A Survey of Local Public Health Departments And Their Directors

C. ARDEN MILLER, MD, EDWARD F. BROOKS, MBA, GORDON H. DEFRIESE, PHD, BENJAMIN GILBERT, MPH, SAGAR C. JAIN, PHD, AND FLORENCE KAVALER, MD

Abstract: In 1974 a questionnaire was mailed to the nation's local health officers. Responses were received from 1,345, at least 68 per cent of all local health departments. The present paper presents selected summary data from respondents concerning the health departments, their jurisdictions, organization, finance, functions, staffing, and about the training, salaries, and other characteristics of local health officers.

Health departments are extensively involved in rendering health services, including direct personal services (25 per cent of all departments). For many services the health department is the sole provider of essential services in the area of jurisdiction. These services include ambulatory care (8 per cent), maternal and child health (48.5 per cent), home care (44.8 per cent), and family planning (38 per cent).

The major constraints to improvement and expansion of programs are perceived as limited financial support, insufficient staff, and inadequate facilities. (Am. J. Public Health 67:931–939, 1977)

Current data about local health departments are not readily available. In 1966 a survey questionnaire was conducted of all local health units, and from that survey a report on their medical care activities was published in 1968.[1] The Department of Health, Education, and Welfare once maintained a registry of local health departments but this was abandoned after 1971.

Interest in the real or potential roles for local health departments has increased. Published reports have emphasized the importance of local governments and their health departments with regard to health planning, monitoring and regulation of health services, provision of personal health care, maintenance of community health services, and other functions.[2–6] These reports with few exceptions have focused on policy analysis that has not benefited from up-to-date data on the actual structure and function of local health departments.

Method

In 1973 a group of investigators associated with the University of North Carolina developed plans for a study of local health departments. In 1974 a query was sent to all state health departments, seeking information about local units. A request was made for names and addresses of local directors, and for statutes or regulations that define the status and function of local health units, and for definition of administrative relationships between state and local units. From these responses a mailing list of local health units and their directors was established, and a questionnaire* was prepared and mailed to all local directors. Data from responses to that questionnaire and from the queries to state health departments form the basis for this report.

Additional studies consisted of review of statutes in all 50 states relating to administrative relationships between local and state health departments and on the statutory authorizations that are provided local health departments. Selected findings from these efforts are summarized in this report, and form the basis for additional detailed reports.

Addressees: For purposes of addressing and mailing the questionnaires, the rosters that were provided by the state health departments were used. The rosters presented difficulties in several states where many hundreds of "local health officers" were listed. Further inquiry revealed that the title "local health officer" in these states was conferred on physicians in private practice as well as non-professional persons in order to honor their functions in reporting vital statistics. The titles in these instances have nothing to do with authority over an administrative or service unit that is traditionally regarded as a local health department. In states where the number of local health officers exceeded 200 a spe-

From the University of North Carolina's Health Services Research Center; the School of Public Health's Departments of Maternal and Child Health, and Health Administration; and from the Milbank Memorial Fund Commission for the Study of Higher Education for Public Health. Address reprint requests to Dr. C. Arden Miller, Department of Maternal and Child Health, School of Public Health, University of North Carolina, Chapel Hill, NC 27514. This paper, submitted to the Journal February 4, 1977, was revised and accepted for publication April 25, 1977.

*Available on request to authors.

cial query was sent asking if the local health officers administer a public health unit that employs at least one full-time employee. From these responses the rosters were revised. The questionnaires were followed by mailings at biweekly intervals in order to increase the response rate. Responses were received from 65.4 per cent of the addressees or their surrogates (Table 1).

Corrected Response Rate: A total of 1,355 responses was recieved. Any report that failed to indicate a staff of at least one full-time person, be it nurse, director, secretary, or sanitarian, was dropped from further analysis. After these eliminations a study group of 1,345 responses formed the basis for reporting in this study.

