A report is presented giving up-to-date information on State Boards of Health covering composition, functions, method of appointment, term of office, professional representation, consumer representation, recent changes, and a number of other topics. This is a useful review for all concerned with the health services.

State Boards of Health, Their Members and Commitments

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Introduction

New interest attaches to mechanisms of state government as potential means to provide or guarantee the quality and extent of health services. Somers has suggested that each state, acting within federal guidelines, might establish community health service programs by granting franchises for that purpose, most likely under the authority of the state health department.[1] Of more immediate interest is the action of the federal government to phase out many federal health service programs in favor of revenue sharing which places both expenditures and responsibility for health services increasingly at the state level.

Even prior to revenue-sharing state departments of health served as vehicles for expenditure of a large amount of federal money. The aggregate amount is difficult to determine because of different patterns of expenditure in the various states and because of changing federal mechanisms of payment. Federal money that was once granted to state health departments is increasingly channeled through Comprehensive Health Planning Agencies. Even so, much of the money ultimately is spent in support of programs still operating under authority of health departments.[2] In fiscal year 1971 nearly one billion dollars, identified for health purposes, were granted to the states; most of this was spent through state health departments.[3] The mechanisms and policies which operate at the state level to influence expenditure of this large amount of public money are a legitimate matter of national interest.

These considerations invite analysis of state health departments, their means of governance, and the influences to which they are responsive. State health departments, or their equivalent, are served in some fashion by a board. The functions and membership of that board are the subject of this study.

Background

A thorough review of state boards of health, their functions, membership, and methods of appointment, was prepared by Flook in 1954.[4] Several more recent studies have been prepared as part of executive reorganization at the state level. Useful reports were prepared for the Kentucky Legislative Research Commission,[5] and in Delaware for the Governor's Task Force on Reorganization of the Executive Branch of Government.[6]

Flook reported in 1954:

> Functions of the state board of health vary from those which are solely advisory to those which are completely regulatory, including the excercise of executive and police powers for enforcement of all state laws pertaining to public health. The most usual duties are identified with the determination of health department policy and the promulgation of rules and regulations, particularly the drafting and revising of State sanitary codes. Occasionally the board of health has appointive authority, although it is more apt to be empowered only to prescribe qualifications and/or to approve appointments which have been made by the State health officer.

Method

Data for the present study were collected by means of a letter-questionnaire addressed to chairmen of state boards of health in the 50 states. The letter asked for information regarding membership, term of office, method of selection, and powers and duties of state boards of health. The data were collected in early 1971 but were not complete. In early 1972 the data set was reviewed for completeness, and missing data were again requested. In this manner responses were received from all states. Most respondents sent either complete copies of state statutes dealing with public health departments and their boards, or sent excerpts of statutes dealing with the items requested.

The information was received and tabulated into several categories as follows: membership of boards specified by statute, membership as it exists in fact, methods of appointment, terms of office, and powers and duties of state boards of health.

Special attention was directed toward professional members, and mechanisms of their appointment that involved participation be professional societies. Consumer membership was analyzed both from the standpoint of seats specified by statute, and seats occupied currently by consumers who were identified by respondents. Some uncertainty attached to defining consumer seats, as no definition occurred in the statutes that were examined. In fact, the term consumer was seldom used in the statutes and reference was made instead to lay or public members. For purposes

Table 1—Statutory Powers and Duties of State Boards of Health

Powers and Duties	Number of States
1. The board is responsible for making, adopting, promulgating and enforcing rules and regulations pursuant to state health codes as found in the statutes.	37
2. The board appoints the department's chief executive officer.	15
a. The board approves of the appointment of the chief executive officer, but he is appointed by someone else such as governor or chief executive of an umbrella agency.	
3. The board appoints other members of the department.	2
4. The board has other executive/administrative prerogatives such as setting up major divisions within the department.	9
a. The board appoints committees such as hospital committee or advisory committee.	5
b. The board has power to formulate budget or approve budget request.	4
5. All other health related boards are inferior to state boards of health.	4
a. The state board sets standards for local boards of health and local health services.	6
b. The state board appoints local and district boards of health.	1
6. The board has power to hold hearings.	15
7. The board has power to advise and recommend.	20
8. The board hears appeals from the department.	3
9. The board conducts health studies and investigates public health needs, conditions, and activities.	13
a. The board may employ experts to conduct studies and investigations.	2

Note: In many states the powers and duties of state boards of health deviate in practice from the exact authorization provided in statute.

of this study we identified as a consumer any board member who lacks a career identification with provision of personal health services.

