Observations on Current Practices in Municipal District Health Administration

GEORGE A. SILVER, M.D., M.P.H., F.A.P.H.A.,* AND ABRAHAM M. LILIENFELD, M.D., M.P.H.

District Health Officer, Eastern and Southern Health Districts, Baltimore City Health Department, and Department of Public Health Administration, Johns Hopkins University School of Hygiene and Public Health, Baltimore, Md.

IN the development of urban health departments, the principle of decentralization—"neighborhood health centers"—has been casually accepted. In routine fashion, local planning has provided for health officers of urban health districts, tables of organization, and carefully vague limitations on autonomy. Most of the larger cities have now, on paper or in fact, divided the city into health districts, adopted an organizational plan for staffing these districts, and to a greater or lesser degree provided structures for district operations.

Philosophically, the stimulus for such programs, and the easy, unquestioning acceptance of the principle, probably stem from American tradition. We remember nostalgically the town meeting and the benefits that accrue from public administration close to the source of responsibility and sensitive to local needs. The great bugbear of political and economic life is centralization, the "curse of bigness," monopoly, and impersonal administration. In addition, it is felt that the job to be done, specifically health education in its many manifestations, depends on a homogeneous group. In 1915, in an address to a welfare conference, Adolph Meyer expressed this desire as follows:

> Can you see the ward or district organization? With a district building instead of a police station, with policemen as constructive workers rather than watchdogs of their beats, a district center with reasonably accurate records of the facts needed for orderly work; among the officers a district health officer, and a district school committee and a district improvement and recreation committee, a district tax committee, a district charity or civic work committee, a tangible expression of what the district stands for.[1]

The growth of health centers and the concomitant decentralization were reviewed by Hiscock.[2] The design and impetus were spontaneously developed in many places almost simultaneously. At the turn of the century, as an outgrowth of settlement house work, there resulted the formation and growth of various neighborhood facilities: visiting nursing services, milk stations, and tuberculosis clinics, all established by nonofficial agencies. Out of these beginnings there developed the plan to group together those various facilities into health centers. These became related to definite areas of the city and they formed the headquarters of the generalized nursing service working in that area.

Despite the fact that district administration is now generally accepted in

* Now Chief, Division of Social Medicine, Montefiore Hospital, New York, N. Y.

principle and is an organizational pattern recommended by authorities in the field, there has been practically no evaluation of this method of administration. Several expositions of district organization and health centers have appeared by Hiscock [2] and Wilinsky.[3] These presentations were published in the second and third decades and to them belongs the credit for popularizing the concept of districts. Hiscock reviewed district administration as a technique and presented some cogent arguments in its favor. However, it was not until 1947 that any evaluation of what had actually been accomplished over the years was attempted. In that year, Gordon [3] made a general survey of district administration in eight large cities (population between 500,000 and 1,000,000) and actually found only a relatively small degree of success in their operation. One of the major defects discovered was the absence of the necessary delegation of authority and responsibility to the district health officer.

Gordon states, "In general, there is a lack of appreciation of the full value and potential advantages of district health administration organization. Policies, objectives, and functions of district units are not clearly and adequately defined, and disagreement exists on the relative value of factors determining the size of district units, the services to be decentralized, and the manner best suited for their administration and organization." He thought that "The relationship between the bureau director and the district health officer, in particular, requires definition. The bureau director still remains reluctant to release control over any part of administration of service functions. This results in lack of responsibility for the office of the district health officer. There is a general belief on the part of bureau directors that introduction of a system of district health administration entails a stripping of their power." [4]

It is important to see why, after 40 years of district health administration, the success originally hoped for has not been attained. Before looking into this matter it is essential to distinguish between two concepts of decentralization. The term "district health administration" has carried with it the implication that administration has been decentralized at a district level. This has to be distinguished from the concept of a "decentralization of services," which might be more preferably termed "localization." Localization can be realized under either a centralized or decentralized administration. The localization of services to various neighborhoods has had a large degree of success. When we speak of the lack of success of district health administration, we mean the lack of success of the decentralization of administration and responsibility to the person of a district health officer, with only technical supervision and city-wide planning responsibility remaining vested in the central bureaus.