From experience with rosters of local health officers, and from review of responses from the survey, an operational definition of a local health department emerged as an administrative and service unit of local or state government, concerned with health, employing at least one full-time person, and carrying some responsibility for the health of a jurisdiction smaller than the state. Clearly the original 2,073 addresses included names that do not qualify as local health departments by this definition. Efforts to refine the list by means of re-confirmation with state health officers and by mailings to local addressees always resulted in revision downward of the number of addressees. The actual number of local health departments probably falls between the inflated estimate of 2,073 represented by the address list in the present study and the 1,073 reported in 1966.[1] Hence, data reported from the present study cover at least two-thirds, and possibly as many as three-fourths, of all local health departments. The higher response rate is suggested by data on the non-respondents. Sixteen per cent of them represent addressees in communities of less than 2,500 people; 63 per cent of the non-respondents are in communities of less than 10,000 people. Only one per cent of the non-respondents represent addressees in communities exceeding 100,000 people. These data suggest that the roster of addressees may still contain a considerable number of "health officers" who do not in fact administer a functional service unit.

TABLE 1—Number and Per Cent of Questionnaires Returned by Local Health Officers for Departments Employing at Least One Full-Time Staff Member, by Census Region, 1974 National Survey of Public Health Officers.

Census Region	Number of Addressees	Number of Responses	Per Cent Response
New England	237	145	61.2
Middle Atlantic	297	143	48.1
East North Central	351	257	73.2
West North Central	127	96	75.6
South Atlantic	273	209	76.6
East South Central	331	178	53.8
West South Central	244	172	70.5
Mountain	88	64	72.7
Pacific	125	91	72.8
United States	2,073	1,355	65.4

Results—Health Departments

Patterns of Organizational Structure

Three organizational patterns characterize operative administrative relationships between local health departments and state or local government:

Centralized Organization: A state department of public health or a state board of health operates local health units that function directly under the state's authority, sometimes through regional administration and sometimes with the help of a local board that maintains advisory functions to the local unit. (Examples: Arkansas, Connecticut, Florida, Hawaii, Louisiana, Maryland, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Dakota, South Carolina, Tennessee, and Virginia.)

Decentralized Organization: Local government—city, township, country, or some combination—operates a health department either directly or with the authority of a local board of health intervening. The state health department offers consultation and advice either to the local board or to the local department, or to both. (Examples: California, Idaho, Illinois, Iowa, Kansas, Maine, Massachusetts, Nebraska, New Hampshire, New York, North Carolina, Ohio, Oregon, South Dakota, Texas, Utah, and Washington.)

Shared Organizational Control: Local government may operate a health department either directly or through a local board of health. Under circumstances that are more or less well defined, these same departments fall under the authority of state health departments. The state department sometimes retains appointive and line authority over local health officers who are also responsible to local boards or commissions. Sometimes the local departments must submit programs, plans, and budgets to the state health department in order to qualify for federal and/or state funds. (Examples: Alabama, Arizona, Colorado, Georgia, Indiana, Kentucky, Michigan, Missouri, New Jersey, Pennsylvania, Oklahoma, West Virginia, Wisconsin, and Wyoming.)

Relationship of these categories to other characteristics of health departments will be the subject of a separate report.

The relationships between local and state health departments and their respective governments are seldom explicit in the statutes, at least not in ways that are consistent with existing operations. In many instances the statutory patterns date back to an era of public health that was predominantly concerned with regulatory functions related to sanitation and communicable disease control. Only seven states have made major revision in public health codes since 1965; one-half the states have not revised their health codes for the past quarter century.

Jurisdictional Characteristics of Local Health Departments

Single units of local governmental jurisdiction form the base for 70 per cent of all responding local health departments: city, 14.1 per cent; county, 47.4 per cent; towns, 8.9 per cent (Table 2). Nearly all of the city health departments (80 per cent) exist in New England, Middle Atlantic, and

TABLE 2—Per Cent Health Departments by Type of Jurisdiction, 1974, United States and Census Regions.