Analyzing and codifying the authorized powers and duties of state boards of health presented some difficulty. The method chosen was to survey the statutes from all states (in a few instances only the respondent's letter) for wording that was similar in regard to powers and duties, to group the states according to similarities, and to characterize each group with wording taken from a representative statute. A list of the powers and duties characterized and collated in this way, is presented in Table 1.

The final step taken was to send to the 50 respondents for their review and correction copies of the compiled data and analyses. Assistance was sought in identifying and correcting errors or oversights. These corrections were incorporated into final revision of the data.

Results

There is a state board of health in some form in all but two states, Alaska and Rhode Island (Table 2).* Two additional states were not counted as having boards of health in this study: Illinois has statutory provision for a board of health, but none is currently appointed; and Delaware recently changed its board to include only two members, the Secretary of the Department of Health and Social Services and the Director of Physical Health Division.

With the above exceptions there are 433 seats on boards of health in 46 states. The size of boards range from as few as five members to as many as 19 members. The average size of boards is 9.4 members, and nine is both the median and mode of board size.

Most states have a separate board concerned with health distinct from other considerations such as welfare. However, 16 states have combined departments of health with at least one other agency, and sometimes (4 instances) have established a large conglomerate or umbrella agency which is generally referred to as a department of human resources that combines health, social services, and usually other functions such as vocational rehabilitation or correctional institutions (Table 3).

Functions—Powers and duties of state boards of health are listed and summarized in Tables 1 and 2. Thirty-seven states have boards that have responsibility for formulating codes and rules relating to health matters. Staff members in a department of health do the actual implementation; the board holds an overall policy-making and regulatory role. In fifteen states the director of health is appointed by the board and in three states the board must approve the appointment of the director of health although someone else, usually the governor, appoints the director. In twenty instances a state board has power to perform other administrative duties including the appointment of sub-committees or advisory councils, or has statutory authority to review or approve budgets.

Eleven boards have supervisory powers over local boards of health, and fifteen boards have power to hold hear-

Table 3—States Having Public Health Functions Combined with One or More Other State Services

State	Services	Board Powers and Duties*
1. Alaska	Health & Welfare	No Board
2. Delaware	Health & Social Services	†
3. Florida	Health & Rehabilitation Services	7
4. Georgia	Human Resources	1
5. Maine	Health & Welfare	7
6. Maryland	Health & Mental Hygiene	7, 8
7. Nevada	Health & Welfare	1, 5, 6
8. New Hampshire	Health & Welfare	7
9. New Mexico	Health & Social Services	7
10. North Carolina	Human Resources	1, 2, 4, 4a, 6, 7, 9
11. Oregon	Human Resources	1
12. Utah	Social Services	1
13. Vermont	Human Services	6, 7, 8
14. Washington	Social Services & Health	1, 9
15. Washington	Health & Social Services	1, 2, 7
16. Wyoming	Health & Social Services	2a, 7, 9

**Numbers refer to items listed in Table 1.*
†Delaware has a board of health, but its two members are executives of the combined agency.

*This table is omitted from the published report but is available on request to the authors. It presents a tabular summary of each state's health department through 1972.

ings. Three states give boards power to hear appeals from the department or the public. Sixteen states are specifically granted power to conduct health studies and investigations.

In nine states boards have largely advisory roles. In six of these states the boards can advise and recommend, but all decisions rest with the departmental executive staff. In three of the nine states the board has one or two other powers of a limited nature (Table 6).

It should be noted that some boards of health may exercise powers and duties different from those recorded in the study and listed here. Some states have boards with powers and duties that have been defined in practice but are not specifically stated in the statutes.

Method of Appointment—Members are appointed to boards of health by a number of mechanisms; they include action by the governor, by the state legislature, and sometimes by professional societies of the state. In 45 states the governor makes appointments to the board, and in 25 of those instances the state legislature is involved in confirmation. Twenty-two states require senate confirmation and two states require the entire legislature to approve. In Maine the senate names one member to the local board and the house two members on a board which totals eighteen. In 9 states professional societies or associations are mandated by law to provide a list of nominees from which the governor is obligated to make his selection. In two states, Alabama and South Carolina, the medical association is by statutory provision the state board of health; committees of the medical societies carry responsibility on behalf of the state for its public health functions. In one state, North Carolina, the medical association names four members to the board of health and the governor appoints an additional five.

