. We will now adjourn until 2 o'clock.

MONDAY, SEPTEMBER 9

Afternoon Session

Four group conferences followed by reports by the leader of each conference.

Dr. Vaughan: We will now proceed with the report of the four groups.

Group 1—Leader—F. C. BEELMAN, M.D., Secretary and Executive Officer, Kansas State Board of Health

Consultant—HAVEN EMERSON, M.D.

Dr. Beelman: The various points developed in Dr. Emerson's paper this morning were discussed by the group with the following results:

1. That it was desirable for the state health officer and his agency to assume the leadership in the promotion of a state-wide program for the development of state-wide coverage of local health units; that there must be a state plan in detail; that the committee's report and the material might be used as a pattern. What was useful might be accepted by the state, might be pulled out of the report with credit given to the committee. It could be elaborated on and used for promotional material within the state.

That it was desirable first to secure the approval of the plan by the state medical society. Further, to secure the approval of all interested lay groups and health agencies. The health officer should use and well organize those lay groups to support him in the development of the program within the state.

2. That there should be promotion of permissive legislation to enable local governmental units to combine and form the most efficient unit for administration and financial support of the health unit.

3. It was further recognized that there will be a variation by states as to the number and types of personnel essential for adequate health services. Such decisions must be made a part of the state plans. The state health officer must be willing to assume the responsibility for the best possible development of those services within the state.

Those were the primary points of discussion that were emphasized by the group. It was felt that the group wanted to support the entire program, that the state department of health should assume the leadership.

Dr. Vaughan: The second group, which concerned itself largely with the paper by Dr. Van Volkenburgh, met with Dr. Halverson, the Director of Health of California, and had as its consultant Dr. Van Volkenburgh. Dr. Halverson will now report for Group 2.

Group 2—Leader—WILTON L. HALVERSON, M.D., Director, California State Department of Public Health

Consultant—V. A. VAN VOLKENBURGH, M.D.

Dr. Halverson: Mr. Chairman, and members of the Conference—

The Group discussed the question of the development of multi-county health units, or districts, and especially in that

regard the elimination of competing territorial jurisdictions covering the same area, especially territorial jurisdictions interested in health services. We thought in those terms of the question of school health services, the problem of county hospitals and general hospital facilities, the question of health services given by towns, townships, etc., and over against that we discussed to some extent the problem of the county health department as distinguished from the local health district as the unit—the governmental unit having the responsibility for the administration of local health services in the county.

That may be a technical question and we will not take the time of the session here, suffice it to say that I believe it was the general feeling that wherever possible a new governmental jurisdiction should not be set up.

The question was asked whether or not there were any circumstances under which the state department of public health should plan to administer local health services rather than to encourage local health departments to administer health services on the local level, and the answer to that was no, excepting possibly in a few areas where the people were not ready to assume the responsibility, and the example given by Dr. Smillie was that of the Indians in some sections of the country.

Then as a counter-current to our enthusiasm and interest in the development of local health service someone said, "Why should we be talking local health service at the present time when there are already more areas set up for development of local health services than we have personnel to serve these areas." We have many areas at the present time that lack essential personnel. Dr. Getting, I remember, said that his state staff is depleted by 50 per cent at the present time. And that led us out of our field into a discussion of this whole question of shortage of personnel.

Out of this discussion we would like to present as a suggestion to the conference a statement something like this:

Because the personnel shortage is the most difficult problem confronting public health administration at the present time, and the problem which chiefly hinders the advancement of local health services at the present time, now it is apparent that the conditions of inflation are the most important factor in this situation, public health salaries not having been increased in proportion to other possible sources of income of professional personnel. We therefore suggest to the conference that special consideration be given by state health departments to the recruitment and training of personnel. In some instances it may be wise to set up separate divisions or sections in the state department of public health to recruit personnel, and train personnel. In any case there must be closer coördination between state health departments and departments of preventive medicine and public health of our medical schools on the one hand, and our schools of public health on the other.

This, then, I believe is the recommendation that we wish to bring to this council at the present time. I think those are the most important points that were discussed during our Group conference, Mr. Chairman.

Dr. Vaughan: As I understand the recommendation it is that it should be a function of the state health department to concern itself with recruitment of personnel and the training of personnel. Not necessarily that organizationally speaking there should be a separate department of training and recruitment as recommended by Dr. Van Volkenburgh, but that, of course, will depend upon the size of the state health department and its problems. It naturally follows that in a large state like New York the director of local

health service, Dr. Van Volkenburgh, to whom this task would normally be assigned is busy with the large—very large—personnel at state, district, and local levels, and that he has quite probably recommended that there be a full-time man in charge of this service. In other state health departments it may appropriately be the director of local health service, or it might even be the health officer himself. That, I believe, was the gist of our Group discussion, so that Dr. Halverson in presenting this resolution to you for your consideration does not wish to imply that you must of necessity have a separate division of major rank in the state health department concerned with the recruitment and training of personnel. May I say that from the viewpoint of the schools of public health this suggestion is a happy one because it would provide an organization through which we might return to you—or refer to you from other states—persons who need a training in residence, the internship type of training following the securing of a degree at the school of public health.

In our own state Dr. DeKleine is organizing a division of the State Health Department with that in view, and even now we do not refer our trainees to the W. K. Kellogg Foundation area, which consists of seven well organized counties in Michigan, but we are referring our trainees to the State Health Department through its facilities set up for the recruitment and training of personnel, and we would like to do the same thing with others who have training facilities in their own states.

The W. K. Kellogg Foundation, I believe, is at present supporting a program in Tennessee, one in Minnesota, and there are one or two others under consideration. This recommendation of Dr. Halverson's discussion group is before you. Is there any discussion?

If you have the problem well before you, Dr. DeKleine has suggested that we put the resolution on the table and bring it up for a vote tomorrow afternoon after we have discussed this whole question of training of personnel.

We will put it on the table until tomorrow.

Then, we will proceed to Group 3, which had before it for consideration the remarks by Dr. Mustard.

Group 3—Leader—CARL N. NEUPERT, M.D., State Health Officer, Wisconsin.

Consultant — HARRY S. MUSTARD, M.D.

Dr. Neupert: Group 3 reviewed Dr. Mustard's paper, making use of the general principles embodied in it as basis for discussion. His reference to, and quotations taken from, a paper written by Dr. Allen Freeman in 1920, are as applicable now as just after World War I when it was written. It developed an ideal system of health organization and administration to be provided for within a framework of law.

The group then adopted the eight broad principles set up by the Committee on Administrative Practice in *Local Health Units for the Nation.*

It is recommended in planning new legislation, or modifying existing laws having to do with local health units that:

1. Each state should enact legislation providing for the organization of full-time local health units. A local unit is defined as an individual government area, city, county, township, borough, and so forth, or a combination of two or more contiguous jurisdictions of local government organized to carry out the accepted functions of a local public health department.

2. The authority to approve the organization of a local health unit should rest with a state department of health. The approval should be governed by rules and regulations adopted by the state health department, or by the state board of health, or public health council. Included in the rules, but not in the basic law, should be definitions of the

area covered, population to be served, budget, and personnel.

3. The consolidation of two or three contiguous areas of local government into a single administrative health unit should be—and we used the word "*instituted*"—either by resolution of, and agreements between, the governing bodies of such areas, that is, boards of supervisors, councils, commissions, etc., or by referendum vote of the populations in each area, or by whatever other mechanism is legal to accomplish the purposes in that state.

4. The authority to determine the minimum, essential functions of the local health unit should be vested in a state department of health, or board of health under rules and regulations adopted by that body. These should in all instances include at least the six standard functions accepted as basic for local health departments.

5. Each health unit should be administered by a full-time medical officer of health or health commissioner appointed by the local constituted authority.

6. The selection of health officials and other personnel for service in the local health unit should be in accordance with standards and qualifications prescribed by the state board of health or department of health. The director of the local health unit should appoint necessary subordinates and assistant personnel who should be qualified in accordance with standards of education and experience and whose compensation shall be on a basis prescribed by the board, Civil Service, or merit system, whichever governs.

7. The removal or discharge of a health official or other personnel in the local health unit should be by the local appointing authority in accordance with regulations of the merit system or rules and regulations of the state board of health or state health department.

8. Provision should be made in an act separate from the enabling act for adequately financing the activities of local health units.

Dr. Vaughan: Would it not be well to have these recommendations of Dr. Neupert's mimeographed and brought before you either tomorrow or the next day in the afternoon so that you can study them at leisure? If that is agreeable, we will take that action.

Now we come to Group 4.

Group 4—Leader—G. G. LUNSFORD, M.D., Director, Division of Local Health Organization, Georgia Department of Public Health.

Consultant—RICHARD F. BOYD, M.D.

Dr. Lunsford: The eight points discussed by Dr. Neupert presumably are of very great importance because that is all that was discussed in our group. They were discussed pretty thoroughly for the two hours and, strange to say, we reached the same conclusions that Dr. Neupert's group reached. So that Dr. Neupert has made my report for me. I cannot refrain, however, from saying that my chief, Dr. Abercrombie, whom most of you know, has either had all of these eight points incorporated in the state law or by regulation of the State Board of Health.

Dr. Vaughan: Well, that was short, sweet, and to the point, Dr. Lunsford.

You will have an opportunity of discussing these two reports of Groups 3 and 4 tomorrow, and if they are not in complete accord, reconciliation can be made at that time.

We will now adjourn and convene again tomorrow morning in this room at 9 o'clock.

Tuesday, September 10

General Session

Presiding: CLARENCE L. SCAMMAN, M.D., The Commonwealth Fund

Dr. Scamman: If the members of the conference will come to order we will proceed with the day's business.

The first speaker on the program is Dr. Harry S. Mustard.

Scope and Facilities for Local Health Units

HARRY S. MUSTARD, M.D.

Dean, School of Public Health, Columbia University

The discussion of this subject might be undertaken in either one or both of two ways. First, the matter might be considered in terms of the extent and character of the public health program in an individual health unit, and the facilities necessary in such a program. Second, it might be assumed that the title invites exploration of the practicability of utilizing local health units as instruments for rendering public health service in the different parts of the United States, and the facilities that exist for making such utilization nation-wide.

It is the second approach that will be followed in this discussion, for there is already considerable accumulated experience as to local health programs. In this connection the American Public Health Association in 1940 published an Official Declaration which is generally accepted as forming a sound basis for local health work. To go further into detail than the minimum basic functions set forth in that document would be unwise, for local health problems, resources, legal provisions, and individual opinions differ very greatly in the several states; and no single detailed public health program could be evolved that would meet these varying conditions and opinions.

It is generally agreed that the most effective and satisfactory method of providing routine health service in any locality is through a group of competent professional workers who operate a balanced and continuing public health program which includes basic activities in the fields of vital statistics, sanitation, control of communicable and preventable diseases, protection of health in maternity and childhood, laboratory services, and public health education; and it is further generally agreed that such a group of workers may best function when the services are rendered as a part of the local government for the area served. Because these principles are subscribed to by the majority of public health administrators, this discussion need not be concerned with whether or not a local health unit is the admnistrative mechanism best adapted for community health service, but may be directed, more productively, to a consideration of the present opportunities and difficulties and the practicability, of having such local health units serve every community in every state in the nation.

There are such difficulties and such opportunities, but before exploring and weighing them in terms of practicability, it would perhaps be helpful to review briefly the genesis and development of local health units, for the manner and circumstances in which health work developed in the past will, to some extent at least, shape future events.

The earliest health activities in local areas in the United States were born of fear, or, to go further into their ancestry, they were sired by nuisances and conceived in epidemics. They were, therefore, of an emergency nature and intermittent; and they far antedate the establishment of state boards of health. These facts are important. In the first place, the public, having lived under these intermittent and emergency health services for a good many generations, became accustomed to and satisfied with them, and in some communities still believe that this type of health work is all that is needed. In the second place, most local health activities that developed in the first three quarters of the 19th century arose as separate entities and not as a part of a state-wide program. In the latter part of the century some states enacted laws requiring the appointment of part-time local health officers for counties, townships, villages, jails, or poorhouses, and while this may be considered as a first step in state planning for public health, the state boards of health did not themselves enter the field as agencies for the promotion of locally administered health units until some years after legislation requiring the appointment of part-time health officers went into effect.

In the meantime, however, new forces were stirring and tended to change the situation. Dr. Charles Wardell Stiles had demonstrated hookworm disease to be prevalent in the southern United States, and the Rockefeller Sanitary Commission undertook detailed studies of the epidemiology of that disease and conducted demonstrations in treatment of the individual and in the application of measures for prevention and community control of hookworm. Not long after this, the U. S. Public Health Service began its investigations of typhoid fever and its demonstrations in rural sanitation. These two undertakings were well under way in the second decade of this century and, in relation to establishment of local health units, that decade should loom as large in public health affairs as does the year 1492 in American history. In the decade in question, state boards of health were discovered by Ferrell and Lumsden; and, reciprocally, Ferrell and Lumsden, and through them the Rockefeller Foundation and the U. S. Public Health Service respectively, were discovered by the state boards of health. The new friendships that resulted from these mutual discoveries were quite different from the acquaintanceships brought about through professional meetings, or even through the annual conferences of the State and Territorial Health Officers with the Surgeon General of the Public Health Service. There developed what might be called a dynamic relationship, without protocol. It involved immediate and informal pooling of interest. It crystallized a purpose so important and an enthusiasm so fresh that there was no necessity or desire to maneuver for position. It brought, too, a recognition of the principle that to be most productive public health services must be rendered continuingly and with definite consideration of the circumstances and the places where the problems were occurring. This meant that establishment of full-time, local health units would become a major consideration of state board or departments of health, and it implied that, through the states, such local health services would be fostered to the limit of the legal, financial, and professional resources of

the Rockefeller Foundation and of the U. S. Public Health Service.

Naturally, not all state health officers participated in these new relationships nor concurred in this concept; and perhaps some do not even now. Nevertheless, the essential point is that about one-third of a century ago, the cornerstone was laid for development and extension of local health units on a state-wide basis. Substantial progress has been made in reaching this goal, but much remains to be done. Although the reasons why more has not been accomplished are diverse, they must nevertheless be recognized if full use is to be made of facilities and resources already available.

Some of the factors that have and may continue to serve to limit the extent of utilization of local health units on a state-wide and national basis are fairly clearcut. Others are masked and to some extent intangible. Briefly, and as a basis for discussion, certain of these deterring factors may be listed as follows:

1. By constitution and, or, legislation, authority to levy taxes and expend funds for public health purposes is in some states vested in units of government unsuitable for effective and economical local public health administration.

2. In contrast with the situation that exists in relation to certain other elements in local government, as in education, the provision of reasonably adequate health service is in most places entirely a matter of local option.

3. The cost of an effective health unit is in many instances greater than local authorities are willing to impose upon tax payers.

4. With few exceptions, state funds for aid in the development of local health units have been inadequate. Ordinarily there is enough money to assist in the organization of a new local health unit here or there and from time to time, but not enough to give this financial assistance, all at once, to every local jurisdiction in the state.

5. Only a few of our states have developed a satisfactory schedule for state aid, applicable to every local situation in the state. Aside from the administrative difficulties that arise from rule-of-thumb and separate dealings with each local authority, the absence of such a definite schedule makes it difficult to approach the matter of local health units on a state-wide basis.

6. In an effort to provide some public health service to as many local jurisdictions as possible, large areas in a considerable number of states are served by staffs that are not adequate in quantity or diversity to render effective service; but these are designated as local health units.

7. The development of local health units in most states was of necessity undertaken on a piecemeal basis and as the opportunity arose. Under the influence of this method of approach a great many public health administrators find it difficult to visualize or to undertake a new approach which has as its objective the mass solution of the problem on a state-wide basis.

8. State-wide coverage by adequately supported local health units is not likely to be effected until it is accepted and promoted as an important part of the state's administrative program and policies; state health officers are not, as a rule, members of that small circle which, in association with the governor of the state, determines such broad administrative programs and policies. It is, therefore, unlikely that state-wide coverage by local health units will be promoted as part of the state's administrative program unless and until influences more general, and politically more important than those of the state health officer, are brought to bear on the governor and legislature.

9. Federal financial aid to states is not granted on a basis that encourages to the maximum health service in all parts of the state, and although the amount of such a federal grant to a given state is to a considerable extent in proportion to that state's population, there is no assurance that such funds will be utilized for the benefit of all citizens in the state in question.

10. The public is inclined to demand only that amount and character of health service which the information of the average citizen suggests as necessary.

11. There exists, at the moment, and there is likely to continue, an acute shortage of trained and competent public health workers in the various categories.

It would be unproductive to attempt to discuss each one of these deterrents as an isolated entity, and, further, our concern is more with how difficulties may be offset than with emphasizing them. It is obviously necessary that

we consider ways and means of solving legislative problems in relation to establishment of local health units; but this phase of the subject is covered in another section of the conference and will not be developed here other than to express the belief that many of the legal obstacles which in some states seem insurmountable, are not necessarily so; and to recall to the attention of this conference that it was only through a willingness to adopt a new and fresh approach that many difficulties in relation to the administration of vital statistics, apparently insoluble 40 years ago, have been overcome.

Perhaps the present facilities available for furthering local health units over the nation may best be grouped under three major headings as follows: Financial Resources, Administrative Resources, and Potentialities of Public Opinion.

One cannot, of course, discuss the extension of local health units without giving serious consideration to the matter of finances. Further, in the matter of extending local health units into all sections of the United States, it must be borne in mind that such a program would infer participation by many local communities which are in an unfavorable financial position. Many small town and rural areas now receiving only inadequate public health service, or receiving none at all, will have to be considered, and important in this connection is the fact that the ratio of assessed valuation to population in rural communities is much lower than in urban ones. A given tax rate in cities will produce from two to four times as much money per capita as would be provided by the same tax rate applied to the assessed valuation in small towns and rural areas. Further, in the matter of ability to pay, the average small town and rural citizen is in a disadvantageous position in that his per capita income is far below that of the man in the city. Not only this, but the small town and rural citizen is highly sensitive to taxes on his land which is the principal tax yielding source in such circumstances, and he is personally much closer to the officials who determine the local tax rate than is the case in the more impersonal urban situation.

All the above means that to extend the scope of local health units on a statewide and nation-wide basis, there must be reasonably generous grants-in-aid. Some may object to this because it is contrary to their general political philosophy. On the other hand, the grant-in-aid movement, wherein larger units of government subsidize smaller ones, is a tide that is in full flood, and from a practical standpoint it is only through such aid and through the leadership of federal and state agencies that one may hope for the provision of local health service in every community.

Both from a state and national standpoint, this matter of grants-in-aid is important and complex. Each health officer is familiar with the situation in his own state as regards state funds for aid of local health units, and each has had experience with the various federal funds from which such aid comes. It is unfortunate that the latter are multiple, scattered, limited to one purpose here and another there. On the other hand, it is encouraging to note that the amounts of federal funds now available for state aid are vastly greater than they were some years ago, and such funds may, therefore, be regarded as one of the important facilities now available for the furtherance of local health units.

Not many state health officers facing their acute day by day problems and administrative necessities, would agree with a proposal that federal grants-in-aid be provided only under terms requiring a certain proportion, the major proportion, to be used for development

of local health units, and requiring that such health units be on a state-wide basis. And yet, such federal requirements would probably do a great deal to level many of the legal and administrative barriers to local health units that now exist, and, further, would create a situation where governors and state legislatures find it essential to give serious consideration to the subject.

Lastly, in relation to financial matters, a plan for state-wide coverage by local health units will demand in each state some precise schedule or formula for providing this state aid. A procedure that is easily understandable and obviously fair must be evolved before one may gain the interest of the public, of local authorities, and of members of the legislature. Many suggestions have been made as to such a schedule. A few states have adopted procedures of this sort which they believe are suitable to their respective needs. Obviously, no one procedure will meet conditions in all states. But even though this is true, there are certain general principles that appear to be generally applicable. They are somewhat as follows:

The state should participate financially in all local health units.

The local authority should always participate financially.

There should be an equalization feature.

The budget for each local health unit should be such as to insure at least a stated minimum of service, perhaps best expressed as per capita expenditures.

State aid should be contingent upon approval of budget, proposed program, and personnel standards by state health authority.

While it must be recognized that in a number of states there are administrative difficulties in providing health service through local units, in most states organizational facilities are sufficiently elastic to permit immediate progress. In this connection one thinks particularly of the situations where there must be combinations of local jurisdictions too small in population and with too scanty resources to maintain an efficiently and economically administered health unit. Obviously, such local jurisdictions should be combined into larger administrative units, and desirable procedures and principles to be observed in this connection have been suggested by the American Public Health Association's Subcommittee on Local Health Units. It would seem important to bear in mind, however, that while it is highly desirable that there be established a legal basis or authority for such groupings of local jurisdictions, the matter need not wait upon legislative enactments in most states. Temporary and voluntary grouping of local jurisdictions for such combined undertakings are generally possible. And though such informal arrangements do not constitute the ideal basis for local health units, this might be a wise first step, pending formal action of the legislature. Further, an approach to the legislature on this matter must be made cautiously, for local citizens and local officials are extremely sensitive to any infringement on the existing structure of local government. Even to appear to threaten this might result in having every sheriff and magistrate and trustee, and their uncles and aunts and cousins, present a solid and formidable opposition.

The possibility of overcoming many of the difficulties which exist will depend largely on public opinion. This merits further discussion, and important for consideration is the fact that the general public, particularly in small town and rural areas, has heretofore been satisfied with but little health work. The average citizen is inclined to regard the difference between the part-time work of old Doctor Jones and that proposed in a new health unit, as being not very great. From this citizen's standpoint, Doctor Jones has in

the past carried on his private practice and, with very little additional effort, has served the health needs of the community; so he concludes that there cannot be much to do. Not only is this type of reaction found in the average citizen, but is likely to be encountered in influential local officials in other phases of government, officials such as the supervisor, the magistrate, the auditor, the treasurer, and constable. But the fact that there is not an insistent and widespread public demand for modern health work is not an insurmountable barrier.

As a matter of fact, the greatest facility for furthering of local health units for the nation is to be found in the possibility of arousing public opinion and interest in this connection. And not only can there be developed a public demand for health service under local health units, but psychologically the public is right now at that stage where wise leadership and guidance is all that is needed. This, of course, means that there must be a carefully developed program of health education with a specific purpose in view.

Even at the danger of taking too much time on this phase of the discussion, it seems advisable to emphasize that the kind of health education essential in this instance is not that concerned with sex education, personal hygiene, or vitamins, for it is doubtful that a mere knowledge of the protective foods, or the habit of taking a bath daily, would impel the storekeeper or the young bride to demand that the town trustees or the county board of supervisors undertake the establishment of local health units. But, on the positive side, the public and local officials are potentially interested in two things: (1) a local undertaking, and (2) the possibility of getting financial aid from outside sources. And it would perhaps not be unethical to take advantage of the fact that a bill proposing giving some money to the home community is popular with legislators.

The kind of health education program that seems to be necessary, therefore, is one that has as its objective the creation of a public demand for health units as local undertaking here, there, and elsewhere, in which the cost of each such local undertaking is to be offset partially by outside funds. Further, and in contrast to what has been done in the past, it would appear to be highly desirable that the program reach *simultaneously into all local jurisdictions* of the state, and that the aroused demands on local and state authorities be coincident and coördinated.

Such a program would necessitate obtaining the endorsement of national, state, and local organizations of various sorts, in addition to such endorsements as already have been obtained. However, mere endorsements are not sufficient, and it would be necessary to translate these endorsements of national and state organizations into local action in every community in the state and in the state capital; action by medical groups, by chambers of commerce, by fraternal organizations, by luncheon clubs, women's clubs, by parent-teacher associations, granges and farm clubs, labor, industry, school authorities, churches, and even political parties. The old technique of intensive isolated work with citizens and authorities of each separate locality is still good, but to get state-wide action it must be supplemented by a carefully planned and more broadly launched undertaking, bringing the public and its representatives in government to the point of obtaining the desired action.

This public action exists as a potential facility in reaching the goal of state-wide service through local health units, but it is dormant. It is not likely to be activated by launching this program of health education as a minor matter, under the part-time amateur direction

of an already harassed bureau chief. If state health administrators, without loss of dignity, could create in the public mind as widespread and exact knowledge of what to do about local health units as the public now knows of where never to put bananas, the problem would be solved.

And now, all the foregoing may be summarized as follows:

1. Public health authorities, legislators, and the public generally, are in varying degrees agreed that every citizen in each state is entitled to public health service.
2. The most effective and economical method of providing public health service is through local health units.
3. While in some states there are legal, administrative, and financial barriers to establishment of local health units, it would appear that these and other incidental problems are possible of solution by wise utilization of resources and measures that are at present available.
4. Perhaps the greatest of all facilities now available is to be found in a carefully developed, intensive, and state-wide program of health education.

Dr. Scamman: Thank you, Dr. Mustard. Dr. Mustard has given us, from an unusually rich experience of his own at the local, state, and federal level, a most challenging paper on the subject he had to discuss.

The next paper on the program is by Dr. Getting.

Dr. Getting: Dr. Scamman, and Members of the Conference. It is, indeed, a pleasure to appear at a meeting of this type and it isn't an enviable position to be placed on a program between two authorities, and national authorities, on health, but I will try to do my best.

Indispensable Functions from Viewpoint of the State Health Commissioner

VLADO A. GETTING, M.D.

Commissioner, Massachusetts State Department of Health

The local health department must be a service unit. Above all, this is its primary function. In presenting this talk it is not my intention to outline in detail the various fields of activity in which a local health department must participate in order to give essential service to the community. It is, however, my intention to discuss the administrative aspects of rendering these services.

Whereas, national and state health departments are primarily concerned with policy formation and are, as a matter of fact, distant from the ultimate consumer of health, the local health department is, in reality, a service unit with everyday intimate contacts with the consumer of the health program. It might, therefore, be best for the few minutes during which we shall discuss the indispensable functions to regard the local health department as a business or commercial activity selling its commodity—health—to its customers. In addition, we must remember that the health department is a servant of the public; that it receives its support from the tax payers of the community; and that the old saying " the customer is always right," may apply also to the public in its dealings with the health department. Too often the local health officer assumes that he is an authority

on the subject, that he is above criticism, and beyond reproach. Thus, over a period of years he sets himself up on a pedestal from which he does not retreat or move forward. Under such circumstances, the local health program becomes static. Failing to advance it becomes retarded and, in comparison with more progressive communities, becomes quickly outdated.

If a health department is to be of service and desires to sell its merchandise—health—in an efficient and effective way, it must be organized soundly, be adequately staffed, properly financed, and must invite the respect and confidence of the public which it serves. Moreover, the health department and its staff must not only be well trained and adequately experienced in the administration of the work but must maintain an active interest in the daily progress of public health and the medical arts throughout the nation. The local health department staff must likewise not only be cognizant of the progress but must, together with the community representatives, preferably in a community health council, make periodic surveys of the needs of the community, the facilities to meet these needs, and establish plans to fill unmet needs. As new scientific discoveries make additional weapons available, these should be utilized so as to reduce to an absolute minimum that lag between the discovery of scientific knowledge and its application to daily life. There is, really, no reason why the citizens of a rural community must forego some of the advances and developments of public health and the medical sciences, while citizens living in an urban community with an adequate health department are able to benefit from these developments.

The objectives of the work of a health department must be measured or evaluated by the results obtained, and it is therefore necessary from time to time to evaluate carefully the services rendered by a department in order to ascertain whether progress is being made and whether the individual health department is maintaining its relative position in the field of public health. For this purpose the *Evaluation Schedule* of the American Public Health Association has met a great need. However, this form needs simplification and is now in the process of revision. Periodically, the health department should carefully analyze its program in relation to that of other official and voluntary agencies in the community. As voluntary agencies demonstrate new programs and prove these to be of value to the community, the official health department should be ready to take over these new activities, while the voluntary agency continues to pioneer in new fields. Often demonstrations, through the loan of personnel from the voluntary agency to the health department, can quickly convince the public as well as the city fathers of the desirability of the new program. The ultimate benefits of a health program are measured in 3 ways. These effects are—(1) prevention of disease, (2) the prolongation of life, and (3) the improvement in health and the attainment of optimal health.

CLASSICAL PUBLIC HEALTH PROGRAM

Dr. Mustard in his book *Government in Public Health* has ably defined the classical programs for which a local health department must assume responsibility. He has also indicated in this volume the methods by which we judge the seriousness of a particular problem and how we determine and plan a program to meet a particular situation.

Environmental Sanitation

Back in the days when Paul Revere made George Washington's false teeth and when he assumed his position as the first chairman of Boston's first health department, the common concept of the

origin of disease was that illness was the result of filth. For that reason, environmental sanitation has always played an important part in the work of the local health department. Too often, however, the collection of garbage and refuse, maintenance of town dumps, and the investigation of nuisances has taken up too much time. Ideally, the collection of garbage and refuse and the maintenance of dumps should not be a health department function, and every effort should be made to limit the number of nuisances investigated so as to avoid neighborhood quarrels and other so-called complaints which are not, in truth, matters of health.

Often the water supply and sewage disposal supervision are also assigned to other departments of the municipality. Unfortunately, licensing of food establishments is also a function in many municipalities of special licensing boards or commissions. The supervision of the water supply and sewage disposal system on a state and national level are always considered as proper functions of the health department, and certainly on the local level they should likewise be considered and become a part of the function of the local health department. Since the licensing of food handling establishments should and can play an important part in the proper handling of safe and nutritious food and in the prevention of food-borne diseases, this duty should likewise be assigned to the health department whose personnel should not only supervise food handlers, but should also conduct courses for food handlers and intensive educational programs for the public as well, in the proper methods of handling food. Unfortunately, some municipalities still foolishly expend funds for the examination of food handlers, a procedure which experience has proved ineffectual. Naturally, the health department should have the power to make regulations in all fields dealing with health, including milk and food sanitation. Private water supplies and private sewage disposal systems, the environmental sanitation of recreational and overnight camps, housing standards, smoke abatement, control of noisome trades, industrial sanitation, the prevention of pollution of streams, ponds and tidal flats, rodent and fly control, are some aspects of environmental sanitation for which the local health department must assume its proper responsibility. Naturally, environmental sanitation must be under the direction of properly qualified personnel who are trained in sanitary engineering as well as in the methods of controlling foods, including milk. This work in environmental sanitation must be coördinated with the work of the rest of the department, and this can be done best through periodic staff conferences and by participation in planning and policy formation.

Infectious Disease Control

When Dr. Boylston introduced vaccination in Boston he laid the cornerstone for our present program for the control of infectious diseases. While isolation and quarantine regulations made on a state level should apply to all communities within that state, often the local board of health has the prerogative of making more stringent regulations. However, there is merit in having standard regulations over large areas, and all of us who have worked for any number of years have seen ludicrous situations where on one side of the street a person may have been released from isolation after one week and across the street he would have to remain in isolation for two weeks because the regulations of that town were more stringent. Boards of health should, therefore, endeavor to standardize their regulations. Departments of education or school committees should not be authorized to require extended absences

from school of children who had been released from isolation by the board of health. We must in the final analysis, agree that for many diseases isolation of patients and quarantine of the household contacts is not effective in limiting the morbidity of the disease. However, the experience of the Scandinavians has demonstrated, especially in scarlet fever, that isolation of the patient may reduce the mortality of the disease. Isolation and quarantine regulations, therefore, are made not only for the protection of the community, but also for the protection of the patient. Unfortunately, too often such regulations are made not because of any scientific background, but because they have always been so and because the community or doctors are not ready to have them modified or shortened.

It is not enough for health department personnel to tack an isolation sign on the door frame of a home wherein there is scarlet fever. The posting of such a sign has little, if any, benefit to the community. However, a visit to that home by the public health nurse giving the housewife the proper instruction in isolation techniques for the protection of her child, will be greatly appreciated not only by the family concerned, but may lessen complications in the patient, bring about a more rapid recovery, and afford an excellent opportunity for the nurse to disseminate information which will help achieve the objectives of the infectious disease control program.

A local health department should not only supply consultation and laboratory services for the diagnosis of questionable cases, but it should also afford diagnostic centers for such diseases as tuberculosis, syphilis, gonorrhea and the other venereal diseases. There should likewise be a proper follow-up of these cases and their contacts, and proper treatments should be readily available to tuberculosis and venereal disease patients. Naturally, the community must provide hospitalization and medical treatment for the more common communicable diseases and be prepared in case of severe outbreaks to call upon other resources when their own facilities are not sufficient to meet the need. The treatment of infectious diseases may be supplied in infectious disease hospitals, or preferably in special units of a local general hospital, or by contract with some other nearby hospital if local facilities are not available. Thorough epidemiological studies should be made of all major infectious diseases and an adequate control set up for the prevention of such diseases as may be readily preventable, such as proper food handling regulations, pasteurization and proper handling regulations for milk, and adequate supervision of hospitals and nursing homes for the prevention of cross-infections.

The prevention of infectious diseases is best achieved by specific immunization. The local health department should provide biologicals free of charge and make available to all who care to use them clinic facilities for the prevention of the following diseases:

1. *Whooping cough* — This immunization should be given before the child is one year of age and may be begun any time after 3 months and perhaps should be given prior to any other, since whooping cough causes more deaths of infants under 2 years of age than all other infectious diseases combined.

2. *Diphtheria*—This may be begun preferably at 9 months of age by giving either two doses of alum-precipitated toxoid or three doses of fluid toxoid. This may be combined with tetanus toxoid and, wherever possible and where community means are ample, it is recommended that the combined diphtheria and tetanus preparation be used.

3. *Smallpox vaccination*—This can be given simultaneously with the last dose of the diphtheria toxoid prior to the first birthday. When the child begins school he should receive a booster dose of the combined diphtheria and tetanus toxoid and be revaccinated against smallpox.

Routine vaccination against typhoid fever is not recommended unless this disease is prevalent in the area. Scarlet fever immunization is still experimental and should not be considered as a proved and accepted procedure for the community. The early immunization program prior to the first birthday benefits not only the community, but gives the child the best opportunity for protection against the specific diseases for which he is immunized. The revaccination and reimmunization at 5 or 6 years of age enhances continued immunity against these diseases. Without these repeated immunizations the child would not be protected for life, in many instances against smallpox, and in a substantial number of children the immunization against diphtheria would wear off and might cause a relatively high incidence of diphtheria among older children and young adults.

Last, but not least, is the problem of dental decay in children. It is an acknowledged fact that 85 per cent of children in the average community need dental care every year, and yet the average health department does not provide the necessary service for the prevention or correction of this highly prevalent disease—dental caries. Ideally, the health department program should provide free clinics available to all, regardless of income. These clinics should serve all school children through all twelve grades. Certainly, studies should be conducted in these clinics for the evaluation of various methods for the prevention of dental caries, such as the topical application of fluorine to teeth, since this method indicates a possible prevention of 50 per cent of all dental caries.

Cancer and Other Chronic Diseases

The fight against infectious diseases has gone very well. Not that the work is completed, but certainly the mortality and morbidity of some of the more important infectious diseases are now far less extensive than in the past. Diseases such as typhoid fever, diphtheria, and tuberculosis are no longer the hazards that they have been. However, in the meantime we have increasing new problems. At the time of the Battle of Bunker Hill, a new babe born to a Yankee in Boston had a normal life expectancy of 35 years. Now a child born in Massachusetts and most other states has a normal life expectancy of 65, and it is possible that this life expectancy will extend to 75 years. Thus, it is to be expected that those diseases which are primarily due to wear and tear on the human body and mind and those diseases which are more prevalent during old age should become increasingly larger problems. Today our community population consists of more "oldsters" than ever before and our aging population will grow older with each generation. Therefore, health departments must make plans for the treatment, control and, if possible, prevention of such diseases as cancer, diabetes, the allergies, heart disease, the arthritidies, kidney disease, and the like. These programs should include not only an educational aspect but also a direct service program including diagnosis, treatment, and follow-up of the individual patient. Special procedures should be designed to treat, follow up and, if possible, curtail mental illness.

Since the development of medicine in these fields is now rapid, the health department staff must not only maintain its knowledge of these developments, but must make available to local practitioners information concerning new developments in the diagnosis, treatment, and prevention of cancer and other chronic diseases. The economic loss to the community from chronic diseases is vast. It has been estimated, for example, that in Massachusetts with a population of 4,500,000, fifty million dollars are lost annually due to the in-

ability of these individuals to work. This does not take into account the cost for the care, medicines, and hospitalization required to look after these unfortunates. Health departments, therefore, have a definite challenge and must plan together with other community groups a more complete and thorough program for cancer and chronic diseases.

Promotion of Optimal Health

Too many persons, including many doctors and some health officers, still believe that public health is preventive medicine and that the function of a health department is to prevent something which is undesirable such as an overflowing cesspool or a malodorous dump, or an outbreak of diphtheria by immunization. To be sure, there is a definite preventive angle to public health but the work of the health department is much more than prevention. Public health is, and should be, a positive program wherein the health department takes every measure possible to increase the good health of the community. Public health is a positive asset to the resources of the community. Optimal health increases the opportunities for greater income, better morale, greater happiness, and prolonged life.

When God created the human body he devised a machine which is far beyond the ken of the human mind. It is vastly more intricate than radar or the atomic bomb or even the most intricate computing machines in some of our universities. It is small wonder, therefore, that the individual does not know how such a machine works and what care must be given to it. The invididual must be taught the rudiments of healthful living. He must be given an opportunity to learn about the various vital portions of his body, how they function, and what care must be given his body in order to have it functioning at its greatest peak of efficiency. This entails an educational program which should ideally begin in the schools. School health education programs should be the responsibility of the school department, but the health department should coöperate with the schools in devising such programs. On the other hand, the medical service aspects of a school health program, such as the services rendered by doctors, dentists, nurses, dental hygienists, and other practitioners of the healing arts should be a function of the health department and be closely integrated with other work of the health department. For example, there should not be a special classification of school nurses. These nurses should work in a generalized health program under the supervision of a health department, covering certain prescribed districts in the community. Moreover, such nurses should work the usual hours of health department personnel, thus bringing about greater efficiency in nursing services at a considerable saving to the community.

The educational program should extend beyond the schools into the home because, after all, education in itself is not of any value unless the facts which are learned are actually utilized in everyday life. It might be well sometimes for health department personnel to realize that the attitudes often assumed by them as super-experts of health and education may be erroneous. It is far better for a health worker not to consider himself a teacher, but an individual trained in public health who is thus more fortunate in possessing certain information, and who, because of his profession, has an obligation to disseminate such information. Too often, talks to the public by a doctor are in terminology which only doctors can understand. Speaking in plain words which the high school student can understand will oftentimes bring across one or two points which will be

utilized in the home, whereas a highly scientific talk may, under similar circumstances, bring about not only no utilization of the facts given, but actual criticism of health departments.