	United States	New England	Middle Atlantic	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific
City	14.1	38.0	25.4	25.0	14.7	6.2	—	3.5	1.9	1.1
County	47.4	0.7	19.7	44.9	56.8	61.7	64.4	66.7	42.6	62.2
2 or More Counties	8.4	0.7	0.7	8.6	4.2	14.8	10.7	5.8	29.6	7.8
Town	8.9	55.6	27.5	—	1.1	—	—	—	—	—
City Plus One County	15.2	0.7	0.7	19.1	22.1	11.0	22.0	21.6	22.2	22.2
City Plus Counties	4.9	2.1	19.7	2.0	1.1	6.2	2.8	1.8	3.7	5.6
Other	1.1	2.1	6.3	0.4	—	—	—	0.6	—	1.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(1337)	(142)	(142)	(256)	(95)	(209)	(177)	(171)	(54)	(90)

East North Central regions.* The township rather than the county is the predominant local unit of government in New England; town health departments are nearly confined to the New England and the Middle Atlantic areas.

Collaboration of several governmental jurisdictions for purposes of operating a combined health department commonly involve a city with one or more counties (20.1 per cent of all departments). Multi-county departments are not common (8.4 per cent), although there are striking regional differences. Thirty per cent of the local health departments in the Mountain region involve more than one county. Multi-county departments are next most common in the South Atlantic (14.8 per cent) and East South Central (10.7 per cent) regions. Excluding New England with its different pattern of local government, city-county health departments constitute about one-quarter of all jurisdictions, ranging from 28 per cent in the Pacific region to 17 per cent in the South Atlantic region.

*References to regions conform to the regions of the United States census. They are: New England—CT, ME, MA, NH, RI, VT: Middle Atlantic—NJ, NY, PA; East North Central—IL, IN, MI, OH, WI; West North Central—IA, KS, MN, MO, NB, ND, SD; South Atlantic—DE, DC, FL, GA, MD, NC, SC, VA, WV; East South Central—AL, KY, MS, TN; West South Central—AR, LA, OK, TX; Mountain—AZ, CO, ID, MT, NV, NM, UT, WY; Pacific—AK, CA, HI, OR, WA.

Sources of Finance

The total budget for reporting local health departments in fiscal year 1974 amounts to about $1.8 billion (Table 3). About 60 per cent of local health department funding comes from local government, 20 per cent from state government, and nine per cent is identifiably derived from federal sources. The balance (about nine per cent) comes from fees for services. If the source of dollars could be accurately traced, it is likely that local and state sources would be somewhat less than reported and federal sources would be more. Accurate data are not available on the amount of federal money that finds its way to local health departments through fees collected from agencies (e.g., welfare departments) that in turn receive their money from federal sources (e.g., Medicaid).

The average annual budget of reporting local health departments in fiscal year 1974 was $760,000. Some regional differences are noteworthy. State support is proportionally highest in the South (nearly 50 per cent) and least in New England (3 per cent). Local health departments are heavily dependent on local sources of support in New England (89

TABLE 3—Mean Per Cent of Health Department Budget Funding by Source, 1974 United States and Census Region.

Budget Source	United States	New England	Middle Atlantic	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific
Federal	8.6	4.4	2.8	8.2	9.5	10.7	13.6	6.9	10.7	14.1
State	21.6	2.8	12.2	10.1	19.2	37.5	39.0	38.9	20.7	14.6
Local	59.8	88.8	79.0	63.4	59.4	46.1	38.8	50.6	61.6	60.9
Fees	5.3	1.7	3.1	10.5	7.3	3.9	5.4	1.8	5.4	7.2
Other	1.9	.2	.2	4.6	2.5	1.9	1.4	1.0	.5	2.4
TOTAL	97.2	97.9	97.3	96.8	97.9	100.1	98.2	99.2	98.9	99.2

Mean Total Budget:				
	United States	$759,864	South Atlantic	$1,226,683
	New England	336,412	East South Central	303,292
	Middle Atlantic	681,604	West South Central	331,572
	East North Central	643,463	Mountain	648,469
	West North Central	451,383	Pacific	2,779,539

Note: Columns do not total 100% due to missing data and rounding.

per cent) and the Mid-Atlantic region (79 per cent). Identifiable federal support is proportionally least in these two regions (4.4 and 2.8 per cent respectively). Federal support is highest in the East South Central and Pacific regions (13.6 and 14.1 per cent respectively).