There are many reasons why this decentralization has not occurred. First of all, it is administratively difficult to decentralize an already functioning department. Bureau directors feel that much of their influence and authority is decreased by this process. Possibly if a new department were being created—districts established first, and then central bureaus set up in order to provide the necessary help and guidance—district administration would be a successful venture. The seniority of the bureaus has acted as an influential deterrent to successful district administration.

The major administrative problem resulting from the inauguration of districts is the relationship between the district health officer and the "central office," which includes the directors of the various specialized bureaus. Hiscock devotes a considerable portion of his

presentation to methods of dealing with this problem.[2] It is rather interesting to note, however, that even though Hiscock recommends that the district health officer be made responsible for the execution of the program in the district and that his work should not be limited to the mere routine of executive detail, he emphasizes what the district health officer should *not* be doing, while he discusses the central office bureaus' activities more positively. He makes a distinction between technical advice, which the bureau chief is supposed to offer, and supervision and administration, which are to be the district health officer's function. However, this is a distinction that is difficult to make in actual practice; and if the central office bureaus furnish not only technical advice but supervision and administration of the various specialized programs, the activities of the district health officer become very limited indeed. This basic problem of administrative organization and relationship is discussed in various works on public health administration.[5, 6]

It may be that one of the more important reasons for fostering the concept of decentralization was to justify the necessity for a health officer. The need for district health officers was probably of great importance in the twenties and thirties because it was essential for the health department to have an epidemiologist "on the spot" for communicable disease control. A good portion of the health officer's time actually was devoted to "shoe-leather epidemiology." In addition, in many situations the health officer could serve as a clinician. He doubtless devoted a not inconsiderable portion of his time to school medical inspections and to various clinics. This is still the practice in many communities. However, the changing pattern of public health administration following changes in medical knowledge has gradually altered the area of activities of the health department and the health officer. Today, communicable disease control occupies only a small portion of his time. It is also not considered desirable to have a physician trained in public health work in clinics, particularly where qualified part-time clinicians are available to do the job. The result has been to reduce the scope of activities of the urban district health officer.

One other aspect of district-central office relationship bears discussion. It has been the practice of health departments to obtain as bureau heads specialists who have been trained previously in their clinical fields, having a small amount of public health experience. (The undesirability of this type of preparation has been discussed in a report of the Committee on Professional Education of the American Public Health Association.[7]) The district health officer, on the other hand, is the general practitioner of public health. The difficulties in general practitioner-specialist relationship that exist in the practice of medicine in general are likewise reflected in the operations of the health department. The specialist does not particularly care to permit the district health officer, who is less well trained in a specialty, to take over the administration of a special program. He is loath to allow the health officer to make decisions in his specialized field. Probably the importance of this factor varies considerably in time and place, but that it exists cannot be denied.

Many urban health officers faced with this problem have fallen back on the fiction of "organic integration." The district health officers and bureau directors meet at intervals to thrash out their common problems. Policy decisions are made after "consultation" with the district health officer. The district health officer is "advised" on personnel, clinic sessions, and professional policy. He is "informed" before any changes are made. These are devices necessary

for harmonious operations, but they accentuate the essential uselessness of a district health officer.

It is quite possible that the existing situation is merely an intermediate phase in the development of district health administration. However, since the present compromise is administratively an unsatisfactory and undesirable one, consideration should be given to alternatives. Districts may be placed in a semiautonomous position, which, it must be admitted, was what was originally implied when they were established. In that case, district health services would be relatively more expensive, possibly less efficient, but much more satisfying as a job opportunity and as a training opportunity for public health work in general. The district health officer would be able to organize community, school, and industry groups into active participation in health work and would have the authority to make changes and provide additional services within appropriation limitations. He would play a more active role in the actual planning of programs which would probably be more responsive to local needs and conditions. The community would no doubt be the richer in terms of health services provided.