The promotion of optimal health must extend to the adolescent and young adult and must come into the home to the parents. Maternal health is one of the bulwarks of the community, and the program of the health department must be designed to protect the health of the expectant mother and that of the baby after his arrival. Oftentimes health departments have rather elaborate programs for maternal and infant health, and the school program may also be well developed; but in between there is a so-called neglected age of the preschool child and this facet must be covered more adequately. Periodic well child conferences under the direction of a physician and, when possible, with the assistance not only of a nurse, but also a nutritionist and a dentist and possibly a psychiatrist, have their place.

In some states local health departments may have authority over boarding homes for children, housing, convalescent homes, hospitals, and industrial establishments. Where such authority is vested in the local health department, an unusual opportunity is afforded the staff to provide conditions which are more conducive to the development of optimal health.

The health education program of a health department is oftentimes thought to consist of a series of lectures, radio broadcasts, and newspaper releases. While these are important methods for the release of information, it must be remembered that often the sanitary inspector and the public health nurse who visit the home have the best opportunity for the dissemination of information. Each visit to the home should be an educational experience for the person visited. Each contact with the public, whether it be personal, in the office, or by telephone, is a means for educating the visitor.

The educational program of a health department should have a twofold purpose—(1) the dissemination of information relative to health matters, and (2) the dissemination of information relative to the activities of the health department, designed to obtain the support of the community for the health department. To be progressive and to obtain the necessary funds from the town fathers, the health department must obtain the confidence and support of the public. This must be done by keeping the public informed of the activities and progress made in their health department. The utilization of health councils and all other means, including the radio, the press, and personal talks should be employed in this effort.

Records and Vital Statistics

Some departments have rather elaborate record systems and can produce any type of analysis of vital statistics. In other communities the records are disorganized, haphazard, and often incomplete. Certainly, a health department should carry on a program designed to encourage complete reporting of births and deaths and the reportable diseases. It must also have a certain amount of statistical analysis and a system of record which is carefully planned and kept up-to-date. However, we all know of some communities where record systems have been overdeveloped, where information is collected, carefully filed, and never again used; where field professional personnel spend a considerable portion of their time in filling out forms and records and thereby using time which could more profitably be spent in giving further service in the community. The records of a health department should be so designed as to include only such information as is useful. They should be periodically re-

vised and evaluated as to the need for the record which is being used. Records should be so designed as to be readily completed and easily analyzed by statistical machine methods. The standardization of records has value in that comparisons between communities are possible.

CONCLUSION

In presenting the indispensable functions of a local health department, I have tried to visualize myself as a city health officer, a position which I have held in the past. We all know that in some part of the country some of these functions may be delegated to the state department of public health, and in some states certain of these functions may be delegated to other departments of state or municipal government. Nevertheless, the indispensable functions as I have outlined them should be carried on in each community either by the local health department or by some agency to which this specified function is delegated. Ideally, the local health department should be responsible for all of these functions. However, to perform efficiently, the health department must be properly organized and authorized to carry on this work and must coördinate its work with other official or voluntary agencies. It should be under the direction of a full-time trained and experienced medical health officer who has an adequate staff of trained and experienced assistants. The medical health officer should be the executive and administrative head of the department and should have available to him the assistance of an advisory board of health. He must have some security of tenure, adequate compensation, and freedom from political interference. Similarly, the entire staff of the department must be adequately compensated and should have security of tenure. Health departments can perform these indispensable functions only if the opportunities offered in public health are great enough to invite able persons who are willing to devote their entire lives to the performance of these responsibilities.

The health officer and his staff must always keep in mind the fact that they are expending public funds, that they are the servants of the people, and that their professional status carries with it certain obligations which they must fulfil sincerely. An efficient health department which is progressive and enjoys the confidence of the medical profession and the public can carry on the indispensable functions of a health department so as to fulfil the objectives for which it is designed; namely, the prevention of disease, the promotion of good health, and the prolongation of life.

Dr. Scamman: Thank you, Dr. Getting. As I listened to this interesting paper, I shivered to think of the number of responsibilities that a local health officer really has. They kept piling up it seemed to me until I actually did a little suffering with the number of them.

There was one point that Dr. Getting made in the early part of his paper which, it seemed to me, might be emphasized, and that was the importance of a local health officer seeking periodically an appraisal or evaluation of his own health department, and, by the same token, the interest which state health departments, state health officers should take in promoting annual or biennial appraisals of local health service.

The next paper on the program will be presented by Dr. Smillie.

Dr. Smillie: Mr. Chairman, Members of the Conference—I might reply to Dr. Getting with a statement that it is an almost insupportable and hopeless situation for a professor to be sandwiched in between two experienced and

very successful state health officers such as Dr. Getting and Dr. Blackerby. It makes one feel a little bit like a fluffy lettuce of theory ground between the solid components of our daily bread and butter, which they obviously represent in public health work. What Dr. Getting has presented to you this morning, a program of functions for local health work, is quite concrete, in theory at least, and as you know, we professors deal almost exclusively in theory—this is the professor talking to you now—as we do to our students.

Personnel and Training for Local Health Units

WILSON G. SMILLIE, M.D.

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In theory, at least, it should be possible to select personnel for a local health service which would meet all the needs of the community, which would be in harmony with all well recognized administrative principles, and which would function smoothly and effectively. It obviously should be provided at a cost which the community would be able to pay.

One must remember that in a local health service, personnel is everything. There is little capital outlay, no extensive operation cost, and little overhead. The great part of the budget of the department is utilized directly for salaries of personnel. In other words, personnel is the health department.

Thus, in organizing a local health service, one should be able—

1. To delineate clearly what the functions of the health department are, and to determine what services it will render to the community.

2. To plan the activities of the health department in order to fulfil these functions.

Having completed these two tasks, one would simply calculate the amount of work to be done, and then select the quality and quantity of personnel that would be required to fulfil these objectives. Our work is done. Write "finis." Let us wash our hands, and go ahead with some more important and difficult task.

But practical considerations circumvent our most beautiful theory. The main difficulty with this approach is that we do not always know just what the functions of the health department are, or what the activities will be within the next few years. We have changed our policies in many ways during the past twenty years. There is every reason to believe that we shall change in the future. Furthermore, a plan that is quite suitable for one community is an impossible administrative structure in another.

What procedure shall we follow in personnel selection? Shall we simply select the most available individuals, head them in the general direction that we think they should go, and give them a kind pat on the back, or a strong shove, in accordance with our disposition or temperament, and tell them "to use their God-given intelligence, initiative, and imagination"? That is the way most of us got our start. Often this has been our method of personnel selection in the past. Strange to say, it has worked reasonably well.

Surely there must be some general principles that may be applied in selecting personnel and preparing for their training.

It may be interesting to digress for a moment and secure a historical perspective in these matters. The appointment of district health officers was perhaps the first serious attempt to develop an effective local health service. These men were physicians, and their function was in most part that of deputy state health officers, and their activities were largely epidemiological. But they established the principle of full-time medical leadership in local health services.

When Dr. Lumsden made his recommendation to Yakima County, Washington, in 1911 that a county health department should be established in that area, he obviously was interested primarily in the prevention of communicable disease. The county had just suffered from a disastrous epidemic of typhoid fever and, sensibly, the people had asked how further epidemics might be prevented.

Thus the initial full-time county health department personnel was a medical health officer, alone. Jefferson County, Kentucky, also appointed a full-time medical health officer at about this time—1908—and Guilford County, North Carolina, did the same thing in 1911. In this way, the pattern was set for the development of local health services with a *full-time* medical officer in charge.

Nursing services in rural areas had been initiated on a county-wide full-time service basis before 1911. The Red Cross and the National Tuberculosis Association sponsored local health services, in which a public health nurse was the only member of the staff. The value of a public health nurse in a rural community was clearly demonstrated by this work, but the nurses were the first to recognize that they were giving an incomplete service.

The hookworm campaigns of the Rockefeller Sanitary Commission that were carried out in the southern states, beginning in 1910, brought out the fact that extensive health campaigns were of little permanent value unless a nucleus of key personnel remained in the area to continue the efforts of the initial work. Thus, more or less by chance, a tier of southern states became the experimental zone, the proving ground, in local health administration in the United States. This trial period lasted for nearly ten years, 1911 to 1920. At first, varied combinations of personnel were tried: (a) a medical health officer and one nurse, (b) a medical health officer and one clerk, (c) a medical health officer and a sanitary inspector, (d) a sanitary inspector and a nurse; with other possible combinations.

These field experiments developed certain broad principles relating to personnel, upon which we have founded successful local health services in rural areas:

I. *Basic Personnel*

1. The basic, or foundation, personnel of a local health service should consist of

a. A medically trained health officer as administrator.
b. A public health nurse.
c. A sanitary officer.
d. A secretary.

2. The key personnel should be on a full-time basis, with no other professional obligations.

3. The key personnel should have special training for their work, in addition to their fundamental training in medicine, nursing, or other science.

4. Personnel should be given opportunity for professional advancement, with security, and with sufficient pay to make the work acceptable as a permanent career.

5. Personnel should be given opportunity to do developmental work, such as field research in epidemiology, initiation of new methods in health educa-

tion, improvement in administrative technics, and the like.

6. Responsibility for the local program must rest directly with the local health personnel, with advice and aid from the state health department.

7. Standards for (a) selection of personnel, (b) for determination of their qualifications, and (c) assistance in providing for their training, are functions of the state board of health.

II. *Additional Personnel*

Once the pattern has been set, it has been a simple matter to add more personnel as demand for their services became evident. The most rapid development was the demand for an increased number of public health nurses. Many areas that began with one public health nurse now employ one nurse per 5,000 population, with a supervisory nurse for every five to seven staff nurses.

Additional clerical staff has been added, and the quantity and quality of environmental sanitation activities has increased, as the need for this type of personnel became apparent.

III. *Supplementary Personnel*

Direct health activities may require the utilization of certain skills that are readily available in the community, and these skills often can be purchased on a fee-for-service or other basis.

For example, medical services in school health work, pediatricians for well baby clinics, physicians for venereal disease clinics, for chest clinic work and the like, may be mentioned. Dental services can often be secured in the same manner, and a local veterinarian may be employed in meat inspection, in dairy inspection, and the like.

This type of personnel we may designate *supplementary personnel.* Their work is initiated, organized, and directed by the medical health officer, and no extensive special training or special public health experience is required to prepare them for their work. They are almost always *part-time* personnel.

IV. *Advisory Personnel*

Certain activities of the local health department may require a high degree of special knowledge and special skill. Notable are the field of nutrition, mental hygiene, sanitary engineering, epidemiology, industrial hygiene, social service, cancer control, and others.

It does not seem feasible for each local health department to employ a full-time nutritionist, a full-time sanitary engineer, psychiatrist, vital statistician, or epidemiologist. Yet suitable personnel must be available to advise the health department in these fields and help solve the health department problems.

It is, I believe, the function of the state health department to furnish these *advisory services.* This type of personnel gives no *direct service.* For example, except in demonstrations, the state nutritionist does not go into the home, in any community, in order to aid the mother in meal planning and food budgeting. Rather the nutritionist teaches the public health nurse to carry on this work as part of her regular home visit activities.

In large local health organizations, it is quite possible that the department itself may employ this type of advisory personnel, but for the most part, this service will be furnished by the state health department.

TRAINING OF LOCAL HEALTH PERSONNEL

The pioneers who initiated local health services soon recognized the great need for personnel which had had special training that would qualify them for their work. The obvious solution seemed to be *schools of hygiene,* that is, graduate schools of public health.

These were established. Unfortunately, they were staffed for the most

part by men who had no broad experience in public health. The curriculum was poorly planned, a great deal of the student's time was wasted, and the work was highly theoretical, often inconsequential. It was neither long, nor broad, nor deep.

We learned with time, and gradually modified the training to such a degree that most of the leaders in public health now agree that a year of academic (theoretical) training in the various special fields of public health is well worth while. But most health officers will also agree that, just as a medical school training must be supplemented by an internship, so a course in theory at a school of public health must be supplemented by a period of practical field training.

The Committee on Professional Education of the American Public Health Association has a special Subcommittee on Field Training, of which Dr. Gaylord Anderson is chairman. I shall take the liberty of presenting to you excerpts of its early deliberations. These are not, as yet, accepted by the committee as a whole. They are not definite, but they may give you an idea of the trends in our thinking.

Types of Training

1. *Observation*—duration: 1 day to 1 week.

The individual takes no direct part in the activities of the health department. This training is burdensome on the health department, and has limited value. It is best suited for a well trained, experienced person who simply desires to learn of new procedures or to discuss new policy. It is not of value to the novice.

2. *Orientation*—duration: 1 to 2 months.

This is training to prepare an individual for a specific position in a specific place. It is intended to familiarize a skilled person with the particular problems, laws, codes, customs, and procedures of that area or state in which he is about to work. We recommend that every state should provide its own orientation training.

3. *Field Experience*—duration: 3 to 6 months.

This training is supplementary to a theoretical, academic training in public health. It is comparable to an internship which follows medical training. The training areas should be carefully selected and will require teaching personnel, in addition to standard personnel for the areas chosen for the training. It is not necessary to have one of these areas in each state. They should be regional, and will of course receive special financial aid. At the present time, the Kellogg Foundation has agreed to underwrite the establishment of a limited number of these field training areas, on a trial basis. Eventually, if they prove of real value, they should be supported by governmental funds. Is this a federal function? Certainly they should not be the financial responsibility of the schools of public health, nor of the state in which they are located. Should they be self-supporting, e.g., by tuition?

4. *Apprenticeship*—duration 3 to 12 months.

This training is given *before* the candidate has had his academic year of work at a school of public health. It has special advantages in the selection and training of *medical health officers*. The individual is employed as an apprentice by the health department, and if he likes the work and proves to be capable, he is then given a period of academic training by the state and returns to his official sponsor at the completion of the theoretical work. This is essentially a state health department function.

5. *In-service Training.*

This is simply a continuous educational program for all types of personnel in the health department, in order to keep them abreast of the times. It is a special function of the local health department, with aid from the state health department.

QUALIFICATIONS OF PERSONNEL

The establishment and acceptance of certain uniform standards for the training and qualifications of the various types of professional public health personnel is of great advantage from every point of view.

The Committee on Professional Education of the American Public Health Association, which functioned so effectively under the chairmanship of Dr. Leathers for years, and is now under the chairmanship of Dr. Shepard, has worked long and hard on the establish-

ment of acceptable standard qualifications for various types of personnel. These are revised from time to time, as conditions require, and have the official approval of the American Public Health Association. Local and state health departments have found these standards of great value.

The latest revision of the *Report on Educational Qualifications of Health Officers* was published in the August issue of the *American Journal of Public Health*. Reprints will be sent to each registrant at this conference.

CONCLUSION

In conclusion, one must admit that our ideas of the functions of local health services are changing so rapidly that everything presented to you at this time may be completely revised in the near future. If our health officers are to undertake new types of community service and broaden their administrative responsibilities, then a different type of person and entirely different type of training may be required for local health department personnel.

In a recent informal discussion of these matters, a professor of bacteriology said to me: "If and when a sociologist enters the doors of this medical school, I go out the window." Probably he and several of the rest of us will be "going out the window" in the near future.

At our afternoon discussion session, I suggest:

1. A discussion of the changing concepts in personnel training to meet changing needs.

2. A discussion of another pertinent topic, namely, a specialty board for public health officers, with official recognition by an authoritative body of those who have prepared themselves for a career in public health.

3. In addition, a discussion of another point brought out in Monday afternoon's discussion, namely, the responsibility of the state department of health for the establishment of special facilities for recruitment and training of personnel.

It must seem to you that we have given undue importance to this matter of personnel selection and training for local health services. We certainly have devoted a considerable period of our conference to these matters. The only answer that one can give is contained in our opening paragraph: *Personnel is the local health department.*

Dr. Scamman: Thank you, Dr. Smillie. Dr. Smillie has presented not only an interesting paper, as one would expect, but has projected his thinking distinctly forward in one or more respects. I was particularly interested to have him mention the possibility of changing concept in the kind of individual we may need, the kind of training an individual must have for public health in the more or less distant future. And, I was particularly interested, Dr. Smillie, because two separate representatives of state health departments have already raised that question casually with me since the conference started.

One of the other points which seemed to me important was the discussion of either supplementary or advisory personnel, suggesting the importance of this type of service provided by the state health department, and, as all of you know, that is becoming more and more essential.

Finally, I was rather glad that Dr. Smillie felt he could present to the conference, however tentatively, some of the definitions or objectives of Dr. Anderson's subcommittee of the Committee on Professional Education related to good training of health officers.

The next speaker on our program is Dr. P. E. Blackerby.

The State Health Commissioner Looks at Personnel and Training

P. E. BLACKERBY, M.D.

Commissioner, Kentucky State Department of Health

There is no question in my mind that when they selected this topic for a state administrator—maybe in selecting me they made a mistake—they were looking for a magician, or somebody with second sight, maybe a juggler or a contortionist, or something of that kind. "The Administrator Looks at Personnel"—imagine such a thing now! Down in Kentucky, yes, we have no bananas.

A short time ago we took our personnel officer and sent him out in the state with nothing to do for three months but to try to find some nurses, up hill and down dale, here, there, and everywhere, and it got so monotonous that as she would meet people she would say, "I want a nurse." Well, she got to the point where an old woman met her, an old grandmother type, and parrot-like she said, "I want a nurse," and the old lady said, "God bless you, haven't you been weaned yet?" You just can't tell what reaction you are going to get when you talk among each other about these problems of personnel. I dare say there isn't a health officer here in this meeting that hasn't asked—I mean, state health officer or director of county health work—that hasn't asked some other state health officer or director of county health work whether he could help him find some personnel. I met Dr. Hutcheson yesterday—or was going out the door here with him and I said, "Dr. Hutcheson, have you any personnel at all to loan, or to give away?" And he wanted to charge me a commission for answering the question.

Down in my state we have constitutional inhibitions, and every once in a while when we think we have a lead to some personnel—we begin to get enthusiastic—I know a lot of us down there are shouting Methodists, we like to shout when we get happy, and if we can find a lead toward getting some personnel, we just begin to get happy and want to shout, and then along comes somebody and points out our constitution to us and says, "You can't pay anybody in Kentucky over $5,000."

So, that is the way we are when we just begin to pick up a little encouragement about personnel. And we are losing personnel down there in Kentucky because of those constitutional inhibitions, and we are losing them awfully fast. And I have a crow to pick with some of the states that are a little bit more fortunate. You know, you wouldn't believe it, but two southern states have really got a fortune. I think maybe some of those Yankees are beginning to pay off down there. One of these states has taken seven of our best trained health officers and we are losing them every day, and could lose all the rest of them if we didn't have some ties on a few of them yet—they have to stay at least a year with us after they got their fellowships.

There is another state down south that may have a system that will appeal to you. I know they have a representative here and he will know what state I am talking about. When the *Journal of the American Medical Association* began to publish the list of men returning from the service, dozens of them received a letter from this particular state inviting them to come down to

work in public health and telling them all the attractions about the peaches and goobers in that state.

On this matter of personnel, of course, we are all going through the same experience. We are short of practically every type of personnel, and in trying to maintain our local health service we are spreading personnel too thin. We are, in many instances, brought to the position of just doing our dead level best to hold the organization together. And somebody made the remark here yesterday that we have in too many instances too high civil service or merit system restrictions. You can understand that in trying to replace personnel at this time of great personnel shortage and no available resource for recruitment we have got to use, if we are going to keep going through the emergency, some lesser qualified and trained persons. It may be that for a while we are going to have to relax to a considerable extent the merit system requirements and civil service standards. Lord knows, they did it during the war.

I represent the group of states with low economic levels. We are having an awfully hard time because the more wealthy states are in the position to be more selective in the matter of personnel because they can pay the tariff. Unfortunately for the rest of us, they can go out and outbid the other fellows and take personnel away from us, and it is a tremendous problem. Down in Kentucky we have had a county unit law ever since 1918, and out of 120 counties we have had 105 organized. During the period of the war we made combinations, until now, well over half of our counties are in combination units. But I also recall to mind one 3-county combination unit that has no health officer, and has lost all but one nurse. Fortunately, it is a small combination unit and for the time being until we can get some personnel, we are using a couple of local physicians as consultants. We can't elect them as health officers but are using them as consultants and clinicians.

The tendency is becoming more and more, in the matter of personnel, for specialized services. And I don't know what the reaction of you administrators is about specialty services. As the federal program is developed for aid to the state, and more money comes in, we have funds for cancer, for tuberculosis, for venereal disease, and for this or that special type of service. The tendency is to recommend that we employ a nurse specialized in cancer, specialize this one in tuberculosis, and another in venereal disease, and so on, until we have as specialized a public health nursing and maybe some of the other programs of public health as they have in general medicine. I believe most of the health officers will agree, in the matter of special services, particularly nurses, that the whole program ought to be integrated and the nurses ought to be general staff nurses with opportunity occasionally to get some special training in some of the specialized services, but made a part of the general nursing program of the department, and not a special nurse. Let them work on rotating services in the matter of special needs.

There are shortages in all types of personnel. We have in Kentucky in connection with our cancer program, I think, one of the best advisory councils that you will find in this country. We were fortunate in having a State Cancer Society of some of the leading surgeons and physicians in the state, and out of those we selected our cancer council. They have been discussing with me the question of getting some medical social workers. Well, we have a splendid fellow who is doing educational work in cancer in the state—again I am bragging a little—I think, as good as there is in the country, and he is beating the bushes to try to find medical social workers. If

they are available and some of you can give us a tip on them we would like to find some of those for that program because we have developed district cancer diagnostic and treatment centers. From those centers we want to go into the homes in the particular areas and do some social investigations.

I mentioned nurses, I mentioned doctors, and in nearly all the categories of employees there is a shortage. We have a tremendous problem to keep our laboratory services in the state equipped with the proper quota of personnel. We conduct a school of laboratory technicians in the State Department of Health, and it is an accredited school, believe it or not, and the demand for those students—graduated students—begins almost as soon as they have matriculated, somebody is trying to tie them up in the state, and they have laboratory technicians in the state from $250 to $350 with maintenance because of the keen competition and the tremendous need for the services. I don't think there is any possibility for quite a while of our finding in most of these personnel categories the quota to render anything like an adequate service. I don't know what the experience of the rest of you is, but down in our state in some of the county health departments we are using voluntary aides to assist in clinic services and things of that kind.

Now, just a few words in connection with some of the things that Dr. Smillie has suggested, and then I'll get to the semi-formal part of this. I am particularly interested in certain types of personnel that could be qualified for good services in the health department, for whom there is no opportunity for training because of the high standard for admission. I'll give you an illustration of that—and Dr. Vaughan will be familiar with it—we administrators from time to time have to use some independent judgment in the matter of determining the type of employee that we need to fit into a certain part of the program that has administrative responsibilities. In Kentucky in our division of public health education we have always had an administrator with a background of training as a journalist because largely in that division of service his responsibility is for editing all the educational material we get out. If I undertake to prepare a paper I can feel absolutely confident in the rewriting of it he is going to give it good journalistic editing and preparation. We had a man from old Virginia who had been a journalist in that state, and newspaper editor, who, I think, was one of the best men in a division of public health education that I have ever known. Even the presidents of our state medical association called on him to edit their presidential addresses. We want to get a man to head up our division of public health education, not to get out in the field and do public education, but to administer the program and be prepared for the publication of our issues and the editing of all of our material, scientific and otherwise. I had a man a short time ago who could qualify, but who didn't have the basic sciences to get a course in public health education. He just didn't have the basic sciences and his credits wouldn't admit him to a course of formal public health education. All I wanted him to do was to get the techniques in public health education so that when in the editing of the material he met a lot of the phraseology of the trained public health worker and others, he could give the proper editing and proper direction. So I would like to see not a sub-standard course, but courses for some of these people that can be attendance courses, if nothing else, without certification—if some one of these universities could make such a course of training for what you might call semi-skilled, or semi-technical trainees.

In connection with the program of

public health nursing, I predict—and I don't know what the rest of you think—that it will probably be ten years before this thing is going to level off and we are going to have access to a pool of nurses sufficient to take care of our needs. We have been picking up during the period of the war nurses of pretty nearly any age in order to meet the situation. A good many of those nurses were graduated when they didn't have to have more than two years of high-school as pre-nursing training qualifications. Some of those have demonstrated in their work that they are practically as good as some of our better trained nurses. That must be the experience of most of you. A lot of these nurses have more or less natural ability, they have an adaptability, and they have a love of people, and an interest in their work.

In considering the problem of personnel and training from the standpoint of a commissioner of health, one cannot divorce this problem and consider it apart from recruitment. Recruitment begins with the basic training of the individual long before the postgraduate specialized courses are undertaken. It is my belief that greater emphasis should be given in medical colleges and nurse training schools to the impact of social factors upon the individual. Medicine is as much a social science as it is an exact curative science, and the effect of socio-economic factors in the etiology and treatment of disease must receive more attention.

The place of public health as a specialty in medicine needs greater emphasis, and the responsibility of every practitioner to promulgate the broad principles of public health as an essential phase of medical practice in the future should be pointed out. It is not my intent to intimate that medical colleges or schools of nursing should attempt to make health officers, epidemiologists, or public health nurses of all graduates, but rather that they should be thoroughly acquainted with preventive medicine and catch the philosophy and vision that is the heritage of the public health worker. It is my belief that through this medium more persons in professional training will be interested in taking up public health as a specialty. We have failed to capitalize on the glamour of public health but an even greater sin of omission is that we have failed to pass on to the professional neophyte the challenge of the opportunity for rendering service to the populace and the fundamental responsibility to the community of every person engaged in medical practice.

Definite programs for recruitment should be instituted. However, if we are to embark upon a definite recruitment program there are a number of things we must do as administrators. We should have a complete survey of our organization, taking into account our future planning, with complete job analysis. This should include not only the duties to be performed but also the opportunities for advancement and the economic security offered by such employment. If our study reveals weakness in our organization, or situations less attractive than elsewhere, we should make every effort to correct these defects. We should also have some knowledge of the probable rate of replacement necessary for our organization.

All this type of information should be available. Persons who might be interested will want to have an accurate picture of what we have to offer, and they are more interested in facts than nebulous generalities.

It also appears that public health organizations are flirting with personnel problems through drifting into the practice of competitive recruitment. I do not want you to think for a minute that I mention this to register a personal complaint. We, in Kentucky, are limited in the salaries we are able to pay. This, plus the fact that we have one

of the outstanding health programs in the country, has made our state one of the greatest training centers in the United States. We are always sorry to lose one of our workers to a position of greater responsibility but at the same time take great pride in the records set by our personnel. My main concern is in the shifting back and forth of workers from one state to another because of promises of more lucrative positions. Instability in personnel is not conducive to sound public health programs. Also such practices tend to invite inflated salaries and dissatisfied, restless employees.

In regard to the postgraduate training of the public health workers certain features appear to me to be worthy of special mention:

1. Because of the varying responsibilities of the "public healther" in various public health organizations and because of the rapid growth of public health programs, it apears essential that teachers in the schools should have had experience in public health work prior to the assumption of teaching duties. The fact that schools and curricula in public health have expanded so rapidly and have been able to give practical and valuable courses is, in my opinion, largely due to the fact that these institutions have drafted people who have had a tremendous amount of field experience in public health work. However, it is not enough that experience has been a part of the professor's background. He should keep in intimate contact with the practical, through continuing association with health departments on all levels from the federal to the local. This contact should not be merely a casual speaking acquaintance with the staff members but rather an actual working arrangement. This could probably best be done on a consultant basis with the privilege of careful analysis of programs and techniques instituted and under what conditions they succeed and fail. Only through such a method of current source material may curricula be kept pertinent, and faculties keep their fingers on the pulse of public health activity. Our field of endeavor has such a dynamic program, and is such a delicate synthesis of medicine, sociology, economics, political science, jurisprudence, dealing intimately with the lives of so many people, that we can never permit our training program to be divorced from teaching techniques by practical and experienced professors. To allow courses ever to become complete abstract didactic material would mean certain death of public health as we know it. Our place would be usurped by some other agency with a program designed to meet current needs of the people rather than a program designed to meet their needs of yesterday.

2. Our second point for consideration is so closely allied to the first that probably they should be considered as one because each complements the other. However, they are separate in emphasis and are therefore considered individually for purposes of clarity. Schools of public health should develop model health districts, maintained under careful supervision for use as field training units by students. It is readily admitted that techniques of teaching and visual aid materials have greatly increased the effectiveness of presenting didactic material in the classroom. However, we have long recognized the fact that the laboratory is an absolute necessity in the teaching of scientific material. The only laboratory known to public health is the health department and no abstract synthetic problem can take the place of the actual experience in coping with the current problems as they present themselves in the everyday operation of a local department. Students should spend a certain part of their time in the actual work of a going department. This time should not be spent as merely a visitor observing the department, but rather as an actual participant in the program. Such supervised experience would give the recipient a "know-how" impossible to acquire under any other system.

3. A course in political science is sorely needed. It is assumed that anyone who has progressed along the ladder of formal education to the point of postgraduate training in public health has received at least an introduction to this subject. Unfortunately, in most instances the introduction was all that was received and most public health workers learn through the medium of sad experience the basic principles of county, municipal, state, and federal governments. We are all capable of speaking glibly of our democratic government, but when we are suddenly face to face with the stark reality of our working relationships with other official agencies, we are woefully lacking the necessary knowledge to make it possible for us to mesh smoothly into our proper gear in the civil machinery of the community. Many a needed public health program has gone begging because a health officer had no idea of his proper

reciprocal position with other civil authorities. It is detrimental to the cause of public health for these situations to arise and we are remiss in our duties as administrators and teachers if we permit such a weakness in our training program to continue. Our work is so intimately bound to the civil government of our communities that every health worker should have not only a meager knowledge of political science but indeed should be a master of the subject. This is entirely separate from the playing of partisan politics. We feel that this has absolutely no place in health department practice and forbid all our personnel to engage in any political activity in this sense. But the public health workers should know instinctively, if we may use the term, the working relations of civil government and why certain channels and procedures are used.

4. Of special need for health officers are courses in the fundamental principles of business administration and personnel management. A health officer must be a good administrator if he is to be successful, and modern health departments are business concerns the same as a utility supply company. Sound practices of business organization and administration are essential if health departments are to be run efficiently rendering maximum service to the public. Problems of personnel relations and management are just as acute, and probably more so, in health departments as in the local bank or department store. Yet we turn health officers out with not even that first bit of training in these vital subjects. They go as lambs to the slaughter. None come out unscathed and only the particularly agile individual, who has learned the fine art of "rolling with the punch," escapes with minor injuries. Many a valuable worker has been lost to public health through just such an experience. We in high positions of public trust cannot afford to be wasteful. Every individual lost from a health department staff represents a loss of public moneys expended in training as well as the loss of future services of the worker. Therefore, it behooves us to institute measures designed to prevent such occurrences in the future.

5. Certainly more than any other member of the medical profession the health officer is called upon to make public appearances. Every member of the health department staff must first be a forceful educator and should know public speaking techniques in order that each public contact results in an educational experience for the listener. Not only is public speaking useful to the health worker in appearances before large public gatherings, but also in the quiet of the country store at the crossroads. Here, where one or two influential citizens of a community are sold a public health program, is the grass roots of our work. Of great help also would be the poise of the health officer in meetings with public officials and appropriating bodies. Every good administrator has his program planned and his supporting statistical data, but is too often insecure because of a lack of knowledge of proper methods of presentation, thus giving an impression of lack of conviction that even he is not sure the program is sound. Altogether too often I hear public health workers say, "I have to teach a home nursing class," or "I have to speak before a civic club. How I hate to do it." The cause is lost before that worker begins his speech, because he himself doesn't have the self-assurance and public appearance to drive home his message forcefully. All public appearances should be entered into with a joyous zest to put over the point at hand. Such a spirit comes only from a knowledge of the subject matter to be presented and self-confidence in the speaker's ability to present it properly.

6. Briefly, I should like to mention the forgotten man in our health department, the sanitary inspector. He renders an invaluable service to our department doing a tremendous amount of detail and necessary leg work, yet we have no particular training program for this man. All are just haphazard, makeshift, short training seminars. We need to urge our colleges to establish courses leading to a degree in public health sanitation. These courses should be designed to give the inspector a background in mathematics, mechanical drawing, bacteriology, hygiene, and sanitation. In-service training courses by our schools of public health would also be of great help. These short term intensive programs would act not only as an educational experience but could also be used as a system of reward for the worker who has given outstanding service.

Finally, I feel that before any worker takes a postgraduate training course in public health, he should have had a period of work in the field. This not only acts as a period when the worker may acquaint himself with the general aspects of public health and determine his particular fitness in the field, but more important gives him a practical base upon which his year of postgraduate training may be built. His mind is attuned to the subject and he is not dealing in abstractions. The happy result of such a course of training is a well versed, enthusiastic, competent health worker—a real "public healther"—actively engaged in the greatest of all professions, serving the health needs of his community.

I thought it would be interesting to give to this group, you teachers and the administrators the reaction of a man who has had a course in one of the schools of public health and reported back to me something of his experiences. This is not intended as a reflection, but for you to reflect upon, and this is what he said to me in his report in part—

"In reviewing my experiences during a year of formal training in public health, I was impressed by the fact that only nine of the thirty-one semester-hours taken were under medically trained instructors, six in 'Principles and Methods of Epidemiology,' and three in 'Epidemiology of Syphilis.' The course in Environmental Health, 'Principles and Methods of Industrial Health,' was a lecture course by non-resident staff, some of whom were industrial physicians.

"From the standpoint of a health officer, the correlation of administrative principles to the subject matter was not always evident. The student was left to make his own deductions and applications. That defect, if it be such, is due probably to the inability of non-medical specialists to see problems through the eyes of a health officer, especially those individuals who have never been engaged in public health work. I may be unduly critical on this subject, since I am a physician and believe that public health can be carried out most effectively in close coördination with the medical profession. At the same time, I realize that all the profession has not always accepted public health as a specialty in the field of medicine. Perhaps it is well for public health administrators to receive other points of view, lest they should lose sight of their responsibility to the public through the influence of selfish professional groups. It would appear to be a fallacy for a health officer 'to jump off the deep end,' and become so socialistic as to lose the confidence and coöperation of the profession, which could do most to help promote the health of his people.

"The three conditions over which most of the doctors, in public health administration, expressed greatest dissatisfaction were:

"1. *The cosmopolitan nature of classes.* During the first semester, students of all interests and backgrounds, health educators, sanitary engineers, dentists, nurses, and veterinarians were grouped together in most of the courses. In their 'bull sessions,' the doctors generally felt they could have learned more from discussions and lectures specifically planned for them, rather than general subject matter planned for the whole group.

"The school philosophy behind such planning seems logical. It is their contention that the grouping of all health personnel into study units would promote mutual understanding and unity of purpose in a health organization, such as a health department. I am in no position to evaluate this practice, since both points seem to have merit. It occurs to me after having had that experience, that perhaps specific instruction, applicable to each group, might be presented first, and that the correlation of duties and relationships should come later when individual groups have become better oriented in their specialties.

"2. *Excessive amount of routine in assignments and examinations.* One of the common subjects for 'behind the scene' discussions, was the amount of routine assignments which prevented doctors from pursuing subjects of their own interest, or of ever feeling that they were 'up with their work.' For mature men who had received academic discipline in undergraduate and medical schools, extensive reference reading and the submission of frequent reports became burdensome in some instances.

"In some courses, frequent examinations were given, a technique suggestive of high school and college experiences. Of course, there are always some 'irks' and 'gripes,' in every institution, which are forgotten or minimized in time. My own impression now is that for professional men, interested in personal improvement, frequent examinations are less desirable than comprehensive examinations at the end of the year's work. Regardless of the intent of the procedure, the results are generally the same. There is an interruption, a diversion or neglect of some subjects when attention is given to the preparation for special examinations in others. Furthermore, such procedure is conducive to the development of a 'grade consciousness' which sometimes becomes detrimental to the real purpose of the course. These are pedagogical considerations which perhaps are as old as teaching itself, and the concept varies with individual instructors and students.

"3. *The Comprehensive Report.* The Comprehensive Report, or thesis, might be considered logically under the preceding paragraph. However, since it was one of the major experiences, I have given it a special heading.

"The value of preparing such a report varies with the purposes of the students. For some, the submission of this report was merely the fulfillment of a requirement; for others, it gave the student an opportunity to prepare a scientific paper on a subject of his interest. In both instances, most of the students felt a certain pressure to produce something at a time when their efforts were needed in the study of the more formal classroom work.

"My own impression now is that of satisfaction for having produced something definite. The amount of time and effort spent on my report seems commensurate with the needs for concentration on the more formal assignments. However, at the time of its preparation, there was some concern, lest time and effort be disproportionately allocated to the various academic requirements."

Please understand that I, as an administrator neither want nor hope to qualify as an expert to cope with trained teachers in discussing or fixing standards that may influence or determine the curricula of our great schools of public health. I have been asked to discuss personnel and training problems from an administrative view.

I am a novice as to those conditions that influence great teaching colleges in the setting up of high academic standards. I do not confess to being a novice in the field of public health administration. Thirty-one years of public health service and administration of service programs entitles me to the airing of views on the subject, regardless of academic influences. I am familiar with developments from the period of Rockefeller Foundation grants for hookworm investigation with related sanitation environment to the modern concept of scientific resources for complete health protection. Believe it or not, I am familiar almost firsthand with Smillie as a figure in county health administration; Mustard as a director of programs demonstrating county health services and standard procedures; with Vaughan as a recognized leader in administration of municipal public health programs; Freeman on county, municipal, and state levels as a great service leader in health direction. More might be added, but I mention these as teachers with a broad background of practical public health leadership. Where have we gone from these health teaching practitioners? We have seen great universities capitalize on the achievements of these administrators, gradually bringing them into teaching administrators and academic leadership. They have done yeoman work, increasing a demand for better

training of health workers, but they know, and we administrators know that there has developed, as in the case of all health education programs, a tendency to replace standards of practical procedures with more high-falutin academic, research and educational set-ups. I would bow my head in shame to disavow the great need of these, but you and I know that all discoveries and scientific application of newer procedures must have a practical avenue for test and usage. Scientific development must meet the test of scientific and practical determination of values; new procedures must not fail in service application.

We in administration are cognizant of the need for training of men and women in all the public health classifications and cannot afford to frown upon your offerings, but you have a tremendous responsibility to give training that will qualify trainees for useful, serviceable programs that will bring about actual—not theoretical or maybe doubtful statistical—results, but real honest-to-God health protection.