Mean total health department budgets are highest in the Pacific region ($2,780,000) and lowest in the East South Central region ($303,300). In spite of the relatively high proportion of city health departments in New England, suggestive of large size, average annual budgets are among the lowest ($336,412 per year).

Approximately 57 per cent of local health departments collect fees for personal health services. South Atlantic and Pacific regions report the highest percentage of health departments that collect such fees (81.2 and 77.3 per cent respectively). A national pattern distributes the source of fee payment to the patient (20 per cent), another agency (20 per cent), and to both (60 per cent). Substantial variations from this pattern occur in New England and Middle Atlantic regions where the patient is the sole source of payment in nearly one-half the instances (47.7 per cent and 44.6 per cent respectively). The South Atlantic and Pacific regions present a different pattern where the patient is the sole source of fee payment in only 8.0 per cent and 14.9 per cent of the instances respectively. In these same regions about 80 per cent of fees are collected from a combination of patient and other agencies.

Staffing

The mean number of physician, nursing, outreach, environmental, and administrative/support personnel employed in reporting local health departments of the United States is 34.40 employees. In general, one-third of the staff are administrative/support personnel, another one-third are registered nurses, and about one-fourth are sanitarians. There is an average of one physician for every 30 employees in health departments.

Health departments in the Pacific (81.6 employees)* and South Atlantic (74.1) regions are largest in terms of mean number of employees. New England (11.6), West North Central (15.5), and East South Central (17.8) are smallest.

Departmental Functions (Services Provided)

More than one-half of all health departments in the study provide each of the following services: immunization programs, environmental surveillance, tuberculosis control, maternal and child health, school health, venereal disease control, chronic disease programs, home care, family planning, and ambulatory care (Table 4).

The majority of health departments are the sole sources in their localities for programs of environmental surveillance (70.4 per cent), tuberculosis control (63.3 per cent), and immunizations (57.7 per cent). Other major obligations for which the health departments are sole providers are maternal and child health (44.8 per cent of reporting departments), school health (38.5 per cent), family planning (38 per cent), and chronic disease programs (25.7 per cent), (Table 4). Other functions, although less common, are of special interest: more than 7.5 per cent of health departments are the sole source of ambulatory care in their areas; and 20 health departments (1.4 per cent) report themselves as the sole source of acute hospital services (Table 4).

TABLE 4—Per Cent of Health Departments Providing Selected Services, 1974.

Services	Per Cent Providing Each Service	Per Cent Serving As Sole Provider of Each Service
Immunization Programs	96.3	62.3
Environmental Surveillance	96.0	70.4
Tuberculosis Control	93.9	63.3
Maternal and Child Health	89.4	48.5
School Health Program	89.2	38.5
Venereal Disease Control	88.0	57.7
Chronic Disease Programs	84.3	25.7
Home Care	76.7	44.8
Family Planning	63.3	38.0
Ambulatory Care	50.3	7.6
Mental Health	47.4	5.4
Chronic Institutional Care	11.8	1.5
Acute Institutional Care	8.4	1.4

Respondents were asked to indicate their departments' three most important functions; "disease prevention" and "environmental surveillance" head the list, each function being recorded as among the three most important functions for about three-fourths of the departments. Closely related functions are disease control (34 per cent) and public education (23 per cent). Slightly more than one-quarter of all departments list "direct delivery of medical care" as one of their most important functions.

Important *regional* variances exist as follows:

- *Health code enforcement* ranked high in New England (70 per cent) and Middle Atlantic (71.8 per cent);
- *Direct delivery of medical services* ranked highest in the South Atlantic (43.8 per cent); lowest in the Middle Atlantic (12 per cent) and New England (18.6 per cent);
- *Coordination of health services* ranked high in New England (36.6 per cent) and lowest in the East South Central (10.4 per cent).

Respondents indicated programs that are major as measured by commitment of staff and budget, and then identified programs that are expected to expand. In general, health officers expect to expand those program which they already consider major, namely: Environmental Surveillance, Immunization Programs, and Maternal and Child Health. Relatively few health officers expect to expand or institute Ambulatory or Institutional Medical Care Services, Tuberculosis Control, or Mental Health Services.

