Financing Local Health Services

By JOSEPH W. MOUNTIN, M.D.

The future of Federal support for local health services is difficult to prophesy. On the one hand, the future appears to hold a progressive increase of appropriations for bigger and better health units; another view points to a drying up of the streams of Federal funds, with the future of local health units in the lap of the gods—the State and local appropriating authorities. Possibly both of these views are partially correct. In other words, we may well have an increase in the flow of funds which will help sustain a material growth of local health services, but only after an indeterminate period of drought.

Public Awareness and Demand

The prediction of Federal support for bigger and better local health units is based in large part on the clear and steady growth of public awareness of what good community health can mean in terms of total well-being and long-run economy. The American people have learned to value good health as a positive resource and to ask for those things which will protect and improve that resource. This is evidenced by the importance given to building good health into almost every aspect of our daily life. We see it, too, in the increasing number of community health councils and in their vigorous programs that emphasize cooperative planning and action.

One example of this popular interest is the strong and united support given by many groups—professional, voluntary, and citizen—to the local health unit bills which have been under consideration by the Congress since 1948. One of the bills was passed unanimously by the Senate in 1949 and was recommended favorably by the House committee in that year, but did not reach the floor of the House for debate. The Senate again passed a similar bill last year, but to date it has not been reported out of the House committee. These bills, like other domestic measures, have been slowed down by the momentum of defense and international demands. But we can all take courage from the unanimous agreement on the objectives of the bills: to strengthen local public health services in all areas of the Nation through the development of sound administrative units with adequate staffs.

The proposed local health bills would make grants-in-aid available to States to be used only for the provision of local health services. This differs from existing grant authority, under which the State agency may determine, subject to approval of its plan by the Surgeon General, whether grant funds will be used to support State-administered services or be used for locally sponsored services. The proposed bills would provide for Federal financial support to cover a portion of the cost of local health services in each State; and Federal participation would be contingent upon a definite State plan for eventual extension of local health services throughout that State. The percentage of Federal share in these costs would vary from

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State to State, depending upon population and per capita income of the State compared to that of the United States as a whole.

Questions have been raised about the sharing of costs and the defining of public health functions. These controversial issues will be considered later. But first let us examine the significance of the wide-ranging agreement on the need to extend and strengthen local health services. What events, influences, and experiences have persuaded so many people and so many groups that well-organized and well-staffed local units can best serve community health, and that more such units need to be encouraged and supported? From this background, perhaps some clues can be found as to how and when prediction might become reality.

Federal Aid and Local Services

The enactment of the health sections of the Social Security Act in 1935 marked a milestone in public health history. The grant-in-aid mechanism authorized by that act has served as a bridge for bringing to many communities the resources they need and lack, and for equalizing the financial burden. Federal grants for public health services have worked toward the following objectives: (*a*) to establish a working partnership of Federal, State, and local governments; (*b*) to equalize State and local ability to provide services; (*c*) to make possible a concentrated attack upon specific health problems; and (*d*) to preserve local autonomy and initiative while strengthening the services made available through local efforts. To a considerable extent, these objectives have been realized. Whether coincidentally or as a direct result of Federal assistance, local health services have been widely extended during the past 15 years, the period in which Federal aid to States and communities has been available. Geographically, at least, there has been fair success in the establishment of organized local health units. The number of counties served by these units has more than doubled since 1935, having reached 1,542 counties in all. These counties are the more populous ones.

The Federal-State-local partnership has proved to be a stimulating one, and one which produces a fine feeling of solidarity. It has become a channel for exchange of ideas and exchange of personnel. From its wider resources, the National Government can lend supplementary personnel and contribute particular services to local communities either in lieu of, or in addition to, cash grants. It can translate new scientific knowledge into public health practice and, through on-the-spot consultation with State and local health authorities, can adapt this new knowledge to the special needs of communities. Through its corps of consultants in the several public health specialties, it can assist in the development and improvement of the content of local health services.