We administrators recognize the need for and the right of teachers of public health to emphasize good health—public health practices—preventive medicine—but when and why have they the prerogative of molding opinions or judgments regarding medical and surgical practice, or the governmental need for state or nationalistic assumption of control of such practice? Are our teaching institutions the forum for molding these opinions or judgments? Are these institutions to become the centers where medical and public health ideologies for socialistic practices in these and related services are to find sponsorship or encouragement? Don't forget that you in teaching positions and we in public services are salaried with relatively no practical responsibility for medical practice, while those in medical science who have originated and evolved scientific knowledge and practices are constantly on the firing line to see that these work productively and satisfactorily on a professional and public service basis. We are utilizing in a preventive service the scientific developments of a research and applied curative program and are going somewhat far-a-field when we assume or presume prerogatives of the profession in sponsoring radical social measures for distributing these professional and scientific services. Academically, scientifically, and ethically it is ours to encourage the individual and collective enterprise of scientific medicine without bureaucratic administrative control just as other American enterprises under the sponsorship of individual and collective efforts have made our nation the greatest. Just because we are in position to theorize and philosophize on socialistic issues and tendencies gives us in public health no justification to endorse programs of medical care that run counter to the traditions and professional practices that through the years have established and maintained the highest standards of medical education and medical practice of any nation in the world.

Dr. Scamman: Thank you, Dr. Blackerby, and I am sure that we have not only "rolled with Dr. Blackerby's extemporaneous punch" but have reflected and will continue to reflect on his more formal pronouncements.

I hope that the group leaders will present their discussions as they did yesterday in the stimulating way, and you know that you meet promptly at 2 o'clock in the groups as indicated and again here at 4 o'clock for general session.

TUESDAY, SEPTEMBER 10

Afternoon Session

Four group conferences followed by reports by the leader of each conference.

Dr. Scamman: The conference will come to order, please, for the business of the afternoon, namely, the reports of the leaders of the Group discussions.

You recall that yesterday a resolution was presented by Dr. Neupert—or report, which it was decided would be mimeographed and presented this afternoon. With Dr. Neupert's agreement the chair suggests that you have an opportunity the rest of the day and the evening to study this set of resolutions, or statement, and it will be brought up for discussion sometime tomorrow, unless there is an objection.

We may proceed to the reports by the several leaders of the groups. The leader of Group 1 is Dr. Harold M. Erickson, State Health Officer of Oregon; Consultant, Dr. Mustard. And I'll ask Dr. Erickson to make his report.

Dr. Erickson: I am very pleased to present the report of Group 1. We are indebted to Dr. Mustard as our consultant. We used the subject material of his paper this morning as the springboard for our discussion, and we have the following results.

Recommendation:

WHEREAS, the nation should have total coverage with local health services for all of its people and

WHEREAS, state health officers and state boards of health have a primary interest in the organization of such full-time health services.

THEREFORE: It is the sense of this conference that:

Every state should have or should immediately develop a plan for providing for full-time local health services for all its people and, further, that this plan should include programs for:

1. Enabling legislation

2. A definite schedule or specific criteria for dealing financially with local health jurisdictions to provide full-time health service

3. The recruitment and training of personnel, and

4. The development of a state-wide program of health education to be carried on at both state and local levels but only in accordance with the available facilities for providing the services which may be demanded as a result of such program.

Respectfully submitted:

Dr. Scamman: Thank you, Dr. Erickson. You have heard Dr. Erickson read the summary of his group discussion. Will the conference vote on this summary now and accept it? May I have a motion?

Dr. Getting: In view of the manner in which we dealt with the resolution of yesterday afternoon, would it not be appropriate that this resolution be mimeographed, distributed tomorrow, and perhaps acted upon on Thursday?

Dr. Godfrey: I second the motion.

Dr. Scamman: Will you indicate by a yes or no vote what your pleasure is about this resolution? All in favor please signify by saying aye.

Audience: "Aye."

Dr. Scamman: The vote is unanimous. Dr. Halverson has a statement he wants to make to the conference having to do directly with this same general discussion, and he is ready to make it now.

Dr. Halverson: Mr. Chairman and Members of the Conference—This is the resolution that was presented to the conference yesterday, which I was asked to bring back, and which I sug-

gested to the chairman be brought in at the present time because of its direct relationship to the report that Dr. Erickson has made. I'll read it.

"In view of the acute shortage of trained personnel in all public health categories, which shortage seems likely to continue for some years to come, it is the sense of this conference that special consideration be given by state health departments to the recruitment and training of public health personnel. In some departments it may be wise to establish a separate section or division for this purpose. And in any case there should be close coordination between the state health departments, preventive medicine departments of medical colleges, and schools of public health. Some of the essentials to an effective recruitment program are:

1. Adequate orientation of recruits
2. Salaries commensurate with the individual's qualifications, experience, and responsibilities
3. Reasonable tenure of office
4. Opportunity for advancement
5. Acceptable retirement plan."

I submit this for consideration.

Dr. Scamman: Motion is made and seconded that the report be adopted. Those in favor please signify by saying aye?

Audience: "Aye."

Dr. Scamman: Vote is unanimous.

The next report is from the leader of Group 2, from Dr. George T. Palmer. The consultant is Dr. Getting. Dr. Palmer—

Dr. Palmer: We had a very successful group meeting. Some fighting "punches" were delivered and the meeting had an international flavor—we had representatives from Czechoslovakia and Norway. Can any other group say that?

This meeting discussed the paper presented by Dr. Getting this morning on the "Indispensable Functions from the Viewpoint of the State Health Commissioner." I haven't been able, in the few minutes since the close of the meeting, to condense this into a report to recommend to you for adoption, but I should say in general the group was quite sympathetic with the functions of a local health department as outlined in the report *Local Health Units for the Nation.*

The first point made by Dr. Getting was that the primary function of the local health service is as a service unit. Ideally he thinks that that is where the service ought to be rendered, in the local unit rather than elsewhere. Although it was agreed in the group that if not done by the local health service it was the duty of the state to step in to provide service and protect other areas of the state. There was little feeling against any mandatory law, however, for the establishment of local health services. There was also a feeling that in the passage of any such law the establishment feature should be separated from any financing features. There was good agreement on that.

Another point made by Dr. Getting, which was thoroughly discussed, was that one of the indispensable functions was the supervision of the water supply and sewage disposal. There was a little discussion over that as to the relative functions of the state health department and the local health department, but the general opinion was expressed that the local health department could not avoid direct supervision of the condition of the water supply and the operation of the sewage disposal plant. There was a feeling that a sanitary engineer was definitely needed, in the larger units at least, but there might be a difference of opinion on the smaller units. In other words, there was an approval of this principle, subject to the natural variations that would occur

—the varying needs in different parts of the country. It was agreed that the local health unit should regulate milk and food sanitation. An opinion was introduced that milk ought to be under the control of the state health department. It was agreed that the supervision of the quality of the milk ought to be under health departments, whether state or local, rather than under departments of agriculture or any other special commission or board.

We got into quite a little discussion as to the method of milk supervision, the difference being over whether a local health department should engage in farm inspections or confine its work to sampling analysis and visiting such farms as were indicated by the bacterial analysis.

It was agreed that an indispensable function of a local health department was to provide free biologicals and make available to all who cared to use them, clinic facilities for the prevention of whooping cough, diphtheria, and smallpox, this to be done prior to the first year of age in babies, with provision for supplementary immunization at school entrance.

There were one or two members of the Group who felt that typhoid fever should be included, but the prevailing opinion was against that.

Then, there was a little bomb shell turned into the meeting by Dr. Getting's paper this morning in which he said that one of the indispensable functions was to provide free dental clinics, available to all children regardless of family income. In other words, that there should be no economic barrier. There was some question whether there were enough dentists in the country to carry this out, but I think Dr. Getting answered that by saying nevertheless he would go at it that way.

Another bomb shell came in from Dr. Getting in which he said that an indispensable function of the local health department was to make plans for the treatment, control, and, if possible, prevention of the older age diseases. That was modified by Dr. Getting's permission in this manner, that at least among the indispensable functions of the local health department should be included their attention to this question and their responsibility to engage in the production of services needed in the days ahead. Dr. Getting also included this item as a function of the local health department, to design special "procedures"—that was the word he used—to design special procedures to treat, follow up, and, if possible, curtail mental illness. And, again, I think the sentiment of the group was that the local health department could not ignore this question, but I think they were not willing to go the full extent with Dr. Getting that the health department should enter actively into diagnosis and treatment.

Dr. Scamman: Thank you, Dr. Palmer. You have heard Dr. Palmer's statement, what will you do with it? I shall be glad to entertain a motion to accept it.

It was moved, seconded, and voted that Dr. Palmer's statement be received as information.

We now have the report from Group 3, led by Dr. John Shackelford in place of Dr. Mathews, who couldn't be here. The consultant for that group is Dr. Smillie. Dr. Shackelford.

The first topic for discussion, I believe, was, "Shall a state department of health operate a training program?" This was favorably considered.

A great deal of time was given to the discussion of the clerk training program as it is operated in several states as in Mississippi, Oklahoma and Tennessee.

We went from that to the discussion of the advisory service and a part of

the in-service training program. I believe several states, aided by one of the philanthropic organizations, have established what they have called a field training unit composed of at least the basic personnel in the way of experienced and medical trained officers, one or more nurses, and sanitarians or sanitary engineers and clerks.

Summing this up, a resolution was passed that it is the sense of the group, discussing training of personnel for local health units, that it is a responsibility of state health departments to establish facilities for continuing in-service training, and for the training of newly employed personnel prior to assignment, and in anticipation of intramural study for those, who, after field experience, may be found fit to be trained for public health service.

The next question for discussion, "How may the curricula of public health schools be modified so as further to meet the needs of the several states?" New responsibilities are being assigned to health departments, among them the responsibility for developing the hospital program throughout the states and in some states for care of the indigent sick.

In summary: "Resolved that inasmuch as a well grounded health officer should be familiar not only with the usual things in public health but also present trends in the field of medical care, the suggestion be made to schools of public health that consideration be given to the possibility of so broadening their courses for medical health officers as to include instruction in this field, the goal to be a more effective coördination of the fields of medicine and public health."

The third topic of discussion was the matter of a specialty board in public health. It was the opinion of the group that consideration should be given to the advisability of setting up a specialty board in public health.

Dr. Scamman: You heard Dr. Shackelford's report and the chair suggests in view of the fact that there are at least two, and possibly three, resolutions here, which it seems to the chair should be brought to the attention of the conference to be voted on later, that these resolutions be mimeographed and distributed tomorrow for action tomorrow. If there is no objection from the conference the chair will handle it in that way. I hear no objection.

Group 4 the leader was Dr. Atwater in place of Dr. Gaylord Anderson, who is unable to be here, and the consultant is Dr. Blackerby. Dr. Atwater.

Dr. Atwater: Mr. Chairman, you will recognize what a wide area of coverage we had in trying to summarize Dr. Blackerby's interesting contribution this morning. We felt indebted to him for what he said, for the way he needled us, for the way he brought down our complacency, and for many other things. But it is quite beyond the realm of possibility to summarize that in a few neat resolutions. There will be nothing out of this report, Mr. Chairman, that can be voted upon.

We tried to learn from Dr. Blackerby just how he succeeded so eminently in "rolling with the punch." We think that that was one of his great achievements.

First, there was general agreement in this group that there ought to be some provision for systematic, academic training of sanitarians, sanitary inspectors. The group felt, though there was some difference of opinion, that this remained a challenge to the schools of public health, and that the matter had not yet been solved in a satisfactory manner. It was pointed out that in the western states, especially Washington, Oregon, and California, a situation relating to sanitarians existed quite different from that in many other areas of the country.

In the west coast states a good many of the sanitarians who held bachelor degrees wanted to go on to get some academic recognition. The schools of public health at the present time are not granting, so far as we know, any degrees to these sanitarians unless they go through to qualify for the master's degree in public health, and very few are doing that.

It was pointed out that young persons could not reasonably be encouraged to start a career which had such definite limitations as the present ceilings on sanitary inspectors. It was conceded that the future must find some means of recognizing these persons. Dr. Vaughan suggested that conceivably a bachelor's degree in environmental sanitation should be the solution.

In any case, the group felt that a large area of our personnel was uncovered, without any systematic method of recognizing their academic achievement. The suggestion was made that while we are talking of courses, the schools of public health consider courses in personnel management and in business administration as being entirely appropriate and necessary.

Second, the group expressed some doubt about the ratio of engineers proposed in the report on Local Health Units for the Nation. It was brought out that the comments on engineers and their staffs and sanitarians in that report had brought more difference of opinion than any other part of the report, both from the engineers and from the subprofessional sanitanians. The ratio as proposed in the report, you will recall, is that the minimum unit of 50,000 persons, in addition to the medical officer of health, the nurses, etc., should have one engineer of professional grade and one sanitary inspector, making, in other words, a minimum staff of two persons in environmental sanitation in the smallest unit. The opinion was rather general among our group today that they would not advise so many engineers, that in large areas of the rural portions of the United States engineers could well be used in the larger units, but in the smaller units the job could be better done by engineers under state supervision under a district system.

So, in brief, this group would throw some doubt on the necessity of increasing the present number of engineers employed in local health service, which in 1942, according to the report, was 343. They would express some doubt about increasing that number to 1,300 as is recommended in the report, believing that fewer engineers distributed on a state advisory basis could achieve the same purpose.

Third, we raised the interesting contrast between what Dr. Van Volkenburgh said yesterday with reference to New York State about multiple health units. Dr. Van Volkenburgh said that they in New York State were skeptical about the ability to operate units comprising more than one county because of local jealousies and the centrifugal forces that would drive them apart. Today Dr. Blackerby had described Kentucky's experience in having approximately half of its units made up of more than one county. And it was interesting to find that Dr. Blackerby had no history of difficulty in making those multiple county units work. Other state health officers from the south, and directors of local health administration confirmed this experience in Georgia, in Mississippi, and in, I think, one other state. The skepticism of Dr. Van Volkenburgh may be reasonable and fully justified, but at least those states which I have mentioned had accomplished multi-county units without difficulty.

Finally, we took up this matter of the specialty board, which Dr. Shackelford has mentioned. We focused our attention on the advisability of a specialty board in public health administration assuming that the specialty boards for

pediatrics, for dermatology, and syphilology, for internal medicine, recognizing tuberculosis, etc., and the other specialty boards would continue. We discussed the pro's and con's; for example, it was recognized that there is a ferment abroad demanding attention to this subject. It was recognized that the veterans' administration is paying persons—physicians with specialty board ratings 25 per cent more salary than to physicians in the same positions without those ratings. It was recognized that the Army and the Navy had been giving higher wages to men with specialty board ratings than to those without. It was recognized that specialty board ratings on the part of public health administrators might make it much easier for them to deal with their professional colleagues, giving them recognition as medical specialists through medical societies and in other ways, and the sentiment representing the favorable sentiment was confirmed by those present. Some of the drawbacks were brought out in that there seems to be in some areas quite a satisfactory substitute for this. For example, United States Public Health Service physicians would not need specialty board recognition. The physicians who are qualified in such states as New York which have public health council grades would scarcely need certification. Such certification for the other specialties represents a monetary consideration of no small amount, perhaps $250 beside the time and trouble involved. And there were some other doubts which have been expressed. We took a straw vote, for what it was worth, of the 20 persons who were there, and it was interesting that no contrary opinions were expressed by this group. All seemed to be favorable in principle to the idea, and it was pointed out that the matter has moved forward now to the stage where the Committee on Professional Education of the American Public Health Association has conferred with officers of the section on preventive medicine, public health, and industrial medicine of the American Medical Association, the latter section at its July meeting having voted to explore the subject and having appointed a chairman who is Dr. Ernest Stebbins also a member of the A.P.H.A. Professional Education Committee.

The matter is going forward at the moment with extraordinarily little contrary opinion. It is reported to you for what it is worth. All of us felt grateful to Dr. Blackerby for the breadth of his discussion and apologetic that our coverage was so limited.

Dr. Scamman: Thank you, Dr. Atwater, for a most comprehensive summary for the discussions in your group, which the chair, unless there is an objection, will accept with thanks. Is there any further discussion of any of these four group discussions by the conference?

Dr. Palmer: May I ask a question?

Dr. Scamman: Yes, Dr. Palmer.

Dr. Palmer: Was there any discussion in your group, Dr. Atwater, as to the need of a separate grouping called sanitarians, in between the engineer and the untrained or uneducated sanitary inspector? That has been put forward frequently and I wonder whether there was any recognition of that?

Dr. Atwater: There was no recognition of that as such. But the copy of the report of the A.P.H.A. in this field of environmental sanitation, which Dr. Smillie is distributing, makes such a distinction. I may say, however, that the report which was adopted about 1936 or '37 is presently being revised and in the opinion of the Committee on Professional Education ought not to be urged as the considered judgment of the Association at the present time. I

do not know of any current inclination to set up an intermediate grade between the untrained sanitarian and the trained public health engineer.

Dr. Scamman: Is there any further discussion?

Dr. Emerson: Three kinds of action have been taken at this session. One a vote of approval with postponement for consideration, one a vote of acceptance for information, and one a declaration of the chair that he would take it in hand. I don't know just what is the proper way of procedure in an informal academic conference of this kind. But one objective of our having papers presented and then having discussions afterwards is to see that there is a documentary record of this unique experiment in self-education. We know we are going to find means of publishing in some form the collected papers and it would be of value to people reading this over who have attended the conference, or others into whose hands it may come, to have the considered opinion of these discussion groups, and I should hope that each of the reports of the subcommittees could be so acted upon here that they will form part of the corpus of the publication. It is easy to distinguish between those which have unanimous approval and those on which there is some difference of opinion, but it seems to me even those where there is an uncertainty of judgment at the moment, we ought to have available and at least authorized for publication together with the papers that gave them origin.

Dr. Smillie: I would like to point out, Dr. Scamman, although no resolution was made by Dr. Atwater's committee, nevertheless two definite recommendations were made, it seems to me, that could be put in the form of a resolution, namely, that facilities be developed for the benefit of sanitary inspectors, and second, that it be recommended that incorporated in schools of public health curricula might be courses in personnel management and business administration, I believe.

Dr. Emerson: Similarly in Dr. Palmer's report from the conference on Dr. Getting's material. We were asked to consider indispensable functions for local health departments, and it appeared in the discussion that what Dr. Getting was proposing to use was the idea of $2.50 or up instead of the basement or cellar of $1 as a minimum for indispensable services. It would be, I think, very valuable to have the consideration of this ample scope with future possibilities which Dr. Getting proposed indicated in some way as not being a minimal basic service which would justify the creation of a local health department, but a comprehensive scope which would give a vision of the future to which we hope all the local health units may attain later. These matters, I think, we should in some way clarify.

Dr. Scamman: May the chair try this out? May I ask the group leaders and the consultants to determine if it is the pleasure of the conference to decide what in their opinions should come into any final report beyond those things that are coming before the conference for approval later? This is a suggestion. May I ask for your approval or disapproval?

Dr. Godfrey: This is a great deal of attention to Dr. Palmer's report, it seemed to me more or less of a narrative and I was somewhat confused as to whether the group approved of these things or Dr. Getting did. I would like to have the matter clarified and if there are resolutions in there, if we are going to give consideration to the basic materials for a county health program, why

then, they ought to be stated there so that we can vote on them.

Dr. Scamman: Dr. Mustard?

Dr. Mustard: I think the mere fact that these gentlemen haven't written these things out in precise form as did the committee of Dr. Erickson means that you can't safely leave this thing to their good nature. I think you ought to order them each one to prepare a written report. If they want to talk in a narrative form and say what the discussion was, all right, but also commission them or insist that if there is any community of agreement on which they wish to submit a resolution or recommendation that that be set forth clearly so that when we get through here we shall have done justice to Dr. Erickson's report and for the one that we had in group 1 yesterday a written document. If they want a lot of verbiage, all right, but if they have any recommendations put them in. I move that written reports be submitted from each of the four group conferences and that they be mimeographed and distributed for subsequent action and printing. This motion was seconded and passed.

Wednesday, September 11

General Session

Presiding: WILLIAM DEKLEINE, M.D., Commissioner, Michigan Department of Health.

Dr. DeKleine: The conference will please come to order.

This morning the first speaker is Dr. Robert S. Ford. Dr. Ford is Director of the Bureau of Government, University of Michigan. That is the research agency concerned primarily with the study of problems relating to government and taxation. I think he is partly responsible for the high taxes that we are paying. I am not sure, I'll let him describe that. He is also Associate Professor of Economics in charge of public finance and taxation. I have known Mr. Ford for several years—he is a very able professor. He was in the Governor's office in Michigan for about three years on leave of absence from the University to help the Governor streamline state administration. He is now back at the University. We are very glad to have Dr. Ford with us and he will talk this morning on the subject of "Principles of Local Government Organization and Finance." Dr. Ford.

Principles of Local Government Organization and Finance

ROBERT S. FORD, PH.D.

Director, Bureau of Government, University of Michigan

I am glad of this opportunity to be with you today. It is a new experience for me to be talking to a group of this character.

I have been in Philadelphia the last two days attending a meeting of a group of college people discussing problems of public administration. I think that you would have been interested in some of those discussions. We talked some about public health programs—that is, only as an incident because most of us didn't know anything about them. But, we were talking about the nature of training in public administration that is carried on at the University of Pennsylvania and Syracuse, Wisconsin, Michigan, California, and a number of other places. And, of course, one of the things that they are concerned with there is the in-service training programs and the contacts with professional schools. I am not going to try to summarize that conference for you, but just to point out that there certainly is a desire on the part of the public administration people to coöperate in any way with the professional schools, and particularly the schools of public health in doing anything they can to contribute to the development of courses that might be useful to persons getting their technical training in public health.

On this subject of "Principles of Local Government Organization and Finance." I puzzled quite a little as to just how to go about taking up that subject with you. So far as the prin-

ciples of organization go the traditional approach there is to get into such things as the administrative organization of city or of local government, the types of departments that exist, the grouping within those departments, the placing of similar activities within a single department, the establishing of definite lines of responsibility between department heads, and so forth. Or, it could lead into a discussion of the city manager plan or the commission form of government. But, it seemed to me that it might be of more interest to you to use a different approach here, looking at it from the functional standpoint and, of course, being public health people that is the approach that will interest you. I thought I would talk a little about the problem of state-local relationship because that has probably affected the structure and the finance of local government more than anything else in recent years. I think we are all interested in a strong local government. That is one of the chief assets of a democratic system, to have strong local government which is effective in fulfilling the needs of citizens and providing an opportunity for citizens to participate in government, and particularly in that government which affects them in their daily life, the things that are closest to them.

We have in this country a strong tradition of local government and yet that is being whittled away in many respects. Sometimes it is gradual and other times much more rapid and evident, but at any rate this process, this whittling process has been greatly accelerated in recent years. Yet, the emphasis on local government is seen from the fact that we have 165,049 units of government in the United States. The 49 on the end is the federal government and the 48 states. In other words, there are 165,000 units of local government. That is a lot of local government. Maybe we have too much. You can carry things too far, and you can have so much organization that they get in each other's way. Of course, the large bulk of local units are school districts, 119,000 school districts, counties a little over 3,000, cities and villages 16,000, town and townships 19,000, special districts 8,000. A lot of those special districts are public health districts, that is, sanitary districts of one sort or another, whether for mosquito abatement or what not, drainage, or something else. Yet those local units are creatures of the state and they are subject to control by the state. The authority and powers that they have stem from the state. So, the state could tell them what to do, what not to do. If we go back through some of the earlier legislation we find the duties spelled out right down to the most minute details in individual charters for individual cities. The cities were very dependent upon the legislatures. A way to get around that was by the development of the home rule idea, and that usually came in the form of an amendment to the constitution, which would give local units constitutional authority for the things they might do, and a general grant of authority rather than making them dependent to the extent of having to get individual approval for many different things that they wished to do. And, so, home rule made it possible for them to have whatever form of government they wanted, to choose their own form, whether the commission form, or the manager plan, or whatever they might want, and also to have their own legislative body. The city council is a legislative body, and so it is possible for the cities then, or the local units in the counties—in the counties, of course, it is the county board of supervisors—to have their own legislative body.

Of course there are restrictions on what local units can do. Just by way of illustration, there was discussion here a few years ago of the imposition of

local excise taxes, but under the interpretation of the home rule principle, the constitutional lawyers are uncertain about that, but on the whole they do not believe that cities have the authority to levy excise taxes. That is why Detroit could not go out and levy a city sales tax.

The reason I mention home rule is not to get off on that detail so much as to raise the question—taking this functional approach—can we say what should be the powers and duties of state government or of local government? Can we set up those functions which are strictly local and should be performed by local units? That was the meaning of the home rule doctrine when it was put forth and adopted on such a wide scale, to prescribe what the local units could do. It really means a complete separation of power with definite things set aside for the local units and certain ones for the state.

I don't need to elaborate on that point. A lot of things which formerly were strictly local are now of state-wide or even national concern, and while home rule still has its place nevertheless so far as this separation of functions is concerned it is pretty much of an anachronism, or is becoming more so.

I want to make one other point in connection with the home rule idea. You may hear in your own state some discussion in favor of county government. We have had a lot of it in Michigan in recent years since about 1934, an effort to get county home rule, or to make it possible to reorganize county government. As it is now, they can't reorganize county government very much because that is another one of those forms of government that is prescribed in state constitutions. And you have these officers, prosecuting attorney, sheriff, the clerk, the registrar of deeds, the county treasurer and board of supervisors—all mentioned in the constitution—and there has to be constitutional amendment. What they would like to do is get a county manager comparable to city managers, and it is curious though how hard it is to change the governmental structure. I mentioned the fact that there are 3,070 counties in the 48 states, and only 11 counties of the 3,070 have been able to get a county manager.

There are some states where they have pussy-footed and developed a kind of a compromise that would make it possible to change the form of their county government a little, but they have not gone over to the real manager form of government. That is something of immediate interest here in Michigan, and I imagine you have heard something about it in other states too, because where you have county health units certainly they would be affected by the structure of your county government. But, it seems to me that any sharp division of power between the state and local government is not likely to endure in a changing society. Actually to try to set up sharp divisions and say, "Now, the local units only shall be responsible for this particular function," obviously is not likely to work. Many illustrations could be offered of this tendency of things which were formerly of only local concern to take on a state-wide interest, certainly in the fields of public health and education, traffic, legislation, public safety. Out of these changing state-local relationships we are getting a better administrative balance between local and state governments. That is particularly pronounced in those areas where we find persons of competence and integrity who are in charge of the administration of those functions, that is where people of that character are holding high positions in government. I think that movement is being facilitated also by the rise of the official organizations in the field of public health and education, welfare, public works, planning, because their activities in so

far as they bring together state and local officials are tending to break down some of that old hostility that was present and which was a real factor in the development of governmental relationships.

I would like to review briefly, taking these up function by function, pointing to some of the developments where we have this trend towards administrative centralization. It is, of course both towards state capitals and towards Washington, but I would like to hold it pretty much to the state capital because that latter one is such a big story in itself.

If we look at the matter of finance, for example, sources of local revenue have usually been established by the states since the beginning. I have mentioned already that we find in the constitution reference to the county clerk, county treasurer, and also to assessors, and other financial officers in state laws. It has been left pretty much to the local units to work out their own financial salvation, and so we had the general property tax which formerly was used by the state along with local units. About 20 of the states don't levy any property tax at all, it has become primarily a local tax. There is some state supervision of this local property tax through the state tax commission and state boards of equalization. Even when it was both the state and local tax you had a state board of equalization designed to correct errors in original assessments, and so if a person felt aggrieved and thought his assessment was not proper he could appeal first to his local board of review and carry it on up to the state tax commission eventually. Likewise in the case of a township or a city or a school district, if residents of an area felt that they were paying more of the property tax than the residents of another town within the county, that was all supposed to be corrected by the county board of equalization. If one county was paying more than another that was supposed to be corrected by the state equalization board. So, through this process of state equalization something was corrected that couldn't be handled locally. We find that financial supervision by the state has developed to a considerable extent.

Likewise in the case of public utilities. The public utilities were formerly assessed, and still are for that matter, in a good many states by local assessors and yet most of them are state wide in character. You had the ridiculous situation in Texas, for example, of an assessor placing assessment on that part of a trans-continental railroad which runs through the school district. The parts don't add up that way; the assessor wouldn't know the value of the little segment of tract and portion of operating property that passes through the school district.

Michigan and Wisconsin have long been leaders in the development of state assessment of utility property, and for a good many years have had it. Other states have come along and adopted the practice. But, getting away from this assessment of the parts of a system, the unit rule has been applied to determine what the value of the whole property is. For a local assessor to place a value on a fraction of the utility property is like trying to place a value on the left hind leg of a mule apart from the rest of the animal. So, the use of this unit rule of assessment was something which could come only through the exercise of power by a higher unit of government. During the depression with so many municipalities becoming bankrupt, or at least very heavily in debt, it was recognized that the state should exercise greater financial supervision. The authority to incur a debt and to issue bonds should be referred to a state agency, where there would be persons better qualified to examine the

financial resources of the community with a view to seeing whether or not they had any debt carrying ability, whether they ought to be allowed to incur debt. Of course, that is a protection to the public.

As regards the limits which are sometimes set on expenditures, or to debt limits as well as tax limits, this has been left pretty much to local units to specify in their charter. Here in Michigan we have this limitation on the property tax rate. Ours is based on the Ohio plan, which prohibits the imposition of a tax in excess of one and a half per cent of the value of the property. That is of interest to public health people in so far as you are concerned with the contribution to be made by local units to the financing of public health activities, because certainly their capacity to participate will be affected by the tax rate limit, and especially in those cities that have voted to come under the tax rate limitation. Most of the states have some kind of a tax rate limit, but some 15 or 20 states have a rather rigid type of limit which makes it difficult to provide the funds necessary to carry on local government. Of course, that incidentally has a bearing on this from another angle, the real estate people who are primarily responsible for getting this 15 mill limit adopted promised the people they would get more state aid if they would adopt this 15 mill limit. This has forced readjustments, and we find a great increase in the amount of money coming back for education, particularly for the local schools.

I would like to turn to another important function, highways. Highway construction in the early days was undertaken primarily by local government, county, or town, or even a turnpike corporation in the early days, which would build the road and charge a toll to use it. There wasn't much traffic, of course, beyond county boundaries, and a good many people paid out their road taxes in labor, and so that sort of thing was feasible. But, when we had the development of the automobile, the hard surfaced road, the change occurred in the responsibility for highway design, finance, construction, maintenance. This interest in state highway systems was stimulated greatly when the federal government adopted a national highway policy, the national system of grants-in-aid. Most of the hard road surfacing that has come within this country has been done not under local, but under state and federal supervision.

To mention another function, we find that the police force is still pretty much a matter of local activity—although there is some influence towards state control. We see a number of states, with their state police or highway patrol and they have their teletype and radio systems within metropolitan areas. You have bureaus of criminal identification, but this is still pretty much a local function. That is probably due to the emphasis placed on local recruitment and to promotion within the ranks.

Likewise in the case of education. We have had the development of state influence there, but the actual control of it is still largely in the hands of the representatives of local government, and a large part of the proceeds of the property tax are used for financing education. So, that has been kept pretty much at that level. Incidentally, there has been quite a little controversy going along in that field as to what extent the state should share in financing, whether or not we shouldn't go on over towards state responsibility. Here a few years ago during the lifetime of Senator Moore a resolution was introduced in the legislature that it would be the sense of the legislature that the state ought to pay 75 per cent of the cost of public schools and local units 25 per cent. That was defeated, of course. In a state like North Carolina you have a high degree of centraliza-

tion that has developed with the state practically taking over, but there seems to be a very definite feeling that education should be, to a considerable extent, a local responsibility, and perhaps for the state not to finance more than about 50 per cent of the cost. People do favor a fifty-fifty split there, they don't want the local units to get too much money from the state for that purpose, they feel they will continue to take a greater interest in the function of public education if they have to pay a good share of the costs. Now, that is interesting—the emphasis that is placed there of not getting too much of outside money or grants, the feeling that money is wasted, that when you have too much outside money coming in people lose the sense of responsibility and interest in that function, and maybe there is a lot to it. They say here in Michigan, for example, that we would never go over to a centralization such as they have in North Carolina in public education. I don't know what the situation may be in your respective state, but we have a strong tradition here in Michigan on local home rule, on local responsibility, and the same idea has influenced our thinking in regard to public education. Yet there are a number of points where state influence is apparent. One is in the establishing of teaching standards by certification. Another is in the determination of standards for secondary schools through the accrediting process. These standards usually relate to such things as general organization and a library building, maybe something on general curriculum. Although the state may require certain subjects to be taught the control is still pretty much in the hands of local boards of education.

Let's take a quick look at another function, relief. Prior to the depression that was primarily a local function. In most states it was still carried out under the old poor law based on the Elizabethan poor law. Then the depression struck with such severity that something had to be done almost over night to meet the problems. It was too big for local government, it was really too big for the state, and so a national policy had to be developed. With the adoption of the National Social Security Act in 1935 certain important requirements now have to be met by all states in order to qualify for federal grants to assist the aged, blind, and dependent children and other forms of public assistance.

For example, the whole state plan must be approved by the Social Security Board, must be applicable to all political subdivisions of the state, and the state must participate in the financing. A single state agency must administer the plan. That suggests the highway development. About 1917 when that national grants-in-aid policy was adopted the federal law required that an appropriate state agency be created to handle this money. So state highway departments developed in this connection. Likewise, following this requirement in the Social Security Law we had the development of State Departments of Social Welfare. The state plan must be at least as liberal as the federal plan as regards certain standards relating to age, residence, or citizenship.

It is important in the case of something as highly personalized as relief, that local interest and concern should be present. A local organization responsive to local sentiment will facilitate minimizing waste and also the elimination of relief recipients who are not entitled to public assistance. But, on the other hand that feature may be more than overbalanced by the presence of local politics in relief administration, which has been one of the hardest things to rout out. Even though city and county responsibility must be present it is also likely that a certain degree of state and national influence will prevail.

Far be it from me to review the public

health situation for you, but just to put it on a comparable basis with some of these other functions. We find the influence of the state and federal governments steadily expanding there, and that includes the state action in the collection of vital statistics, supervision of water works and sewage systems, the inspection of local hospitals, the elimination and control of tuberculosis, and establishing and extension of local health units. Of course state units for child and maternal health were greatly assisted by the Sheppard-Towner Act, and extended and approved by the federal assistance that came under the Social Security Act. With the adoption of the Social Security Act in 1935 the federal government assumed definite leadership in the development of a national health program.

I don't want to appear to have strayed from the subject too much in having given this review of the evolution of some of those functions from local over to state and federal with about a couple of them, the police and education, still continuing to have a very strong local emphasis. But I did that on the premise that we can't consider local government to the exclusion of state government and even federal government now. One of the most significant recent developments in government is this interlocking of federal, state, and local relationships, physical and administrative. The influence of the federal and state on local government is probably greater than might appear from the standpoint of the money involved.

Before going over to the matter of the physical aspects though I would like to point out here briefly some of the techniques of centralization. First there is advice and information. The higher unit of government may do no more than to maintain research and informational service which is available to other administrative agencies. The second type is the coöperative administration. Coöperative relations may be established between separate agencies at different levels of government with each on a basis of equality. A fairly good illustration of this is the coöperation between state and national game wardens. There are probably illustrations of coöperative administration in the public health field.

A third type is in the periodic reports. Local authorities may be required to do no more than to report periodically, with the form of the report prescribed so as to get uniformity.

Another is inspection or advice. That represents a transitional stage from local to state where the central officials may be authorized to inspect and advise without being able to compel compliance with their recommendations. That probably sounds pretty familiar to you, and I suppose the outstanding cases are schools and sanitary installations.

Another type is central review. Most administrative acts by local officials are final, but they may be subject to review. That is primarily in the financial field, where I mentioned a while ago the assessment of a local official might be subject to final review and collection by the state tax commission.

Another technique that is developed here are grants-in-aid. We usually distinguish between two types, conditional grants and unconditional grants. It is the conditional grant that carries on with the implications of federal supervision or of state supervision. Many of the grants are of the unconditional variety and the unit receiving the funds does not have to do anything in particular in order to get the money. That is the case of the grants for public schools. Public schools get the money. The grants are not contingent upon anything. The state maintains certain teaching standards. To give you an illustration, if it were a conditional grant you might find, for example, that the state

would require some reduction in the number of school districts in order to get state aid. We talk a lot about reducing the number of school districts, and most of us have a lot of them. We have 6,200 of them here in Michigan. That raises the question as to how far the state wants to or should go in attempting to determine the form of local government, because it gives it some money. And it is very evident why they haven't done anything about it so far because a thing like that would have to be passed through the legislature. Presumably the legislature represents the public and they are not ready for it. They don't want the state government dictating the form of local government to that extent.

Another type is in the setting of standards. Higher standards, are being required in many fields, and undoubtedly the effect of the state and local government has been to raise standards of local administration, recognizing, of course, that there are always certain progressive communities in which standards are well above the minimum prescribed. These standards may refer to administrative methods, to the amount and character of the expenditure, the qualifications for appointment, etc. There is another technique of centralization, the requirement of prior permission. Very often the local unit—and this is particularly true when a grant for a hospital or some kind of a public building is involved—may have to submit the building plans for approval prior to the grant of funds.

Finally there is partial or total assumption of the activity by the state. The state keeps doing a little more, using a little stricter technique, a little stricter control, and might of course finally reach the point, when the state just takes over the function entirely. But that doesn't necessarily follow, as in the case of the early railroad commissions or public utilities commission. Simply because the state or federal governments grant funds and set up certain standards of performance, it doesn't necessarily follow that eventually they are going to take over the function.

Local government though is pretty suspicious along those lines. They feel that they generally wind up holding the bag, so to speak, with the state eventually taking over. They often point to the case of the state wanting to make a local tax a shared tax, and they wind up with the thing being administered 100 per cent by the state. First they get quite a bit of revenue when the state takes it over and then they gradually get shaved down as the state gets a bigger part of it. So, they are pretty suspicious on that point. Certainly the federal and state governments are assuming responsibility for the kind and quality of administration through supervision and review, through the setting of standards, and through conditional grants.

Just how important are the grants-in-aid that come to local units. Some figures from a Census Bureau Report show the relative importance of grants and of taxes to the various units of government. In the case of school districts, for example, the property tax accounts for 60 per cent of the revenue, grants-in-aid for 33 per cent. That doesn't add up to 100, but there are some other miscellaneous sources. That is a pretty high proportion still coming from local sources, but at the same time 33 per cent is pretty high from grants-in-aid. This is for all states, an average for the United States.

Cities get 65 per cent of their revenue from the property tax, 10 per cent from other taxes, making a total of 75 per cent of their revenue from local taxes and 15 per cent from state aid. The cities have been pretty much on the losing end in this state aid arrangement. We have a rural legislature, and of course they are going to see that a good part of that money is returned

to rural communities. On the other hand, in a lot of this assistance going back to rural communities we find very great need and relatively low tax paying ability as compared with the city. The poor areas are there, and that is the very reason why we find the so-called equalization principle playing such an important rôle in state grants for education—this effort to equalize educational opportunity throughout the state.