Some interesting regional variances in the rank of programs expected to *expand* are as follows:

- New England—"School Health" ranks third;

*Interpretation of these data in the Pacific Region must be cautious. Some health departments in the far west are part of larger human resources agencies. Some of the staff of the larger agencies may be included in these figures.

- Middle Atlantic—"Chronic Disease Programs" rank third;
- East North Central—"Venereal Disease Control" rank second;
- South Atlantic—"Family Planning" ranks first;
- East South Central—"Family Planning" ranks first;
- West South Central—"Chronic Disease Programs" rank first;
- Mountain—"Venereal Disease Control" ranks first;
- Pacific—"Family Planning" ranks first, "Maternal and Child Health" ranks second.

Relatively few health officers expect to reduce programs; tuberculosis control heads the list of programs slated for reduction.

Influences over Program Priorities

Health officers see themselves as the major source of influence on departmental priorities (Table 5). Other important sources of influence are the state health department, and a local board of health, which is important for the priorities of more than one-half the health departments (53.1 per cent). Only 41.5 per cent of respondents see local government as a strong influence in local health departments; 28.3 per cent report consumers as a strong influence.

Selected points of regional variance in the ranking of *influence on priorities* of local health departments are:

- New England, East North Central, and West North Central—local boards of health rank first.
- South Atlantic and Pacific—local government ranks third and second respectively.

Respondents were asked to indicate the processes by which consumers might influence departmental priorities. "Direct access", i.e., telephone calls, letters, complaints, etc., is the major mechanism used by consumers to influence health department program priorities, according to health officers. Only departments in the Pacific and South Atlantic Regions commonly provide formal processes for consumer influence in the form of Citizen Task Forces (46.9 per cent and 41.7 per cent of the reporting departments respectively).

Constraints on Programs and Services

In the United States and in every region, "lack of funds" and "lack of staff" are ranked first and second, respectively, as constraints on programs and services. "Professional groups," including medical societies, "lack of consumer acceptance," and "legal constraints" are generally ranked lowest as constraints.* In the East South Central and West South Central regions the state health department is seen as the third ranking constraining influence.

When asked to assume that present legal or economic constraints might be lifted, respondents project an ideal role for local health departments that emphasizes coordination, leadership, and general expansion of all services.

TABLE 5—Number of Respondents Perceiving Selected Persons or Groups as a Source of Strong Influence on Program Priorities, 1974.

Source of Influence	Number of Responses
Health Officer	882
State Health Department	831
Local Board of Health	713
Local Government	558
Consumers	380
State Legislature	262
State Board of Health	194

Statutory Authorizations

Statutes were examined to clarify the nature of the legal mandate to local health departments in all 50 states. Particular attention was directed toward personal health services, environmental protection, provision of resources and facilities, enforcement/monitoring, and regulatory functions. Comparisons were made between mandate as provided by public health statutes and actual performance as reported in the survey. These findings will be reported in detail in a separate paper but the following observations are warranted:

- Most health codes abound with ninteenth century concerns over sanitation and communicable disease. All of the states mandate control of epidemics, and collection of vital statistics. Other common examples: V.D. control, 92 per cent; quarantine 92 per cent; refuse disposal, 64 per cent.
- Services that can be identified with personal health care are specifically mandated, either to local or state health departments, in less than one-half the states.
- Community services are mandated in some ways that have been recently superseded by other initiatives. Fifty per cent of the states mandate health planning to the health departments. Other authorized functions are occupational health, 60 per cent; indigent care, 58 per cent; and mental health, 50 per cent.
- If a series is ranked according to the frequency of their mandate to local health departments and then compared with a similar ranking of what those health departments are actually doing, the two ranks bear an almost inverse relationship to each other. What local health departments are actually doing bears little relationship to their statutory authorization.
- Insofar as enforcement powers and regulatory functions are defined in health codes they are overwhelmingly assigned to the state rather than to the local level. Regulatory and enforcement powers are common with relation to sanitation, control of communicable disease, and monitoring of health facilities. Virtually no powers are defined to restrict or regulate providers of health care.

*The influence of the medical society is seen as a constraint in only one of ten of the big city departments, but in one out of five of the small city/town and county departments (Table 7).