The record is eloquent also with respect to the Federal Government's interest in specific health problems. Grants for special health purposes have encouraged concentrated attack upon particular disease entities. New health programs have been initiated and old programs revitalized. Health problems to which Federal aid has been addressed through the categorical grants have responded well to intensive programs. Control of tuberculosis and the venereal diseases is at the most effective level ever known in this country; malaria has been virtually eradicated; infant and maternal death rates have been dramatically reduced. Hospital construction grants have brought about expansion of much-needed facilities.

In general, we have seen a remarkable improvement in the health status of the Nation. Of course, no one is satisfied to stop at this point, nor should he be. Many problems are yet to be solved, and their solutions in many instances would entail an outlay of funds in larger amounts than are available in present budgets.

A New Base of Services

We must remember that public health concepts apparent to us now had not emerged in earlier days or were crowded out of our perspective by the multiplicity of primary problems which had to be met. The pace of progress has brought us to the realization that today's health needs cannot be met with an organization and type of service geared to an earlier set of problems. The changing character of community health services demands a broader administrative structure and a wider range of professional

competencies. In the beginning, public health physicians, nurses, sanitarians, and laboratory technicians made up the staff. The demands on this team of organized workers have gradually expanded to require the addition of health educators, dentists, dental hygienists, veterinarians, and statisticians. Today, a great variety of specialists—cardiologists, pathologists, psychiatrists, psychologists, medical social workers, nutritionists, and even anthropologists—have a place in health service programs.

In addition, a number of new kinds of facilities are now necessary. Among these may be mentioned diagnostic clinics, X-ray facilities, and other case-finding devices.

Unfortunately, many small political subdivisions simply do not find it possible to provide the multiplicity of facilities, equipment, personnel, and funds which may be necessary. Then we must ask: "How local can a local health unit be without loss of effectiveness and without impairing its financial base? What services must be included if it is really to influence health under present conditions?" A sparsely populated rural county or a single township can usually provide such traditional health services as improvement of sanitation, performance of immunizations, and giving advice to mothers on how to rear healthy children. A larger, more rational type of local health unit, with more extensive resources, is required for such services as screening tests for chronic disease, mental and school health programs, and rehabilitation of handicapped persons. In many instances, local governmental jurisdictions must combine if they are to become functional areas which can provide the newer health services.

One still hears emphatic statements to the effect that political units cannot be merged. This is quite contrary to the fact insofar as health administration is concerned. Practically all county health departments serve from several to all of the incorporated municipalities within their boundaries. And of the 1,542 counties receiving the benefit of full-time local health services, about half are in health districts combining two or more counties and municipalities.

This trend is encouraging, but it does not extend far enough. On the other side of the picture, we see that 37 percent of the full-time health units now in operation serve a population of less than 35,000; 59 percent serve areas of less than 50,000 population. Generally, such jurisdictions represent too small a base for administration of up-to-date public health programs. More than half of the units still serve single counties only. This situation is reflected in their serious staffing deficiencies. Only 6 percent have enough nurses, 35 percent enough sanitation personnel, and somewhat less than half have sufficient physicians to meet minimum requirements recommended by professional health organizations.

There are still between 35 and 40 million people living in areas without organized full-time local health services. However, this represents only one phase of the need; in fact, as far as nominal coverage is concerned, the record is not too bad. Of much greater concern is the fact that many local health departments now have only skeleton staffs and serve areas too small for either economical administration or comprehensive service. They cannot afford the kind of organizational framework needed to initiate community activity which will result in all needed services being made available.

Some of these difficulties must be resolved by legislative or administrative action taken within each State. A number of States still lack enabling legislation for the establishment of multicounty or combined city-county local health units. Other areas, although they have such legislative authority, have been slow to reorganize on a broader base. Part of this reluctance lies in the fear of losing local identity and autonomy in the process. Actually, the best assurance of local autonomy lies in so organizing local institutions that they will serve the needs and desires of the people.

These, then, are the facts which clearly indicate the need for a broader basic framework of local health organization than we now have. To hasten this achievement and to provide stability, Federal grants for local health services must not only continue but also increase.