In Alabama the membership of the state medical association elects 10 of its own members to comprise a "Board of Censors," and this board is the executive committee for the state department of health. No state officer or public mechanism is involved in appointing the committee. In South Carolina the executive committee that serves as a state board of health consists of 13 members, seven of whom are elected by members of the medical association; the governor appoints four other members, who are required to be health professionals nominated by their respective professional societies; the statute provides that two more members serve by virtue of holding the offices of attorney general and state comptroller.

Among all the states members of eight professions are given preferential consideration ofr inclusion on boards of health through nomination by professional societies. Medical associations are the most prominent in this process. In addition to the three states where professional societies comprise or directly appoint members to the board, medical associations in nine other states provide nomination lists from which the governor is obligated to make his choice. In eight states nominations are made by the state dental association, in five states by the nurse associations, in five states by the pharmacy associations, in five states by the veterinary association, in two states by the engineer or sanitarian associations, in one state by the osteopathic association, in one state by the public health association, and in one state by two voluntary agencies that make a joint nomination for one seat.

Term of Office—Information on term of office is available for all but two states. Also eliminated from tabulation are those states with no board, Alaska and Rhode Island; Delaware with a board entirely ex officio; Illinois with no currently appointed board; and South Carolina where members serve at the pleasure of the governor and the medical association. The remaining states have terms of office ranging from two years to nine years. The average term is 4.8 years and the median and mode terms are four years. In nearly all instances the terms are staggered so that not all terms expire in the same year.

Professional Representation—All but seven states require that health professionals be appointed to boards of health (Table 4). Statutes in 35 states specify which and how many professionals shall be named to the state board of health. Medical doctors are prominent both for the many states that require physician membership and the large number who serve. In the 35 states which specify professional membership, one from each professional group is generally the extent of representation, medical doctors excepted. as previously discussed some professionals are nominated by respective professional associations, but this is not true for all; in other instances the statute merely provides that a given professional must be appointed to the board. Refer to Table 4 for the distinction.

Twenty-two different health and health related professions have, by law, seats on state boards of health. Physicians, dentists, pharmacists, and veterinarians most frequently serve on boards and in the descending order. Nurses and engineers/sanitarians are the next two most frequently represented groups, followed by osteopaths, hospital administrators, chiropractors, and dairymen. The category in Table 4 listed as "Other Dr(s)." includes optometrists, podiatrists and chiropodists.

Health professionals listed in Table 4 as "other" include the chairmen of the tuberculosis council and the mental retardation council in Connecticut, an attorney in Idaho, a nursing home administrator in Kansas, an allied health person (nominated by the Kentucky Public Helath Association), an ecologist in Kentucky, a professional educator in agriculture in Louisiana, a physical therapist in Nebraska, a psychologist and social worker in New Hampshire, a local health officer and chairman of the comprehensive health planning council in Oregon, and a person learned in mental retardation in Tennessee.

Some states provide in the statutes for representation on the state board of health by "health professionals" without specifying which professions. In some of these states the language is such that a knowledgeable consumer could be construed as meeting the requirement for the specified representation.

In the seven states with boards that do not have statutory requirements for representation by health professionals, a review of actual membership shows a high proportion of health professionals. Forty of 61 such "undefined" board seats are held by professionals.

Physician Representation—Inasmuch as physicians and other doctors play such a prominent role in state boards of health a more detailed analysis of their representation is warranted (Table 5). Excluding the four states previously noted (Delaware, Illinois, Alaska and Rhode Island), 32 of the remaining 46 states have boards comprised at least one third by medical doctors, whether or not their appointment is provided by statute. In 12 of 46 states in the study medical doctors are a majority of the board; in an additional seven states medical doctors with the one dentist on the board

comprise a majority. In twelve additional states all those who use the title "Dr.", but are not necessarily physicians, make up a majority of the board.

Physician Representation Related to Board Function—Boards with policy making and administrative functions tend to have more professional representation than boards with only advisory functions. In every instance but one where physicians constitute a majority of the membership the board functions in policy making and administrative capacities (Table 5). In no instance do physicians constitute a majority where the board functions only in an advisory capacity (Table 6).