Results—Health Officers

Personal Characteristics

Slightly fewer than one-fifth of all health officers are female. In the Middle Atlantic and East North Central regions only one out of approximately every 12 health officers is female. In the West North Central, West, and East South Central regions, about one-third of all health officers are female. The average age of health officers in the United States is about 50 years and most health officers (57 per cent) are between 40 and 59 years old. Health officers tend to be slightly younger in the Mountain region (median age is 45.9) than in the other regions. Health officers' mean age is highest in the South Atlantic region (54.2) where over 70 per cent of the officers are 50 or more years old.

Professional Education

Nearly two-thirds of all health officers in the United States have an MD degree; nearly one-third have an MPH (or similar) degree; about 23 per cent have both an MD and MPH (or similar) degree; about 9 per cent have a bachelor degree, or no college degree at all.

The highest proportion of health officers who are physicians is found in the Pacific and South Atlantic regions (96.6 per cent, and 88.2 per cent respectively). Only about one in every four health officers in the Middle Atlantic and New England regions are physicians.

About one-half of the health officers in the South Atlantic and Pacific regions have MPH or similar degrees. The West North Central region has the lowest per cent (14.3) of health officers with formal graduate degrees in public health.

Most of the health officers with a bachelor's degree or no degree are located in the Middle Atlantic, New England, and West North Central regions.

Time, Effort, and Salary

Nearly three-fourths of the reporting health officers in the United States serve only one department. Of those who serve multiple departments, most (about two-thirds) serve only two, and nearly all the rest serve three departments. About three of every five health officers are employed full-time.

The mean salary of health officers including part time is, $20,096; median salary is $17,140 (See Table 6 for detailed data). The lowest mean salary of any group of health officers occurs among those who serve one department, part-time in New England ($9,085). Highest salaries are for full-time health officers serving one department in the Pacific or South Atlantic regions ($31,934 and $29,931 respectively).

Health officers average 14 years of experience in public health. There are no strong regional differences except for somewhat greater length of service in the South Atlantic region.

Results According to Jurisdiction

Selected data on the characteristics of health departments by jurisdiction appear in Table 7. Only three kinds of jurisdiction are included: city populations in excess of 250,000; town/city populations between 25,000 and 100,000; and county/multi-county populations.

The data are of interest chiefly for the absence of important differences that distinguish city departments. One dif-

TABLE 6—Health Officers by Salary, United States, 1974.

Annual Salary	United States	
	Number	Per Cent
Less than $5,000	198	14.9
5,000-10,000	200	15.1
10,000-15,000	207	15.6
15,000-20,000	138	10.4
20,000-25,000	121	9.1
25,000-30,000	157	11.8
30,000-35,000	154	11.6
35,000-40,000	66	5.0
40,000 plus	87	6.6
TOTAL	1328	100.0

TABLE 7—Selected Characteristics of Health Departments in City/Town and in County/Multi-County Jurisdiction

Health Department Characteristics	Population Size In City/Town Jurisdictions		County Or Multi-County Jurisdictions
	>250,000	>25,000-<100,000	
Number	36	151	1096
	%	%	%
Full-Time Director	85.7	72.0	59.2
>25% Funds From Federal Gov.	23.5	8.6	12.3
>25% Funds From State Gov.	14.7	17.9	40.7
>25% Funds From Local Gov.	86.2	90.4	6.2
>25% Funds From Fees	7.4	6.2	4.5
>25 Full-time Employees	77.8*	39.0	23.0
No Full-time M.D. Employed	17.1	65.3	68.9
>10 Full-time RN Employees	45.7	2.0	3.8
No Full-time Outreach	77.1	3.1	1.8
Workers Employed	34.3	70.0	69.6
>10 Full-time Outreach Workers		2.0	3.7
Important Constraints on Program:			
Insufficient Staff	50.0	52.5	52.8
Insufficient Facilities	23.6	36.9	36.5
Insufficient Funds	67.6	66.7	62.4
Medical Society	11.8	21.0	21.7
One of Three Most Important Programs			
Direct Medical Care	34.3	20.0	27.8
Health Code Enforcement	60.0	55.0	35.8
Sole Provider in Jurisdiction			
Home Health Service	8.9	32.1	48.3
Environmental Surveillance	58.8	75.5	70.2
Family Planning	6.1	20.0	41.9
Ambulatory Care	0	8.0	7.9
Chronic Disease Program	11.8	15.0	27.8
Maternal & Child Health	21.2	31.2	52.0
Immunizations	39.4	55.5	64.2