That is the national situation through a microscope because you carry over to the problem of grants-in-aid from the national standpoint, there we have many of our southern states with less tax paying ability. There is, as you know, quite a controversy raging on the application of the equalization principle, for example, in the case of relief or even public schools. We hear it in Michigan, you probably hear it in a lot of your states. If we adopt a national system of education, then you are going to have Michigan residents contributing to the people in Tennessee. Well, that is the implication of your equalization principle. Maybe I should use other states, but I probably would be safer to refer to the situation here and say that it is the city of Detroit versus the rest of the State of Michigan.

Incidentally, in Detroit they got so heated up over this question of state aid and felt they were being gypped and not getting back as much as they put in—which they weren't—that there was a movement to secede from the State of Michigan and create a separate state of Industry, and that was a serious movement. They didn't get very far, but in the case of the counties state aid is likewise a large factor, 33 per cent and 55 per cent from the property tax.

As long as I was taking those figures down on revenues I though you might possibly be interested in the United States Census Bureau's classification of public expenditures and how much is spent for sanitation and public health. The cities make 7 per cent of their expenditure for sanitation. For all the cities of the United States, 7 per cent of public expenditures are for health and hospitals. The Census Bureau refers to that as public health, that makes 14 per cent if you want to add those together. They spend 24 per cent for public safety, which includes police and fire, 10 per cent for highways.

I think the financial question here relates primarily to this question, to what extent should the local unit participate in financing the functions of local government? What percentage will they pay? Will it be fifty-fifty? Will it be a third? Will it be about two-thirds? Should we approach it purely from a functional standpoint? That is about the only way we can.

Here in Michigan a few years ago, under the authority of the governor, a commission to study public education was appointed. They were very much concerned over the discussion of federal participation in public education and likewise of state aid for that matter and about what the percentage should be. I was interested in their final recommendation on that point. It was their conclusion that the local community should provide from 60 to 70 per cent of the total cost of financing the schools, with the state contributing 30 to 40 per cent. Some of the educational people have gone a step further to give us a clue as to how they figure federal grants should fit into this, and have set it up on the 20, 30, and 50 basis—federal 20, state 30, and local 50.

As to highways we don't have very much information. I was going the other day over probably the most authoritative study that has come out in the last few years, and they didn't give a figure for local, but they had set up the expenditures covering 20 years, from 1921 to 1940. Of the $41,000,000,000 spent for highways in that period, 16 per

cent was federal and 84 per cent state and local. Of course there is not much local, because the states have the gas taxes, the proceeds of which are used almost entirely for financing road construction. This use of so-called user taxes—highway user taxes to finance the highway makes it pretty much a state concern, but it is 16 per cent federal for the highways—the school people say the federal ought to spend 20 per cent for education.

Coming over to relief, looking at the Social Security Year Book, the state share was fairly stable for relief, about 43 per cent. The federal share rose between the years 1936 and 1944, from 13 to 41 per cent, and the local declined to 13 per cent. I don't know of what significance those figures are, but I think they are meaningful to get the relative proportions in these other functions. I don't know what figures you would have in mind for public health. I have heard the suggestion of fifty-fifty between the state and local, but I don't know what the proportions are for federal, state, and local. Some of you probably have those. I bring these forward for you with the thought that you might be interested in making some comparison with the amounts for other functions.

Just a few words in conclusion here. The fact that these state-local functions have developed as they have is quite evident that it is not a superficial trend. During the war years the thing has not eased up very much either. We find practically every state has appointed a special commission to look into the tax problem within the state, with special emphasis on state-local relationships, and Michigan is included in that list. Probably you find in many of your states you have this condition, with the state having a surplus and the local units eyeing it and wanting some of it. On that very matter we are going to vote in November on a constitutional amendment to return one cent of the three-cent sales tax back to the local units.

This state-local relationship thing is certainly wide open. I wish I had the time to go into county reorganization. That was the thing I wanted to talk about and get particularly into the significance of the county health unit movement because that is a very significant thing from the standpoint of functional reorganization that is taking place, and this county coöperation in the performance of certain functions. We are like ostriches, you know, we don't like to see the form of government change. The 165,000 units of local government probably will be with us for a long time. While so many students of public administration and government have long advocated that townships should be abolished—and we have about 1,200 here in the state—we don't talk about it here any more because it is such a hot issue, and we never can do anything about it. But the interesting part of it is that the functions are all being transferred from the townships over to the counties, and about the only thing that is left to them is the conduct of elections and assessment of taxes—of course, those are pretty important from the standpoint of grass roots democracy. You get the transfer of health, roads, and relief. You probably don't care about elections or the assessment of taxes. Public health functions should be placed where they can be administered in the best manner and do the most good. Citizens can't get all they want from government as it exists in its present form. That doesn't mean that the cities and the towns can't assume a substantial share of responsibility for these governmental services. They can. And it doesn't mean simply because authority passes over to a higher unit of government that it has to do all the performing. It does indicate that we need a lot more attention given to the new

types of administrative areas. That is where the public health people are doing some real exploration in connection with your public health units; the county health unit for that matter. But, certainly, these administrative areas are going to receive a lot more attention in the years to come.

Now, these local units certainly perform many services with high standards. The administrative responsibility doesn't necessarily have to be transferred up there, but the federal government may have to set the standards for it. It is evident that one problem after another has been, and is being, forced into the field of national administration, and we see the evident demand for the equalization of educational opportunity, providing adequate health protection, and setting up protection against loss of economic security, providing assistance for the handicapped, and all of those things. Certainly they are beyond the responsibility, or the ability, I should say, of local units to handle from the policy standpoint. I think we all favor maintenance of our local government. Traditions have modified local functions to some extent. Administrative standards have been improved by the influence of such agencies as the Public Roads Administration, the Federal Security Agency, the Public Health Service, the United States Department of Agriculture, and the United States Employment Service, and I think we might mention a lot of others. Of course, all such developments constitute a challenge to the state to carry on in the same way too if it is to maintain a strong place within the setup.

Dr. DeKleine: The next paper is by Dr. Hutcheson.

How to Finance Local Health Units

R. H. HUTCHESON, M.D., AND MONROE F. BROWN, M.D.

Commissioner, Tennessee Department of Public Health; Director, Local Health Service

Whenever I come before a group to discuss a subject, and particularly if it is a group such as this, where each one of the group I know knows more about the subject than I do I feel a little embarrassed.

I am going to tell you a little about financing local health departments and it will be a little, I am afraid—you can follow it or not as you like—and I would advise some of you who are doing a pretty good job of it just to keep on as you are doing because you may find it a better set of directions than I have in here.

Our entire public health experience having been in a southern State (Tennessee), we naturally think of a county health department when the term "local health department" is used. To us a local health unit usually includes a county and the contained incorporated towns. When this pattern is not followed, we think of the isolated unit as an exception to the rule, to be tolerated until such time as we are able to combine the public health services of the county and the cities.

In speaking before this assembly, we are aware of the fact that a much more liberal definition of the term must be employed, and we shall endeavor to avoid the term "county health unit" and adhere to the term used in the title, "local health unit." Such a department, to be successful in fulfilling its

obligations to the people, should, according to Dr. Harry S. Mustard, meet certain community conditions in terms of government, wealth, and legal authority. Quoting from "Rural Health Practice," these are:

"1. The area should be a political entity.

"2. It should possess legal authority to levy taxes and disburse funds for organized, full-time health service.

"3. It must be able to invest personnel appointed with necessary legal status.

"4. It should possess a wealth, which, when moderately taxed, will provide sufficient funds to pay for reasonably adequate full-time health service.

"5. Its population, area, and health problems should not be disproportionate to the budget provided."

Assuming that the conditions for the establishment of the local health unit have been met, we may now attack the problem of financing the unit.

First, there should be some one service within the State Department of Public Health responsible for all contacts between the State Department of Public Health and local official agencies. In Tennessee this responsibility is delegated to Local Health Service, a section of Central Administration. The director of this service is not only the service director but also assistant commissioner, and as such he proceeds to the local area, and all preliminaries being dispensed with, he gets down to the business of discussing local participation in the health unit budget. A short method of presenting this part of the subject (and one we suspect is employed in many states) could be stated about as follows. Get all you can when, as, and if you can.

Since one must present some concrete proposal to the local appropriating body and since this proposal must be easily and readily understood, we have up to the present avoided the use of a mathmatical formula. We have devised many formulas, but instead of using them, our approach has been about as follows. The local appropriating body is told that the State Department of Public Health is interested in assisting in the establishment of local health units throughout the State and that certain funds are available, both from federal and state sources, and under certain conditions these funds will be made available to the local area to assist it in establishing its own local health unit. The officials are told further that when these conditions have been met locally, the State Department of Public Health will allocate their proportionate share of state and federal funds to the local unit. We explain that we will not participate financially in a program that falls below a certain minimum population personnel ratio. For example, the unit must have a medical director and a sanitarian and the unit must employ a nurse for each approximately 10,000 population. Clerical personnel must be available to carry out the routine clerical work of the department in ratio of about one clerk to each five or seven technical workers. We are careful to explain to the local officials that such personnel will not be able to render the most desirable service for the area, but, in general, they will be able to carry on an acceptable public health program. We then estimate on the basis of personnel to be employed in the initial unit funds necessary to meet the total operating expenses, including salaries, and it is rare that we find a county which when equitably taxed possesses a wealth sufficiently great to meet one half of the necessary budget. In general, we suggest to the local appropriating body that they make available for public health purposes a special tax levy equal to ten cents on each $100.00 of the total assessed valuation (this sum was formerly five cents). If the local appropriating body prefers to pay the county's share of the budget, from the County General Fund, we ask for an

amount equal to three per cent of the total tax revenue. This has been found in Tennessee to be equal to approximately a ten cent levy.

Indirectly, another important item in the financing of a local health unit is office space. On several occasions Dr. Joseph Mountin has discussed the need for adequate quarters for local health units. The question is not one to be discussed in detail at this time; however, we want to emphasize the need for adequate quarters and suggest that when computing your original budget for a local health department, this item be given close consideration. In the future it is our plan to insist that adequate quarters be provided for before or at the time of the establishment of the local unit and that the cost of rent or purchase be over and above the estimated operating budget.

Now, I am going to stop and say a little more about that. There are several ways to get a governmental building in a county, and they are ways actually better than federal grants—far better. We have tried, I think, all of them. One way is to organize within your county a corporation and incorporate it under a name similar to Amos and Andy's Incorporated Adventures, or you might call it Blank County Corporation Incorporated, if you like, which has nothing at all to do with public health. Usually those stockholders in it rarely know just exactly what the health department is for, but it looks like a good venture and it isn't hard to sell. In any county of moderate size a good health officer can find at least 50 business and professional men in the area who are willing to buy stock in a public venture and in one instance we had 50 men sign a note. We told them it would never cost them a dime, all they had to do was sign a note for One Hundred Dollars each, interest free, they would not be held accountable for any interest on this money—they might some day be called on to pay the note. They did it, and they did it willingly. And the health department took the notes and went down to the bank and borrowed some money on those notes, bought a duplex—a nice duplex too at that time of building—for $5,000. It was small, I'll admit, but it was large enough for this county health department, and they paid rent, which they would have had to pay wherever they may have been—the only difference being that this building was exempt from taxes, being incorporated under the bill which permitted that. They had the insurance to pay, and they didn't need the top section of this duplex so they rented it for $30 a month. The health officer was an enterprising person. He got the city to give him $30 a month for rent, and he paid $30 more out of his budget, so that it wasn't more than a few years until that building was paid for.

Interestingly enough along about 1932—some of you remember things got tight and a friend of mine, a boy who is now a very good friend of mine—I didn't even know him by name at that time—I had just gotten into town, he met me on the street one day and very formally said, "Dr. Hutcheson," he said, "this previous health officer that was in here sold me a bill of goods one day and got me to sign a note on this health department down here and I hear the magistrates in the county are going to reduce the appropriation 50 per cent. What effect will it have on that note?" I said, "Nothing particularly, you will have to pay it, but after all you have a good piece of property down there that will secure you against loss." "Well," he said, "At a time like this, I don't particularly like to have to pay notes on anything. Can't we do something about it?" I said, "You have a secretary of this corporation, why don't you call a meeting?" They got them together that night and briefly stated it

was something like this. They asked me if I had seen the magistrates. I said, "Why?" "Do you know how they feel on this subject?" I said, "I think I do." They started down the list. The first man on the list owned a farm of about 1,500 acres. "If the county acts to cut tax rate he told me he was going to vote against it." The banker said, "Wait, just leave him to me. I think I can handle that. He has a note of $20,000 down at the bank now." Well, when the thing was over everybody had taken one or two names—there was 46 magistrates. And a few days later they told me to make another round and see how they felt. I went to this first man again. He said, "Look, have you been down town since the other day?" I said, "Nobody asked me if you were for it. I thought you were not." He said, "I was only kidding, I wouldn't do without that health department for anything." And we actually got an increase in our appropriation that year.

That can be done in any county and with interest rates being what they are now the banks will be glad to loan you money at 4 or 5 per cent, and you can build your building. There have been others where the federal agencies have made grants and we actually had the experience of having counties appropriate money for their part of the federal grant on the condition that we would pay rent until notes of the county were paid on it, it's the same thing. And then we found out that by not taking the federal money we could build a building on exactly the same floor plan and so far as usefulness is concerned just as good as we could by following the federal specifications, and save money.

That has happened in three instances in Tennessee. It sounds funny, but it is true, because if you get the federal money you have to build a fire-proof structure usually, and you have to build to certain specifications that are difficult to meet. I have some contractor friends who tell me that any time they start a federal project they add 15 to 25 per cent to their estimated contract just to take care of nuisances.

We have persuaded in one instance a private individual to sell the county health department a building, and we take it over for rent and pay for it over a long period of years, and if the county does it itself and puts up money or bond issue they are not going to vote the health department out until the building is paid for, which has a tendency to stabilize the situation.

In discussing local health unit budgets, the general practice of the past has been to add the actual cash dollars disbursed by the local unit and ignore the many direct services rendered by the state agency. In Tennessee we know we have overlooked an important local expense item and we are now coding all state and local health unit expense items with a view toward accumulating data from which we can arrive at a reasonable estimate of direct expenditures for local service administered at the state level. We recommend that you follow some similar procedure. A few of the items you will want to include in your cost study are: Record Forms, Laboratory Service, Epidemiological Studies requested by local health units, Routine Engineering Services. The entire cost of your field advisory staff, if you have one (with appropriate apologies we wish to state that if you haven't such a unit, you should establish one), certain costs ordinarily charged to Industrial Hygiene, and by all means The Tuberculosis Field Diagnostic Services and Crippled Children's Service. There are other services, but the above will suffice to indicate the magnitude of service cost that in many instances is being omitted when we discuss financing local health units, and it is one of the reasons that we find it difficult to

fit a formula to the problem of allocation of funds to local units.

We feel that there should be some fund from state sources specifically earmarked for local health service, and to that end we began in 1935 a program of developing public interest in what we called a Local Health Service Stabilization Law. In the time allotted to this discussion we cannot narrate the events leading up to the final passage of this Act in 1941. The Act provides for an amount not less than $2500 per annum to each county and to each of the four major cities maintaining an approved coöperating full-time public health service. In addition there is made available $50,000 per annum to be used in providing public health services in areas where special financial or public health problems exist, for the establishment of approved local public health services where such services do not exist as of the beginning of a particular fiscal year and for any other emergency or essential public health service required for the protection of the public health. Another feature of this Act is: "that no funds made available under the provisions of this Act shall be allocated or used by the Department of Public Health for state administrative purposes."

You will understand that this was strictly a piece of local legislation applicable to each major political subdivision in the state. The only severe criticism that can be directed justifiably against this Act is that the flat amount of $2500 is not more than one half the amount needed in Tennessee.

No one organization or agency, private or official, can claim credit for the passage of this important piece of legislation. When the Bill was finally accepted for inclusion on the legislative calendar, it had the support of practically every civic club in the state. The Tennessee Congress of the Parent-Teachers Association and the Federated Clubs of Women jointly acted as the spark plug to keep interest alive, and they were in the forefront when the Bill was passed. Many agencies were well up toward second place.

You may well ask—Why so much emphasis on the passage of this bill? Others may think without putting the thought into words—You got the money for local health service which, after all, was what you were after—forget the rest. The Bill was passed and we did get the money, but in accomplishing these results, there was developed something else without which the financing of local health units cannot succeed, i.e., a public consciousness of the need for a stable financial plan on which local health units can be developed. The awakening of this consciousness, the crystallization of public opinion, and the subsequent implementation of the program by the appropriating body is the goal toward which we should all strive. Not one of us can follow the same road; however, when the final picture is painted and the canvas is thoroughly dried, no one should be surprised at the similarity of the scenery. Therefore, I suggest that each in your separate way draw the picture as you see it and call it by whatever name you choose—Health Education, Financing Local Health Services, or A Formula for Allocation of State and Other Funds to the Local Level.

I think this afternoon we can have some good discussion on this, but I think we should come back here when we finish and answer some of these questions—at least in part.

1. Is there any parallel thinking by individual members of the group when the term formula for allocation of funds to local departments is used?

2. Is it necessary to think in terms of algebraic formulae or other mathematical equations in order to devise a satisfactory formula for the allocation of funds in local departments?

3. What services and expenditures should

be included when computing expenditures from state and federal sources to local units?

4. Is it desirable for a state to enact legislation setting forth a specific determination for local health units with appropriate provisions for equalization?

Dr. DeKleine: Thank you, Dr. Hutcheson for this very fine presentation. You have given us something to think about when we go home to try to solve the problem of financing our own health services. When he sold—or got his business men to sign notes for the development of a health center it made me think of the man who sold a milking machine to a farmer and then took his only cow in down payment. I presume they had other cows in Tennessee.

The next speaker is Dr. Carl Buck.

Dr. Buck: Dr. DeKleine and Members of the conference—

Had it been necessary for me to present this paper on Monday I should have done so with great misgiving, but after Dr. Blackerby's talk yesterday so conditioned us to "rolling with the punch," I do so today with no qualms.

Relative Financial Needs of State and Local Health Departments

CARL E. BUCK, DR.P.H.

Field Director, American Public Health Association

The question of the relative needs of state and local health departments can be broadly answered by the simple statement, that, since the essential purpose of all state health programs is to develop and maintain adequate local full-time health services, the financial needs of local health departments are the more important. This answer, while true, is doubtless too broad and general to satisfy those who are interested in this important but complicated question. Theoretically, if sufficient funds could be provided for adequate full-time local health departments, there would be need for relatively small sums for state health departments since then it would be necessary only for state health departments to provide those highly technical services which are unfeasible or uneconomic of local procurement. This statement is more theoretical than practical because as a rule full-time health departments are established only if and when there is effective leadership, stimulation, and consultation service by the state health department. In short, to obtain our primary public health objective of adequate local full-time health services, we must first have a good state health department and that, of course, requires reasonable financing.

On the other hand, even the most adequately staffed and financed state health department will be relatively ineffective unless funds are somehow provided for local health services. The truth of this statement is based on the assumption that the state health department does not expect to supply local health service through its own personnel. This assumption would be accepted by most but not all states. Most states do expect local areas to take the initiative and primary responsibility for developing their own health facilities. An exception is Pennsylvania, whose public health law makes the state health de-

partment responsible for local health services in all areas outside of cities, boroughs, and first-class townships.

Obviously both state and local health departments need adequate financial support. Which has the greater need and from what sources this financial assistance should be obtained presents a problem with various possibilities. Unfortunately, accurate data as to the present situation are lacking. To be sure the U. S. Public Health Service and the U. S. Children's Bureau do have what purport to be state health department budgets including local health department budgets. These budgets, however, are not infrequently incomplete, inaccurate, and misleading. The word "inaccurate" as used in this statement doubtless needs some explanation. What we mean by "inaccurate" is that sometimes items are included in these budgets for matching purposes which are not normally considered as expenditures for basic health department activities. For example, in two states with which I am familiar, sizeable amounts were included in the budgets, as presented to the U. S. Public Health Service, which were actually appropriations by another governmental agency for tuberculosis hospitalization or subsidy. While one does not for a moment question the need for such expenditures, their inclusion in one state health budget and not in another means that it is impossible to make accurate comparisons concerning source of funds for basic health activities. The real difficulty lies in the fact that one cannot tell whether such funds are or are not included in the budget unless he is in the field and has the opportunity of discussing the question with the personnel of the state health department. To use a single concrete example, the budget of the Wyoming State Board of Health includes an item of $43,000 for tuberculosis control. Actually the state board of health has not a single cent for tuberculosis control. The $43,000 included in its budget is spent by the Department of Welfare for tuberculosis hospitalization.

Some months ago one of our more capable state health officers prepared and distributed a very interesting pamphlet showing the source of funds in various state health department budgets. It was used to show that his state was not contributing, through local state tax funds, its fair share of the total health budget. While we have no doubt that the conclusions reached are correct, there were, however, certain inaccuracies in respect to other states which were in no way the fault of the health officer in question because he had no way of knowing what was included in the budgets of other states. For example, the pamphlet indicated that one state (Colorado) was spending about 22 cents through state tax funds for basic health activities. Actually basic public health expenditures in that state total but 9.8 cents per capita; the 22 cents per capita included well over $100,000 which was being spent by another governmental agency for tuberculosis hospitalization. Another inaccuracy which sometimes appears in health department budgets is the inclusion of the total cost of a merit or civil service system rather than only the actual amount which the health department spent for its support. In short, it seems evident that state health department budgets are so padded—not dishonestly but as a necessary means of obtaining more federal funds—as to indicate a greater proportion of state funds than actually exists for basic health functions.

While state health department budgets are likely to be padded as to state tax funds, local health department budgets, on the other hand, as presented to the U. S. Public Health Service and U. S. Children's Bureau, are apt to be incomplete and minimal. In general, they include only such local funds as are

used for matching purposes. Not infrequently, they fail to include expenditures by boards of education and by the voluntary agencies, such as the tuberculosis association. This incomplete discussion leads to the conclusion that state health budgets, as presented to the federal health agencies, are inaccurate and not susceptible of comparing one state with another. In general, they show more state funds than are actually appropriated for basic health activities and less local tax funds than are actually being expended. It is greatly to be hoped that in the future the federal health agencies will insist upon a more accurate and complete report of actual appropriations of basic health activities. If this is done, it is obviously necessary to define what is meant by basic health activities. It may be perfectly justifiable to permit states to use these, other than basic health activity, appropriations for matching purposes, but the budgets should clearly indicate what are and what are not basic health activity appropriations.

This discussion indicates clearly that we do not have sufficiently accurate data to answer the question as to the relative financial needs of state and local health departments. Information which would permit a reasonably accurate guess as to the answer to this question can be gleaned from some of the 15 state health studies made by the A.P.H.A. in the last ten years.

The data presented in Tables I and II are roughly suggestive and perhaps indicate, that in so far as this limited number of states is concerned and for the years indicated, states have been shirking their responsibility for providing state tax funds for necessary health protection and health promotion services and have been leaning altogether too heavily on the federal government for financial support.

They also suggest that too great a proportion of funds is being devoted to the central office and not enough to assist in financing full-time local health departments.

Similarly data for local health department expenditures* indicate clearly that local tax appropriating bodies are not spending as much as they could or should for public health protection. Among 225 health departmens for which reasonable data were available only 11 spent more than $1.00 per capita and the median was 29.2 cents. The median expenditure from all sources was 68.2 cents per capita, the majority of the extra funds being supplied by the federal agencies rather than by state funds.

Incomplete as the information is, we nevertheless seem justified in drawing certain conclusions:

(1) In general, state health departments rely altogether too greatly on federal funds. Most states are not assuming their rightful financial responsibility for health protection and health promotion services even when we consider the financial status of the various states.

(2) Most of our states spend too great a proportion of available funds for central administration and not enough to aid in the establishment and development of local full-time health departments. Good central administration is, of course, essential and worth paying for but too many of our states are inclined to over-centralize.

(3) There is an urgent need for state health departments to stimulate, encourage, and insist upon local health officers assuming a greater responsibility for the development of their own local health department budgets. In too many instances, the local health officer assumes little or no responsibility for developing his own budget. Most local health

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* See pages 75–77 in *Health Practice Indices*, 1943–1944. American Public Health Association, 1790 Broadway, New York 19, N. Y.

TABLE 1

State and Federal Public Health Funds Devoted to Major Purposes *

Purpose	Per Cent		Per Capita in Cents		
	State	Federal	State	Federal	Total
Central Administration †					
California, 1942	78.4	51.7	5.1	7.5	12.6
Colorado, 1946	100.0	64.0	9.8	27.7	37.5
Florida, 1939	73.2	56.0	14.4	13.3	27.7
Oregon, 1943	97.3	49.8	4.5	10.8	15.3
Full-time county health departments					
California	4.0	27.8	0.2	3.9	4.1
Colorado	—	36.0	—	14.7	14.7
Florida	9.4	24.0	1.7	5.6	7.3
Oregon	—	38.8	—	14.5	14.5
City health departments					
California	4.6	9.8	0.3	1.4	1.7
Colorado	—	—	—	—	—
Florida	—	—	—	—	—
Oregon	2.7	8.9	0.3	5.6	5.9
Unorganized areas					
California	—	3.6	—	0.4	0.4
Colorado	—	—	—	—	—
Florida	16.5	9.0	3.1	2.1	5.2
Oregon	—	2.5	—	7.9	7.9
Other purposes					
California	13.0	7.1	0.8	1.1	1.9
Colorado	—	—	—	—	—
Florida	0.9	11.0	0.2	3.7	3.9
Oregon	—	—	—	—	—
Total, all purposes					
California	100.0	100.0	6.4	14.3	20.7
Colorado	100.0	100.0	9.8	42.4	52.2
Florida	100.0	100.0	14.4	13.3	27.7
Oregon	100.0	100.0	4.7	38.9	43.6

* The figures do not include local county or city appropriations.

† Central administration here means the central office with its various bureaus and divisions, including funds for training.

TABLE 2

Percentage Distribution of Source of Funds Administered Directly by State Health Departments *

State	Year	State	Federal	Other	Total
California	1942	31.1	67.1	1.8	100.0
Colorado	1946	26.0	69.7	4.3	100.0
Florida	1938	39.6	39.2	21.2	100.0
Illinois	1942	54.2	45.8	—	100.0
Michigan	1938	57.4	41.0	1.6	100.0
Oklahoma	1938	42.5	47.8	9.7	100.0
Oregon	1943	29.6	69.5	0.9	100.0

* The figures do not include local county or city appropriations.

areas could and should finance a larger proportion of their own health services.

(4) As previously stated, many states are receiving more federal funds than their financial status would seem to entitle them to, which would indicate a need for a more equitable formula for the distribution of federal funds to the states.

(5) For the most part, the distribution of federal and state funds (unfortunately they are all too greatly federal funds) is on a catch-as-catch-can or dicker basis. There is a pressing

need for the development of criteria that would be useful in establishing a more equitable system of distributing funds from the state to local health departments and, as previously indicated, a need for appropriating more state funds for assisting full-time local health departments.

(6) Too much money is being spent in so-called unorganized areas, that is areas without full time health services. It would seem wise increasingly to divert these funds to full-time health departments.

Dr. DeKleine: Thank you, Dr. Buck. Dr. Buck's paper brought out very forcefully the need of going after more state and local funds before the federal government takes us over entirely.

The last paper for the morning is by Dr. Burney of Indiana.

Public Relations as Affecting Financial Needs for Local Health Units

L. E. BURNEY, M.D.

State Health Commissioner, Indiana

It may appear illogical to ask the Health Commissioner of a state which has only three full-time local health departments and 173 part-time health officers to discuss this subject. It might be assumed that this invitation was tendered in recognition of the personnel, organization and services of our Division of Health and Physical Education. On the other hand, the planners of this conference may have felt that we certainly needed a good public relations program in Indiana and used this method to stimulate thought and action upon our part.

Seriously, though, it is a distinct honor to appear before the members of this conference and I am happy to have an opportunity to express the opinions of myself and certain members of my staff upon this important subject.

My remarks are presented to you not as anything new or unusual but merely as an expression of methods, experiences and plans of the Indiana State Board of Health for the organization of community resources, lay and professional, to secure public understanding and support of full-time local health departments.

I want to preface my remarks with a fundamental truth, recognized and accepted by all, but one we may lose sight of in our rapidly mushrooming growth. That truth is this:

There is no substitute for quality of service and efficiency of service in securing public confidence and support. We must do a good job with existing personnel and facilities. We must consolidate and perfect the basic essential elements of a public health program before launching on new, untried and uncharted pathways. The good will and respect of lay and professional groups depend, to a very large degree, upon the integrity of those of us in public health work and upon the scientific soundness of our program.

What I have to say applies to the activities of any health department, state or local. It applies to a full-time department firmly established or one in the process of being established. I don't need to tell you that good public relations are extremely important to any

organization or industry—vital to an agency which depends directly upon public understanding and support for its effectiveness. You, who are working in public health, know that it isn't a question of having a public relations program; it's a question of having the most effective one.

The work which an official health agency is authorized to do, cannot be done without the intelligent and enlightened support of the people. To secure that public support, the department must first perform the functions expected of it; secondly, it must interest the public in the importance of these functions and acquaint them with the fact that they are being performed, or, if not, why not. Lastly, it must work through public and semi-public organizations to accomplish the first two aims. In an official, tax-supported health department, all three are public relations jobs.

Bauer and Hull in *Health Education of the Public* state: "Whatever combination of methods may be adopted, it must never be overlooked that the objective is the motivation of individual conduct. Whether the purpose is to promote disease prevention or better sanitation or improve nutrition, success depends finally upon whether individuals in the community can be persuaded of the desirability of procedures recommended, and stimulated to action rather than mere passive acquiescence." All the work done by a local health department will be done through, by and for the local community. We know that success depends upon stimulating individuals within the community to desirable action. You may call it education. It is. But it's also public relations.

To those of us in public health, public relations does not mean whitewashing unsatisfactory conditions. It means primarily that we interpret and explain, community needs and our responsibilities and plans for the solution of those needs.

Commercial concerns have what they call "good will advertising" and "point of sale" advertising. The former is continuous. It's exemplified by the advertisers' efforts to represent themselves as fair and reliable makers and sellers of quality goods. It's illustrated in their public relations, in their general advertising when a sale isn't an immediate prospect. It's done to whet public appetite for a product. It's done to keep a company and the product of that company before the mind of the public, so that when individuals are ready to buy, they will think first of that brand which is identified in their minds with a company that's reliable and a product that has quality and/or low price. Point of sale advertising is intended to clinch the deal. It's used mostly when an individual is all ready to buy and it's just a question of which brand he selects.

Health departments would do well to remember those differences when conducting health education programs. Health departments, state and local, would do well to keep them in mind always to avoid scattering their fire and dissipating their energies. Good will advertising with the health department is almost synonymous with public relations. The health department interprets its product. Good will, sympathy, confidence and support are its profits.

The health department, unlike private industry, cannot go out any day in the week and open a new department or start a new program. Generally speaking, private industry needs only to have the money to expand and the market for increased production. The health department may have the market, in a sense, in the widespread need for public health services. Nevertheless, many needs exist long before there is a general awareness of them. So the health department must educate by means more

sober and conservative than those employed commercially. It is necessary that we avoid stuntism, barnstorming tricks and the like. The public must become aware of its needs; the public must become aware that means exist for meeting those needs. They must learn that an adequate full-time health department can work with them to improve present conditions and plan for future development. This is no easy job. It calls for careful planning. The number of persons, organizations, and factions that must at all times be considered are many.

I would like to digress for just a moment and tell you something about a rural health conference that was held in Indiana, and which I know several other states have held, Ohio, for example. We have two committees in Indiana, one a committee of the State Medical Society, and one a committee of the Farm Bureau, who worked together in discussing the needs and plans for improving rural health. The state health commissioner is a member of the farm bureau group. After a considerable number of meetings it was felt desirable to do something beside talk.

So, with the joint sponsorship of these two committees the Indiana State Board of Health and the extension services of Purdue University a meeting was held at Purdue University at which outstanding farm leaders throughout the state were invited. At that meeting papers were presented discussing frankly and objectively such things as the Wagner-Murray-Dingell Bill, the need for hospital beds, the need for full-time health departments, and our state as compared with other states as far as public health problems were concerned.

The State Board of Health was asked by these two committees to prepare a brief survey form which could be given to these individuals to take back home with them. Now, this was not an elaborate form, but it was merely something to give to the people so that they would have something to more or less chew over after they got home. Then the extension service of Purdue University asked that each county agent check the people who were at this meeting from his county and also using other farm groups in that community and the medical, dental, and other professions to discuss this survey and to divide into committees, one to determine hospital needs, one to determine the number of physicians, or pharmacists and nurses in the community, one to determine the school sanitation program, one to determine how much money was being spent for local public health work.

I believe that the public health agencies in Indiana and our ultimate objective to establish full-time health departments has been greatly advanced by this rural health conference from the fact that now we have a working committee, a working group under the direction of the county agent with assistance from our health educators in arousing community knowledge of the health services needed in a community and in preparing plans for solving those needs.

The most common medium for conducting public relations is the press. Many health department events have news value. These should be released to the press unless occasionally extenuating circumstances prevent it. The newspaper editor, always on the lookout for news, will appreciate your cooperation and, at the same time, the public is kept informed of what its representatives are doing. News that a water system isn't safe is important information and lets the public know that its department is on the job. In so far as possible the public should be taken into the confidence of the department where affairs of public health are concerned. Progress in the correction of the defect offers further opportunity.

Caution should, however, be exercised in handling press affairs. Press

relations should be conducted by one reliable person. It is no job for the vainglorious seeking personal publicity. When news is given to the press, *news* should be paramount and not the individual giving it. That doesn't mean that department personnel should be excluded. Far from it. Editors like authorities for their stories. If a milk supply is bad, they want to know who says so and by what special knowledge he presumes to say so. But newsmen are quick to sense the publicity hound, the seeker for the spotlight.

News should be accurate and expedited with all possible speed. Long delays on release of events or programs which have news value neither help the program nor encourage the cooperation of the press. The person in charge of press relations should be taken into the confidence of the medical director whenever possible in order that news releases can be expedited and feature releases can be discussed with a view to total program planning.

Perhaps the most effective, telling public relations is carried on daily by all members of the health department when they meet with advisory committees, councils, clubs, and various other organizations. To a great extent, these organizations are the public. They are made up of active people who take part in community affairs. Since each individual employed by the health department influences public opinion, it is important that the director, the clerk and custodian be as well informed as possible concerning the general program. This indicates the necessity for staff education. Here, again it isn't a question of public relations, but a question of *good* public relations.

Patience may not be the essence of advertising, but it's a valuable characteristic of those who work with people. People usually, individually and collectively, are slow to act. Too much high pressuring through the press, radio, public meetings may arouse resentment and postpone action indefinitely. Civic groups are interested in community betterment. That's why they exist. Nevertheless, the impression must not be left with them that the department is trying to *drive* a program through. Health department personnel often refer to "our problems" and "our program." They are *community* problems and the *program* should be the *community's*. This philosophy, firmly imbedded, will do much to encourage individuals to assume the initiative, accept responsibility, and act as members of the community under their own leadership.

Organizations such as the Tuberculosis Association, the Cancer Society, and the Foundation for Infantile Paralysis were pioneers in their fields. They can help us and we can help them. We must not forget that they saw needs early and were attacking specific health problems when many of our local departments were nonexistent. The time is near when they will expand their activities to encompass other fields of health work. Official health agencies will carry on some of the work they started originally. The fact remains that in all our relations, we must meet them on a cooperative basis.

As a result of this approach Indiana has profited materially. The Cancer Society has agreed recently to provide the Health Department with a yearly budget of $6,000 to employ an additional health educator and an exhibits technician and an additional $4,000 to establish a Cancer Registry.

I might digress there just a moment to say that does not mean that we are going to secure an additional health educator as a specialist in cancer control. Our agreement with the cancer society was that we would add an additional health educator to the staff and that all of them then would do cancer education, tuberculosis, or general health work. I think this is much more de-

sirable than for the cancer society to go ahead and set up its own special health education program with its own health educator.

The Tuberculosis Association is alloting an amount necessary to pay the salary of a health educator engaged in a special pilot program in one of our cities. We have just completed a two week working conference in School and Community Health Education. This was sponsored jointly by the State Board of Health, State Department of Public Instruction and Indiana University. The county chapters of the Infantile Paralysis Foundation allowed stipends to students amounting to approximately $2,000. In addition the Cancer Society, Tuberculosis Association, Crippled Children's Society, the Department of Public Welfare and the Division of Vocational Rehabilitation furnished consultants.

I want to add a few more remarks about that work shop. That was begun about three years ago. Originally the intention was to bring teachers, primarily high school teachers, down to Indiana and give them a two week intensive course, in public health as it related to the teacher and his responsibilities as a teacher and as a member of the community. That person got two and a half hours' credit from the university. We found as a result of those conferences that when our people went into these communities where those teachers were working we had a friend already, one who could work with us. We even had several instances in which teachers before they attended this conference were rather antagonistic to the public health program, and after attending the conference were extremely helpful in getting something started in that community. This year we had over 100 persons attend this conference, not only teachers but various voluntary agencies saw to it that the leaders in these communities were sent up to this two week conference. We had individuals also from some of the surrounding states. We feel that this is an excellent way to provide leadership in the communities to help in promoting full-time health departments.

State departments and most full-time local health departments either employ or plan to employ health educators. Health educators work closely with the groups I have mentioned and serve an important public relations function. Their forte is community organization. They employ the best methods of education to convey information regarding the prevention of diseases and, at the same time, make a distinct contribution toward placing the health department on a firm foundation with civic groups, volunteer agencies and, parent-teacher associations. After all, intelligent community action is as much a problem of education as is any other health department activity. Most of the local advances in public health will be made as a result of community action rather than as the result of individual application or improvement. Desirable community action in matters of public health is dependent largely upon the standing of the health department in the community. That is, if the department in its relations with the community has portrayed every activity in its true perspective, if it has been tactful, above board, honest, sincere and progressive, it will have the respect of the community and be looked to for leadership.

In Indiana, the Division of Health and Physical Education while a division of the State Board of Health is also responsible for the school health program of the State Department of Public Instruction. This plan has been in effect since 1936 as a result of an agreement between the two boards. This gives us a unique advantage: we have direct contact with the schools in planning courses of study in health and physical education. In fact, such teaching guides are

prepared under the direction of our Director of Health Education. The advantage of such an arrangement is immediately apparent. It automatically provides us with direct contact with every school in the state. The personnel of this division work directly with the teacher without dangers of encroaching on the fields of others. The director of this Division holds strategic office in state educational organizations and maintains a close working relationship with college people responsible for the training of teachers of health and physical education. The facilities and personnel of these colleges are immediately available for institutes and other forms of in-service education.

