Is There a Future for Local Health Departments?

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THE FIRST SEAL of the American Public Health Association depicted and stated the biblical phrase, "And the leaves of the tree were for the healing of the nations" (Revelation 22:2). The seal was changed several years ago to something that looks like a wheel with big teeth. Maybe this symbol is appropriate—perhaps the change represents a subconscious feeling that the public health profession is caught in the gears of social change. Indeed, the way things often seem, I venture to suggest another change in our professional heraldic symbol—a crossed broom and shovel rampant on a worn but comfortable bed of straw, since instead of proudly carrying the flag at the head of society's troops and resources, increasingly we seem content to trail along at the tail end of the parade, catching the droppings and leavings of others.

The results of the efforts of earlier public health workers were truly remarkable, especially when one considers the pathetic paucity of their resources. But we are not justified in merely taking credit for accomplishments while at the same time we back away from our responsibilities and opportunities to help solve some of the consequences of our actions. Something unhealthy seems to have happened of late to public health. We seem caught in the doldrums or in some kind of professional Sargasso Sea. This lassitude is evidenced by the titles of numerous conferences and presentations—titles such as "Where Are We Going in Public Health?" "Are Health Departments Really Necessary?" and my topic, "Is There a Future for Local Health Departments?" But we must do more than voice collective concern and wring our hands. This introspection, of course, is not necessarily all bad, provided it leads to intelligent adaptation and action.

A common and popular form of response is reorganization, and obviously a great many outdated and creaky organizations cry for adjustment. However, mere reorganization of the formal structure of an agency will not in itself produce improved public service. Reorganization alone can merely remove some of the barriers to the provision of a balanced, efficient, and effective service and create a framework in which those with varied but pertinent skills may find it easier to collaborate to help those in need.

The necessary companion to reorganization is operational integration. In the sense in which I use the term, operational integration is the real test of the success of reorganization. It results from deep and profound attitudinal changes, changes which are much more difficult to effect than the task of making changes in a formal organization.

It is never easy or comfortable to cast out the old and ring in the new. Physicians, nurses, environmental personnel, administrators, and others must be persuaded to broaden their horizons, to let their imaginations, interests, and courage soar away from their existing philosophic and professional restraints so that they view the public's health problems and needs in the total context and can then consider solutions from this new perspective. Only with a changed perspective can we achieve the 200-year-old constitutional goal of equality of health opportunity for all citizens without reference to age, sex, race, creed, or station in life. It is well, in this regard, to remind ourselves that the Constitution of the United States proposed to guarantee only three things—life, liberty, and the pursuit of happiness—and health is critical to the achievement of each of them.

The Rationale for Change

How do these thoughts relate to the future of local health departments? With reference to organization on the one hand and constitutional commitment on the other, it is obvious that we cannot hope to provide equitable health opportunity as a human right to all of our people as long as public health activities in our States and localities are organized along the lines of the pre-World War I Balkans. We simply have to pull ourselves together. In the course of working on all levels of government, I have long been deeply troubled by the extent of pernicious and destructive jealousy, distrust, provincialism, status consciousness, competition, and, above all, inadequate communication that has been allowed to exist within organizations on each level of government and among the several levels of government. The confusing and inefficient plethora of conflicting, hence ineffective, in toto policies, ordinances, programs, and so forth is the bitter price the public pays.

In the name of heaven, humanity, and health, why should the State or community a person lives in determine what life-preserving services he is entitled to, are available, or under what conditions? Our present situation is little short of indecent and inequitable chaos. And part of the fault is ours. Not many of us, I fear, have sufficient conviction, idealism, and courage to provide the social leadership which, after all, is our mandated responsibility. Hence I suggest the bed of straw on our heraldic shield.

All these shortcomings imply a need to change our priorities, our relationships, our way of doing things—which is another way of saying we have to change our role. We have gone through a substantial period during which the philosophy for our programs has been based, with considerable justification, upon the concept that we should do things that no one else could do, that no one else wanted to do, that no one else could in our view be trusted to do, and largely for components of society with which no one else wanted to be bothered—indigents, certain ethnic groups, and persons with difficult or unpleasant problems such as alcoholism, venereal disease, geriatrics, and chronic mental illness.

But now in the late 20th century we must recognize that we have entered quite a different period of public health and social history and development, a period when such a philosophy no longer is valid. We must learn to join and to work with the many forces and components of the total community toward the assurance of total health care for the total people to an extent far beyond that to which we have been accustomed and with which we felt comfortable. We must seek partners in these endeavors and we must, by various means, make certain that we in turn are dealt in as partners in any game in which we should play a part. By doing so, we will maximize understanding and support, minimize opposition, achieve more for our communities, while retaining and enforcing our credibility and appropriate impartiality. We need to realize that we are exhausting much time, money, and effort in doing outdated things or things more appropriate for others to do. The price paid for not accepting this concept is failure to take our place in the future—which is now.

There is no longer any question that truly comprehensive health services will soon be made available to the American people. I do not foresee a single monolithic approach. The approach will probably involve a combination of means and

methods. Whatever forms evolve, it will be necessary to pull together or at least closely interrelate to resources and activities of a variety of institutions—private and public medical practice, hospitals, the various insurance mechanisms—and health departments. This network poses the most critical question for the health department. Is it going to carry the flag in this endeavor, or is it going to follow with a broom and shovel? Let's examine what is involved in the answer.

Local public health programs had their genesis partly in safe milk programs for children of the poor. Subsequently these developed into so-called well-child clinics and prenatal and postnatal services for the disadvantaged. Similarly, widespread communicable diseases led to the development of health immunization clinics, as well as early diagnosis and treatment of such conditions as tuberculosis and venereal diseases, again largely for those unable to pay.