Consumer Representation—The extent of consumer participation on state boards of health was analyzed according to criteria previously described. Twenty-six states have consumers on their boards of health. Seventeen of these states have statutues which specify consumer seats. In 13 of these states the statutory language specifying consumer is

Table 4—Statutory Representation of Health Professionals on State Boards of Health: Relationship to Policy/Administrative Powers of Boards

	Professional												Board Powers	
	Chiropractor	Dairyman	Dentist	Engineer-Sanitarian	Hosp. Administrator	Medical Doctor	Nurse	Osteopath	Other Dr (s).*	Pharmacist	Veterinarian	Other	Policy Making	Administrative
Alabama						X‡							P	A
Arizona						X‡	X‡						P	A
Arkansas			X‡	X‡		X‡	X‡			X‡	X‡		P	A
California			X			X							P	A
Connecticut			X	X		X				X			P	
Florida			X			X		X		X				
Georgia						X‡							P	
Idaho						X						X	P	A
Indiana			X	X		X	X			X	X		P	A
Kansas			X	X	X	X				X	X	X	P	A
Kentucky		X	X‡	X‡	X‡	X‡	X‡	X	X	X‡	X‡	X‡	P	A
Louisiana			X			X				X		X	P	
Massachusetts						X							P	
Montana			X			X							P	
Mississippi			X‡			X‡			X‡				P	A
Missouri						X							P	A
Nebraska	X		X	X		X	X	X	X	X	X	X	P	A
Nevada			X			X					X		P	A
New Hampshire			X†			X†						X†		
New Jersey			X			X							P	A
North Carolina		X	X			X‡				X	X		P	A
North Dakota			X‡			X‡	X‡				X‡		P	A
Ohio						X				X			P	A
Oklahoma						X‡							P	A
Oregon	X		X	X	X	X	X	X	X	X		X	P	
Pennsylvania			X	X		X	X	X		X			P	A
South Carolina			X‡			X‡	X‡			X‡	X‡		P	A
South Dakota	X		X		X	X	X	X		X	X		P	A
Tennessee			X‡		X‡	X‡				X‡	X‡	X‡	P	
Texas			X	X		X				X			P	A
Utah			X			X							P	
Vermont			X			X		X						A
Virginia			X‡			X‡				X‡			P	
Washington				X		X	X						P	
Wyoming			X‡			X‡					X‡			A
Totals:	3	2	26	10	5	35	11	7	4	17	12	8	32	24

‡Nominated or appointed by professional organization
†Nominated by representative agency
**Optometrists, podiatrists, chiropodists*
P-code in Table 1
A-code in Table 1

clear and unequivocal. Statutes in an additional four states provide for certain seats which may possibly be filled by consumers, but the language in these statutes is ambiguous and could provide for either a health professional or a consumer. In such circumstances professionals hold about thirty per cent of the seats.

Table 5—States with More Than One-Third Physician Membership on State Boards of Health

Relationship to Board Function

State	Physician membership: MDs are a Majority	MDs are a Majority with DDs	MDs comprise 1/3 to 1/2	Those who use Title "Dr." a Majority*	Powers: Policy	Administrative
Alabama	X§‡				P	A
Arizona	0		X§‡		P	A
Arkansas	X§‡				P	A
California	X§				P	A
Colorado				X	P	A
Connecticut		X	X		P	
Florida			X§	X§		
Georgia			X§‡		P	
Hawaii			X	X		
Idaho	X				P	A
Indiana			X§	X§	P	A
Iowa		0	X	X	P	
Kansas		X§	X§		P	A
Louisiana	X§				P	
Massachusetts			X§		P	
Mississippi	X§				P	A
Missouri			X§		P	A
Montana		X§	X§		P	
Nebraska				X§	P	A
Nevada		X	X§	X§	P	A
New York			X		P	A
North Carolina	X	X§	X§‡		P	A
Ohio		X	X§‡		P	A
Oklahoma	X	0	X§‡		P	A
Oregon				X§		P
Pennsylvania			X§		P	A
South Carolina	X§‡				P	A
South Dakota				X§	P	A
Tennessee	X	X§	X§‡		P	A
Texas	X§				P	A
Utah		X§	X§		P	
Vermont				X§		A
Virginia		0	X	X	P	
Washington			X§		P	
West Virginia			X	X	P	A
Wisconsin	X				P	A
Wyoming		X§‡	X§‡			A
Totals:	12	9	23	12	33	25

Includes MD, DO, DC, OD, DDS, DVM, chiropodist, and podiatrist.