At the present time the State Parent-Teachers Association is distributing to component groups, packets prepared by our Division of Health and Physical Education. These packets contain literature and charts which point up certain public health needs in Indiana. I mention this because other organizations are doing similar things. We realized early that it would be impossible for our staff to assume responsibility for the direct education of the individuals, so groups and organizations are encouraged to assume this obligation.

It goes without saying that relations with the medical and dental professions must at all times be the very best. We will be successful almost to the extent that we gain their confidence and coöperation. Our State Medical Society several years ago passed a resolution recommending the establishment of local full-time health departments and since that time a number of editorials of the same tenor have appeared in their Journal. County Medical societies in four of our communities that have expressed an interest in establishing local units have gone on record endorsing this program. I should like to read you one such resolution from the Elkhart County Medical Society: " Probably no one is in a better position to realize the desirability as well as the necessity of such an organization if we are to fulfill our obligations to the public than the medical profession itself.

" It is our fervent hope that your organization will continue its educational program for such a county health unit and you can rest assured that you have the wholehearted support of the physicians of this county in your undertaking."

The medical profession can be of inestimable value in gaining the support of local officials. At the same time we can be of assistance to them, as physicians and as members of the community. Health education encourages sound health practices not the least of which is the avoidance of self-diagnosis, self-medication, and quackery. In meeting those problems we have a contribution to make to the medical profession.

Community respect, understanding and coöperation are the foundation stones of your department. They are laid by good will advertising, or good public relations. What I have said thus far relates to the ground work. One thing more remains in that respect. Earlier I mentioned that dissipation of energy should be avoided. Public relations of the health department which closely resemble "point of sales advertising" should be anticipated by this careful building of understanding in the community. In other words, we should know far in advance where we want to go and conduct all activities with that end in view.

Finally the time comes when a new program or department is to be launched, the time for the use of point of sales techniques. If past programs have been well handled, if effective public relations have been employed, the desire for the new program or department should spring from within the community, outside the health department. Ammunition must be ready and

dry. Plans are laid before the public in an orderly fashion from point to point through the press, radio, public meetings, personal contacts and other techniques familiar to the individual experienced in health education. Careful presentation of community needs as shown by surveys, studies, et cetera, is made. If specific plans have been released prematurely, some of the advantage of timing may be lost.

The department may now have to present its needs and its budget before the State Legislature, the tax board, the county commissioners, or the city council. Frankness and directness pay dividends. In our State, we have been accused of asking for special treatment in regard to classifications and compensation. We admit without reservation that this is true. We believe that our work is deserving of special consideration. We have benefited by this approach. The department has two jobs here: to show that its requests for financial support are legitimate and to prove that its proposed program will meet community needs. It may also have to demonstrate that the community is ready to accept what the department has to offer. The commissioners and council like to know what their leading citizens think. Do they approve? Can it be demonstrated that they approve?

Sometimes the department is asked to recommend methods of raising additional money and it must be prepared to offer some logical suggestions. Although this is outside the field of public relations, it is important here in that it illustrates the detailed planning necessary to effect a broad program. At this point the effectiveness of the department's past public relations program is going to tell.

In Indiana, as others in many states are doing, we are trying to promote the establishment of local full-time health departments. Many factors enter in—community needs, community interests, community wealth. Everything we do or say in Indiana is going to indicate to groups and communities that we understand their problems. If not, then our public relations is bad and we have slipped somewhere. In order to attain our goal, we must have the coöperation of the groups I've mentioned. We must have a sympathetic press. We must have the support of the medical and dental professions.

The need for local full-time departments in Indiana is great and cannot be met overnight. The full-time department has something to offer Hoosiers and we have evidence to prove that they are realizing it more each day. If so, then some of the points I've discussed here today—methods we've tried conscientiously to apply in Indiana—have been effective.

CONCLUSION

In conclusion, I should like to present for your consideration and discussion four points referable to a public relations program of interest and concern to both state and local public health administrators.

1. Define the content of a public relations program and enumerate the most effective methods and procedures for accomplishing the desired objectives.

2. What is the value of a Local Advisory Health Council; how can it be used most effectively; what should be the basis for the selection of members?

3. What are the responsibilities of health educators in a public relations program?

4. How can voluntary agencies, civic clubs, women's organizations, county agents, Farm Bureau Federation, the Grange and other local groups be used in a public relations program for the establishment and maintenance of local full-time health units?

Dr. DeKleine: Thank you, Dr. Burney, for an excellent presentation of the subject of public relations, which is something that we all need to think about and go home and apply.

WEDNESDAY, SEPTEMBER 11

Afternoon Session

Four group conferences followed by reports by the leader of each conference.

Dr. DeKleine: Will the conference please come to order? The first report to be made this afternoon of the papers that were discussed this morning is the one for Group 1 by Dr. Dolce, a discussion of Dr. Ford's presentation this morning. Dr. Dolce.

Group 1 — Leader—DR. JAMES A. DOLCE, Director of Local Health Administration, Connecticut State Department of Health.

Consultant—ROBERT S. FORD, PH.D.

Dr. Dolce: Dr. DeKleine, and Members of the Conference—

We in Group 1 had an interesting discussion of the paper on "Principles of Local Government Organization and Finance," which was so admirably presented by Dr. Ford, and in which he indicated that while the democratic form of government recognizes local autonomy, as certain problems of administration or service become too great for the local community to assume, those functions are taken over by the state, and sometimes by the federal government.

From the discussion we arrived at the following recommendations:

1. That we strongly recommend that local administrative autonomy for the basic local public health services be retained.

2. That strong leadership and adequate financial assistance from the states be provided in the development of these local health services.

3. That a standardization of personnel qualifications and services are to be functions of the state health department.

Dr. DeKleine: You have heard the report. Are there any questions or any discussion of the report? The report is brief, but right to the point. I don't think a motion is necessary, but if there is no discussion we will consider the report accepted.

The second report is by Group 2. The leader is Dr. Leavell, discussion of Dr. Hutcheson's paper. Dr. Leavell.

Group 2—Leader—HUGH R. LEAVELL, M.D., The Rockefeller Foundation.

Consultant — R. H. HUTCHESON, M.D.

Dr. Leavell: Mr. Chairman and Gentlemen. Dr. Hutcheson fortunately started us off on our discussion by having presented some questions at the close of his paper this morning. Our group found those questions rather difficult to deal with in some respects. We spent a rather lively two hours, but did reach certain conclusions and felt that perhaps we had arrived at some of the answers.

The first question which we discussed was, "Is there parallel thinking in the group when the term formula for allocation of funds to local departments is used?" And we heard reports from several different states as to formulas that they were using, some of them quite mathematical, others based on computation of what service was needed in a given area with some consideration of the ability to pay demonstrated in that area by actually what it was spending for other types of services and various and sundry methods of arriving at this problem of allocation.

It was pointed out that we were getting bogged down in a pedantic problem and we would do well to eliminate the word "formula" and stop thinking about it as some sort of an algebraic expression that would declare that X plus Y equals Z or something of the sort; it was suggested that really what we meant was an expression of an equitable plan of financial relationship between

the state and local health units, which would be easily understood and self-evidently fair, rather than a single formula applicable to all the states. I think every one in our group agreed that that really was what we were trying to get at.

The second question that Dr. Hutcheson had raised was the following, "What services and expenditures should be included when computing contributions of the state to local units?" And you remember this morning that he enumerated a number of those things such as record forms, laboratory services, epidemiological investigations, engineering services, and so forth. It seemed fairly apparent after we grappled with this question a bit that we would have to draw some dividing line. But then, however, Dr. Harry Mustard suggested, for example, that Dr. Hutcheson's services, including depreciation, wear and tear would be a logical service to all the citizens of the state of Tennessee, but that it would be difficult when you divided it up by two and half mill or so to express it in terms that would be very useful. So, that there needs to be some careful consideration of which of these services actually might be chargeable to the local units, and I think there was also fairly general agreement that it was desirable to point out to the local units that they were receiving these services from the state health department and even to express this pretty much in dollars and cents. It was the sense of the group that it was a very desirable thing, and that perhaps some candidates for a doctor of public health degree might go into the details of which one of these services would be so charged. It is apparent that several of the states are doing that and others are planning to do it and feel that it is useful in pointing out that the states are making more contribution to local services than some of the localities might ordinarily realize.

Then you will remember Dr. Hutcheson told us about a law that was passed in Tennessee in 1941 providing that a minimum of $2,500 must be put in by the state to each of the local units operating on a satisfactory basis, and he was anxious to find out from the group whether it thought it was desirable that such a flat sum should be appropriated from the state to the local units. And we grappled with that for a while, some feeling that that was a desirable thing and others that there ought to be fairly complete flexibility in the hands of the state health officer as to the distribution of funds. But we did reach agreement and passed a resolution which we would like to recommend for your consideration as follows:

"This group endorses the principle of subsidy of local health work from state funds through the state health authority."

Some of the states, of course, are not able at present legally to make contributions to their local units but we did agree on that resolution and would like to submit it to this conference group.

The final question which was discussed was concerned particularly with fees for health services, and the problem came up particularly as related to inspection fees that might be charged for milk inspection and meat inspection and perhaps restaurant inspection, is that or is that not a desirable method of obtaining funds for local health work. And it looked as though for a while we might be able to reach some conclusion on that and suddenly it dawned on the group that we were grappling with a pretty big proposition, so we voted to table that on the suggestion of Dr. Sowder.

I think, Mr. Chairman, those are the principal points that we covered and we have just the one definite resolution to present.

Dr. DeKleine: Thank you, Dr. Leavell. Do you want to act on that resolution? Will you read it once more, Dr. Leavell?

Dr. Leavell: "This group endorses the principle of a subsidy of local health work from state funds through the state health authority."

Dr. DeKleine: That is the resolution.

Dr. DeKleine: Is there any further discussion? If not, all in favor of this motion will signify by saying aye.

Dr. DeKleine: The motion is carried. I think, Dr. Dolce, you can consider your motion accepted by the same token.

The next is a discussion of Dr. Buck's paper this morning by Dr. Blackerby. The leader, Dr. Blackerby.

Group 3—Leader—P. E. BLACKERBY, M.D., State Health Commissioner, Kentucky.

Consultant—CARL E. BUCK, Dr.P.H.

Dr. Blackerby: Mr. Chairman, and Members of the Conference—

I think we all realize that in discussing the topics that have come up in this conference in relation to local health services it has been difficult or impossible to avoid some duplication. I have noted, as I am sure most of you have, that in the reports by the leaders on the afternoon discussions, similar topics have been included in the reports with some duplication, and I know that is unavoidable.

This afternoon in the group that discussed the report of Dr. Buck there was a great deal of interest. I noted that there was more individual participation in the discussion than in any other group that I have attended so far.

I think you will recall that in discussing the financial needs of counties Dr. Buck from his analysis of central administrative costs indicated that administratively maybe some of us had been somewhat niggardly in our response to local needs. When that was brought up this afternoon it elicited a great deal of discussion and there was response from all parts of the room. I think we pretty generally agreed that in Dr. Buck's analysis of percentage of central administrative cost of the whole funds available for health programs within the state he had looked at the picture entirely from the standpoint of administrative expenditures in the central department of the state government for all services regardless of whether they had direct or indirect local application. I am making that as an introduction, and so will the report, that it was agreed that Dr. Buck's analysis, after careful breaking down would disclose many activities included in central administrative budgets that are direct service to local units either in part or in full. It is difficult in many instances to draw distinctions as to those that are administrative and those that are direct or indirect services to local units. It was further agreed that there was a definite need for a device to find a differential that will apply and justify defining specific administrative costs as chargeable to the central state agency.

I hope that is clear enough for you to understand just exactly what the discussion was around. I might interpolate there that we were taking into consideration a great many services within a state health department that are rendered almost entirely or entirely on behalf of the local unit. As one illustration, we have our rapid treatment centers that are chargeable entirely to central administration, and yet the services rendered in such centers are almost entirely for the individuals in the counties where we have treatment centers. In most instances this is a direct service to local departments and the

people locally. There were many other illustrations.

I might illustrate that by saying that it was agreed that there were many services that were carried on by the state health department the benefits of which accrue almost entirely to the people in local areas and to the credit of the county health department. We might refer to mobile x-ray diagnostic units, which go into the counties at the invitation of the county health department and render a direct service locally. Yet the cost is carried by central administration.

It was agreed finally that more state funds should be allocated to local units with more local responsibility for services.

From that we came to the question of the matching of funds in the overall picture. It was finally agreed that administrative policies are tending toward broader inclusion of state funds that are used for health purposes. In many instances the state health department is administering state tuberculosis hospitals or other state hospitals, the support of which comes from public funds.

Then, we took up the question of allocation formulas, which is somewhat over-lapping the report of the preceding leader. It was agreed that no standard formula on the national level could apply to all states and therefore is not feasible. The formulas now in operation, or in process of being put into operation, by the various states were described as simple in their operative procedures though varied in considerable detail. It was suggested that the Committee on Administrative Practices of the American Public Health Association secure copies of these and make them available to state health departments, but only on request.

Dr. DeKleine: The last report is by Dr. Godfrey and it is on Dr. Burney's paper. Dr. Godfrey.

Group 4—Leader—EDWARD S. GODFREY, JR., M.D., State Health Commissioner, New York.

Consultant—L. E. BURNEY, M.D.

Dr. Godfrey: Mr. Chairman and Members of the Conference—

Group 4 discussed a number of the items included in Dr. Burney's paper of this morning, and a few items were extracted simply to report on them as being of greater importance than some of the details of his paper. We have endeavored to condense here what we felt were the outstanding features of the public relations or public health education division in a department of health.

We believe that first of all the department of health must give the quality of service. That service in itself is of the utmost importance in obtaining good public relations and in inducing belief on the part of the public on the material which is submitted. The department in its publicity and education must be truthful with respect to its publications and other media of education. It should abstain from offensive self-praise. In carrying on a public relations service the department should begin at home, and suggest and advise all of its employees how to deal with people. The Commissioner of Health of the State of Washington stated that the telephone company in his area provides a public relations in-service training to employees of large subscribers upon request. Those are the reception clerks and people who deal first hand with the public. Also the type of correspondence, replies to request for service, are items sometimes overlooked by subordinates in the department, and frequently are not considered by the top officials. Acquainting the public with the health services available for the purpose of establishing good will towards the state and local departments of health is of primary importance. This would comprise the usual

news releases, and radio programs, and moving pictures, and other forms of education that are well known. And since much of the volume of health education work is done throughout the country by voluntary agencies on both the state and local levels the state and local health commissioners should increasingly solicit coöperation and assistance from such agencies and likewise seek opportunities to provide cooperation on their part. Provision should be made for the concentration of whatever health education services may be available upon particular areas or on particular objectives requiring relatively short term effort.

Finally, a director of public health education should be employed (if the local health department does not serve too small a population to justify it) whose education and training enables him not only to use effectively the usual channels of publicity, but to discover new avenues of creating a consciousness of the value of the actual and potential services of the public health department.

Dr. DeKleine: Are there any questions or remarks? It was moved and seconded that the report be accepted.

Audience: The motion is carried.

Dr. Emerson: On Friday we plan to face you with the present situation after a discussion on the recruitment of personnel which is the major problem that you face. We mean to devote the afternoon three hours, from 1:30 to 4:30, not to these group discussions but to a presentation of the record of the 48 states as of August 1, 1946. We have maps prepared from your own information showing the location and percentage application of full-time health departments by units diagrammatically represented on the outline of the map for each of the states, and we should like to have at that moment approximately four minutes for each state, to take in the picture and respond to it. You are asked to have these three questions in your mind, taking for granted that every state will be represented, the first one is "What is now hindering complete coverage in your state?" Second, "What are you doing to overcome these difficulties?" and third, "When do you believe you can complete your state's coverage?" You see that leads us off into prophecy and speculation of all kinds, but we would like very much for the guidance of the committee on local health units, to have some idea from the results of this conference as to what we can do further to help the interests of total national coverage and what information that we have now will result in that condition being changed in the course of the next six months, or year, or five years. We expect to cover the map at some subsequent conference with a perfect record of all states.

Dr. DeKleine: Thank you, Dr. Emerson. There are left over three resolutions, or something in the nature of resolutions.

One was acted on officially, copies of which are in your hands. We will discuss them in the order that I have them before me. The first one is Dr. Erickson's report of Group 1 relating to Dr. Mustard's paper, which reads as follows:

"Whereas, the nation should have total coverage with local health services for all of its people and

Whereas, state health officers and state boards of health have a primary interest in the organization of such full-time health services.

Therefore: it is the sense of this conference that:

Every state should have or should immediately develop a plan for providing for full-time local health services for all its people and further that this plan should include programs for:

1. Enabling legislation
2. A definite schedule or specific criteria for

dealing financially with local health jurisdictions to provide full-time health service

3. The recruitment and training of personnel, and

4. The development of a state-wide program of health education to be carried on at both state and local levels but only in accordance with the available facilities for providing the services which may be demanded as a result of such program."

Unknown: I move its adoption.

Dr. DeKleine: Motion has been made and seconded that this report be adopted.

Dr. DeKleine: The motion is carried.

The next one that I have before me is the report by Dr. Shackelford of Dr. Smillie's paper, relating to training. There are three questions raised. First is, "Should state departments of health operate training programs?" And under that, "Resolved, that it is the sense of the group, discussing training of personnel for local health units, that it is a responsibility of state health departments to establish facilities for continuing in-service training, and for the training of newly employed personnel prior to assignment, and anticipation of intramural study for those, who, after field experience, may be found fit."

Number 2, "How may the curricula of public health schools be modified so as further to meet the needs of the several states?

"Resolved, that in as much as a well grounded health officer should be familiar not only with the usual things in public health but also present trends in the field of medical care, the suggestion be made to schools of public health that consideration be given to the possibility of so broadening their courses for medical health officers as to include instruction in this field, the goal to be a more effective coördination of the fields of medicine and public health."

Number 3, "A Specialty Board in Public Health.

"It was recommended that consideration be given to the advisability of setting up a specialty board in public health."

Dr. DeKleine: What are your wishes? There are three different resolutions or recommendations, whatever you want to call them. The first one is in relation to training.

Dr. DeKleine: Motion has been made and seconded that these recommendations be adopted. All in favor will say aye. Motion is carried.

Dr. DeKleine: Dr. Neupert's report, the discussion of "Legal Aspects of Planning for Local Health Units."

"It is recommended in planning new legislation, or modifying existing laws having to do with local health units that:

1. Each state should enact legislation providing for the organization of full-time local health units. A local unit is defined as an individual government area, city, county, township, borough, and so forth, or a combination of two or more contiguous jurisdictions of local government organized to carry out the accepted functions of public health.

2. The authority to approve the organization of a local health unit should rest with the state department of health. The approval should be governed by rules and regulations adopted by the state health department, or by the state Board of Health, or Public Health Council. Included in the rules, but not in the basic law, should be definitions of the area covered, population to be served, budget, and personnel.

3. The consolidation of two or more contiguous areas of local government into a single administrative health unit should be *instituted* either by resolution of, and agreements between, the governing bodies of such areas, that is, Boards of Supervisors, Councils, Commissioner, etc., or by referendum vote of the populations in each area, or by whatever other mechanism is legal to accomplish the purposes in that state.

4. The authority to determine the minimum, essential functions of the local health unit should be vested in the state department of health, or Board of Health under rules and regulations adopted by that body. These

should in all instances include at least the six standard functions accepted as basic for local health departments.

5. Each health unit should be administered by a full-time medical officer of health or health commissioner appointed by the local constituted authority subject to the approval of the State Board of Health.

6. The selection of health officials and other personnel for service in the local health unit should be inaccordance with standards and qualifications prescribed by the State Board of Health or Department of Health.

7. The director of the local health unit shall appoint necessary subordinates and assistant personnel who shall be qualified in accordance with standards of education and experience, prescribed by the local Board of Health, Civil Service, or Merit System, whichever governs.

8. The removal or discharge of a health official or other personnel in the local health unit should be by the local appointing authority in accordance with regulations of the merit system or rules and regulations of the State Board of Health or State Health Department.

9. Provisions should be made in an act separate from the enabling act for adequately financing the activities of local health units."

Dr. DeKleine: The motion has been made and seconded that we adopt these nine sections as amended. Are there any remarks? If not, all in favor will say aye. The motion was passed unanimously.

Thursday, September 12

General Session

Presiding: REGINALD M. ATWATER, M.D., Executive Secretary, American Public Health Association.

Dr. Atwater: Gentlemen, I suggest that we come to order for this Thursday morning session.

You will notice that the Thursday program, being like the three preceding days, is the last day's program of this kind, tomorrow being set up on something of a different pattern. So, we shall make the most out of our opportunities to be together today.

As we turn to this program today I am reminded of the discussion that the Program Committee had in planning this session. Among those subjects which they wanted put into the session was consideration of the coöperative approach between voluntary and official agencies. Those of you who have read the Gunn and Platt report on "Voluntary Agencies: An Interpretive Study," will recall the chapter there in which the authors describe the experience in New York State and in California as being typical of good state organization coöperatively set up between the official and voluntary agencies.

We are fortunate today in having a representative from a voluntary agency in the New York State area, Mr. George J. Nelbach, who for a long career has been the Executive Secretary of the New York State Committee on Tuberculosis and Public Health. That committee covers the upstate area, not the New York city area. The coöperative understanding which has been developed there across the years between the State Committee on Tuberculosis and Public Health and the State Health Department is unique and very productive. Mr. Nelbach in speaking on the subject of "Promoting Public Support for Local Health Units" will give you one example of how that coöperative program works out. Mr. Nelbach.

Mr. Nelbach: Dr. Atwater, Dr. Vaughan, and Friends—

The organization which I represent has been engaged in the organizing and promoting of health education and legislative aspects of tuberculosis work since 1907, and as the chairman mentioned, we operate only in the upstate region, so what I am telling you will be quite typical of what goes on elsewhere in the country because our upstate region does have all types of communities, counties with populations of less than 10,000, sparsely settled poor economic units in the Adirondack and Catskill mountain region with only one truly large city in the upstate region, namely, Buffalo. The relationships which Dr. Atwater alluded to have been brought about largely through careful planning from the very outset of our work. The State Commissioner of Health has always been not merely a member of our board, but on the Executive Committee, so that he sits in when programs, policy, and finance are discussed. We have never in our organization adopted a program of work or a budget without the State Commissioner of Health participating and guiding us in reaching our conclusions.

We also have periodic conferences with various divisional staffs of the state health department. While our work is financed by Christmas Seals we are also, through the courtesy of the National Tuberculosis Association, privileged to

use funds for closely related lines of work. We have been promoting public education in diphtheria immunization since 1926. We have been actively engaged in the venereal disease control movement since 1932. We have always taken an active interest in the framing of general health legislation. Parenthetically, I think I can safely say there has never been an important bill drafted either by the state health department or by our organization but what both agencies have worked on the draft of the bill, have helped to secure its introduction, and it often falls to our lot to lead and spearhead the movement to arouse public support to get the bill passed. The department, wisely I think, in numerous cases asks for a citizen organization like ours to go to the front and bear the brunt of whatever odium may befall an organization that is proposing something new in the legislative line.

So much for introduction.

Now, my subject this morning is "Promoting Public Support for Local Health Units," and by arrangement of the Planning Committee Ira Hiscock and I have divided the field up. So, what my title is interpreted to mean is "The Process of Promoting and Organizing Public Support," for, first the creation of such local health units, and also for expanding and strengthening existing local health units.

Promoting Public Support for Local Health Units

GEORGE J. NELBACH

Committee on Tuberculosis and Public Health, New York State Charities Aid Association

By agreement with the Planning Committee of this Conference, the title of my address is interpreted to mean the process of promoting and organizing public support for the creation of local health units with full-time health officers in charge, and also the expanding and strengthening of existing units, including the mobilizing and focusing of public sentiment upon the particular local governmental authorities which have the power to establish such units and to make appropriations for their support.

The creation of such local health units generally involves a marked change from the status quo—that is, from a long-time existing system under which a local part-time and relatively untrained and inadequate public health service has been provided to the people by a county or a city or, as in some states, by a sizable number of smaller governmental units within a county such as towns, incorporated villages and small cities.

To bring about such a change is usually not easy. Generally speaking, one or more, if not all four of the following obstacles and handicaps need to be surmounted. First is the fear of immediate or of eventual separation from their jobs on the part of those who are now holding them or their fear of demotion to less responsible positions involving reduction in pay and lowered prestige in the public eye. These are what may be called the vested interests in the present situation and they usually have many relatives and friends who collectively can muster considerable influence against the full-time plan if they want to. Second is the fear of state domination or control of the local health work under the proposed new dispensa-

tion—a fear held by numerous local public officials and others in the political group and by some private physicians and medical organizations and by others who may share with them a strong dislike and distrust of supervision from any central state authority. Third is the fear of change just because it is change; this is held by numerous quite conservative persons, some of whom are influential because they are well-to-do people, rather heavy taxpayers and quite accustomed to express their opinion about governmental matters to those holding public office. Fourth is the widely prevalent lack of knowledge about public health, particularly with respect to its organization and administrative aspects.

In some states the statutes relating to the creation of full-time local health units call for a referendum of the voters on the subject at a general election; in several the statute calls for both the initiative and referendum processes of governmental action. In most states apparently the creation of such local units is dependent upon affirmative action being taken on such proposals by the representatives of the people elected to public office on county boards and, in the case of cities, on the boards of aldermen or common council and to the office of mayor. Thus, in each such situation, a campaign of public information, education and agitation may be and usually is essential for the achievement of the objective. The more intensive, comprehensive, resourceful and vigorous such a campaign can be made the better are the chances for getting a full-time unit established. Abraham Lincoln made one of his sagest pronouncements when he said, "Public opinion is everything. With it nothing can fail, without it nothing can succeed. He who moulds public opinion goes deeper than he who enacts statutes, for the moulder of public opinion makes statutes possible or impossible to execute."

Because of the widely prevalent fear of state domination and control of local health work, it would seem advisable for the State Health Department to remain in the background and to encourage and stimulate citizen organizations to go to the front and conduct the campaigns of public education and agitation that are usually necessary to bring about the creation of full-time local health units or to help already established units to secure substantial increases in local funds for the expansion of their existing services or for adding new lines of work to their service programs. Almost every state has on the state level and practically every county and city has on the local level citizen organizations that are engaged in conducting one or more branches of health work, such as the tuberculosis association, an infant welfare society, a visiting nursing association. Also, there are numerous other groups that are interested in public health though that may not be their prime interest, such as parent-teacher associations, family and child welfare societies, the farm bureau, home bureau, 4-H clubs, labor unions, chamber of commerce, men's and women's luncheon clubs and others. In the nature of the case, the advocacy of the creation of local full-time health units by such local health, social welfare, and civic agencies can much more readily win local public support for such projects than can representatives of the State Health Department, working alone or chiefly by themselves.

Of course you understand I do not mean to suggest that the state health authorities should play a passive rôle. On the contrary, I feel that the State Department should be extremely active but that its representatives should remain practically anonymous in the localities to which they are assigned; that they should work behind the scenes, so to speak, in advising, assisting, stimulating and energizing the local citizen

group or groups that are to conduct the campaign work. The state Department should make studies and surveys and prepare suggested programs and budgets and assemble and provide the data needed with which to convince the general public and their representatives in public office of the need and merit of the full-time health unit plan. It should of course prepare and publish appropriate literature for selective distribution on the state level and for wide distribution in the localities that are being "campaigned."

It almost goes without saying that the State Health Department would do well to solicit the coöperation on the state level of the one or more state-wide citizen organizations and groups that are actively concerned about the public health, particularly the state tuberculosis association, and from which valuable staff coöperation and other practical assistance, financial and otherwise, may be secured for campaign work on both state-wide and local levels. For example, take the matter of the preparation of literature. Some state health departments are hampered by restrictions with respect to public printing, which, often make it impossible to produce really attractive, attention-getting literature and some such departments are not able to employ competent pamphleteers. The voluntary associations are under no such restrictions. In many states they could finance, in whole or in part, the expense of publishing good literature: two-color jobs, with pictures, drawings, attractive lay-outs, good paper stock, and so on; and some have, and others can secure, competent pamphleteering skills—writers who can present the case for local health units effectively to lay readers in two and three syllable words and with a minimum of the mumbo-jumbo of scientific terminology which so often obscures the clarity and otherwise diminishes the value of such literature as an educational medium for non-medical persons.

In undertaking an organized effort to promote the establishment of local health units, the State Health Department will wisely decide in what particular counties, cities or other areas the chances for success are most promising. Failure in one or several areas to achieve the desired objective would have a deterrent effect upon similar efforts elsewhere within the state and perhaps in other states, especially adjoining ones. Before selecting the particular areas in which to conduct such campaigns, the state department of health in my judgment would do well to call into conference representatives of the unofficial statewide health and medical organizations so as to pool with them all the information and knowledge that they may severally possess about the economic, political, social and other considerations that have a bearing upon the case. The department should also enlist such staff and other assistance as these statewide citizen organizations severally might be able to supply in the areas selected for promotional work. Our New York State Committee on Tuberculosis and Public Health, with funds from the annual sale of Christmas Seals, has often provided staff and other assistance to such campaign projects.

The next step is for the State Health Department and these statewide agencies to send representatives to the selected areas to confer with their local affiliated authorities and agencies and some other representative citizens about the need for the establishment of a local full-time health unit, about the timeliness of proposing it, and to ascertain whether these agencies and persons are willing to become the nucleus of a citizens' organization to conduct an organized effort for the creation of such a unit. Assuming that they are willing to undertake such an effort, they should then, in my judgment, create a temporary organizing committee whose duty

it would be to form a larger organization to conduct the campaign of public information and agitation. Special pains need to be taken to inform, enthuse, and inspire this temporary organizing committee so that they will do a good job in selecting and forming the larger campaign organization.

The citizens' committee, under whose name and sponsorship the project is to be promoted throughout the area—whether it be a county or a part of a county or a city—should be composed of many persons who exercise leadership in the various walks of life that make up the community: financial, commercial, industrial, organized labor, agriculture, religious, fraternal, educational and from foreign-born and racial groups, if either or both are quite numerous, and of course from the professions that are naturally interested in the subject: medical, dental, nursing, veterinary medical; as well as persons from the voluntary and unofficial health and social agencies. The composition of a citizens' committee made up of such leaders from a cross section of the community would of itself give standing and prestige to the health unit proposal and would considerably improve the chances of success, either at the election polls or at the hands of the county board or city council.

The process of securing the acceptance of influential persons to serve on this campaign committee and of getting the committee into action requires careful work upon the part of selected local people, assisted by representatives of the state health department and of statewide associations. After the list of persons desired as members has been carefully compiled, the method of approaching them should be likewise carefully determined. In the case of some individuals, their consent should be obtained through personal interviews. In the case of others their consent could be secured through letters, and others may be enlisted over the telephone. Whether such prospective members are approached in person or by letter, the essential points are: first that they be approached by influential persons in whom they have confidence, and second that they be made fully acquainted with the facts and considerations relating to the project, either through personal conversation or through literature, or both. If, before an invitation is extended to a large number of prospective members, a nucleus of a dozen or so of the most influential and best known persons in the area can be secured, this would have much weight in persuading others to join.

The campaign committee should have the usual officers: chairman, vice-chairman, secretary and treasurer. There should also be an executive committee which should meet frequently to determine questions of program, policy and finance and in other ways to direct the organization and conduct of the campaign of public education and agitation. This executive committee should consist of the officers of the campaign committee and the chairman of its various sub-committees.

A meeting should be arranged of those who accept membership on the campaign committee for the purpose of organization. This organization meeting may well constitute the formal launching of the organized effort to secure the creation of the health unit. This meeting might take the form of a dinner or a luncheon and should be thoughtfully arranged in advance. For this occasion an outside speaker representing the State Health Department or other agency interested in and thoroughly informed about public health administration should be secured. He should be such a person as would bring to the meeting and to the project the prestige of his position and he should be able to outline fully and clearly the plan proposed and to answer questions

about it. There should also be one or several local speakers.

Before arranging this combined organization meeting and launching of the campaign, the temporary committee on organization should make up a slate of the persons who are to be proposed for election to the offices of the citizens' committee. This should be done well in advance of the date on which the campaign committee is to be formally created. Particular attention should be paid to the filling of the most important office, the chairmanship of this citizens' committee. The chances for securing a successful outcome of the campaign might hinge upon the choice of this person. He should be a recognized leader in public affairs—the more influential the better—the kind of man at whose request numerous members of the citizens' committee would be willing to serve as volunteers in capacities suited to their abilities. The likelihood of his acceptance would be enhanced if it were made clear to him that he would be assisted by a salaried campaign manager, serving preferably on a full-time basis for the duration of the campaign and who would relieve him of burdensome, time-consuming details. It should be made clear to him that as Chairman, his main duties would be to select the persons who are to serve as chairmen of the various sub-committees and to direct the execution of decisions reached by the executive committee on matters of policy, program and finance. In practically every county and city there are several persons who possess a high order of executive ability and who through war work or community service of one kind or another have acquired the experience that would enable them to serve most acceptably as chairman of such a campaign committee. Most any such person could be induced to take charge of this enterprise if its value were made clear to him in concrete terms of its benefit to the lives, health and well-being of the people of the community.

A big attendance at the organization meeting of the county campaign committee should be worked up and plans laid for securing adequate newspaper reports of the transactions of the meeting. The newspaper publishers and editors should be prevailed upon to attend the meeting. Its importance as a community function merits special efforts to secure their attendance as citizens as well as their assignment of reporters to report the meeting.

Next in order is the selection and appointment of subcommittees. For the twofold purpose of inducing many persons to take part in the campaign and of getting the multitudinous details attended to, it is proposed that some subcommittees be appointed by the county campaign chairman. I suggest that the subcommittees be as follows:

(1) *Committee on Speakers*

Its work would be to recruit and assign persons with successful experience in public speaking to give addresses about this project before regular or special meetings of county-wide or local organizations, societies, labor unions, granges, home bureau units, lodges, clubs, and so on, and to stimulate them to adopt resolutions in favor of the project and to send copies thereof to their local representative on the county board or city council as the case may be—whichever body has the power to establish a full-time local health unit.

Lawyers, priests, ministers, college and high-school instructors in public speaking, club women, and those who have served in war bond, community chest and other fund-raising campaigns are excellent groups from which to recruit speakers for this enterprise. If possible, several speakers should be enrolled from each town and numerous ones from each city within the area.

The State Health Department will of course provide an appropriate leaflet as source material.

At the outset, it would be well to have a meeting of the speakers held at some central point with the campaign committee chairman and a representative of the State Health Department or other state health agency present for the dual purpose of indoctrinating them about the project and of explaining how to answer questions about it and arguments that

may be advanced against it at the meetings which they are to address.

(2) *Committee on Meetings*

Its work would include:

Arranging with the president, secretary or other responsible officer of local organizations for the delivery of an address on the need and value of full-time health units at their regular stated or special meetings by a speaker to be provided by the Committee on Speakers.

Arrangements should also be made for the showing of motion pictures and for the distribution of literature at these meetings. Portable motion picture projectors could probably be borrowed from the local tuberculosis association, the schools and other organizations.

(3) *Committee on Publicity in Newspapers and House Organs*

The fact that a campaign is being conducted in a county or city is itself news. The details of the campaign as it develops creates news. Much of the material in the various leaflets and booklets is news. The addresses of speakers who discuss the project before all sorts of meetings should be reported in the newspapers—by the papers' own reporters if the editors can be induced to assign reporters. In any event this Sub-committee should make certain that reports of all meetings and addresses are furnished in concise, newsy form to the newspapers promptly while it is still news.

It is especially important to bear in mind that in creating interest in the subject in each village, town or city of the county, the *local* phases of the project should be stressed. Indicate in news stories and in addresses what the local bearing is: how it would affect the whole community; who are the local people serving on the county, town or city campaign committees; what they think and say about the proposal. Less material should be furnished to the weekly papers than to the dailies because the space of the former is more limited. Photographs about public health services and cuts of speakers are welcomed by the city press.

All resolutions in favor of the project that are adopted at various meetings should be sent promptly to the local newspapers of the locality in which the meetings occur, as well as to the locality's representatives on the county board or city council. If a resolution has been adopted by a particularly influential county organization, it should be distributed not only to the local paper or papers but to the entire press of the county and copies should be mailed to the individual members of the county board.

So-called "house-organs", bulletins, trade journals, are commonly published by corporations, churches, chambers of commerce, service clubs, fraternal organizations and the like. Appropriate articles should be prepared and supplied for publication in such printed or mimeographed house organs.

The membership of this Subcommittee on Publicity should be made up of those persons in the community who have had experience in preparing or otherwise securing newspaper and kindred publicity for the organizations or groups with which they are connected, such as the tuberculosis association, chamber of commerce, community chest, home bureau, and the various character-building agencies that are accustomed systematically to obtain publicity about their activities, such as the Y.M. and Y.W.C.A., the Boy and Girl Scouts, and the churches.

With the exception of places in which open, organized opposition or strong undercover opposition is being put forth against the full-time health unit project, I do not suggest that resort be made to the insertion of *paid advertising* in the newspapers. I am inclined to favor that only in such places where there is opposition and in which also the creation of the health unit is subject to a referendum of the voters. Then I would be inclined to try to get a quarter-page, half-page or even full-page ad in the daily paper or papers having the largest circulation and have it appear two or three days before election. Such an ad should constitute a last-minute appeal to each voter of the county or city to vote "yes". In the preparation of such an ad, good local talent can usually be found in the employ of a local department store or other frequent advertiser or on the staff of a newspaper. The expense of such ads could be met by inducing a group of regular advertisers to share it upon some mutually acceptable basis, with appropriate acknowledgement that they are doing so being made in the ad itself. This is what is called by professional publicists "underwritten advertising."

(4) *Committee on Radio Broadcasting*

In counties and cities in which this subject of full-time health units does not, in the course of the campaign, become a highly controversial one—and in most places it will not—the proprietors of broadcasting stations will generally be willing to give *free* time on their programs on the score that this project is a community welfare enterprise. Advantage

should be taken of their willingness to do so and an appropriate subcommittee should be appointed to prepare the script. Persons who have had experience in this special type of publicity may be found on the staff of the tuberculosis association and other community agencies. The presentation of the subject should take the form of a dialogue, or round-table discussion or drama featuring some concrete example of a health need and the provision of a health service to meet that need. The New York State Health Department has been conducting an excellent periodic presentation of health subjects in drama form over a considerable period of years. Perhaps other state departments could provide services and skills for use by such a subcommittee.

(5) *Committee on Literature and Exhibits*
Its work would be:

To prepare and publish such local literature as may be deemed necessary in addition to that provided by the State Health Department.