Status of Federal-State-Local Partnership

However, instead of progressively measuring up to the new demands and concepts, Federal

grants for general health services have leveled off. The general health grant has decreased slightly in dollar amounts each year since 1950; in purchasing power it has declined materially. Furthermore, relatively little progress has been made in extending local health services during the past 3 years.

Why has this leveling-off occurred? Is it because of inflationary fears, the clamor for tax reduction? Is Federal aid for local health services no longer needed? Is it because our Federal monies are so widely needed elsewhere in these troubled days? Is it because changes in public health problems and principles now demand a different fiscal approach? Certainly there are divergent opinions on the how and why of Federal aid in this field. This may be the time to try to crystallize the varying opinions into constructive thinking and action to move beyond the plateau.

It seems philosophically significant that the leveling off of Federal assistance for general health services has been accompanied by the initiation of additional grants for special purposes. Many public health workers, as well as segments of the general public, have felt that this specialization is proper and wise. Other public health administrators feel equally sure that endless difficulties are caused by the increasing number of categorical grant funds, and would like to see such grants absorbed in a larger general health grant.

No matter how we look at categorical grants, no one can deny the remarkable influence they have had in sparking public interest in health. Specialized grants have captured public imagination in a way that could not have been easily accomplished under general grants. From the financial viewpoint, however, categorical grants can lead to burdensome accounting requirements on all government levels. They also carry the potential handicap of too much rigidity in that they might work against the redirection of money and efforts as health needs change.

It is not certain whether a new and different fiscal approach is needed. Part of the answer must come from the people who administer the services to the ultimate users. I do believe we have a sound pattern on which to make the adjustments that may be necessary and the kind of partnership which will make the adjustments work satisfactorily.

There are some who feel that the Federal-State-local alliance may be an unholy one. In their reluctance to see further extension of Federal aid to local services, supporters of this point of view seem more concerned about theories of government than about the actual realities of operation. Nevertheless, honest criticism can be highly constructive if we will so accept it and will consider the questions raised as a challenge. Even those of us who are the most enthusiastic advocates of our present system do not claim perfection for it. Unquestionably, some changes are needed if local health services are to expand beyond the point at which we now find ourselves.

There are also those who take a fatalistic view and say that expansion of local health programs cannot be accomplished, no matter how much financial assistance is available, because of severe personnel shortages. That there is a serious shortage of public health personnel is undeniable. However, some health departments have been able to recruit and train staff to fill their vacant positions and to utilize auxiliary personnel effectively within a professional staff. The key to their success appears to lie in an adequate budget. Local health departments must be in a good position to attract and hold qualified personnel. Adequate pay and suitable conditions of employment are of paramount importance. Although there has been steady improvement in the salary schedules for public health workers, the rate of increase has not been sufficient to keep up with the inflationary spiral, to say nothing of competing favorably with outside demands for professional services. Given a larger budget, readjustment of salary schedules would be relatively easy. Likewise, it would be possible to step up training programs in order to establish a larger reserve of qualified personnel from which to draw.

Possible Alternative Approaches

Simply augmenting the present scheme of Federal grants for general health purposes would not, of itself, assure the needed expansion in local health services and personnel. Al-

though this grant has many advantages in that it can be used for a variety of purposes at both the State and local levels, its very flexibility permits the State to concentrate a large proportion of the funds in the State agency. Only 36 percent of the $13,500,000 general health grant now available annually is being used to support the basic local health structure; 64 percent is expended for State-administered services. When all Federal funds (categorical as well as general) are considered, only 23 percent is spent by local health departments. Up to the present time, this has been wholly justifiable in order to build up the needed State strength. We must also remember that much of the State spending directly benefits local communities, as in providing laboratory services, operating mobile X-ray units, and the like. One reason that the State agencies perform as much direct service as they do, however, is the necessity to compensate for services which are not available through local auspices. This gap must be filled by local departments before many State services can safely be reduced.