KEY
X-De facto membership
X§ -Membership by statutory requirement
X‡-Nomination or election in membership by professional association–a statutory requirement
P-Code in Table 1

Only 17 states clearly specify seats for consumers; an additional nine states actually have consumers on the state board of health. Recalling that there are 433 seats on boards of health in 46 states, only 54 (12.5 per cent) are occupied by consumers. Even among the states where consumers are represented they represent a small minority. Looking at the 26 states that have consumers, 45 seats are specified by statute and 54 seats are occupied by consumers. Of 236 seats in these states 22.0 per cent are filled by consumers.

Recent Reorganizations—In 1969 eight states were identified wherein health was combined in departments with one or more other state services. In 1972 that list had grown to 16 states and Louisiana's legislature is currently considering a possible combination of services that would include health. The trend toward merged departments has not produced a consistent pattern for the boards which serve those departments. One of the 16 states, Alaska, eliminated its board and one state, Delaware, established a board in name only. Six states retained boards that are concerned only with the division or department of health, and 8 states formed boards that are concerned with all functions of the combined agency.

Mergers appear not to have changed board functions substantially. Seven merged departments have boards that retain policy-making functions; the other seven have boards with essentially advisory roles. One state, Wisconsin, provided a policy board for the combined agency and advisory board for the Division of Health.

If any change in the functions of boards derives from recent administrative mergers, that change is away from policy and administrative roles and towards exclusively advisory functions.

Comment

New interest attaches to state boards of health out of several concerns. They include consumer participation, conflicts of interest, and expanded roles for health departments.

Consumer participation presumes that the governance of services must be directly influenced by the recipients of those services in order to assure that client interests and priorities are served fairly in an acceptable style. Advocates of consumer participation present a range of opinion on the nature of influence which consumers should exercise. An extreme view holds that one option that should be available to all consumers is health care from an agency that operates under their direct control.[7]

Many questions about consumer participation are incompletely answered. Who is a consumer? Who are his representatives? How are they identified and selected? Who are their constituents? Should they be denied participation in decision-making around some issues of a technical nature? In the process of becoming knowledgeable about an agency do consumer representatives lose those qualities which first made them helpful to their constituents? How does direct consumer participation in the governance of an agency relate to more traditional democratic participation by means of voting for responsible public officials?

In spite of these unresolved issues, consumer participation has been an important feature of national health policy and practice. It was operative in the Hill-Burton granting mechanisms for several decades. It achieved renewed atten-

Table 6—States with Boards That Are Advisory

State	MDs are a majority	MDs are a majority with DDS	MDs comprise 1/3 to 1/2	Those Who use title "Dr." a majority	Other professions by statute	Powers & duties****
Florida			X§	X§	X	7
Hawaii			X	X		7
Maine						7
Maryland*						7, 8
Michigan						7
New Hampshire						7
New Mexico						7
Vermont**				X§	X	6, 7, 8
Wyoming***		X§	X§‡			2a, 7, 9

*Hears appeals from the department as well as being advisory.
**Hears appeals from the department and has power to hold hearings.
***Approves appointment of executive officer and conducts studies and investigations.
****Refer to code found on Table 1.

tion through the Office of Economic Opportunity's community programs which required maximum feasible consumer participation. Regional Medical Programs required consumer participation; and Comprehensive Health Planning was established with 51% consumer participation. Many of the federal programs which provide greatest opportunity for consumer participation are among those now being phased out in favor of revenue-sharing in support of state and local agencies.

In recent years some states have moved to provide for increased consumer participation on state boards of health, but it is a small trend. Still only twelve per cent of seats on boards of health are held by consumers. Recent trends have not substantially affected the firm domination of these boards by professionals. The professionals most commonly involved are not experts in public health, but are active participants in the private provision of personal health services. Their usual requirement for service is that they be licensed to practice medicine. This circumstance invites interest in boards of health around concern for possible conflicts of interest.

Under most circumstances the view prevails that no public official should derive beneficiary interest, beyond that of an ordinary citizen, in the activity or program with which his office is concerned. Courts and legislatures (certainly Congress!) have in recent years taken a stringent view on the potential for conflicts of interest in high public office. The consideration is new to boards of health. Most of them were established at a time in our nation's history when consumer participation, aside from elective processes to duly established public offices, was not a conspicuous consideration in public affairs. The view prevailed that health services should be controlled by health experts and this view was reflected by statutes and practices that caused boards of health to be dominated by practicing physicians. In that same era a clear separation existed between reimbursement for professional services from private and from public sources. As recently as 1966 only seven per cent of payments in support of physicians' services came from public sources. In 1970, 25 per cent of payments to physicians derived from public sources and the trend continues upward.[8] The nature of physician influence over these growing public sources of payment has acquired new importance.