To provide for the distribution of such leaflets at meetings and by churches, libraries, factories, public utilities, insurance companies, department stores and laundries.

To get up exhibits and arrange for their display at fairs, conventions, meetings and in store windows.

To organize poster contests among high-school art students with prizes to the winners provided by the campaign committee. Such posters would constitute excellent exhibit material for display on various occasions and places including the public hearing on the project that presumably would be given by the county board or city council.

To arrange for essay contests on the subject in the high-schools and for compositions to be written about it by older grade school children. In this case too prizes might well be offered by the citizens campaign committee.

Persons experienced in this kind of work are the advertising display managers of public utilities and department stores, instructors in colleges and high schools, school superintendents and principals, tuberculosis association personnel, Farm and Home Bureau managers, Chamber of Commerce secretaries.

(6) *Committee on Ways and Means*
Its duties would be:

First, to draw up a budget of the necessary expenses to be incurred in conducting the campaign. The chief item, in my judgment, should be provision for the salary, travel and incidental expenses of a campaign manager in case the services of such a key person in the scheme cannot be provided, free of charge, by the local Tuberculosis Association, Community Chest, Red Cross Chapter, Home Bureau, Chamber of Commerce, or similar agency.

Other budgetary items would include rent for the headquarters office of the citizens campaign committee if free space cannot be obtained; the loan or rental of desks, chairs, filing cabinets, typewriters; mimeographing machine, motion picture projector; postage and telephone service; letterheads, stationery and other office supplies; wages for stenographic and clerical services; and for the printing of such local literature as may be needed in addition to that provided by the State Health Department and other state agencies.

Second, to raise the necessary funds for the campaign budget by solicitation of contributions from organizations and individuals. The Tuberculosis Association and the Red Cross Chapter would probably make substantial contributions.

Funds should be solicited from individuals as well as from those other social welfare and civic agencies which are deeply interested in the project, such as labor unions, parent-teacher associations, women's clubs, civic improvement societies and the like.

The key persons in the campaign organization set-up which I am suggesting are the chairman of the campaign committee, whose qualifications for the office I have already specified, and the campaign manager. It is very desirable that the campaign manager be employed on a full-time basis for the duration of the campaign period, which I believe should be not less than three months and probably need not be more than six months at the most. If full-time service from a campaign manager cannot be arranged, the next best plan is to get the service of such a person provided for at somewhere between half-time and full-time. Preferably such a manager should be a resident of the county but that, in my judgment, is not essential.

In a number of similar campaigns with which I have been connected in New York State—referendums of the voters on the establishment of county tuberculosis sanatoria—the campaign managers were members of the staff of

the State Health Department or our State Tuberculosis and Public Health Committee, chosen because of their skills in organization, promotion and publicity. They were successful in each of the twelve election campaigns. They were very good at working behind the scenes; their names rarely appeared in the press. The names of the chairman of the campaign committee and of the chairmen of the subcommittees and of the members of the speakers bureau were the ones that were usually played up in the newspapers.

Within the past five years the number of executive secretaries employed by Tuberculosis Associations and Red Cross chapters has increased greatly. Many of these persons have the skills needed for the post of campaign manager. Also the number of Community Chests has increased and more of them have taken on all-year-round executives who usually possess the aptitudes and experience needed for campaigns of this kind. Accordingly, the availability of such talent should be explored with a view to obtaining the services of such a worker with little or no expense to the campaign organization and as a contribution to the cause of public health from the agency by which he or she is regularly employed.

With respect to office space, the possibility of securing that essential item free of charge in a county or city building or in an office building or vacant store with a substantial concession in rental expense should be investigated.

The correspondence of the campaign should be typed on an attractive letterhead containing the names of the officers of the citizens' campaign committee and the chairmen of its subcommittees. If the entire sponsoring body is not too large to have their names printed either on the front or back of the letterhead, that is desirable. The printing should be done in the county, if possible, and should carry the union label.

Most public boards do not take decisive action immediately on new proposals that come before them, particularly if a marked change from an existing system or policy is involved. They generally refer the proposal to a special committee or standing committee of their own number for study and consideration and subsequently act upon a report embodying the findings, conclusions and recommendations of their committee. Such procedure is usually followed with respect to the creation of full-time health units. The citizens' committee for a new health unit should be conducting its campaign of public information, education and agitation while the study and investigation of the project is being made by the committee of the county board or city council, as the case may be. This campaign should be in high gear and at full momentum when the time comes for the committee of the public board to make its report. Such timing of the campaign by the citizens' campaign committee is for the dual purpose of influencing a favorable report by the committee from the public board and for securing decisive affirmative action by the public board itself upon the report of its committee.

All during the period while the committee from the public board is making its study carefully chosen persons from the citizens' campaign organization should be seeking opportunities to be helpful to the committee of the public board, furnishing them with information on the subject, answering questions, clarifying points that may be obscure and making available the experience of similar units in the same and other states.

A "Go and see" visit to localities that have full-time health units is extremely desirable. It often is the case that "seeing *is* believing." So, the committee from the public board should be encouraged, stimulated and, if need be,

assisted by the citizens' campaign organization to visit a number of places in the same state or in an adjoining state where full-time health units are in successful operation. Nothing will bring the advantages of the full-time plan home to them like actually visiting and seeing such departments at work, talking with the officials in charge, comparing the services and results now in that area with those before the full-time unit was established and securing the views not only of officials but of representative citizens and taxpayers. If it can be managed, one or two members of the citizens' campaign committee should contrive to be invited by the committee from the public board to accompany the latter on their visits to such areas. The writer knows of numerous instances in which such was done in conjunction with visits made to county sanatoria in various counties by committees from boards of county supervisors in New York State who had been appointed to study and report whether their counties should establish such institutions. In the course of such visits the citizen member or members in the party found innumerable opportunities to be helpful to the members of the public committee. The upshot in more than a dozen cases was that the citizen members of the delegation were invited to help draft the report of the public committee back to the board recommending the establishment of county sanatoria and even to help write the text of the resolution that was subsequently adopted by the public body definitely providing for the establishment of the sanatoria. In five of the six counties in New York State that have full-time health units, the writer recalls that members of the citizens' group were requested to and did provide assistance of a similar character to the county authorities.

Soon after the campaign has been launched and is well underway on the county or city level (as the case may be), the promotional work should be extended into each subdivision that has a representative on the county board or city council. A substantial volume of sentiment for a full-time unit should be aroused and expressed directly to him. Petitions should be circulated for signature by local residents requesting him to vote for the project. Resolutions should be passed by local organizations and sent to him. If he is married and has adult children, careful consideration should be given to the question whether it may be desirable to try to "sell" them on the project in the hope that they may do some "home mission" work on him. Of course, his family physician, his clergyman and other influential friends and associates should be induced to ask him to support and work for the project. Otherwise he may fail to vote favorably when the matter comes up before the county board or city council for decisive action on his allegation that there is little or no public sentiment for it in his district and hence that he does not see his way clear to vote for such a marked change from the *status quo* which a full-time health unit would entail.

This job of arousing and mobilizing public sentiment for the full-time health unit in the home bailiwicks of the various representatives on the public board needs special emphasis. This is particularly the case in those states whose local (county or city) legislatures have a rather large membership. In New York State, for example, the number of members of the county board of supervisors ranges, in most counties, between 15 and 30. Only 12 counties have less than 15 members on the county board and 17 have more than 30. One has 42 members, a second has 43, a third has 45, a fourth has 50, and a fifth has 54 members!

After a good start has been made in launching and conducting the campaign on a countywide or citywide level, from

that point on if all the steps I have outlined up to this point cannot be taken and it comes down to a choice as to what to do, then in my judgment the intensive propaganda work in the home bailiwicks of the public board members should be given precedence over further countywide or citywide efforts. For—may I repeat?—many years of experience have demonstrated that the attitude of many public legislative officials is influenced much more by what they hear and see done in their own home areas about a proposed county or city project than what they hear said and done about it at the county seat or in the city hall.

Usually it is desirable to request the county board or the city council to grant a public hearing upon the subject. A strategic time to have such a hearing is just before the board's special committee on the subject is making its report thereon, or soon afterwards. The citizen campaign committee should make appropriate plans for the presentation of its case at the hearing. These plans should include the selection of several of its ablest and most influential speakers to set forth the reasons why the full-time unit should be established and these speeches should dovetail together and not be unduly time-consuming. It would be well to have their speeches followed by a series of one to two-minute declarations by representatives from various countywide or citywide organizations to the effect that their societies are in favor of the project. Efforts should be made to work up a big attendance from the various localities within the area. The bigger the delegation is in numbers and the stronger the public standing of its members is, the more impressive it is likely to be to the county board or city council.

In those places where the creation of a full-time health unit is subject to a referendum of the voters, steps should be taken to organize a corps of volunteer workers to pass out appropriately worded circulars to the voters as they approach the polls. This serves the dual purpose of an appeal to the individual voter to vote on the proposition and also to vote "yes." There is danger that if only a minority of the voters vote on the proposition even though a majority of them who vote do vote favorably, the result may not be deemed impressive by the public board, and as a result dilatory tactics may subsequently be put forth by some members thereof to thwart the creation of the unit or to provide an inadequate appropriation for its organization and work.

What I am now about to suggest should be given very thoughtful consideration by the key figures in the citizen campaign committee. This is whether it would be good tactics to let the political leader or leaders, if there be more than one, in the dominant political party know that an organized effort is about to be made to arouse and mobilize public opinion for a full-time health unit. Many such leaders are likely to be better disposed toward such a project if they are told in advance what is in the wind. At this juncture of course he, or they, should not be asked to take a position on the subject, but to keep an open mind on it. Most of them are likely to say that they are willing to do that and that they want to see the will of the people prevail. The liberal, forward-looking leader may confidentially volunteer the opinion that he is in favor of the project and would like to see a substantial volume of public sentiment aroused to support the action of the public board in creating it. It may be well later on when the campaign is in high gear for representatives of the citizens campaign committee to see him again and ask if he has any suggestions. He may then tell them in what localities they should put forth special efforts to win the support of particular members of the county board or city council.

Occasionally a leader may be found who sees in the full-time health unit project a proposal which is bound to have much public appeal and which he will arrange to have incorporated into the platform or program of his party. The writer knows of several such leaders who did precisely that.

In places where the political control of the county is narrowly held, it may be well for the citizen campaign group to contact also the leader or leaders of the minority party.

I would not be surprised if some persons in this group may feel that the campaign set-up and plans I have proposed are a counsel of perfection. They may question whether the amount of time and effort this involves really needs to be put forth to secure the creation of full-time units. I concede that such possibly may be the case, but I do not believe in taking chances. Many years of experience have convinced me that it is extremely difficult to predict in advance how a public board may act or how some thousands of citizens may vote on election day on a project that involves such a marked change from the *status quo* as the creation of a full-time health unit does. So I believe in playing safe and in doing all, if possible, or certainly the majority of the things I have suggested.

Furthermore, the creation of a really impressive volume of public sentiment will favorably influence the attitude of the public authorities while they take the various steps indicated for setting up the unit and providing the funds for its work. The possibility of a political organization of the health unit is much reduced if the kind of public campaign is conducted which I have advocated.

The campaign organization should not be scrapped right after the decision to create a unit has been reached but should be kept intact and active in pressing for the right kind of action by the public authorities in setting up the unit and providing a liberal appropriation for its work.

Up to this point I have been sketching the campaign organization, plans and methods that I believe should be employed in pressing for the creation of full-time units. With regard to the expansion and strengthening of existing full-time units, I believe it desirable to develop a similar campaign set-up and use many, if not all, of the same methods and procedures, if the expansion and necessary appropriation therefor are substantial. But for more gradual and less substantial expansion in program and funds, the authorities in charge of the full-time unit should surely ask for and expect to receive from the existing voluntary health, social welfare and civic agencies their moral and active support of such requests, vigorously expressed by them to the county board or city council.

Clearly, the voluntary health organizations should take a deep and abiding interest in the work of the full-time health unit and should be on the alert for opportunities to help interpret the work of the unit to the citizens and taxpayers and by so doing help to build up for the unit increased understanding, good will and support from the people in general.

The voluntary health organizations should also year in, year out, help promote higher standards and objectives upon the part of the full-time unit through creating an informed public opinion that will expect and, if need be, demand proper support from whatever governmental administration or officials might happen to occupy the legislative and executive positions. This helps to reduce the danger of a slump in the official public health work, if and when changes occur in the county or city government, due to the shifting of political control from one party to another.

Likewise, the voluntary health organization should rally public opinion to

the support of efficient public authorities if they are unjustly attacked. Finally, as a corollary to that these citizen health organizations should have the courage to go to the front and spearhead an organized effort for the removal from office of a thoroughly unworthy board of health or of a health commissioner whose work or conduct or both fall far short of what they should be and are having the effect of impeding the advancement of the cause of public health.

Dr. Atwater: I know you have all enjoyed hearing that description of at least one method of approaching this subject.

For you folks who would like to know of another technique of organizing a state-wide citizens' committee, I suggest that you make it a point to attend the Group 1 this afternoon under Dr. McKay's chairmanship. I suggest that Dr. Buck be there to let it be known how several of these state-wide committees have been set up.

Thank you, Mr. Nelbach.

Our next speaker, who speaks on the subject of "Physician Participation in Supporting Local Health Units," has been known to a good many of us in various connections. Dr. Dean F. Smiley has been known to us in the student health service, Cornell University, and in many inter-institutional studies in the field of student health. He has been known to us for the last four years because of his identification with the Bureau of Medicine and Surgery of the United States Navy. He appears today, I think, in his first public address in his new capacity, as staff member of the American Medical Association attached to the Bureau of Health Education. He speaks here as a representative of Dr. George Lull, Secretary and General Manager of the American Medical Association. Dr. Dean Smiley, an old friend of the health movement.

Dr. Smiley: Dr. Atwater, Dr. Vaughan, and Members of the Conference—

I feel rather handicapped coming here cold after the conference has been in operation for several days. This is my first meeting here. If some of the things I say in my short paper are trite and have already been said, hope you will bear with me.

Physician Participation in Supporting Local Health Units

DEAN F. SMILEY, M.D.

American Medical Association

The plan before this Conference for providing local health units for the Nation *should* have, and *will* have I am sure, the whole-hearted support of the rank and file of the practicing physicians of the country.

Throughout the country, physicians have become painfully aware of the urgent need for a plan which will operate in rural just as well as in urban areas to provide modern public health and preventive medical services. With regard to the problem of providing *clinical* care our practicing physicians are still, in my opinion, predominantly of the belief that the answer lies not

in government organization but in stimulating the private practice of medicine in rural areas through the provision of health and diagnostic centers and supplementing it with practical schemes of voluntary prepaid medical care insurance which will so spread the costs of clinical care that that care will be available to all.* The problem of providing *preventive medical services* is, however, an entirely different matter. It requires laws, inspection and enforcement (in regard to communicable disease control, sanitation and vital statistics, for example); it necessitates community facilities (such as public health laboratories and school health services); it calls for mass education of the public (in its health education, and child health phases, for instance). The practicing physician wants to see these services provided but he is thoroughly aware of the fact that he is sometimes poorly equipped to provide them and seriously handicapped by the ethics and personal nature of his calling in the promotion of them. It is to be expected therefore that this new plan will be welcomed by the practicing physicians and accepted as the first step toward implementing the resolution of the A.M.A. House of Delegates June 10, 1942 calling for the achievement "at the earliest possible date of complete coverage of the nation's area and population by local, county, district or regional full-time modern health services".

POSSIBLE STUMBLING BLOCKS

The advantages to the practicing physician of full-time public health service for his community are so many and so obvious that one hesitates to suggest that there may be minor stumbling blocks which may in some instances stand in the way of his complete coöperation and participation. Such is the case, however, and if such blocks are to be avoided they must be foreseen and recognized.

First among these possible stumbling blocks *is the threat to the security of present part-time rural health officers.* These men through the years in many of the New England and North Atlantic states have carried the burden of town and village health officer duties on top of the never-ending task of medical service to their widely scattered clientele. Their recompense for this added duty has been small indeed, but many of them have come to take a pride in their public health work and to appreciate the value of the contacts with the state and federal public health authorities which the position of local health officer brings. To be suddenly and completely severed from any connection with the local public health work would be a severe and undeserved blow to the interest and prestige of these loyal workers. If any scheme were ever developed for subsidizing physicians to enable them to maintain a practice in rural communities it would in all likelihood involve the payment of much larger sums than are now involved in the present system of remunerating part-time rural health officers. For all of these reasons it is suggested that the faithful services of these workers be recognized, that in those instances in which the local part-time health officer is able to demonstrate his value as a part of the new county-wide organization his services be continued (though perhaps in a somewhat different capacity), that where the new plan calls for the elimination of any such part-time position the change be made over a period of time sufficient to permit the present holder of the position to make proper adjustment to the change. It is of some interest that the New York State Medical Society in its recent resolution urging "the voluntary establishment and maintenance of county health depart-

* *Rural Health Service.* A.M.A. Committee on Rural Medical Service. The American Medical Association, 1946. Chicago.

ments throughout the State at the earliest possible date" assumed that their state after January 1, 1947 "through increased State financial assistance to counties will make it increasingly advantageous for counties to establish and maintain modern health service by organizing a county health department staffed by full-time professionally trained medical and auxiliary personnel on a merit system basis, and at the same time permit the retention of local part-time health officers able to demonstrate their value as a part of a county wide organization".

A second possible stumbling block is the *threat of increasing centralized control over local public health administration.* Increasing state aid almost inevitably carries with it increasing state control. If we believe in the soundness of the basic principle of home rule, definite steps must be taken to protect that principle and guarantee that local health service shall remain in local hands. This means that membership in the local Board of Health must carry with it a vote that really counts and that when a local community through ignorance or bad leadership obviously fails to meet its public health responsibilities the State authorities will attempt to remedy the situation not by edict or financial pressure but by education and persuasion. Time-consuming and painful as these latter processes are, they must be the only ones used if we hope to conserve the values inherent in local responsibility and local participation.

And not only must actual coercion be avoided but unintentional slighting as well. I had the experience of sitting as a physician member first of a county nursing committee when it heard the county nurses' monthly reports and had to act on the cases brought before it, then later as a physician member of the county public health committee where the efficient State District Health Officer simply reported on what problems had come up and how he had handled them. The first involved considerable thought and some worry and responsibility—the members of the committee were almost always present. The second involved only rubber-stamping the well considered acts of the District Health Officer—members of that committee were frequently absent because of duties considered by them more pressing. It is obvious that if local participation and interest are to be gained by the state authorities they must be gained by honest sharing of responsibility and policy making. State and federal health authorities *do* get a long range view and a wide experience which should enable them to outline new policies and procedures with greater wisdom and foresight than local boards would be apt to have. On the other hand, local authorities by their knowledge of local people and local conditions are usually much better prepared than are distant administrators to gauge the acceptability and practicability of a suggested policy or procedure for that particular area. It is therefore not so much the necessity of using *good psychology* as it is the necessity of using *good sense.* It is *good sense* in developing public health work to lift the sights of local workers by means of suggestions that develop in the minds of workers in the upper echelons of administration. It is equally good sense to subject plans conceived at upper administrative levels to the stabilizing influence of criticism and evaluation by practical workers who visualize the plans entirely in specific terms of their own local situation.

Another possible stumbling block is the *threat that the public health authorities will increasingly enter into the clinical practice of medicine.* While the physicians will enthusiastically support local public health units as their most effective allies in the fields of preven-

tive medicine and health education they will not be inclined to be sympathetic with those units that leave the wide field of their 6-point public health program relatively untilled and rush rapidly and unthinkingly into the provision of multiple clinics and treatment facilities. Since the staffs of these contemplated units will be full-time and professionally trained it would appear to be entirely unlikely that they will fall into this error. Since it has been the clinician assuming a public health post without adequate preliminary public health training who has in the past most frequently made the mistake of developing clinical services in the name of public health, there is every reason for believing that this proposed reorganization of public health services should reduce rather than increase the chances of this mistake being made.

GOALS FOR PHYSICIAN—HEALTH UNIT COOPERATION

When Dr. C.-E. A. Winslow made his survey of the well known Cattaraugus County Health Demonstration in 1930, 7 years after its inception, he found, as you may remember, that of the County's 68 physicians 17 were hostile to the Demonstration, 18 were neutral toward it and 33 friendly. Thirty physicians out of the 68 were actively participating in the work of the Demonstration. There were 11 physicians who were friendly but were not participating; 4 physicians were participating but nevertheless hostile. Apparently both friendliness and participation can be won but they are two distinct achievements and each must be won separately. In every local public health unit whether single-county, multi-county, county-district, or city, the following goals might reasonably be sought:

1. A general feeling of friendliness between the practicing physicians and the staff of the local public health unit. This feeling should be based on the premise that both groups have the same purposes at heart, both have something definite to offer each other and both should therefore be mutually helpful.
2. Approval of the program of the local public health unit by the State Medical Society and by the County Medical Societies of the counties served by the unit.
3. A clear understanding on the part of the physicians in the area as to what services are provided by the unit, what the limitations on those services are, and in what ways the unit is expecting coöperation from the physicians. Particularly important is an understanding regarding the report and control system for tuberculosis, venereal disease and the communicable diseases and regarding the services offered and the necessary limitations on such laboratory srevices as water analyses and blood counts. The health officer can assist considerably in developing this type of understanding by requesting each County Society to devote one of its meetings each year to public health problems and by making a special effort to see that the physicians on the Board of Health and the physicians on the County Medical Society's Committee on Public Health serve the purpose for which they are appointed and actually act to keep the Society informed as to the activities of the Health Department.
4. Widespread participation of local physicians in the work of the Health Department:
   (a) As members of the County Board (2 or 3 of the 5 to 7 members should be physicians according to the Emerson Subcommittee Report)
   (b) As medical consultants (particularly in such fields as tuberculosis, venereal disease, the communicable diseases and child hygiene work)
   (c) As part-time workers (in child hygiene conferences, immunization clinics, venereal disease clinics; in the local tuberculosis, cardiac or mental hygiene programs)

In regard to this utilization of part-time physicians' services it is of interest that C.-E. A. Winslow concluded after his survey of the Cattaraugus County Demonstration " that the maximum possible utilization of the properly compensated service of private physicians is essential to the sound development of our public health program in the future ".

CONCLUSION

The practicing physicians of the country are as anxious as the public health authorities to see full-time public health service with professionally trained personnel made available to all our population, rural and urban.

Though there are stumbling blocks which may in isolated instances prevent the local physicians from giving their wholehearted support to this well considered and concerted effort at reorganization of public health services, these stumbling blocks are already so well known and so well marked for all to beware that it is my opinion that under the wise guidance of this group here today they can be completely and successfully by-passed.

Dr. Atwater: Thank you, Dr. Smiley. You have pointed out some of the pitfalls, you have quoted the actual experience of several areas. We are glad that you, yourself, have had first-hand contact with county public health committees, nursing committees, etc. You quoted the experience of Professor Winslow in Cattaraugus County, the canvassing of physicians who were friendly, unfriendly and neutral. I think it is significant that 16 years after the study that you report it is possible to say, as several of you know, that the present office of the Cattaraugus County Medical Society is in the office of the county health unit and that the county commissioner of health, is secretary of the society. That is an achievement that I think we should credit to those who have reached it locally.

Across the years some of us have felt much indebted to the next speaker for his contributions to understanding of human nature. I well recall the obligations which those in attendance of the American Public Health Meeting in Atlantic City in 1941 felt to Dr. Overstreet. The section of the proceedings containing his contribution has been printed, and reprinted, and is still in demand.

The next contributor to the program is Harry A. Overstreet, Ph.D., Emeritus Professor of the College of the City of New York. He will speak to us on "How to Influence People." Through his books, and through a long career Dr. Overstreet has placed us in his debt, and we are glad to have his participation now in this program.

How to Influence People

H. A. OVERSTREET, PH.D.

College of the City of New York

My special job today is to speak to you not as a public health officer but as an educator. I should be most embarrassed if you were to look to me for advice in your special fields of medical service. I am no expert in those fields; and I should look foolish if I were to pretend to be. But I don't think I shall look foolish if I come to you as a fellow educator. That is my field of expertness—such as it is; and that, I am happy to believe, is also your field.

Public health service has two sides to it. One is the side of giving expert service in behalf of public health; the other is the side of persuading the public to want that kind of service.

Most Americans still think of health as an individual matter—as something

between the individual and his doctor. Also, most Americans think of medical service as something to be avoided as long as possible—something that is costly and usually painful. Again, most Americans have more or less distorted notions of their bodily and mental functions, both in health and disease, and have only the foggiest notions of how to utilize the health opportunities that advancing medical and nursing service provide. Finally, few Americans have yet learned to think of their individual health as a public concern—public, because, as sources of infection or disability, they can drag their fellow-men into ill-health and disability.

In short, since most Americans in health matters are still deplorably backward, your task, as experts in public health, is also one of being experts in education. You have a public to enlighten, and, like all educators, you have to know how to do the job of enlightening.

Teaching is a bridge-building job. It is a process of building bridges from our own minds to the minds of those we teach. I want to speak briefly of seven bridges that I think men and women of your profession are required to build.

The first is the bridge of a *story to tell.* Have you a story to tell? Is public health so fascinating and so compelling a story to you that you can tell it so that others will catch fire? If it is not that—if it is routine administration; if it is a sour business of periodically reporting morbidity statistics; if it is a kind of watch-dog business—barking at bad sanitation, or housing, or what not—the bridge will not be built. The public will not be aroused to listen.

We teachers have to remind ourselves every now and then that a story is the most powerful means of getting an idea across. When a story is told, the listener instantly wakes up and begins to identify himself with the characters. The *American Journal of Public Health* in a recent issue (April, 1946) told how some 2,000 conscientious objectors who served in mental hospitals are telling a story to the American public. They did the dirty work in the hospitals. They served as hour by hour attendants—carrying the bed-pans, changing the bed linen, bathing the patients. Thus they learned from the inside how profoundly important the hospital attendant is to the well-being of the patient; and they saw, to their horror, that the hired hospital attendant is the lowest paid, the least regarded, the poorest educated, and the most demoralizing member of the whole hospital outfit.

They have a story to tell, and they are telling it with such clarity and deep feeling that, as the *Journal* reports: "This may be the dawn of a new day in the management of mental hospitals . . . They have let light into one of the dark places of the earth."

As a layman, it seems to me that the public health officer has a compelling story to tell. Here is drama: the drama of taking sick people in a sick society and making both the people and the society well; the drama of fighting off contagion and contamination that make people ill; the drama of creating sound conditions of mind and body for the creating of a sound society.

It is a story to be told as many stories: this particular local fight against disease; this particular fight for good housing; this particular winning of a fight for decent recreation. . .

To tell these stories so that people get the intense drama of them is to make public health service come alive in people's minds.

The second is the *bridge of words.* Do you use the right words? Or do you use words that repel or confuse or frighten or mislead?

Scientific specialists are subject to a peculiar occupational disease when it comes to the use of words. It is the

disease of perversely using the wrong words to say the right things.

The disease has its source in a special kind of scientific pride: the pride of being able to use technical terms that ordinary folk are supposed to view with awe. When the specialist uses such words he becomes a happily inflated ego. Sitting like Little Jack Horner in his scientific corner and looking out at the world of lesser people, he pulls out his plum of a horrendous seven syllable word and cries "What a big boy am I!"

Technical words are good in their place. Their place is where professional accuracy is required. But technical words are bad when they cause confusion or fright or when they are simply not understood.

Let me recall to you the word "psychoneurotic." It is a perfectly good word, absolutely necessary for professional use. But when the word is tacked on to a boy who has suffered an emotional breakdown in the army, it can do an enormous amount of harm. The boy goes back into civilian life a marked man. No average employer wants a psychoneurotic in his shop or factory; no school board wants him as a teacher. Why? Because of the terrifying sound of a word that neither employer nor school board rightly understand. A word is used as a label that makes a victim of the boy who is labelled.

It would have been wiser if our army psychiatrists had used the good old sympathetic word "shell shock." Anyone can understand what shell shock means. Anyone can realize that it is nothing to be ashamed of. But psychoneurosis! The psychiatric experts seem to forget that a word may not mean to the layman what it means to them as experts. They ought to have watched their word!

The first need of an educator of the public is to be an expert in word connotations. How do the words you use sound to the average layman? Can you find simpler words? Warmer words? Words that give him a glow of confidence? Words that invite him in rather than shut him out? Words that make you appear not as a pompous technician but as a man among men, talking their language and thinking their thoughts.

In every public health set-up, there ought, I think, to be a place for a periodic clinic on words. By laying out before you the words you use in your conferences and in your publicity you can look at those words objectively, asking how you would feel if you were a layman and they were hurled at you.

The third bridge (or obstruction) is *our manner toward people.* Do you and your staff have manners that repel or that attract?

This applies all the way up the scale; from the receptionist in the outer office to the top official in his inner sanctum. Strangers who come into an office to ask advice or to get help—if they are like myself—are usually embarrassed people. A receptionist who receives them with a glassy stare, or a gum-chewing indifference (not unusual in public offices), or who ignores them completely, is registering strike one against the public office. A receptionist, on the other hand, who has imagination enough to know that those people are embarrassed and that they need to be made to feel at home is an ambassador of good will between the public office and the public.

The telephone operator is a continuous point of contact between the health office and the public. Let her have a hard voice, an abrupt manner, and the public is pushed off. "Disagreeable people" is the verdict. Or "snooty" or "high hat."

The top officials suffer a danger that is common to all medical men. Medical men are a kind of surrogate for God. They have the Word. They lay down the law. In other words, they write out the prescription. Such power of per-

emptory decision often breeds a peremptory manner, particularly with subordinates and unimportant people. Doctors are notorious for their brusqueness—shall we call it bad manners—with the nurses who serve them. Since public health officers live within the aura of medicine—know the things that ordinary mortals need to be told—there is the danger that they, too, falling victim to the medical God-complex, may adopt the manners of dogmatic assertion and dictatorial peremptoriness.

Public health officers suffer from another possible danger. They are *public* officers. Public officers—on the civil service level—easily develop an air of officialdom. The characteristic air of officialdom is composed of three factors: irritation that the public exists; contempt for the public's never ending stupidity; and the assumption that the public needs to be taken more or less roughly in hand.

It might be well if public health officers—from top to bottom—thought of themselves first as *educators* of the public. If they thought of themselves as educators they would be more inclined to watch the effect of their own manners upon those they were trying to educate.

It may not be altogether true that "manners maketh man," but it is surely true that manners that repel or infuriate make a whale of a difference where public relations are concerned.

The fourth bridge is a *right publicity attitude*. Here the public health official often faces a major decision. Is the publicity that he issues to be about *him* or about public health. There are public health officers who quite obviously use publicity to toot their own horns. They seem unaware of the fact that in this area of science and medical service a tooter of his own horn is bound eventually to have his horn taken from him. Tooting your own horn may work in politics or in business—where that sort of thing is expected—but in a disinterested area like public health it does not work for long. Public health officers work in an area where self-interest comes second and the work itself comes first. It is so in the whole area of science. A scientist who sets out to toot his horn soon comes to be rejected among his fellow scientists and eventually by the public; for in the realm of science it is the job to be done—the research to be made—the truth to be discovered that ranks as number one.

This is a matter that requires a searching of the soul. If the public health officer is mainly interested in boosting himself he does not belong in the service. He had best find that out early and either change himself or his job. On the other hand, a public health officer who sinks himself in the good of his community; who passionately cares about developing health intelligence in his community, will put first and foremost into his publicity a concern for the community welfare. In so doing he will be convincing.

The effective writing of publicity material is a long story that cannot be gone into here. It is enough to say that the use of the story form and of words that attract rather than repel or confuse are primary to good publicity.

The fifth bridge is that of *association with other community enterprises*. This is a bridge that many other educators of the public are now learning to build. Let me use the librarian as an illustration. Formerly the librarian thought of himself as a custodian of books who sat behind his desk waiting for the public to come and ask for books. He would have been vastly surprised if any one had suggested to him that he should go out into his community, learn about it, take part in its affairs—in short, that he should bring himself to people rather than wait for people to come to him.

Much the same thing is happening

in the field of public health. Early public health officers sat in their offices, or if they went into the community, they went on strictly office business—like posting a scarlet fever notice or examining a contaminated well. Nowadays the public health officer sees himself not merely as one to whom the public should come, or who serves the public in specialized ways, but as one who should be part of the public in all its efforts to gain a more basic community welfare. Thus the public health officer may well feel that he should serve on a citizens' committee for the study of juvenile delinquency; or on a committee to help solve the problems of returning G.I.'s; or on a Mayor's commission to prevent interracial tensions. All these have to do with public health in the broad sense of the term. The public health officer belongs where such matters are explored.

But he belongs on such committees for the deeper reason that if he wants to win public confidence for his public health work, he has to be part of the public. He has to know the problems of his community and the people who are grappling with the problems. The Latin poet said: "Nothing that is human is alien to me." The public health official might equally say: "Nothing that has to do with community welfare is alien to me."

In the sixth place—another bridge—the public health official needs to know how to make a good speech. This may seem anti-climactic; but in fact it is not. A public health official who knows how to make a good speech—not a dull or rambling speech; not a speech that he reads haltingly from a manuscript; not a speech that he orates by the unmerciful hour, not a speech showing off his high-flown technical learning, but a good speech that makes people sit up and listen and enjoy as well as respect what he is saying—such a man has the whole works, provided, of course, that he knows his stuff. For such a man is able to move about among his fellows, to sit on their committees, join in their discussions, speak at their meetings and win confidence and affection.

Again, this is no place to explore with you the makings of a good speech. "If to do were as easy as to know what were good to do, beggars would go on horseback and paupers' cottages be princes' palaces." Nevertheless, difficult as it is to say how good speech-making is done, it needs to be done.

Finally, a seventh bridge. The first essential bridge, you will remember, was *a story to tell.* The engineering plan for the seventh bridge begins with a warning: Don't think you have to tell all the story yourself; let others tell your story for you. The seventh bridge is that of *awakened community leaders who will tell your story for you.*

Major Lewis Barbato, in the September, 1945 number of *Diseases of the Nervous System,* tells of the novel experiment in the education of community leaders conducted by Dr. Fellows at the San Antonio State Hospital. "He invited a group of ministers to live at the state hospital with the staff for a two-week period attending seminars, lectures and demonstrations, sitting in on staff conferences and conferences with relatives, and taking histories on selected patients. This proved to be an extremely valuable undertaking for, not only did the ministers receive considerable education about mental hospitals and their problems and about mental illness, but they each formed an extension, as it were, of the 'state hospital faculty,' carrying the information they had gained to their respective congregations who otherwise would not have been reached."

The idea is an arresting one. In any dramatic enterprise of public health, lawyers, educators, physicians, social service workers, leading business men and workers in civic groups could be

invited in to see and learn and then go forth to preach the gospel.

This is a psychologically sound procedure because it enlists pride. The official who feels that he and his staff must be the sole spokesmen for public health in the community are apt to give the impression of being jealous about their professional vested interest. Better the staff that cordially welcome in the community leaders. Such a staff builds up the feeling that theirs is no snooty branch of government that intends to have its way, come hell or high water. Rather, they build the feeling that they are host to the community: welcoming in everyone with eyes to see and mind to judge; and happy if these people they invite will go out and tell the story in far more effective ways than they are themselves able to do.

In summary, public health service can reach and influence people only as it has a compelling story to tell; tells it with the right words; has a right manner to go with the words; has a way of keeping the official ego well in the background; has an eagerness to join with others in what they are also trying to do for the public good; has a gift of speaking; and is willing to let others tell the story that needs to be told. Some of these bridges are hard to build; some are easy, requiring only that we be reminded to build them. But all are essential if expert knowledge is to move out into the area of the layman's needs; and if laymen are to be aroused to understand public health and give it their warm support.

Dr. Atwater: Thank you, Dr. Overstreet. I know that a good many of us will want to sit in on Group 3 this afternoon, where you, along with Professor Nathan Sinai of the University of Michigan, will pick up this thing for back and forth discussion, and we shall hope that that group will bring in further stimulating material into the afternoon session.

Our fourth speaker today needs no introduction to you. His subject, "Promotional Activities for Local Health Units," you will recall was divided off from the presentation which Mr. Nelbach made this morning. Dr. Ira V. Hiscock, as Dean of the School of Public Health of Yale University, and widely acquainted elsewhere in public health comes to that subject with excellent preparation.

Dr. Hiscock: Dr. Atwater, Dr. Vaughan, and Members of the Conference—

Coming at the end of a series of papers that has been presented during the four days naturally we find that this subject has been touched upon in almost every paper which has been presented to date.

Reference has been made to the discussions of the afternoon, and in order to focus attention on certain special questions, which may be of interest to the group, under Dr. Heering's guidance we have agreed to include, if the group so desires, discussion of the five major points which I should like to give you.

For a round-table discussion:

1. What basic information and types of studies have been found most useful in the promotion of full-time units?
   a. for State Health Department guidance, and
   b. for enlisting the interest of the public.
2. How can usefulness of the evaluation schedule and health indices be increased as a promotional instrument for local health units?
3. What are the functions of a division of records and statistics in the promotion of local health units? How are these functions inter-related with those of the health education staff?
4. How can a health council be utilized to stimulate the formation of a unified city-county program in a state having reason-

ably high per capita income and low mortality rates?

5. The organization and operation of a state-wide advisory health committee.
   a. Relation of such a committee to a division of public information or health education in a state health department.
   b. Relation of such a committee to voluntary health agencies such as cancer and tuberculosis associations.
   c. How is the operation of a committee staffed and financed?
   d. How are the facts from a health survey and the evaluation schedule of the APHA collected and used by an advisory health committee?

Promotional Activities for Local Health Units

IRA V. HISCOCK, Sc.D.

Chairman, Department of Public Health, Yale University

Full-time health jurisdictions in every state, adequate in number, properly organized and equipped to bring the benefits of modern public health service within the reach of every individual! This is our objective. Responsibility for the attainment of the objective is shared by state and local health authorities.

Some of the facts bearing on the situation are as follows:

1. A flexible pattern for promotion may be devised as a useful guide; but it is doubtful if a single, precise formula of organization and operation can or should be applied. The mores, traditions, problems, resources, in short the basic structures in the states, differ widely.

2. Nearly half of the people in the United States lack the benefits and first hand knowledge of full-time health units; hence the task is of great magnitude and significance.

3. Inadequate remuneration goes hand in hand with shortage of qualified personnel and represents a major obstacle to progress. High on a priority list is the institution of corrective measures.

4. Governmental units of education, statistics, health, welfare and other purposes are numerous, complex and competitive; complacency regarding change exists in states and local communities in spite of a lack of central tie-up of activities, even though the public health officials of these areas believe that joint planning and coöperative action (orchestration) are feasible and highly productive.