* Some big city Departments report services that are more extensive than would be expected by the reported number of employees, suggesting that some services are provided by contract with other agencies

ference relates to sources of funding. Big city departments are more likely than county departments to receive more than 25 per cent of their total finances from federal sources (23.5 per cent and 12.3 per cent respectively); and to receive more than 25 per cent of their finances from fees for services (7.4 per cent and 4.4 per cent respectively). County departments are more likely than big city departments to receive more than 25 per cent of their total finance from the state (true of 40.7 per cent of the county departments and 14.7 per cent of the city departments).

Only 17 per cent of city departments do not employ a full-time physician; about two-thirds of country and small/town departments do not employ a full-time physician.

Among the departments' three most important functions direct medical services are higher for city and county departments (34.3 per cent and 27.8 per cent respectively) than for small city/town departments (20.0 per cent). Health Code enforcement is regarded more commonly as an important function in big city departments (60.0 per cent) than in county departments (35.8 per cent).

County and small city/town departments are more often the sole provider in their areas for home health care (48.3 per cent and 32.1 per cent respectively) than city departments (8.9 per cent). Small city/town and county departments are more likely than city departments to be the sole provider of family planning services, and environmental surveillance (Table 7).

Commentary

Extensive efforts to plan, organize, subsidize, and regulate health services in the United States are thrust upon the national scene with little acknowledgment that local health departments are a part of that scene. In 1974 when the U.S. Department of Health, Education, and Welfare issued a *Forward Plan for Health* for Fiscal Years 1976–1980, the official health agencies of local government received scant mention. In the revision of 1976 the *Forward Plan* deals with such issues as Medicaid reform, national health insurance, health education, health planning, and preventive health services in ways that emphasize the responsibilities of local government. But in discussion of those responsibilities the *Forward Plan* never addresses the scope of local government's current or potential commitment through existing health departments. Similarly when Medicaid (Title 19 of the Social Security Act) was enacted it waffled between implementation as a welfare program and as a health service system for poor people, finally falling on the side of welfare. That circumstance has confounded local government's existing programs of health services to poor people which operated out of health departments, or combined welfare/health departments, but seldom if ever out of welfare departments.

Neglect of local health departments was again demonstrated in early drafts of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). Local health planning was proposed to be performed in the public interest by non-profit private corporations that would be newly created for the purpose, ignoring the fact that one-half the states already mandated to health departments the obligation for health planning. The proposed Act failed to recognize that many local health officers view coordination of community health services as one of their most important functions. Following protests from the public health sector, the 1974 health planning law was finally enacted in such a way as to increase the opportunities for discretionary involvement of local health departments in local health planning.

The diminished recognition given to local health departments is sometimes justified on the basis that they are so inadequate. Health departments have indeed received only marginal support. In 1974, when $41.7 billion of tax funds were expended for health services, less than five per cent of it was identifiably spent in support of the work of local health departments.

The case is made with increasing conviction that many health services in the United States are not adequate. However, the case has not been documented any more substantially in the public sector than in the private. In fact, documentation of abuses in medical care identifies the entrepreneural systems as a corrupting influence more strikingly than alleged political interference or bureaucratic incompetence in publicly operated programs.[9]

Programs of health service as offered by local health departments are often targeted for poor people. These efforts suffer from the belief that programs for poor people become poor programs. Such a belief may reinforce a common resentment against doing anything supportive for poor people, be it income supplements, housing, or food stamps. Yet during the past decade many demonstration projects that were designed predominantly for poor people have accumulated impressive records for maintaining quality and containing cost.[10–13]

Increasingly, when the nation's leaders speak of existing patterns of health service they refer to private professional practice, ignoring important resources and potentials in the public sector. The private sector of medical care has demonstrated serious inadequacies in coping with such difficult issues as maldistribution of services,[14, 15] quality control,[16, 17] and cost containment.[18, 19] The survey reported here cannot claim to have revealed public health assets that by themselves can solve the nation's health service problems. However, it does establish that official public health agencies are far too extensive to be consistently overlooked in development of the nation's health policies.