Illustration is provided by the following account in the *Atlanta Constitution* of January 27, 1972. The article gives an account of Governor Carter's conflicts with his Board of Health which at that time consisted of 18 members, 10 of whom were physicians.

> To his dismay Carter discovered there was no outside audit of Health Department Medicaid payments to physicians. Every other Medicaid supplier—hospitals, nursing homes, drug stores—were audited. The governor suggested that physicians should be checked also. The Board of Health wasn't interested. After all the physician might quit the program if auditors started questioning him. Then the legislature got wind of the problems, and it came out in the open; dozens of Georgia physicians had discovered El Dorado in the bureaucratic maze of Medicaid. The Board of Health moved cautiously toward a "peer review" system under which doctors would review payments to their colleagues.*

Conflict of interest is recognized in some states as a threat to the public interest. The Maryland statute specifically prohibits conflicts of interest in appointments to its Board of Review attached to the Department of Health and Mental Health.

The issues of consumer participation and conflict of interest are not unrelated. Less concern might attach to vesting consumers with an interest in the governance of health services if all vested interests involved in that governance were eliminated. Leaky definitions of consumers and providers might become unnecessary; professionals and lay people alike might serve on public boards according to their

*In subsequent reorganization of state government in Georgia, the Board of Health was replaced by another board of 15 members, seven of whom must be representative of the health professions, and five of whom must be physicians licensed to practice in Georgia. Nominations for the physician representatives are provided by a committee half of the members of which are appointed by the state's medical society. (Another medical society in the state, predominantly of black membership, has no privileges of appointment.) The new board serves on behalf of a Department of Human Resources which embraces the previous functions of the Department of Health.

qualifications if none served with the threat of deriving privileged benefit from his service.

The possibility of conflicts of interest of a direct economic nature may be less critical than long standing and continuing indirect influences having to do with inhibitory attitudes toward publicly sponsored health services.[9] The same newspaper account from the *Atlanta Constitution* reports "confrontations" between Governor Carter and his Board of Health. The article alleges lack of responsiveness by the Board to the Governor's proposals for various public programs that would provide treatment for drug abuse, family planning, dental care, and air pollution control.

Statutes authorizing departments of health provide in many states a broad mandate. The Georgia code provides that the State Health Department shall "forestall and correct physical, chemical and biological conditions that if left to run their course could be injurious to health." The code does not specify that those conditions must be of a community nature as opposed to personal conditions. The same code goes on to mandate the state health department to treat people with communicable disease and to "detect and relieve physical defects and deformities."The New Jersey laws established that the State Department of Health through its sanitary codes may cover ". . . any subject effecting the prevention of disease in the State of New Jersey." The Arkansas Act provides that: "The State Board of Health shall have general supervision and control of all matters pertaining to the health of the citizens of this state." In Oklahoma the Commissioner shall "have general supervision of the health of the citizens of the state," and shall "abate any nuisance affecting injuriously the health of the public or any community." The Indiana Acts declare: "The State Board of Health shall have supervision of the health and life of the citizens of the state . . ."

If all of these statutes, and the many others like them, were fulfilled to their limit, the many gaps and deficiencies in American health services might well be substantially closed. Restraints of many kinds have worked to limit the performance of state health departments as guarantors for the health of people within their jurisdiction. Some of these restraints may relate to the membership and to the philosophic orientation of people who serve on state boards of health.

Planning around new mechanisms to deliver health services has surged in recent years that have seen the development of comprehensive neighborhood health centers and health maintenance organizations. These mechanisms, usually independent of health departments, presume a high degree of local organizational initiative by consumers, by consumer advocates, or by professional groups on behalf of a defined group of consumers. The pluralistic nature of the programs, and their diverse sponsorship, continue a strong tradition of American health services: it is unlikely that a single pattern of service can be usefully applied to all people in all situations. But multiple patterns, no matter how varied, probably will never be adequate unless guarantee is provided that everyone is incorporated in one pattern or another. Otherwise people who are least resourceful, least capable of exercising initiative, and often most in need of health services are the very ones who may continue to be overlooked.