5. Small communities with scattered populations need as efficient professional health services as do the large and concentrated aggregations.

6. Many states lack basic legislation which will permit and facilitate the establishment of county, city-county and multi-county health departments.

7. Some state health departments feature a strong central organization, rendering much direct service to local areas at the expense of developing full-time local health services and of rendering consultation-advisory service. Studies reveal that many state health departments might utilize more field service for local health units in terms of a more adequate consultation-advisory field staff representing major phases of public health work.

A plan of action embraces the following activities:

1. Appraisal of problems and evaluation of services
   a. Through use of the A.P.H.A. Evaluation Schedule
   b. Through community health services and follow-up.
   c. Through continuing administration research studies.
2. Promulgation of necessary legislation.
3. Development of community health education including a dynamic program of public relations.
4. Formation of state-wide advisory committees.
5. Organization of local and state health councils representing appropriate community groups.

In this plan, profitable use can be made of the report on Local Health Units for the Nation to acquaint professional and lay groups with important information concerning desirable structure, costs and personnel. The suggestions for consolidated divisions of the state are subject to adjustment on the basis of detailed facts and experiences within each state. Meanwhile, State Health Departments and Schools of Public Health may well give special attention to recruiting and training of personnel, to job analyses, and to schedules for dealing financially with a problem of great public interest.

Each state needs legislation providing for full-time health organization. Authority and approval of local health departments properly rests with state health departments. Provision for financing by a separate enabling act deserves consideration. As a preliminary to the enactment of legislation, the state health department, exercising timely leadership, often secures approval of constructive plans from the State Medical Society and other professional and lay groups mentioned by previous speakers on this program. Such a procedure will also broaden the base of support for the health unit program.

Texas, Michigan and certain other states adopted the Evaluation Schedule of the American Public Health Association for improving quality and quantity of public health work.* The extent to which a state participates in evaluation of local health services may depend on the degree of responsibility assumed for administration of the program in local areas. Some states assume major responsibility for operation, while local official bodies in some states are chiefly responsible for financing and operating the services, and wide variations occur in other states between these extremes. In any event, it is clear that progress was slow in many localities until the State Department of Health stimulated some of the local communities to realize the need for and the dividends derived from better public health service.

The State Health Department is able to view the public health program as a whole and to gain necessary information of relative needs by using the Evaluation Schedule and Health Practice Indices. At the outset, the organization may lack informative records, but this barrier is ultimately removed. There are many instances of improved reporting systems, especially when technical advisory assistance was provided. Schedules tend to show gaps between official and voluntary activities and to indicate the extent of progress if annual comparisons are made. An occasional visit from central headquarters to a community is not enough for developing leadership and understanding of needs and opportunities or for securing action. Facts can be presented and interpreted to local appropriating bodies, and be used as a means of community health education, as well as for in-service training purposes. They provide a useful point of departure for discussion and appraisal. They can be helpful tools for the state consultant. Some schedules submitted in 1946 and before were directed at the promotion of permanent county-wide units to replace war emergency departments.

Emphasis has been given in this Conference to the value of having a statewide official or voluntary agency (or both working together) campaign for complete coverage for all of the people. This may be associated with a statewide study such as is made by the Field Staff of the American Public Health Association. Illustrations may be cited from Florida, Illinois, Colorado, and other states. In Illinois, in 1941, for

* Walter, L. P., M.D., State Participation in Evaluation of Local Health Services. *A.J.P.H.*, March, 1946, Vol. 36, No. 3, p. 269.

example, the only full-time locally autonomous health departments were a few in the larger cities; and legislation permitting counties to establish and maintain health departments was not in existence. Dr. Buck recommended that a large state-wide public health committee be appointed for the purpose of assisting the Illinois Department of Public Health in promoting more adequate health services in the state. This committee, formed in 1942, consists of several thousand influential citizens of the state who have a genuine interest in public health. The committee was largely instrumental in securing the enactment of legislation permitting counties to establish and maintain locally autonomus county and multiple county health departments. The second goal of the committee was then undertaken, namely to secure development of the county and multiple county departments under the provisions of this legislation. Furthermore, many health educational activities have been conducted jointly by this state-wide committee and the Division of Public Health Education of the State Department of Health. The development of some 12 county health departments with several others in progress was not due to accident but followed careful study and planning.

In Kansas, as in most other states, the bottleneck of lack of trained personnel, delays the organization of new units. But the readiness of the people in local areas to participate in the development of health services is attributed largely, by the State Executive Health Officer to:

1. An educational program through farm groups, womens' clubs, and other organizations.

2. Dramatic presentation of disease problems to the public, e.g., outbreaks of food poisoning, or of diphtheria, etc.

3. Available legal machinery to enable local communities to plan and finance their local health department on the basis desired.

4. Special studies of specific problems peculiar to localities with presentation of findings to community leaders and officials.

5. Constant personal contact with county officials and community leaders to gain confidence of key people and develop mutual understanding.

In Maryland, the early division of the State into 10 sanitary districts did not prove as satisfactory as was originally contemplated; and the Director of the State Department of Health became convinced that each county needed its own health officer and staff. The county commissioners were interviewed, the plan was explained and the results to be desired were noted. Likewise the part-time health officers were visited and the changing order of public health was discussed with them. The county health officers of the full-time units became *city* health officers as well, to the apparent satisfaction of all concerned.

Studies are usually necessary to show the interlocking relationships, mutual interests and common needs of cities and rural areas within a single county, together with convincing evidence of values of unification.

Haven Emerson and Miss Luginbuhl have observed how cities and counties can coöperate and the city can be a major influence or a major stumbling block. In Texas, for example, the health departments of Austin, Corpus Christi, and El Paso each started as city units, then covered the entire counties in which they are located, and still later in each instance added a thinly populated neighboring county, unable of itself to support a service but able to carry its proportional share of a combined service. Miami, Tampa, Savannah, Evansville, Peoria, Louisville, Chattanooga, Knoxville, and Memphis—all with populations of approximately 100,000 or more have joined with their respective counties in providing or planning for county-wide health services; in nearly every instance the initia-

tive for the larger unit came from the city.*

On grounds of economy and efficiency, the case can be made quite clear; but the psychology of the people may be a stumbling block. Even if a reasonably equitable plan of governing board representation can be formulated, the officials and other voters of New England cities and townships are reluctant to form a partnership for district health service. More emphasis may be needed to stimulate acceptance of the principles of local coöperation and pooling of community resources that brought about consolidated school districts, road districts and sanitary districts. More than eloquence is needed in a health survey report to convince county boards of supervisors, mayors and city managers of the reasonableness of consolidation or unification, especially if vital statistics are favorable and present operating costs not excessive. A local advisory committee working with a survey staff and subsequently becoming the nucleus of a community health steering committee or council may provide the necessary impetus for organized coöperation or even for unified administration if indicated. To facilitate interpretation and broad understanding, a sound community health education program is necessary. As recently emphasized by J. B. S. Haldane, a broadened perspective is needed. During the war " it was again emphasized ", said Haldane, " that our fight against microörganisms extends beyond the boundaries of nationality, race or even species. Every Rumanian infected with infantile paralysis, every Indian with smallpox, every rat with plague, diminishes the probable length of my life."

In North Carolina, the three district directors of the State Board of Health visit organized counties and stimulate action, besides encouraging the organization of new local health units. The state representative expresses a willingness to help in the training of personnel without extra costs to the county and explains the financial loss sustained in not receiving State and Federal grants-in-aid. Basic studies are featured. The people have responded favorably to an active community health education program wisely conceived and ably directed.

In Tennessee the success of full-time county health departments which were established early on a sound basis, with qualified personnel, favorably influenced other counties to desire similar service. In addition, the director of local health administration found it desirable to show local appropriating bodies that funds appropriated for local health work would return dividends. The fact that this officer was conversant with other subjects than health, especially agriculture, which were close to the hearts of county appropriating bodies, proved to be an important asset in the development of mutual interests, confidence and coöperation.

In New York State, as reported by the Director of Local Health Administration, current studies of local conditions were conducted. The New York State Special Health Committee appraisal was followed by recommendations for a comprehensive program including further development of full-time county services and modifications in the public health law. There has been general and local publicity regarding the law; district staffs work with local people and explain possibilities and cost, and the State Medical Society resolutions indicate a recognition of the limitations of service and urge extensions. Favorable results are anticipated.

As emphasized by Dr. Mustard, it is important that there be a proper balance between local autonomy and state supervision. Local county health units cannot be established by mail; the people

* Emerson, Haven, M.D., and Luginbuhl, Martha. Cities and Public Health of the Future. *American City Magazine*, Nov., 1945.

must be visited and re-visited; members of appropriating bodies and their advisers must be conversant with the facts, and then trained executives must be placed in these key positions. While our chief concern has been with health service at the local level, a problem needing attention simultaneously in some instances is the strengthening of state departments of health to enable them to function more effectively in relation to the health services at the local level. Such a step may include enlistment of organized support of both professional and lay groups throughout each state. In order that state health departments can serve the people most effectively (consulting, advisory, supervisory), strong local health service is necessary. Without such service, federal health agencies will be handicapped in extending and strengthening service on a nation-wide basis.

To advance the creation of local health services, key people of the area or district need an opportunity to study and think through the factors involved and the benefits which may follow. Joint planning and coöperative action will crown the efforts of a field service staff engaged in administrative research and periodic appraisal with the aid of an influential state-wide Health Committee or Council. There is nothing mysterious in the techniques for promotion. Enthusiasm, judgment, patience and skill applied in a constructive community health education program are vital elements in the process.

Dr. Atwater: Thank you, Dr. Hiscock. We will reassemble at 2 o'clock for the meetings of the 4 groups and the general session at 4 o'clock.

THURSDAY, SEPTEMBER 12

Afternoon Session

Four group conferences followed by reports by the leaders of each conference.

We have before us a hold-over report from Tuesday's session, Group 2 on Tuesday, on the "Indispensable Functions from the Viewpoint of the State Health Commissioner." I am going to ask Dr. George Palmer, who was the leader of that group, to present this statement, copies of which are in your hands.

Dr. Palmer: In the hurry of the meeting the other day it wasn't possible to do more than give a verbal report of some of the things that went on. Since then those ideas have been reduced to writing. So that, I am now presenting a review of the discussion of Dr. Getting's paper that went on in that group. In the course of the discussion of Dr. Getting's paper the group expressed agreement with the six basic functions of a local health department as given on page 2 of the report on "Local Health Units for the Nation," namely, those relating to vital statistics, communicable disease control, environmental sanitation, laboratory service, maternal and child health, and health education.

In the elaboration of these six general functions and in the addition of certain functions as enunciated by Dr. Getting, the group expressed itself on major points in the manner indicated:

1. The local health department is the primary governmental unit responsible for direct health service to the community. If this service is not rendered locally it is the duty of the state to provide such service as a measure of protection to other areas of the state. Legislation is necessary as authorization for the establishment of local health units and services, but such legislation should be of a permissive rather than of a mandatory character.
2. The program of environmental sanitation should include:
   a. The supervision locally of the quality of the water supply and of the operating and results of the sewage disposal system.
   b. The licensing of food establishments and the supervision and education of food handlers.
   c. The regulation of milk and food sanitation.

In the further interpretation of these functions, the group approved the need of a public health or sanitary engineer, with knowledge of food and milk handling, in the larger areas, but with recognition of the use of sanitarians with lesser qualifications especially in smaller areas if engineering problems do not warrant a sanitary engineer.

The group expressed preference for the licensing function to be within the health department or if within another governmental department, the licensing to be subject to approval and revocation by the health department.

It was suggested further that supervision of the quality of milk supplies be vested with the health department rather than with other governmental departments.

3. Facilities should be provided locally, preferably by the health department or within ready access to the locality, for consultation, laboratory diagnosis, and follow-up of the acute communicable diseases, of venereal disease, and of tuberculosis cases and contacts, and for the treatment of these diseases.
4. There should be provided locally, without charge, the necessary biological preparations, and there should be available to all who care to *use* them, clinic facilities for the prevention of whooping cough, diphtheria and smallpox, the same to be used particularly for infants under one year of age and with supplementary service for children on entering school.

In areas of heavy prevalence of typhoid fever, typhoid vaccine when necessary should be made available on the same basis.

5. While accepting the principle as expressed by Dr. Getting that dental clinics should be available to all children of school age (with first attention given to younger children), regardless of family income, the group believed that such work would need to be developed gradually within the limitations of available funds.
6. Among the indispensable functions of a local health unit there should be included the study and prediction of the importance of the degenerative diseases of older age groups as a stimulus to community planning for their prevention and alleviation.
7. Unless otherwise provided in a satisfactory manner, the local health unit should make available for local practitioners information concerning the newer developments in the diagnosis, treatment, and prevention of cancer and other chronic diseases.
8. The local health unit should assist in planning procedures for early diagnosis, treatment, and follow-up in the interest of curtailing mental illness.

These attitudes of the group on certain indispensable functions of a local health unit, as thus expressed, are presented for the information of the Conference as a guide in the evolution of a more adequate public health program.

Dr. Atwater: Thank you, Dr. Palmer. You have heard the presentation of this statement of "Indispensable Functions," what do you wish to do with it? After considerable discussion the report with a few verbal amendments was approved by a majority vote.

Dr. Atwater: We turn now to the review of the papers of today. The first topic, namely, that of Promoting Public Support for Local Health Units, Mr. Nelbach's paper. That report will be presented by Dr. McKay of Utah. Dr. McKay.

Group 1—Leader—WILLIAM M. MCKAY, M.D:, State Health Commissioner, Utah

Consultant—GEORGE J. NELBACH

Dr. McKay: Dr. Atwater, and Gentlemen of the Conference—

We had in our conference room a very interesting discussion of Mr. Nelbach's well-written, well organized paper, in which he discussed briefly some of the obstacles that must be overcome in the organization of local full-time health units. He presented a concrete plan of organization for overcoming those obstacles. I should like to read you one of the purposes of an organization—his quotation from Abraham Lincoln—"That public opinion is everything. With it nothing can fail, without it nothing can succeed. He who molds public opinion goes deeper than he who enacts statutes. For the molder of public

opinion makes statutes possible or impossible to execute."

We come to you with this recommendation:

"That it is the sense of this conference that, in working for the creation, development, and support of local full-time health units, the State Health Department enlist the participation of unofficial health, professional, and civic agencies and of representative citizens on both the state and local levels, and invite them to assume leadership in the process of organizing and conducting campaigns of public information and agitation for this end."

Mr. Chairman, I move the adoption of this recommendation.

Dr. Atwater: The motion was carried unanimously.

Our second paper, that of Dr. Dean Smiley with reference to the "Participation of Physicians in the Program," will be discussed by Dr. Carl Reynolds of North Carolina. Dr. Reynolds.

Group 2—Leader—CARL V. REYNOLDS, M.D., State Health Officer, North Carolina

Consultant—DEAN F. SMILEY, M.D.

Dr. Reynolds: Dr. Atwater and Gentlemen of the Conference—

After full discussion of the many problems of local health service, it was the sense of the group that,

1. The plans for state-wide coverage by and through local health services should be endorsed by the state medical association.
2. Before local health services are established in any local jurisdiction the services should be endorsed by the local medical society.
3. All new programs involving medical services should be endorsed by the local medical society.
4. Part-time health officers be replaced, as soon as possible, by full-time competent health officers, and that, where possible, the medical services of such part-time officers be used as clinicians or in other medical services on a part-time basis.
5. The local health department use every available facility to bring the private physician into active participation in the health services on part-time basis.

Dr. Atwater: It has been moved and seconded that this statement, which you have heard from Dr. Reynolds, be adopted.

By unanimous vote it was adopted.

Dr. Atwater: We come to our third paper, that by Dr. Overstreet on "Influencing People," and I hope Dr. Sinai will illuminate some of us who listened in on that conference by explaining to us just what was meant in the discussion by the "crawfish" technique.

Group 3—Leader—NATHAN SINAI, DR. P. H., School of Public Health, University of Michigan

Consultant—HARRY A. OVERSTREET

Dr. Sinai: Dr. Atwater, and Members of the Conference—

I have a note on the "crawfish" technique, but it comes at the bottom of the page, so I am going to wait until I reach that.

Our conference talked of education, and therefore, as you can well imagine, we talked of many, many things. Two features were, one, the unusual accord that prevailed at this public health meeting, and second, that no resolutions were adopted as a result of any of the discussion.

There were discussed the relative merits of the various channels of communication in influencing people. High on the list in quality of channels of communication were the radio and the newspaper, but most important of all was the communication through the various clubs, the voluntary agencies, and groups of people in the community. It was emphasized that there was a great need that some ways and means be developed in order to reach the great mass of the population that doesn't belong to anything, the unorganized population.

It was emphasized that the seven bridges described this morning by Professor Overstreet are not intended only for a one-way type of traffic, that those bridges must also provide for communication from the people to those who are working in public health. That is of primary importance if people are to be influenced satisfactorily. It was emphasized also that there was great need for ingenuity on the part of public health workers to develop new yardsticks and new measurements for what is done in the name of public health. Having developed satisfactory yardsticks, then comes the task of dramatizing and humanizing the work of public health. It is this that is the impulse to crossing what was described as that first bridge—having a story to tell, and then telling it with a certain drama.

Finally there was discussion of the technique of influencing people, and it was at that point that there was mentioned the "crawfish" technique. The chairman can only give you his interpretation. Apparently, the "crawfish" technique is one that is adopted when there is great resistance. It is a technique where if one wants to go west, he indicates that he wants to go east and then permits himself to be pulled west. That is the "crawfish" technique.

The second one—and all of these have names, you see—the second one was the mousetrap technique, and that is to create a better program so that those who will come might look, might like, and might go home and duplicate. That is "mousetrap."

The last one was the "let us reason together" technique, and it was the sense of the entire group that this technique holds the most hope for the development of satisfactory local health organization in the country.

Those, Mr. Chairman, were the results of the group discussion, which was an extremely interesting one.

Dr. Atwater: In thanking Dr. Sinai and Professor Overstreet for their contributions I think you will want to add your word to mine because that, I can testify, was a very fruitful session. Dr. Sinai's report will appear in the record even if he has no resolutions for us to adopt.

Our 4th Group on "Promotional Activities for Local Health Units," Professor Hiscock's paper, will be presented by Dr. Roger Heering of Ohio.

Group 4—Leader—ROGER HEERING, M.D., State Director of Health, Ohio.

Consultant—IRA V. HISCOCK, Sc.D.

Dr. Heering: Mr. Chairman, and Members of the Conference—

I think it was perfectly obvious from the discussion in our group that there is no precise formula of procedure that can be recommended or laid down and followed for the promotion of local health services, that perhaps basic principles may be suggested that may be followed, but they must be of a flexible nature and adapted to the problem as it exists.

Among the measures for promoting local health services there are certain basic factors that must receive prominent attention. Certain basic information must be obtained about the area. We probably should know something about the geography. Certainly, in some of our states the accessability of one area to another is an important factor. The population and its makeup must be known. There must be something known of the industries, if any, in the area. Perhaps, the industries are such that they, themselves, constitute a health hazard to a considerable portion of the population. Certain vital statistical data are important, as are economic influences. What health services there are in the area, if any. If there is no official health agency, perhaps there is

some agency such as the Metropolitan Life Insurance Company, or the Red Cross, or visiting nurse association, or some other agency that we might consider as influencing in one direction or the other the health of the people.

Various means of obtaining some of this information were discussed. Your state health department may have some of it, some of your other state departments may be a source of information. There are self-appraisal methods of determining what the situation may be in the area. These self-appraisal methods, if they are going to turn out anything that can be used, should be under some sort of technical guidance. And thirdly, formal study, such as those conducted by the American Public Health Association, of course would be extremely useful as a means of promoting local health services. There are five basic principles that the group considered important.

1. It would probably be advisable to develop a health council or group or some organization in the community composed of representatives of every stratum in that community—as one member expressed it, get enough of the right people interested and informed.

2. There is the demonstration method. That might mean taking a few of the persons who you think might be influential over to another area that has an effective local health service and showing them what they might have if they were willing to part with a few pennies, or you might set up a demonstration of a particular service in that community itself. It would be desirable if a demonstration set up locally could be participated in by the people in that community, or at least using local resources.

3. Then again there is the timely utilization of information or occurrences, and I am thinking there of the occasional dramatic episode that sometimes fits in with our efforts, such as an outbreak of food poison or any one of the communicable diseases, which we might use as an example to show what might not have occurred had there been an effective health service in that community.

4. And then, there is the principle that we all use of financial or some sort of concrete assistance to that area as bait to promote participation on the part of the local community in a full-time health service. In other words, if we are interested in promoting a full time health service in any given area perhaps we can encourage the people to meet certain qualifications of participation by offering as bait either direct financial assistance or assistance in some other manner.

5. Health education is a part of this whole process, and just how that health education will be applied will depend entirely upon the problem as it may exist in that area.

The ultimate objective in many instances may be combined units. Probably the most effective instrument for promoting combined units, as this group saw it, is subsidization of some sort. Financial assistance is an effective bait in accomplishing such an objective. It was brought out too that in the development of our hospital plans in the various states that have made surveys, perhaps hospital districts may be devised, and it may be that the development of such hospital districts may influence the development of our health districts.

I would like to repeat that there is no precise formula that can be laid down, as this group saw the problem, for the promotion of local health services, that we must arm ourselves with adequate information and meet the problem depending upon the situation as it exists.

Mr. Chairman, I move the adoption of this report. The motion was seconded and passed.

Friday, September 13

General Session

Presiding: HAVEN EMERSON, M.D., Chairman, Committee on Local Health Units

Dr. Emerson: Will the conference please come to order? We are to engage in a reciprocal process of education this morning. We have as our topic, "Recruitment of Personnel," and that will be carried on by, in the first place, introducing the subject and emphasizing its main features on behalf of the panel, and then expressing comments and requests for further information, and development of cross-questioning from the conference itself and members of the panel. Some of you are already familiar with them, others may wish just a word of introduction. Dr. Palmer is the Executive Secretary of the Surgeon's General Committee on the Training of public health personnel. Dr. Kinde is the Director of the Division of Public Health of the Kellogg Foundation. Miss Buker is the Director of the Bureau of Public Health Nursing of the State Department of Health of Michigan. Miss Eskridge is consultant on Public Health Education of the Public Health Service, for the time being assigned, or loaned, to the Michigan State Department of Health in that same capacity, and attached to the Bureau of Public Health Education, working also with the Bureau of Local Health Units, Local Health Administration, and acting, as all public health consultants do, in a widespread capacity wherever education is needed.

We are waiting momentarily for the arrival of Professor Earnest Boyce, Professor of Public Health Engineering in the School of Public Health and also Professor in the School of Engineering in the University of Michigan and until recently for 25 years chief engineer of the Kansas State Health Department.

Dr. Palmer will lead off and give the main structure of the problem, and ask your coöperation. Remember, please, that the panel is here at your mercy and they will expect to express themselves, but want to be sure that they satisfy your curiosity and interest in the problem of recruitment. Dr. Palmer.

GEORGE T. PALMER, DR.P.H., U.S. Public Health Service

Dr. Palmer: We have here first a central panel and in the audience a peripheral panel. There is no certain distinction between those two groups.

We have a serious subject before us because again and again this week we have come back to the question of personnel recruitment. It is back of the whole subject that we are talking about this week. There are things that we can do if we have people and other things that we cannot do if we do not have people. It seems simplest perhaps to start out briefly with a discussion of the scarcity of personnel. First we must recognize that the personnel shortage is general, then consider the causes and proceed from that point to the suggested corrective measures, and finally, who is going to do the correction.

A year ago the Public Health Service made an inquiry of state and local health departments over the country and at that time, in June, 1945, it appeared that there were about 300 medical health officer vacancies, nearly 600 among other medical personnel—

heads of divisions, specialized medical personnel. These were all full-time positions. There were nearly 400 vacancies among public health engineers, some 3,300 vacancies among nurses, and about 100 vacancies among health educators. Since that time we have checked only by a sampling here and there and it appears in some areas that the vacancies are just as bad as they were then. In a few instances it looks a little brighter, but in some states it is apparently worse than it was a year ago.

HELENE BUKER, R.N., A.M., Michigan Department of Health

Miss Buker: All reports that we get from our national agencies indicate that the situation has not improved. In nursing it is not only public health agencies but hospitals and other agencies using nursing that are short of personnel. Here in Michigan at the beginning of the fiscal year, '45 to '46, we had 57 known vacancies in county and district health departments. At the end of the fiscal year, June 30, we had 54 vacancies. So we had improved by 3. Reports from all over the country indicate that there is a shortage everywhere as we had anticipated.

Dr. Hutcheson: (Tennessee) You say you had 57 vacancies at the beginning and at the end 54, which gave you an improvement of 3. Do you have any idea how many you employed during the year and how many resigned?

Miss Buker: I am sorry, but I haven't studied those figures.

Dr. Palmer: There have been some?

Miss Buker: We did employ quite a good many during the year, but then, we had enough resignations so that we came out about even at the end.

Dr. Palmer: Miss Eskridge, what about the situation of health educators?

LOUISA J. ESKRIDGE, C.P.H., Michigan Department of Health

Miss Eskridge: From reports that have come in from different states I would say that the shortage among the already established positions holds about the same as the figures that you gave, but I would like to point out that because we are in a stage of development in the functions and uses of health educators we find that we have many more vacancies that are not yet established positions. We had many more demands for trained personnel than we have personnel to fit the positions. In a number of the states positions have not yet been set up, but I should say they are nascent; they are there waiting to be set up when individuals are trained and available. That is true in Michigan with several local health units. And at the state level we have two positions right now for state consultants in health education which we are having some difficulty in filling because we can't find qualified personnel who have had some experience. There are a number of you particularly in Indiana, Mississippi, and several other states who have positions available and open for persons ready for recruitment and there again, you can't fill the positions because the persons are not trained right now, in the field of health education. This does not include many of the voluntary agencies requesting trained qualified health educators.

Dr. Palmer: Dr. Kinde, how about the physician situation?

MATTHEW KINDE, M.D., W. K. Kellogg Foundation

Dr. Kinde: As far as the shortage among physicians is concerned I think one of the best evidences of the situation was that in the area around my town we needed a health officer so I decided to write to a federal agency and ask them if they could submit some

names and the reply was that "We are glad to hear that you need a health officer, we wonder if you can help us, we need 900." I imagine that is some index to a situation. Some states don't seem to feel that there is much of a shortage and other states have lost a large number of their personnel. As far as that is concerned, I think that we can be misled by that. I mean, there has been a big shift in people and for Dr. Blackerby's consolation, I would say that although Kentucky has lost some of its personnel to other states pretty much the same thing goes on in the state itself. That is, some counties in the state feel a real shortage and other counties that happen to be paying more just haven't noticed it as much. One of the things that has been brought out this week in previous discussions is the competitive nature of trying to get personnel, not only between public health agencies, but also in other related agencies.

Dr. Palmer: Professor Boyce, what about the engineers, is there any question of having plenty of engineers?

EARNEST BOYCE, C.E., School of Public Health, University of Michigan

Professor Boyce: The demand for engineers has been continuous through the war and the training has been largely stopped except for the special training programs for military personnel. Some of those training programs perhaps will produce an interest in and perhaps some qualifications for work in the field of public health. I refer particularly to the ASTP sanitary coöoperation program, a 24-week program, which did increase the interest I believe on the part of a good many young men who had not given previous thought to public health work. Several of those who received training here and elsewhere will be here this fall to continue their work in the School of Public Health, working toward the completion of the M.P.H. degree.

The scarcity on the basis of need is evident, the scarcity on the basis of positions which will attract engineers may not be as real as apparently it is.

Dr. Cannon: (Alabama) We need 18 health officers. We need not fewer than 50 nurses, and we are meeting our needs in the field of sanitation very well by 40 trained men returning from service.

Dr. Palmer: Is the situation better today than it was a year ago or not?

Dr. Cannon: Only in the field of sanitation. I would say the general personnel situation is more acute than during the period of the war.

Dr. Sowder: (Florida) We need one sanitary engineer and 38 nurses, 2 assistant county health officers and a director for venereal disease division. We are in a better position than we were a year ago.

Dr. Walter: (Texas) In Texas our situation is almost parallel to that in Alabama. We have vacancies for 10 doctors, 54 nurses, have plenty of sanitarians, and just about even on engineers. The situation is worse than it was a year ago in all categories except sanitarians and sanitary engineers.

Dr. Van Volkenburgh: (New York) Our field staff, the district state health medical officer, has places for 21 physicians out of a total of 45 positions. On the state nursing staff, there is a vacancy of 10 per cent for local public health nurses. The situation is worse than it was a year ago; in the field of sanitation I think the situation is somewhat improved over a year ago.

Dr. Halverson: (California) Our situation is decidedly worse as far as

medical officers and nurses are concerned. As for sanitarians and sanitary engineers it is better since the end of the war.

Dr. Getting: (Massachusetts) We could use at least 50 doctors, we have approximately 50 per cent vacancies and in our field and institutional positions for nurses, we could use about 200. Our situation is far worse than it ever has been, except for sanitarians.

Dr. DeKleine: (Michigan) The situation in Michigan has improved with reference to health officers. We have, I think, 7 or 8 vacancies. A year ago we had twice as many. Our situation is considerably better.

Dr. Hutcheson: I would like to know approximately how many new men who have not previously been in public health work have entered the field? There is a good bit of shifting around from one state to another seeking 5 or 10 dollars more a month, and whatever state can give it to them, they go to. The real answer would be how many new people have come into the field?

Dr. Palmer: Let's ask Dr. Sowder and Dr. DeKleine, they seem to be in a little better position. What are these brand new people you are getting, or did they come from somewhere else? Have they been in the field a long while?

Dr. DeKleine: We have two new men who came out of the Army and wanted to go into Public Health. We started them out on the basis of employment for a couple of years when we would hope to give them training. Others have come from other areas.

Dr. Sowder: We have about 6 new men and most of those we have employed the last two months have never done public health work before.

Dr. Van Volkenburgh: (New York) We have 8 physicians who have been under training and going to school. This month we have two more coming in for field work—they are on the job now. We have 50 registered nurses undertaking training in public health this year.

Dr. Palmer: Let us move over then into the causes of this situation. I have heard a number of explanations for it. Dr. Kinde, why are there vacancies? How do you size it up?

Dr. Kinde: I think probably the most important one is the one that has been talked about most here, salary and tenure. I think, however, that has been over-emphasized a little. I think there is but little question that low salary is responsible for vacancies in a lot of states, but I think the situation is pretty much a matter of supply and demand. It is a question of getting new people into the field. Another reason for the shortage is the large number of new positions that are occurring all over the country. Some of the people that I know that have had public health training and have gone back into medical practice have been largely physicians who had practices previous to going into public health. A matter that I think needs emphasis is one that Dr. Smiley mentioned. We ought to look into the job itself, see if we can't make it more interesting. That is an important factor. There is too much of a tendency to emphasize salary, though I agree that that is an important factor.

Miss Buker: We are bound to lose a good many of our nurses from year to year for marriage, especially, and for maternity, and during the war the nurses coming out of nursing school were encouraged to go into military service and not into public health. We didn't feel justified in trying to keep them out of the military service natu-

rally, and consequently we have had losses each year without any way of replacing them. We hope now that more nurses, of course, will be going into the public health schools and to the courses for public health nursing, although the quotas on some of the schools are limiting the number that can be prepared.

Dr. Blackerby: Isn't it a fact that the schools for training of nurses are not finding applicants for training?

Miss Buker: That is very true. Sometime during the summer it was announced nationally that only about one-third of the recruits had been gotten for the fall classes.

Dr. Palmer: Miss Buker, would you say that the primary cause is people leaving the nursing field or new demands being created that accounts for the present shortage?

Miss Buker: Both enter in. People are leaving the nursing field, but the number of demands is increasing and so we have not only the backlog of unfilled positions, but also we have new positions being created all the time. I would like to comment, if I may, upon the salary question which Dr. Kinde brought out. At the present time many of our hospitals are raising their salaries in order to keep nurses. One director of nursing told me just a few days ago that in her hospital staff nurses, just out of nursing school, are now being employed at $195 a month, and so we have got to consider competing with other fields in public health, not only with fields outside of nursing, but other nursing fields too. We had anticipated that when the war was over and nurses began to come back from military service many of our public health nurses would be returning to positions, but that has not been the case. In fact, the number returning from military service into public health positions has been comparatively low, and many of those nurses we find are going on to school. In the first place they are restless, they come out of the Army and don't know quite what they want to do. Some have gone into other types of work unfortunately, but a great many of them are in the public health nursing courses. Some haven't had adequate training, others have at least an academic training but are going on to get degrees, in as much as they have their education paid for at this time.

Dr. Palmer: In trying to assess these major causes I wonder if those of you from the different states see it clearly?

Dr. Getting: (Massachusetts) I would say that salaries is the biggest problem. In New England the only physicians we have been able to hire within the last six months are those who are on retirement or pension from one of the federal agencies. Another factor is the civil service. Under civil service regulations—and we were forced into this by the Children's Bureau—we didn't want civil service for professional help—we cannot employ any one from out of the state, and that is a marked handicap to procurement of personnel.

Dr. DeKleine: In Michigan the salary item has been a factor. Dr. Altland and others have talked to Boards of Supervisors where there were vacancies and told them they must raise their salaries. One young man came voluntarily from Oklahoma, we didn't proselyte him—he said he had a salary there of $4,000. He came to Michigan, he said he wanted $6,500. And he had had only two years experience, no training. I said, "You won't get that, be satisfied with $5,000 or $5,500, and we will get you a job." He said no. He

contacted three—I think three different areas and set his mark at $6,500. They offered him $6,000 right off the bat at least in one place. He went to another area and sat there for a week until he got his $6,500. He is employed at $6,500.

Professor Boyce: I am interested in the comment that has just been made regarding residence requirements as a limiting factor in the selection of personnel. If there is an increasing tendency to restrict to residents of the state, it is going to be a serious problem in years to come both from the standpoint of placement of personnel and from the standpoint of obtaining the person best suited for the position.

Dr. Hutcheson: (Tennessee) The limitation we have in Tennessee is that they must be a resident of the United States.

Dr. Getting: (Massachusetts) We can not employ any one who is not a citizen of the state for one year under any circumstances.

Dr. Palmer: One factor that hasn't been mentioned, is the case of physicians leaving the public health field and going into private practice. Is that a big factor or not?

Dr. Blackerby: (Kentucky) I can answer that. We lost ten like that in our state, trained men.

Dr. McKay: That is a factor in our state. We have no limit on our professional salaries except for that of the health commissioner, and I haven't a doctor on my staff that doesn't get more salary than I do. Fortunately, there is no limit to salaries paid to the members of the staff. Since the close of hostilities I believe we have employed about 6 physicians, and we have lost 2 of them back to general practice after being assigned to districts. With reference to nurses in our state, where they must have an automobile, that is a big factor. They are just not to be had, and unfortunately our mileage rate is set by the Finance Commission and it is so low that the nurses can't afford to drive an automobile. Then, a number of the nurses whom we had during the war whose husbands were in the military services have now returned to housekeeping with their husbands home. Many of our nurses whom we lost to the military service instead of coming back into our service are now in other states or positions. The nursing situation is much more acute than it was during the war. In the field of sanitation we have a full staff.

Dr. Mustard: It seems to me that there is a field that hasn't been touched upon, and that is the young physician who is graduated before and since the war began. I think that the factors there must be in the first place that these men have been in a tight organization and they want to kick up their heels. They don't want to go into another organization. A second factor is that many of them want to get more hospital work, even though they graduated four or five years ago. Another factor is that they have heard of these 20 and 30,000 dollars that their colleagues have been making each year in private practice and many of them are going into private practice. Of course, they won't all be going into private practice, but we are not getting our proportionate share. I think that that is where we are feeling it most—no new groups are coming into public health.

Dr. Buck: But is it the question of the low beginning salary, or is it our failure to be able to tell a fellow what he can expect in the next 5 or 10 years in the way of progress that is the primary deterrent factor?

Dr. Palmer: I think it is more the low range salary possibility rather than the immediate entrance salary, but both of them play a part.

Dr. Shackelford: I had a man tell me the other day—and we are paying him $6,000 too—" If I could have some assurance that this thing would continue, I would be interested in staying put, but when we get the thing settled down a little bit, these salaries are going to drop off. You have been paying me $5,000 and then back to $4,500."

Dr. Emerson: May I call your attention to the effort on the part of your committee on local health units to suggest the principle of salaries for local health officers; that the health officer's salary should be not less than the net income of a good internist or surgeon in that area? Now, as the incomes and earnings of surgeons and internists in the area have pyramided, ours have lagged behind. That has been aggravated by the post-war and during-war demand for the medical practitioner. The salaries, the earnings, the net income of physicians and surgeons has gone up a considerable amount all over the country, the salaries of medical officers of health have not followed. In a community where a good internist or surgeon—I don't mean the top flight fellows—is getting $10,000 the health officer at $6,000 is on a par with him, but the discrepancy between those two increases when the scale of medical practitioner incomes go up tremendously.

Dr. Sowder: (Florida) I would like to read just one sentence from a little sheet entitled " Employment Outlook for Physicians " from the Bureau of Labor Statistics, published in October, 1945. " War increased physicians' earnings—in 1943 physicians averaged a net income of nearly $8,700, almost twice as much as in 1939. General practitioners netted about $6,500 annually, and specialists over $10,000. Those are averages for the whole country.

Dr. Emerson: We tried to make it appear that the good internist and surgeon of the area within which the local unit operated was a determining factor in the salary that should be paid to the health officer of that area.

Dr. Palmer: Then we come to the next section, what are we going to do about it? In other words, are the causes going to correct themselves in a year or two? Are we the victims of something that has happened before or will these causal factors not correct themselves? Something has to be done, some push has to be given to remedy the situation.

Dr. Burney: (Indiana) I would like to ask Miss Buker one question, whether the nursing organizations are continuing their efforts to have greater interest placed upon professional training than upon service as a means of attracting young women to nursing courses?

Miss Buker: Our nursing organizations are doing that very thing, and some of our state organizations are working toward it. I might say, for example, that in Michigan we have recently had a survey done by Dr. Genevieve Bixler—and outside of the state by the Nursing Council of the Michigan Council on Community Nursing. I was very much interested the other day to hear that the hospital survey, which has recently been made in Michigan, also recommends that nurses in nursing

schools have experience only in so far as that experience is educational. In other words, that they not be used to service the hospitals. In our recruitment of nurses in nursing schools one of the things which we ask the public health people to do is try and direct the nurses into the right kind of schools. I think perhaps you know that there are three nursing schools now all with degree courses, two to which state high school graduates can go—Skidmore and Vanderbilt Universities—and one which takes only college graduates, the Yale School, which have been accredited to turn out nurses who are ready for first level public health positions upon graduation.