On the other hand, it may be that the consideration of economy and efficiency may be overriding, and thought should then be given to abolition of the district health officer position altogether. In this case, health centers and nursing districts may be maintained, but the center operation could be managed by a nonmedical public administrator with training and experience or both in community organization and health education. Bureau and division chiefs would make policy, plan programs and staff services, and supervise their own programs. Difficulties and friction would be disposed of at periodic staff meetings; and the need for district health officers, a drain on the available supply of public health physicians, would be automatically ended. Health center operations and the neighborhood provision of services could continue at a useful level, and health education, a major activity of a district, would be performed by a person trained and experienced in this phase of public health, under medical guidance from the central office. There may be some objections raised to having a nonmedical person serve in the place of a district health officer on the basis that it is necessary to have a physician in order to maintain relationships with the medical profession. This is a point of view that seems to us to have been overemphasized, particularly since the attitudes of, and relationships with, the medical profession would be determined by the health department as a whole through the services the department renders both the physician and his patient.

Since neither of these alternative proposals has ever been tried, the suggestion that naturally presents itself is that the entire concept of district administration be thoroughly examined and that actual study areas in which these proposals could be carried out be established. Recommendations derived from such studies could have an important influence on future public health practice. This would be valuable from the viewpoint of municipal district administration, but also with regard to local administration in states, since many of the features of district administration are present in the administration of state health services. Such an evaluation could readily be performed by the American Public Health Association or one of the many interested private foundations.

Before concluding, we must mention that one important exception exists to the foregoing. It has been the practice for some schools of public health and medicine to utilize a district for training students. Some health departments

have also set aside a district for training new department personnel. It is obvious that such a district requires a health officer with teaching ability who can devote a not inconsiderable portion of his time to teaching duties. Such a district still remains the most efficient method by which such necessary field training in public health practice can be provided.

REFERENCES

1. Lemkau, P. V. *Mental Hygiene in Public Health.* New York: McGraw-Hill, 1949.
2. Hiscock, I. V. *District Health Administration, Lancaster.* New York: Milbank Memorial Fund, 1936.
3. Wilinsky, C. *The Health Units of Boston, 1924–1933.* Boston, Mass.: City of Boston Printing Dept., 1933.
4. Gordon, C. W. Administration of Health Department Functions Through District Health Organization in Urban Communities of 500,000-1,000,000 Population in the United States. Unpublished Thesis, Johns Hopkins University School of Hygiene and Public Health, 1949.
5. Smillie, W. G. *Public Health Administration in the United States.* New York: MacMillan, 1949.
6. Hanlon, J. J. *Principles of Public Health Administration.* St. Louis: Mosby, 1950.
7. Proposed Report on Educational Qualifications of Medical Administrators of Specialized Health Activities. *A.J.P.H.* 40, 6:733–739, 1950.

Special Invitation to Honolulu

The Hawaii Public Health Association will meet in Honolulu November 5 and 6. The theme of the two day program will be Modern Trends In Public Health. Discussion of heart disease, cancer, civil defense, and rehabilitation as public health problems will be included in the scientific sessions. Tours to the center for the treatment of Hansen's Disease patients, Tripler Army Hospital, and various public health centers, as well as to Pearl Harbor and the Temples of Honolulu are included. Dinner speaker on November 5 will be C. J. Van Slyke, M.D., director of the National Heart Institute. Since the meeting is being held immediately after the 79th Annual Meeting of the American Public Health Association in San Francisco, C. L. Wilbar, M.D., program chairman and president of the Hawaii Board of Health, issues a special invitation to A.P.H.A. members. All meetings will be held in the Mabel Smyth Auditorium.