National discussions of health services focus great concern on personal health care. Note should be made that one-quarter of all the reporting health departments render personal health services. In some counties the health departments is the *only* provider[20]; in other counties private providers may refuse to care for Medicaid patients, making the health department the only provider of personal health services for poor people.[21] For such important programs as family planning, maternal and child health, home care, school health, and chronic disease programs health departments often report themselves as the sole provider (25 to 50 per cent of reporting departments). The scope of these responsibilities is too great to continue to be overlooked. The programs

themselves are too important to be demeaned as poor people programs.

Important further documentation on the extensive participation of public health agencies in the provision of personal health services derives from the Inventory of Programs and Expenditures of the State and Territorial Health Agencies.[22] During the fiscal year 1975, 72 per cent of all expenditures by state health agencies (more than $2 billion) was identifiably allocated for personal health services. The proportion is even larger than indicated by these figures, because another 7.8 per cent of money from state health agencies was assigned for unspecified purposes to local health departments which in turn used part of it in support of personal health services.

It has been reported that some traditional functions of local health departments, such as environmental protection, are being siphoned off to other agencies.[3] Evidence from our survey suggests that this may be true for the largest departments; but in small towns and rural areas the health department continues as a major, and often the only, agency concerned with sanitation and environmental protection.

Medical societies have sometimes been accused of limiting the development of public health departments. Such restraints are not seen as important by the largest departments, but the importance grows with diminishing size of the community. Not unexpectedly the small departments are the ones least involved in rendering personal health services. The small departments are also the ones that report most frequently a desire to expand such services as immunization, ambulatory care, and maternal and child health. Such a desire seems consistent with identified needs as reported by others.[23]

The relative lack of formalized consumer influences on decisions pertaining to programs and priorities of local health departments is a surprising deficiency in view of the emphasis placed on consumer participation by national public health organizations.

Data developed by the survey go only a small way toward updating information and understanding about local health departments. A registry and continuing source of data gathering and reporting are urgently needed. There are insufficient data available on the scope of health services provided under public auspices and the number and nature of people who rely on public providers. Most states face the need to up-date their health codes; scant information is available to assist them.

The Health Program Reporting System of the Association of State and Territorial Health Officers provides useful information on expenditures and sources of fundings for various programs at the state level.[22] The ASTHO report also provides some information on the scope of personal health services provided by public agencies. One out of every four persons in the U.S. was reached in 1975 by some direct personal health service that was rendered under the authority of state health departments. Most of these services were provided by local health departments and delivered by them to the most vulnerable, most neglected, and most medically demanding segments of the population. Further data are required to identify the portion of the contacts that represent isolated and single purpose service (e.g., immunization, sickle cell screening) and the proportion representing more comprehensive primary personal health care. But data are already sufficient to affirm that public agencies are substantially involved in rendering personal health services. Public policy goes astray when its framers allocate resources in ways that ignore the public providers, in ways that imply that the private sector if sufficiently regulated and subsidized can assume responsibility for what is now done in the public sector, that assume people would be better off if they were cared for privately, or that presume everyone prefers private care even if it were available.

The United States has in place an unevenly operative public infrastructure of community and personal health services—understaffed, underfunded, and widely ignored. The possible benefits that might derive from correcting these neglects deserve close attention.

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How Shall We Spend the Health Appropriation?

No health department has as yet been organized on a scientific basis. Its powers and duties are given to it haphazard, sometimes from terror at an epidemic, sometimes at the insistence of a trade which hopes for benefit, sometimes because a councilman through exuberant enthusiasm or for personal reasons pushes a pet project, and sometimes, and this with increasing frequency, because some band of earnest reformers with more energy than wisdom hopes to abolish some sanitary evil by plans of its own.

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