Dr. Hutcheson: Dr. Brown, Miss Hege, our Director of Nursing, and I have been trying to estimate how many nurses will be required in Tennessee to give complete coverage in Tennessee on our formula of one in 10,000, which is not nearly what we would like to have, and we find that for complete coverage—and we were hoping that it might be done sometime in the future, near enough for us to live to see it—we must have between 600 and 1,000 nurses. There aren't schools in the United States to furnish that supply of well trained nurses for Tennessee in accordance with the APHA requirements, much less for the rest of the states. We are going to have to get away from the idea that every public health nurse who is doing work in the field of public health nursing has to have one, two, or three years of training if we are ever to supply the need. Before the war in three years we had a complete turnover, not individually, but in numbers, and we must have some means of training enough nurses to take care of the loss. It is one of the most expensive things I know of in public service, because by the time we get a nurse trained she has spent a minimum, I believe, it is five years, isn't it, in school and she works not quite 3, and during that whole time, of course, she is paying money and so is the state for this training. The only consolation I can see in it is that she is the best candidate for marriage and makes probably the best mother on an average that can be found, and good Parents-Teachers Association leader.

Miss Eskridge: Those of you who have been using health education personnel find an increased demand for services, and that means that your positions at the state level are increasing. Where you once thought you had a stable reservoir of persons providing service to local units you now find that some of your best people are being drawn into state supervisory positions. I think the nurses have positions and activities pretty well established, but those states which are concerned with services of additional health education personnel are finding another vacuum, that of a reservoir to provide service to local units.

Dr. DeKleine: Another thing, about the scarcity of automobiles. Automobile requests came to me sometime ago from nurses and health officers, "How can I get a new automobile?" My secretary and I talked it over and I said, "Well, let's try." So, we wrote a letter. We found out what the name of the agency was where she wanted to buy her automobile and what kind of an automobile she wanted and then we wrote a stiff letter with a good deal of drama in it, something like what Dr. Overstreet showed us yesterday, saying how many people were going to die if this poor nurse didn't get an automobile

and it worked. We have found in Michigan that automobile dealers have such a tremendous number of requests for new cars that they can't meet in a couple of years that they would much rather sell a car to persons who really need one. One of our dentists had a request put in and he said, "You will be about the 10th one on the list to get a new car, you will have one shortly" as a result of that letter. I think it may not work in your states, but it certainly does in our area near the automobile center.

Professor Boyce: I would like to make note of the general reaction here this morning that the situation is not too serious in the field of sanitation personnel. That is a different picture than I have been getting in conversations during the week. We have been led to believe that the training facilities were not adequate, that the program was too rigorous, that there was a need to provide a hurry-up type of training for sanitation personnel. If the present positions are pretty well filled then perhaps they are filled with persons not properly trained, perhaps there is a need for continuation of in-service training of those now occupying the job. If the situation is as it has been indicated here this morning, it is not a serious matter at the present time.

Dr. Palmer: In other words, you are raising the question whether we should seriously try to meet this situation by reducing educational standards or time.

Professor Boyce: The point that I make, Dr. Palmer, is that from the reaction of the group here this morning I would conclude that the situation as to sanitation personnel at the present time is not serious.

Dr. Palmer: Well, that was said. I am not sure whether that was below the grade of engineer or the engineer. I took it that it was below.

Professor Boyce: If I am wrong in that, I should like to get further comment, but it is important in view of the fact that there is a definite stimulation in a number of places in the United States to start up new courses, shorter courses, shorter than those for training of engineers, in order to meet a supposedly existing demand, a demand that hasn't been very clearly brought out this morning, in the field of sanitation. I had the impression up until this morning perhaps there was a need to do something about a situation that presumably existed. I talked to a number who are here, and some, who are not here this morning, during the week and I got the impression that something had to be done to meet a serious emergency. Now, this morning I have a feeling that that emergency doesn't exist in quite the scope that I thought it might.

Dr. Palmer: There might not be an emergency with sanitarians, but there might be with engineers. In other words, does this whole question narrow down really to shortage of physicians and nurses?

Dr. Buck: I think you will find in a good many states a continuing shortage of personnel in environmental sanitation, not only including engineers but also other personnel.

Professor Boyce: I thought if that was true we should make that point clear and not leave here with the impression that the situation wasn't acute with respect to engineers and sanitarians.

Dr. Van Volkenburgh: In the development of any number of county health departments we will need a large number of sanitary engineers.

Dr. Palmer: Do you anticipate difficulty in getting them?

Dr. Van Volkenburgh: I should say yes as conditions exist today, and also there is very little, if any, source of trained sanitarians—that is inspectors who have some qualifications and some reason for being called such.

Dr. Emerson: Might I call attention to the summary that was made in the report on local health units, that of the various categories of employees of local health departments? There was a greater discrepancy between those now employed and those that should be employed in the field of engineering than in any of the others. In other words, everybody accepts the necessity of the physician, the nurse in a local health department, but they do not all accept the necessity of having in any unit of 50,000 people a professionally trained person in the field of environmental sanitation. Now, it may be that we have overshot that necessity in our estimates, but of all the categories of established positions there is a greater discrepancy between those now holding engineering positions in the number of local units recommended than there is in any of the others. The nursing being next in order, approximately a 50 per cent deficit.

Dr. Palmer: No one has mentioned the laboratory field. I haven't heard that mentioned.

Dr. Getting: (Massachusetts) We are having a great deal of difficulty in procuring bacteriologists, serologists, and physicians experienced in laboratory procedure, especially in blood and vaccination programs.

Dr. Kinde: We have been trying to secure people of that kind, that is, pathologists and roentgenologists, and my impression is that the situation was impossible, up until four or five months ago, but now definitely it is improving and we have been able to fill a lot of that type of positions in the last five months.

Dr. Palmer: We have two points in front of us now, what ought to be done, if anything, and who is going to do it. It would be profitable to spend the remaining time on those two questions.

Dr. Palmer: Well, what about the salary situation? Dr. Petty, how is it in Nebraska?

Dr. Petty: (Nebraska) Our salary scale is not high enough. We hope that we can get it higher, and even then I don't know how we are going to attract them.

Dr. Milne: (Mississippi) There is one contributing factor that hasn't been brought out yet in the discussion and that is in regard to housing. In Mississippi we lost five well trained experienced health officers upon returning from the Army because they could not find a place to live. They went into private practice because they could find a locality in which they could locate a home. We had the same thing happen to experienced sanitarians—returned from the Army, not able to find a home in the city where the health department is located.

Dr. McKay: (Utah) I think that the salary factor is important and I think, like Dr. Emerson, that we will have to put our salaries up somewhere near the level of the income a physician

can make in practice. Then too I think that in as much as we are all under merit systems of one kind or another and one of the minimum qualifications is a year of special training in the field of public health we will have to be more liberal with what we pay them in order to get them away for training. I think that the time has come when we should offer a physician whom we find to be good public health timber to let him go away on full salary for his training period. And until we do that I think we are not going to be able to induce many of these younger fellows to come into the field of public health.

Dr. Buck: I think we all know that low salaries are the biggest deterrent factor, but I am wondering if we are putting the best foot forward in recruitment? Aren't many of us more or less taking the negativistic point of view in saying, "Of course, we can't give you much, and we can't guarantee you will get your increases, and we don't have any retirement plan, but we would like to have you," instead of putting forth public health as a challenging job?

Miss Eskridge: I would certainly agree with Dr. Buck in the recruitment of health educational program, sometimes the salaries draw the poorest individual. I am not saying we don't like raised salaries, I am saying the best recruitment is of individuals to whom we present the field of public health and community education as a definite challenge in public service. I am not belittling the salaries, but I think we have been entirely too negative in presenting public health as a definite community service.

Dr. Godfrey: The salary raise is the most important thing, and salaries must not be simply living salaries; they have to be salaries that enable one to live in a dignified way and on the same plane as their colleagues in clinical medicine do. I don't believe that it would be wise to reduce professional standards materially. If we begin doing that, we lower the quality of the service that is given and tend to deteriorate the whole level of public health work. I think that the retirement plan is a requisite that should go with the health officer's salary, but should be secondary to the salary question.

Dr. Atwater: Speaking of early recruitment, many of you have seen a booklet published within the month by the American Public Health Association on "Careers in Public Health." It supplements the bulletin that was published coöperatively with the Public Health Service called "Employment Opportunities in Public Health." It had its use during the war, something like 20,000 copies were distributed. This newer booklet focuses on public health as a career, emphasizing medical, nursing, engineering, and other specialties, and is available and best adapted for high school graduates and college workers. I would like to make a comment on this general subject of salaries in relationship to positions. There has been operated, as many of you know, for about one year an employment service in the American Public Health Association Office, that is coöperatively supported by the Association and the United States Public Health Service. We have sought there, with trained people, to list all the current vacancies and to list available personnel. Almost all of you have been in touch with that employment or placement service and have taken advantage of it. The last time I saw the list there were 664 vacancies listed there and a maximum num-

ber of about 135 candidates covering all positions. In other words, a marked deficit. As we look at the situation from the APHA office it is quite apparent that salaries do have a marked influence. If a candidate comes in, for example, an M.D. and an M.P.H., plus experience, he has before him at least 50 opportunities in the section of the country that he may want. Obviously he is going to be more interested in those which pay higher salaries, and some of you have been disappointed that we have not been able to put you in touch with candidates at the lower salary levels. It is quite obvious that the higher levels have been siphoning off the desired personnel. And if some of you have received names of those who seem to you less than fully prepared and qualified keep in mind the fact that this is a competitive field, and that in almost all of the states residence requirements are unimportant. Dr. Getting has pointed out how Massachusetts has a rigid rule, and some of the other states do. You can readily understand how the cream of the crop is siphoned off into this higher level. At the present time, for example, there are scores of positions offering $5,000 to $5,500 for trained medical officers which have no applicants at all of the desirable class. There are plenty of $6,000 positions available at the present time without takers, and those men who have qualifications can readily expect $6,500 or even better if they are patient. I would not like to have it understood that salaries are unimportant because while that isn't the whole story it is a very meaningful thing to some of these younger candidates, and the same can be said for engineering positions, and for the better class of physicians in other fields. I hope Miss Eskridge will stimulate her group to review the demands for health educators. Dr. Emersons's report points out that when it was prepared there were only 42 health educators employed in local health units in local health service across the country exclusive of state health departments, but including all city and county health departments. The report proposes that something like 470 or almost ten times as many should be employed. I hope Miss Eskridge and her health educators will come back as the engineers and sanitarians are coming back and tell the committee on local health units whether or not they think that is an adequate personnel level at which to shoot.

Miss Eskridge: Dr. Atwater, in that connection do you think that it would be desirable for the health education person, so-called, in view of the stage of development in which that field now exists to attempt to find out potential vacancies? As I pointed out there are many positions in which we could place people if we had people, but those positions are not now set up as actual lines in civil service categories. I can think of a number of states that have that situation. Do you think it would be wise for any such group to search for anticipated opportunities for employment?

Dr. Atwater: Not in the present situation where there are so many actual vacancies that can't be filled.

Miss Eskridge: Well, I am thinking in connection of the problem of training. We find our facilities are even less than the persons we have available for training.

Dr. Buck: To what extent are difficulties due in various parts of the country to inadequately or poorly conducted merit or civil service systems?

Dr. Barr: (Minnesota) In Minnesota we have trained a fairly large number of personnel over years most of

whom have been siphoned off to other states into positions better than we could have perhaps supplied them in our own state even though the salary scale might be the same. They would have stepped up into higher positions, the reason being they had good training and good experience and were well selected men, but we have not had returned to our state even men of a lower class who would fill the minor positions, because they were not available in other places at even the same salary. That would indicate to me that many states are not training personnel but are simply siphoning them off from states that are training them, particularly medical personnel.

Dr. Palmer: A deliberate effort should be made to get into the medical school, reach the third or fourth year man either personally or through printed material or in groups and urge their entering the field of public health.

Dr. Beelman: The training of our doctors in thinking of public health might interest them as they come out of our medical colleges. We are starting at the University of Kansas Medical School, a new department of preventive medicine and public health, largely to acquaint our out-going physicians with the field of public health.

Dr. Emerson: I think that in this matter of selling public health to the medical student we have got to rely on example rather than upon precept.

Dr. Ramsey: (University of Michigan) Dr. Emerson, don't you think that during the last 20 years, say, that there has been really a vast improvement in the quality of physicians in public health?

Dr. Emerson: Yes, but I think that progress, slow as it has been, has been accomplished by the distinguished personalities in public health rather than by any systematic teaching of students to follow their leadership.

Dr. Getting: (Massachusetts) Dr. Palmer, I think improved teaching of preventive medicine is sadly needed in our medical schools and too often the teaching of preventive medicine is in the hands of clinicians who have had no experience in public health. I think that improvement in the teaching of preventive medicine would be a proper step in the recruitment of personnel for public health. Then also I think that the creation of a specialty board in public health is desirable and would do a great deal to increase the prestige of the profession and draw young men.

Dr. Halverson: Dr. Palmer, I think that not only in the field of medical officer, but in the field of nurse training we are confronted with a period of years in which personnel probably will be short, that is the way it looks to me. If that is true, I think it is important not only to do the things that we have talked about in the resolution we passed the other day—salary, tenure of office, opportunity of advancement, etc. I think that we must do what we can during the early training period to interest both nurses and medical personnel in the importance of this field that we are engaged in. I think that we should do both.

Dr. Palmer: Let's get down to brass tacks. Who ought to do it?

Dr. Atwater: I have one angle to suggest that hasn't come out in the suggestions so far, it has not been mentioned that the enrollments in the schools of public health—I am not speaking now of public health nursing courses, but the enrollment in the schools of public health, are very much larger than ever before. The Association of Schools of Public Health reports that their capacity for the MPH degree

in this present year, '46–'47, is about 500 students, and as you all know they are booked to capacity. They say that in addition to those 500 they are prepared to take a number of special students, some even estimating as many as 500 more special students for training in nutrition, in laboratory work, in statistics, in industrial hygiene, in medical specialties like venereal disease control, tuberculosis, maternal and child health, and so on. I think it ought to be noted that potentially there is a reserve of 500 MPH men and women, plus several hundred more of other training, who are going to be available as of the spring of 1947. To be sure many of them are already employed, are sent by state health departments which are expecting them back. To my mind that is a very significant thing, representing as it does a large percentage of those who now have educational qualification in public health as compared with 25 years ago. That is a very significant change in the situation.

Dr. Reynolds: In that 500 you spoke of how many medical men are there?

Dr. Atwater: I haven't the exact count because, of course, the schools of public health haven't yet announced their enrollments. My guess is between 250 and 275 physicians.

Dr. Palmer: Are they all from the United States or quite a number from abroad?

Dr. Atwater: Again, the lists aren't yet available. I know of a few overseas fellows, not very many.

Dr. Palmer: I know that came up a year ago when we made an inquiry of the schools, that while there were 146 physicians in training, 73 were from abroad, mostly from South America, which would not help our situation.

Dr. Mustard: We have at present registered in our MPH group about 40 physicians, 6 of whom are from foreign countries, in general it is a greater number of physicians, but fewer from foreign countries than last year.

Dr. Vaughan: Here at the University of Michigan the trend is definitely the same as at Columbia. There has been a noticeable increase of native sons in the school, both in medicine and in engineering, and the number of students whom we will have from foreign countries is not over half of what it was last year. I should like, however, to comment on one or two other points while I am on my feet. Some one has referred to the teaching of preventive medicine in medical schools. In my judgment this is extremely important. I don't know of any task which is more difficult for a teacher than to try to handle preventive medicine in a medical school. I think our techniques are not properly developed and that we have approached the problem in the wrong way. I think that we should approach the problem from the viewpoint of considering the physician as a potential practitioner of medicine and not as a potential health officer, and through that indirect channel arouse his interest in preventive medicine and public health. From that interest there will develop a worth while group of leaders in the class who will be intrigued by the field of public health. That is, I think, largely the system at Vanderbilt where Dr. Leathers so successfully carried on for many years. We must make the teaching of preventive medicine in our medical schools a living entity, something which is attractive, which will inculcate in their minds a respect for preventive medicine and public health. We have not been doing that up to the present time. I have, however, been impressed from the public health school angle with

the point of adequate compensation. I believe as public health people we have too long been willing to take the crumbs which have been strewn before us after the budget of every department has been considered, and I think that public health should be at the very top of governmental agencies instead of down near the bottom where it has been for so many years. I recognize that we have made good progress in that regard, but we still find the average health department in the basement of the county court house instead of being in a respectable health center where it should be. Conditions are improving, but we must impress upon the public mind and upon public officials that if they are going to have career men in public health, in charge of public health work in a city or a county or a state, the compensation must be somewhere comparable with that which Dr. Emerson has recommended in his report. It must be a compensation comparable with that which is being obtained in other medical specialties. Not with the idea that the fantastic earnings of some distinguished surgeon or specialist in roentgenology will be obtained, but there should be at least a compensation which is up to the average of the man who is in clinical specialties. Mr. A. M. Smith, who is here from the Detroit News, can tell you that we did that in Detroit. When I left Detroit the health commissioner of that city was getting $18,000 a year. The present health commissioner is getting that compensation now. He is paid as much as the superintendent of education and more than the mayor is paid, and he should be. He is a career man, a professional man. The educator and the public health officer should be the highest paid men in commuity life because they are devoting their whole time to this technical professional job. If I were listing the important causes for lack of personnel I would put down as number 1 salaries; number 2 salaries; number 3 salaries, and then when I got down to number 4 I would say higher standards, not lower standards. How are you going to get these salaries unless you have higher standards? I never would consider lowering the standards at all. And finally after that as number 5, I would put selling public health to the public in a respectable way, and 6 I would list as selling it to the medical profession and then at the bottom of the list somewhere I would put " tenure of office " because a fellow who has a good education, has good qualifications doesn't have to worry about a job. There are plenty of jobs all over this country for the well-qualified and trained man today. Halverson here doesn't have to worry about a job at all. Look at Hugh Leavell, how he is traveling around the universe? Now, he is a well-trained man, he doesn't have to worry about a job, every one wants him. A man who has done his work with distinction, who has qualifications, and high standards doesn't have to worry about a job. But we do have to have something which is attractive and commensurate in compensation with what is paid in other fields of medicine. And I probably should not say this, but I have noticed that even our U. S. Public Health Service men who have come here as students are restless. The U. S. Public Health Service isn't paying respectable salaries to our physicians who are lieutenants, captains, and majors in the regular grades of the Service. Our state health departments aren't doing any better in many instances. One point about the schools of public health that has already been mentioned is that most of these students who come to us are already earmarked. About 85 per cent of our students have some sort of a fellowship. They are attached, potentially attached at least to the agencies which are sponsoring their training. If you came to

me today and asked "What is the potential possibility of our getting some health officers at the end of this school year?" I would say, "There might be 15 per cent of the class who are not already earmarked before they come here, and some of those 15 per cent I wouldn't want to recommend." So that you are not going to solve the problem simply by turning to the schools of public health and turning on a faucet and having a flow of medical personnel coming out. It just won't happen that way. Let me again emphasize—I think salaries is the most important thing!

Dr. Applewhite: I believe that Dr. Vaughan has hit the nail right on the head. I agree with him. I think public health has reached that status now where we can go in and demand our pro rata share slice of the pie, as it were. We had that matter of getting personnel pretty well demonstrated in one state, in district 4. Of course, everybody has been poking fun at Dr. Sowder, but Dr. Sowder was elected State Health Officer and he decided he was going to start full-time health departments, and he made up his mind that if he was going to go places and do things in the public health field as a state health officer and make a reputation for himself he was going to do it with decentralization but complete blanket coverage in his state with full-time health departments. And he took off on that program just about like a scalded dog, and the first thing he did was to realize if he was going to get good men he would have to pay them a decent salary. I think at the first fell swoop he took three officers from the Public Health Service. The main thing that attracted those three fellows of course they said was an opportunity for service, but I happen to know he offered those fellows more money than he was getting as a state health officer. I want to second what Dr. Vaughan has said, that I think of the four factors, the first should be salaries. And I think one thing we should not lose sight of and that is to instill into these prospective health officers the opportunity they have for service. I think a word of warning should be offered here lest we become commercialized. I think the opportunity for service in the field of public health is a thing we should particularly stress. The common complaint that we have in almost all the states in district 4 is the shortage of personnel, and I wonder sometimes if we are not requiring our scientific personnel to do things that some other type of personnel can do to a better advantage, and that will release them for the scientific part of the job that they are trained to do. In other words, there are a lot of things being done by a public health nurse that probably a nurse's aide can do, especially is that true in the V. D. control problem in rapid treatment. We want to put a lot of nurses in there, I wonder if we shouldn't be pretty well satisfied to get, especially in the male wards, these corps men from the Army or pharmacists from the Navy. Why consume the time of the nurse with work which these boys can do just as well. I think we should give consideration to relieving the scientifically trained personnel for the job that they are trained to do and supply some of the leg work with less well trained personnel. If we are to get people to head up and go forward with that local unit public health program we have to understand that people want it and are willing to pay for it, and you as state health officers, you should assume the rôle of leadership. I think that the passage in the Holy Scriptures which says, "Ask and you shall receive," should be tried out any way.

Miss Buker: We have been talking mostly about health officers lately,

but I would like to mention nurses again and agree with what Dr. Applewhite said. Too many of our public health nurses have been working more for the love of the work than for the compensation they receive from it. Many of our state health associations at the present time are setting up personnel policy committees and you folks will have an opportunity to work with those committees and approve of some of the things that they are doing. We have found in some states that the recommendations of those committees have been very effective in getting through salary increases for nurses. In some places the recommendations have already been published with approval of the state health department personnel. The Health Commissioner and the medical directors or health officers in local counties have taken those printed recommendations to the Boards of Supervisors and here in the state we hear from one health officer after the other "Well, I took those recommendations into my Board of Supervisors and they have voted to give the nurses the salaries recommended there." And that is one way in which public health nursing salaries are being increased and in your own states you may have an opportunity to help in getting over those personnel policies.

Dr. Boyd: We have received a great deal of support from the Illinois Public Health Association in respect to salaries and due in a considerable measure to their activities we were able to increase salary ranges under position classifications of the Illinois Civil Service Commission the last time the legislature met.

Dr. Lunsford: We raised our salary three times in the last eighteen months and there hasn't been a great deal of success. We are looking forward to raising it again sometime in the next quarter. That hasn't been the solution to the problem with us.

Dr. Atwater: This matter of salaries and adequate compensation for public health personnel was systemically considered by the Committee on Professional Education. Dr. Godfrey will remember the discussions in which for a time there was some doubt as to whether the association should identify itself with a salary raising campaign. We have been told in unequivocal terms by the Governing Council that there is no disrepute in a professional society's being concerned with a matter as basic as compensation. The Committee on Professional Education has declared itself very much in the terms that Dr. Vaughan has so well expressed. At the forthcoming meeting in Cleveland the middle of November Dr. William P. Shepard, Chairman of the Committee on Professional Education, will present, at Dr. Boyd's request before the Health Officers' Section, a review of the salary situation as it is seen from the standpoint of the APHA, what we know in terms of its influence on recruitment, what we know in terms of its influence on stability, on career service, on attracting the best personnel. I think all of you will be interested in that manuscript which is already in draft form and which summarizes some very significant developments. The Association welcomes the opportunity of being of service to state health officers and their personnel, in placing before you the names of persons known to us to be available. We do not enter the field of recruitment in public health nursing. We believe that this a specialized field that ought to be done by those well equipped and we refer such requests to the American Nurses' Association office, which is a joint office with some of the other nursing agencies. With regard to other personnel, health officers, engineers, health educators, and

all the other specialties we do maintain a list and you are welcome on request to the placement service in New York to have lists of currently available people. We have a trained and experienced physician in charge of that bureau, which I said, is operated coöperatively with the Public Health Service in Dr. Palmer's office. We would greatly like to serve the public. You are welcome to use the columns of the American Journal of Public Health to announce your vacancies, to announce salary raises, to advertise specifically, you can either use your names or you can key the responses. We also offer counsel with respect to merit system problems as they affect this recruitment. I think most of you know that the association offers an examination service to merit system units. We have qualified examiners in almost all of the fields now who are prepared to set up these examinations. We have served 25 of the states. A field person now is available for consultation on recruitment as it affects merit systems in the person of Mr. Charles B. Frasher, known to a good many of you as the merit system supervisor of Pennsylvania some years ago, where he did an outstanding job in setting up their plan. Mr. Frasher is now out of the service and is on the staff of the American Public Health Association available to you for counsel on merit system problems. We also have engineering personnel at the present time, Mr. Elder, and we expect to have a second engineer available for consultation on the matter of recruitment and placement of engineers and sanitarians. Dr. Emerson has mentioned the large deficiency of public health engineers; 343 were employed by local health departments when the report was compiled. The report proposes something like 1300 public health engineers, a deficit of a clear thousand. In view of the fact that there is such a demand, that there are so few attractive positions, the Association expects to employ an engineer for field consultation to put in touch with state health officers and others, the available engineers who are coming out of the Army and are known from other sources, and to talk with you about what salaries, what duties, what qualifications should be set up. That is a type of service which the Association is glad to offer, believing that we ought to be a service agency in a subject like this which concerns a professional society so fundamentally.

Dr. Palmer: Do you think this group could use about 50 health officers and engineers that are trained? Because they are on their way in the fellowships that were made available to the Public Health Service by the National Foundation for Infantile Paralysis. Those people are entering school this month and they are going through schools of public health or the schools of sanitary engineering and they will finish their academic training next June. They will go into three months of field training and then are ready for a job. Now, this isn't pulling away people from Kentucky, this is pulling away people from the Army and Navy. Most of these are young people, who haven't been in public health before. I think that the district directors of the Service are familiar with the situation if you haven't heard so much about it yourselves. There is a potential supply of nearly 50 men and women who will be available sometime next summer.

Dr. Lunsford: (Georgia) We were in the market for between two or three hundred nurses and 40 or 50 doctors. Vacancies in the large urban centers are few in number. We need doctors and nurses in the rural areas. Somehow they would rather work in Atlanta or Savannah for less money than they would out in a rural community of about 10 or 15,000 people.

Dr. Emerson: In how many states does the existing legislation restrict you precisely in the range of salaries that can be paid for some of these positions? I don't mean the range within certain grades, but what are the limitations in some states that very seriously prevent your getting professional personnel? I refer to statutory provisions.

Dr. Godfrey: That is a matter we ought to pay attention to. The great difficulty we have had in the City of New York is what is called the "Lyon's Law", which forbids the employment of anybody by the city who hasn't had three years residence within the area of the city. We have been seeking elsewhere persons whom the salary perhaps would attract, but who haven't had the residence. There are limitations in salaries in some states which are so serious that any of this ambition to raise salaries has no effect upon them. It doesn't help them at all. It seems to me that we ought to find legal advice or get Association assistance in seeing that those hindrances are removed, if possible.

Dr. Atwater: (APHA) I might say that since I came to Ann Arbor several state officers asked me to write them letters telling what the prevailing salary rates were in various specialties and what they would have to pay to attract good personnel. In some instances those letters have been useful in raising approved standards. I am quite prepared to coöperate with state health officers in giving statements of that kind on request.

Dr. Palmer: If there is any other comment on some of the topics we have discussed we would be glad to hear it. Our time is about over.

Dr. Emerson: Dr. Getting, I recognize you to present a resolution.

Dr. Getting: "The Association of State and Territorial Health Officers in executive session hereby expresses appreciation for the unusual opportunity afforded by the National Conference on Local Health Units by bringing together for a week's work the leaders in public health training and the state health officers and directors of local health service in the forty-eight states. It especially appreciates the efforts of Dr. Haven Emerson, Chairman of the Subcommittee on Local Health Units of the Committee on Administrative Practice, as the originator and stimulator of the Conference, and those of Dr. Henry F. Vaughan, Dean of the School of Public Health, for his untiring efforts in making the Conference a success.

It expresses its deep gratitude to the University of Michigan for extending its hospitality and making available its staff, to the American Public Health Association for its efficient assistance and co-sponsorship, and to the W. K. Kellogg Foundation for making funds available to make the Conference possible.

To all of the above it is grateful for this unique privilege.

Because of the wealth of the material presented and its potentially invaluable use for the promotion of total coverage of the nation with full-time local health units, it is the unanimous hope of the Association that the proceedings of the Conference will be published as a supplement to the Journal of the American Public Health Association.

The Association of State and Territorial Health Officers."

Signed by the President and Secretary (F. C. Beelman and V. A. Getting).

I move, Mr. Chairman, that this resolution be spread upon the records of the proceedings and that copies of it be sent to all the organizations and individuals mentioned.

The motion is seconded.

Dr. Emerson: If it is your pleasure I'll put the motion. Those in favor of this please say aye. Unamimously carried.

Dr. DeKleine: As evidence of our recognition of the great value of this conference I move that we recommend to those who are responsible for planning this conference that it be repeated not necessarily next year, but at such future time as in their judgment it is justified.

Dr. Emerson: You have heard that motion, it is seconded. I presume that doesn't specify the particular university or the particular setting, but that something patterned in this fashion be repeated?

Dr. DeKleine: Yes.

The motion was passed unanimously.

Dr. Applewhite: While we are passing resolutions, I want to express the appreciation of the Public Health Service—of course I was sent here as an observer—but I want to express appreciation of my fellow workers, fellow district directors for your kindness in allowing us to attend this conference because I think we have learned a lot. Our vision has been broadened, and I think we have become more worthwhile servants to the state health departments whose servants we are. It is our function to serve in an advisory capacity to state health departments, help them in every way possible. This meeting has been most helpful—I know it has to me, and I want to express the thanks of my fellows of the U. S. Public Health Service also for the courtesy you have extended to us.

Dr. Emerson: Everybody will agree that it is quite unthinkable that any conference in this field could be carried on effectively without the participation of the federal public health service.

Dr. Emerson: I think that closes our session approximately on schedule. Unless someone has a further comment to make we will turn the meeting over to Dr. Vaughan to close.

Dr. Vaughan: I don't know why Dr. Emerson should call on me to close the meeting, it is his meeting. All I can say is on behalf of the Planning Committee and on behalf of the School of Public Health, whose privilege and pleasure it has been to take care of your housing necessities during this conference, I want to thank all the speakers, all the participants, and each and every one of you who have really made this conference, I think, a success. I have been impressed with the attentive way in which you have all been here. You have done better than students usually do. My own impression has been that this conference has been well worth while, and the only reason it has been worth while is because of the constant stimulation which has come from the people who have been good enough and gracious enough to come here and give us so freely of their time and to participate in the program.

Dr. Emerson: We will stand adjourned.

The National Conference on Local Health Units for the Nation is closed.

THOSE ATTENDING THE CONFERENCE

Dr. J. K. Altland, Director, Michigan Bureau of Local Health Service, Lansing
Dr. Gaylord Anderson, University of Minnesota School of Public Health, Minneapolis
Dr. G. M. Anderson, Wyoming Health Officer, Cheyenne
Dr. Norman Angstadt, Director, West Virginia Division of County Health Work, Charleston
Dr. C. C. Applewhite, U. S. Public Health Service, Washington
Dr. Robert E. Archibald, Director, Massachusetts Local Health Administration, Boston
Dr. Reginald M. Atwater, Executive Secretary, American Public Health Association, New York
Dr. R. N. Barr, Director, Minnesota Local Health Administration, Minneapolis
Dr. Floyd C. Beelman, Kansas Health Officer, Topeka
Dr. Daniel Bergsma, New Jersey Deputy Health Commissioner, Trenton
Dr. Walter L. Bierring, Iowa Health Commissioner, Des Moines
Dr. P. E. Blackerby, Kentucky Health Commissioner, Louisville
Dr. C. F. Blankenship, U. S. Public Health Service, Chicago
Dr. Richard F. Boyd, Chief, Illinois Division of Local Health Administration, Springfield
Dr. George Brother, Director, Indiana Local Health Administration, Indianapolis
Dr. Monroe F. Brown, Director, Tennessee Local Health Service, Nashville
Dr. Carl E. Buck, Field Director, American Public Health Association, New York
Miss Helene Buker, Michigan Department of Health, Lansing
Dr. L. E. Burney, Indiana Health Commissioner, Indianapolis
Dr. H. Grady Callison, Director, South Carolina Local Health Organization, Columbia
Dr. J. Moore Campbell, Director, Pennsylvania Bureau of Health Conservation, Harrisburg
Dr. Douglas L. Cannon, Director, Alabama Bureau of County Health Work, Montgomery
Dr. John Casperson, Deputy Health Commissioner for Norway
Dr. A. J. Chesley, Minnesota Health Officer, Minneapolis
Dr. Roy L. Cleere, Colorado Health Officer, Denver
Dr. E. R. Coffey, U. S. Public Health Service, New York
Dr. Gilbert Cottam, South Dakota Health Officer, Pierre
Dr. H. B. Cottrell, Supervisor, Mississippi Division of County Health Work, Jackson
Dr. George A. Dame, Director, Florida Bureau of Local Health Service, Jacksonville
Dr. Sarah S. Deitrick, Children's Bureau, Washington
Dr. William DeKleine, Michigan Health Commissioner, Lansing
Dr. James A. Dolce, Director, Connecticut Local Health Administration, Hartford
Dr. Haven Emerson, Columbia University School of Public Health, New York
Dr. Harold M. Erickson, Oregon Health Officer, Portland
Miss Louisa J. Eskridge, Michigan Department of Health, Lansing
Dr. John A. Ferrell, Stamford, Connecticut
Dr. Allan Filek, Supervisor, Wisconsin Division of Local Health Services, Madison
Dr. Robert S. Ford, University of Michigan, Ann Arbor
Dr. Robert E. Fox, Director, North Carolina Local Health Administration, Raleigh
Dr. Thomas Francis, Jr., University of Michigan School of Public Health, Ann Arbor
Dr. Richard B. Fulks, Kentucky Board of Health, Louisville
Dr. Vlado A. Getting, Massachusetts Health Commissioner, Boston
Dr. Edward S. Godfrey, Jr., New York Commissioner of Health, Albany
Dr. Theo. Goldstein, Ministry of Public Health, Bratislava, Czechoslovakia
Dr. Harold M. Graning, Acting Director, Georgia Division of Local Health Organization, Atlanta
Dr. Wilton Halverson, California Director of Public Health, San Francisco
Dr. W. T. Harrison, U. S. Public Health Service, San Francisco
Dr. Roger E. Heering, Ohio Director of Health, Columbus
Dr. Roy Hege, North Carolina Local Health Administration, Raleigh
Dr. John T. Herron, Director, Arkansas Division of Local Health Administration, Little Rock
Dr. Ira V. Hiscock, Yale University, New Haven
Dr. R. H. Hutcheson, Tennessee Commissioner of Public Health, Nashville
Dr. R. M. James, Missouri Commissioner of Health, Jefferson City
Dr. Trois E. Johnson, Director, Louisiana Local Health Service, New Orleans

Dr. J. A. Kahl, Chief, Washington Division of Local Health Services, Seattle
Dr. Roscoe P. Kandle, New Jersey Department of Health, Trenton
Dr. B. K. Kilbourne, Montana Health Officer, Helena
Dr. Matthew Kinde, W. K. Kellogg Foundation, Battle Creek
Dr. Hugh R. Leavell, Rockefeller Foundation, New York
Dr. Fred Loe, Nevada Health Officer, Carson City
Miss Martha Luginbuhl, American Public Health Association, New York
Dr. L. J. Lull, Director, Idaho Local Health Service, Boise
Dr. Guy S. Lunsford, Deputy Commissioner, Georgia Department of Health, Atlanta
Dr. William H. MacDonald, Chief, New Jersey Bureau of Local Health Administration, Trenton
Dr. J. Lynn Mahaffey, New Jersey Director of Health, Trenton
Dr. G. F. Manning, Arizona Superintendent of Public Health, Phoenix
Dr. Fred Mayes, Director, Kansas Local Health Administration, Topeka
Dr. William M. McKay, Utah Health Commissioner, Salt Lake City
Dr. F. V. Meriwether, U. S. Public Health Service, Chicago
Dr. J. A. Milne, Director, Mississippi Division of County Health Work, Jackson
Dr. Roscoe L. Mitchell, Director, Maine Bureau of Health, Augusta
Dr. Harry S. Mustard, Dean, Columbia University School of Public Health, New York
Dr. J. C. Neale, Jr., Virginia Director of Local Health Services, Richmond
Mr. George J. Nelbach, New York State Charities Aid Association, New York
Dr. Carl N. Neupert, Wisconsin Health Officer, Madison
Dr. James P. O'Brien, District Director of Northern Rhode Island Health Unit, Providence
Dr. Harry A. Overstreet, College of the City of New York, New York
Dr. George T. Palmer, U. S. Public Health Service, Washington
Mr. L. J. Peterson, Idaho Director of Health, Boise
Dr. W. C. Petty, Nebraska Director of Health, Lincoln
Dr. John D. Porterfield, Ohio Department of Health, Columbus
Dr. C. L. Putnam, Iowa Division of Local Health Services, Des Moines
Dr. George H. Ramsey, Olean, New York
Dr. Carl V. Reynolds, North Carolina Health Officer, Raleigh
Dr. Arthur L. Ringle, Washington Health Director, Seattle
Dr. T. T. Ross, Arkansas Health Officer, Little Rock
Dr. Ralph R. Sachs, Washington Division of Local Health Services, Seattle
Dr. Clarence L. Scamman, Director, Division of Public Health, Commonwealth Fund, New York
Dr. James R. Scott, New Mexico Health Director, Santa Fe
Dr. John W. Shackelford, Director, Oklahoma Division of Local Health Service, Oklahoma City
Dr. Nathan Sinai, University of Michigan School of Public Health, Ann Arbor
Dr. Dean F. Smiley, American Medical Association, Chicago
Dr. Wilson G. Smillie, Cornell University Medical College, New York
Dr. William M. Smith, North Dakota Acting Health Officer, Bismarck
Dr. Wilson T. Sowder, Florida Health Officer, Jacksonville
Dr. Ellis Sox, California Director of Local Health Administration, San Francisco
Dr. R. G. Struthers, Provincial Department of Health, Ontario
Dr. V. A. Van Volkenburgh, New York Assistant Commissioner of Health, Albany
Dr. Henry F. Vaughan, Dean, University of Michigan School of Public Health, Ann Arbor
Dr. L. P. Walter, Texas Division of Local Health Service, Austin
Dr. William H. F. Warthen, Maryland Deputy Health Officer, Baltimore
Dr. Harry M. Weest, Pennsylvania Health Secretary, Harrisburg
Dr. Richard Wilcox, Director, Oregon Local Health Administration, Portland
Dr. John W. Williams, Jr., Director, Missouri Division of Local Health Administration, Jefferson City
Dr. Ben Wyman, South Carolina Health Officer, Columbia