To assure local use of Federal aid, we probably need to specify that such aid must be used only for the development and support of locally sponsored health services. Because public health problems are never static, local health services supported by a grant of this kind should be broad in scope. A narrowly circumscribed Federal definition of the exact services which could be supported would add greatly to the complexities of administration and accounting. In the long run, too, it very likely would have a limiting and even interfering effect on the content of local programs.

If a general-purpose grant to be used exclusively for local health services were made available, its relationship to remaining categorical grants would have to be determined. I do not anticipate that aid for general local health services will replace the need for limited grants directed toward special problems, since it would be designed primarily to supply those fundamental services necessary for the operation of all programs. Maximum benefits from a general-purpose grant for localities would be derived only if it were made available on a continuing basis. Without reasonable assurance of permanency, health departments would continue to find it difficult to establish and maintain the kind of facilities they need and to recruit essential personnel.

It is entirely possible that we may be forced to resign ourselves to remaining on a plateau until times are less stringent insofar as Federal funds may be involved. There are still difficulties ahead for Federal participation in local health services. Because of the declining value of the dollar, aid at our present level will accomplish less than it has in the past. Prospects are not too good for increased Federal participation because of the financial position of the Federal Government at this time. Demands for defense activities and international obligations, as well as divergent theories of the proper role of the Federal Government, all contribute to a hesitancy to assume any greater support of local functions.

The Long View

In spite of all the seemingly adverse factors, the future still appears rosy, for at least three reasons: First, the people of this country are decidedly interested in, and conditioned to, good public health, not only for their own but for neighboring communities; second, the newer concepts of public health are too promising to be long denied; third, it seems reasonable to assume that international tensions will taper off over a period of time although perhaps not so quickly as we should like. In the event, however, that such tensions increase to the point of all-out war, then, of course, all predictions must be cast aside.

Thus, we come to the realization that there are potentialities over which we have no control. But to a certain extent, we can make the future, and on that premise we ought to set our minds and our sights at this time so that we may move ahead logically and positively when circumstances permit. It is incumbent upon us as public health administrators to stretch our present resources as far as possible, and at the same time to plan optimistically for the future we want. We need not wait for additional Federal aid to start consolidating some of the smaller and weaker units for better utilization of available personnel and facilities. Account can be taken of newer health problems and

methodology and plans prepared for gradually drawing them into the orbit of activities. Each State and local health officer can now critically examine the services of his department with the purpose of developing a coordinative and State-wide pattern which will make every use of local resources and initiative. Imagination can be applied to personnel recruiting and training problems.

Now is an ideal time for this kind of thinking. It has been demonstrated that we are in agreement on the need for expanded local health services. We are aware of the elements which have worked well so far. We have a solid background of experience and knowledge which we can apply to solving the problems before us. And that is the kind of combination which seldom fails when properly used.

Community Health Services for an Aging Population

By JOSEPH W. MOUNTIN, M.D.

One of the great emerging opportunities for public health is health services for an aging population. I am convinced that there is a great new field here for the public health profession, one that is different, more complex, perhaps more experimental than any we have known heretofore. By the same token, however, it is one which offers great rewards to the profession as well as to the community and the Nation.

The current interest in aging is shared by a great many professional and community groups. This interest is a reflection of the problems which strike deep in the hearts and minds of millions of people in this country. Certainly the vast majority of us can expect to face the hazards—and the satisfactions—of aging. Because of the conquest of the diseases to which public health programs hitherto have been addressed, more and more people will live into a period which not so long ago was regarded as very old age. They will have to face the problems of adjustment, of health, and of security that later life brings. For most people, the interest in aging is very personal and very real.

To a considerable extent, therefore, people are waiting for professional groups to take the lead in establishing suitable programs of action. Herein lies our great opportunity—to make the added years really worth while by helping older people remain productive members of society.

It would probably be repeating the obvious to go into the background of the problem or to belabor the point of its significance. The fact that we had four times as many people over 65 years old in this country in 1950 as we had in 1900 is too well known to need emphasis. Present population forecasts indicate that by 1975 there will be more than three people over 65 for every two now in that age group.

Part of the explanation for the increasing community concern can be found in the very numbers themselves. Too many people are involved, both numerically and proportionately,

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