Antedating even these activities, many local public health agencies had to fill a vacuum in welfare services by operating public hospitals, custodial institutions, and even poor farms. Thus, over the years the governmental agencies responsible for the protection and promotion of the health of all of the people were essentially trapped into providing direct personal services to a limited segment of the population. Furthermore, the very nature and complexity implicit in providing direct services to this component of the population limit severely the time and energy which public health personnel can devote to broader considerations that, in the long run, are of greater consequence to the entire population. Beyond this limitation, there is good evidence that continuing down this path tends to isolate the poor further and to make them even more dependent. Public health officials who become enmeshed in such functions sometimes tend to develop a sort of spurious satisfaction and sense of security, based perhaps on a feeling of clinical and political fulfillment.

Using Nongovernmental Resources

The question then is: Are these legitimate and fruitful functions of a public health department at this point in time? Andrew Carnegie, when asked to what he attributed his phenomenal success, replied that he had long made it a rule never to do anything himself that he could employ someone else to do as well or better. This concept is pertinent to a valid answer to the question confronting us. There exist in any community many nongovernmental forces and resources which can and do contribute significantly and critically to the solution of public and social problems, including those which relate to health. Many of them can do so as successfully and efficiently or more so than the public health agency. Furthermore, the alienation, isolation, and pauperization of certain people and groups tend to be minimized when nongovernmental forces are involved.

Why not, therefore, leave the provision of most direct personal health services, preventive as well as therapeutic, to those persons and institutions that are most suitable and best equipped to do so? Among these providers are physicians who practice individually or in groups, the other professions and the technicians related to them, and the private hospitals, clinics, and similar health institutions. Government, and especially health departments, would be well advised to remove themselves from the operation of institutions such as hospitals and clinics, especially now that widespread cost coverage is available through public and private health insurance.

Typically, public hospitals must accept all who come to their doors, and the majority of their patients are the socially and economically underprivileged and the transient, who contribute little or nothing toward the cost of their care. Public appropriations must provide most of the necessary funds; hence, the quality and availability of personnel and material resources tend to be affected by economic fluctuations. To compound the situation, during periods of economic slump, the demand placed upon the public institution increases while its ability to meet the demand declines. In addition, if a unit of government is engaged in operations that are shared or duplicated by the private sector, and that it must supervise to any degree, the governmental unit is placed in the untenable position of conflict of interest and the risk either of upholding hypocritical double standards or noncompliance with its own standards.

What I am suggesting is a policy of using nongovernmental institutions to the maximum feasible extent to achieve governmentally determined objectives. One of the premises of this policy is that government is not, and probably never can be, a truly efficient operator-manager because of the nature of the fluctuating demands placed upon

it and the diverse forces which determine its structure and function.

As a consequence, rather than attempting to provide personal services, the official health agency might better concentrate upon its important and unique potential as community health conscience and leader. Governmental agencies, such as local departments of public health, are in the best position to sense the need for and to promote the establishment of social policy. In their turn, the nongovernmental institutions of society should (*a*) implement these policies, (*b*) establish necessary institutions, and (*c*) provide the needed services. In the process, the nongovernmental agencies may be assisted financially or otherwise by government through subsidies, loans, payment of fees for service, training, equipment, or a variety of other means.

Health Department–Leader and Conscience

What does this allocation of responsibilities leave for the health department? If nothing else, the department should and must serve as the diagnostician of the community as a whole. To do so, the department's most basic function relates to health program data and information—its generation, collection, coordination, analysis, and dissemination. Out of this function, it derives its next basic role—critical assessment of present and potential community health problems and of factors in other fields that may relate to or affect them, stimulation of action by whoever may be of assistance, and evaluation of what is done. Note that important throughout these functions is the development of a network of effective alliances.

The health department's administrators should bear in mind that no end-point may be visualized, either in relation to scientific and technical advances and potentials in the health and medical field or in the extent to which this field may be a significant political issue. Current events provide ample substantiation of this situation. Here again is evidence of the necessity for community health statesmanship, certainly a basic responsibility of the local health department. In the near future, major emphasis must be placed upon early detection and treatment aimed at circumventing the progressive development of disease—primary prevention, health maintenance, and health promotion. It is the health department which should serve as the community catalyst and bridge between the public with the need and the complex of the community's health resources with the solution.

Another important problem to be considered is that it is unrealistic to expect people to forego readily present needs, pleasures, comforts, and conveniences for future safety and health security. A tremendous and continuous educational and perhaps propaganda effort is necessary. While, as with all other community health efforts, many professions and organizations should participate in this effort, the major broad responsibility again rests with the official health agency.

There is no lack of important roles, functions, and responsibilities for a progressive local health department, provided it is not burdened by institutional operations. Some of these roles follow:

—To serve as the community health conscience, the community health analyst, the community health counselor, and the community health catalyst.

—To become a key component of community health planning

—To participate in the development of community health policy

—To develop health criteria, standards, and qualifications

—To promote necessary health legislation

—To work with other components of local government whose work or resources may affect community health

—To lead with new techniques, programs, and alignments

—To conduct or promote research and demonstration in health program management, manpower development and use, clinical medicine, and the like

—To insure involvement of community groups and the public in the decision-making process

—To coordinate the efforts of various health resources in the community

—To maintain surveillance over the activities of private or public agencies or institutions which may affect the public's health

—To educate all components of society—the public, professions, business and industry, elected officials and others—in the fundamentals of community health.

This list, of course, is not comprehensive, but if these roles are adequately served, the local health department need not fear the lack of constituency for support; its constituency will consist of practically the entire community.