By what mechanism can guarantees be provided that every person is covered by health services appropriate to his need? It is difficult to see how that guarantee can be provided except through some agency of government. In some states such a role is entirely consistent with present statutory authority of health departments—e.g., "supervision of health and life of the citizen of the state." Health departments might be expected to guarantee that, through one mechanism or another, public or private, every citizen is covered by health services—and to offer directly those services not otherwise provided. With this local commitment the federal role might fall into place, as it does with education and civil rights, as residual guarantor, exercising that role only in the instance of lapses in protection or services at the local and state levels.

President Nixon, officers of the American Medical Association, and a large segment of the American public speak with increasing conviction about "rights to health." If there are rights to health, then there are rights to mechanisms necessary to maintain health; those rights must be protected. The role of guarantor of rights to health and to health services represents a potential commitment for health departments not inconsistent with their mandate, and with some of their present categorical commitments.

Expectation of new and more effective roles for health departments requires further study of influences to which those departments are responsive. The present study suggests important influence by professional interests including state medical societies. Even if new roles for health departments prove to be unworkable, attention is directed to the position of privilege that professional people and their societies hold with relation to existing roles, especially those associated with expenditure of federal money. The public may rightfully expect that appropriate federal agencies will be concerned over potential conflicts of interest in the expenditure of these funds.

Summary and Conclusions

By mean of correspondence with chairmen of state boards of health, with directors of state health departments or their equivalents, and by review of statutes authorizing state boards of health the following findings were recorded.

- All states but four have boards of health or their readily identifiable equivalents. In 16 states the board relates to a department which combines state health services with at least one other state service, often welfare or social service. In four states the department of health and its board have been merged into an administrative conglomerate known as a department of human resources.
- Statutory definitions of the powers and duties of state boards of health are restricted to advisory functions in only six states. All others are empowered with policy-making or administrative functions or both.
- Appointments to state boards of health are nearly always made by Governors. Such appointments require some form of legislative confirmation in half the states. In two states, Alabama and South Carolina, the Board of Health is defined as the state medical society. In North Carolina the state medical society appoints four out of nine members to the Board of Health. In nine other states professional societies make nominations for the board of health and the

Governor is obliged to make one or more appointments from these nominees.

- All but seven states require that health professionals serve on boards of health. Twenty-two different health related professions are identified for membership in one state or another; physicians predominate by far. Among 46 states for which data are available, thirty-two have boards of health on which one third or more of the members are physicians. In most instances stipulation is made that the physicians must be licensed for practice. Boards with policy-making and administrative functions tend to have more physician members than boards with only advisory functions.
- Consumers are represented on boards of health in 26 states. They are a small minority of members. Consumers occupy 12.5 per cent of the 433 seats on state boards of health.

The implications of these findings are discussed in terms of consumer participation, conflicts of interest, and the potential for new commitments and innovations under the authority of state health departments.

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Governing Council Approves Council Deactivation

In a major reorganizational action, the Governing Council approved an Executive Board recommendation that existing APHA councils and their task forces be inactivated, and a moratorium be placed on their creation through the 1975 Annual Meeting. Those councils and task forces which are revenue-producing or funded by outside sources, however, would continue to exist under new designations.

The action was recommended, the Executive Board said, in the face of the current critical financial situation, and the realization that retrenchment in some areas was necessary. The proliferation of organizational elements dictated by CAFOR had required resources in terms of staff and support which the Association had been unable to meet, the Board reported, and in weighing the various approaches taken in implementing the CAFOR recommendations, it was recognized that the structure devised for councils and their task forces could not be completely successful until the sections had been sufficiently strengthened, and thus had never become fully effective.

At the same time, however, some councils and task forces were recognized as performing valuable functions without draining already-limited staff and financial resources. It was therefore recommended and approved that existing councils or task forces receiving project funds be redesignated "project advisory committees," operating under the supervision of the Program Development Board. Chairmen of such committees will be ex-officio PDB members. This system would allow continued functioning of groups such as the Council on Population and its Task Force on Family Planning Methods, both funded by the Office of Economic Opportunity.

In addition, councils or task forces producing income-generating publications on a regular basis will be redesignated "publications advisory committees," operating under the supervision of the Executive Board through an APHA Publications Coordinating Committee made up of the chairmen of the committees and the various editorial boards.