The Health Department's Dilemma

——*Definitions and Functions*——

By JOSEPH W. MOUNTIN, M.D.

From time to time, the public health profession, and particularly the health department, finds it necessary to redefine its field. The need for a new definition seems to strike us when there are substantial changes in problems and especially when major readjustments are in the making. This mid-century point is obviously one of those times, because many of the old problems have been resolved and because new opportunities for advancing human health are opening up constantly.

A definition, it may be mentioned at the outset, may be philosophical or broadly descriptive; or it may tend to fix boundaries. In the sense, however, that definitions help us clarify and delimit our responsibilities, they have much more than an academic or abstract interest for public health workers. They are the basic tools in determining the direction and scope and value to society of health programs. Certainly those of us who are administering a health program can appreciate the need for delineating functions and responsibilities. Wisely conceived and properly interpreted, a definition can serve a very useful purpose. But if a definition merely serves to restrict health departments, that is, if it is used to shut them out of current problems and activities, it can also be stultifying.

This brings us to a fundamental question: Can we ever hope to arrive at a definition that will give us a focus of operations and yet not be completely limiting? Many health workers know from their own experience how the act of setting boundaries often serves as an obstacle to the progressive development of services. Although the way out of this dilemma may not be readily discernible, we should be able to recognize its complexity and the reasons for its existence.

Dynamics of Public Health

The content and scope of health services, like society itself, undergo constant change. As old problems are solved or fade into minor significance, new ones or those unappreciated in the past arise to take their place. If we attempt to arrive at a frame of reference that will be meaningful in terms of specific health department responsibilities, it becomes obvious that no single concept can answer all our needs. It is almost impossible, in other words, to arrive at a definition that will be enduring and universal. The concepts that were appropriate some years ago do not—nor can they be expected to—take cognizance of current health problems and responsibilities.

On the other hand, an accurate description of public health in this country today would hardly be valid for vast areas of the world. In many parts of the world the absence of simple

Dr. Mountin is chief of the Bureau of State Services, Public Health Service. *This article is based on a paper read at the fifth annual meeting of the Massachusetts Public Health Conference and the New England Health Institute in Amherst, Mass., on June 15, 1951.*

personal and community hygiene underlies most of the health problems, and such diseases as malaria, intestinal disorders, and tuberculosis account for a very high proportion of deaths and disability. It would be necessary to go back, therefore, as much as a century in our own history to seek a suitable content for health programs in underprivileged parts of the globe today.

Public Health in Retrospect

Certainly up to the turn of the century our measures for meeting health needs even in this country, although realistic and effective, were little more than introductory. If public health had followed the comprehensive approach embodied in the Shattuck report (*1*), we might, from the very start, have moved forward on a much broader front than sanitation and infectious disease control. For example, this is what public health meant to Shattuck and his associates over 100 years ago: "The condition of perfect public health requires such laws and regulations, as will secure to man associated in society, the same sanitary enjoyments that he would have as an isolated individual; and as will protect him from injury from any influences connected with his locality, his dwelling house, his occupation, or those of his associates and neighbors, or from any other social causes." The emphasis on man as a social being and as a product of a social environment is amazingly modern.

But the dramatic effects of water purification and sewage disposal on human health were too compelling to be ignored. As a result, public health became set on the road it was to follow for the next 50 years and more—essentially the sanitation of the physical environment.

This is not to deny that environmental sanitation was an indispensable first step. The public health pioneers were fully attuned to the realities of their day. It was the slums and dirt, the overcrowded and inadequately safeguarded living conditions, and the poorly disposed, disease-bearing sewage and wastes that constituted the greatest menace to health in those days. The early leaders may have been vague as to etiology and imprecise as to control techniques. But they were crystal clear about the conditions they wanted combated through organized social action. And it was in response to those needs that organized public health programs developed and that professional responsibilities began to be recognized.

But the needs and the acquisition of new knowledge soon outgrew the original concepts. Public health began to acquire a systematized body of knowledge and experience that enabled it to shift its attention to preventive personal medicine and to tackle environmental hazards with increasing precision. The first decades of this century saw the beginnings of this new type of public health campaign, with its attention to the childhood ailments and the concerted attacks on the infectious diseases. The rapid development of bacteriology had brought many new techniques which enabled us to go beyond quarantine and disinfection, for a long time the principal measures for limiting the spread of contagion. Immunization against a wide range of diseases became possible and specific serums gave us our first effective therapy against many illnesses. The early decades of this century also saw the beginnings of the science of nutrition, which changed the course of control for several diseases. Finally, they were characterized by the development of considerable specialization, both in professional disciplines and in health services.

In these decades public health agencies exerted strong leadership by stimulating the new programs and using the new techniques. The efforts to prevent and control epidemics, to curb such diseases as diphtheria, smallpox, and typhoid fever met a real, demonstrated need of the people. And it was in answer to this need that modern local health organizations began to grow.

It was, in fact, out of this period that our current ideas of public health services evolved—concepts that included a "categorical" approach to disease, specific control techniques, and specialized, even compartmentalized services. As another result, public health workers began to give thought to the organizational structure for conveying services to the people. We began, thus, to acquire rather firm ideas about "basic" responsibilities and services, and about minimum standards of personnel and organization. And these concepts, once highly appropriate,

still cling to our consciousness in the face of changing conditions and altered needs.

New Needs and Directions

That the needs and the problems have changed substantially even within the last decade does not, I am sure, require much documentation. Many of the once most-feared infectious diseases are now negligible problems. The rapid development of antibiotic therapy has reduced the importance of most of those that remain to minor clinical entities. Moreover, the eradication of some transmissible diseases by mass therapy now looms as a distinct possibility. Syphilis is a case in point. In addition, public understanding about personal hygiene, sanitation, and the control of communicable diseases has progressed hand in hand with the improvements in knowledge and methodology.

Nevertheless, there are today many areas of unfinished business in public health—and even more important, many which are not yet started. The factors which have given rise to them are, of course, well known. The general aging of the population, the increase in chronic diseases, the problems associated with our complex industrial and social environment, all combine to create a new setting for public health.

In addition, a new approach to health itself is being fostered by professional groups as well as in the popular mind. Health is now being thought of, not in terms of disease or mortality figures, but in a positive way, in terms of physical fitness, mental and emotional adjustment, and social satisfaction and usefulness. In other words, health is no longer considered solely as an end, but also as a means. The public health responsibility cannot be considered liquidated once we have reduced infant mortality to the vanishing point, or conquered malaria or syphilis, or even cancer and heart disease. It must be geared to promoting ever higher standards of human efficiency and satisfaction.

As an important corollary of this approach, public health workers are obliged to take a new look at the origins of social pathology. Health problems cannot be isolated from the environment—both physical and social—in which they exist. Such factors as the individual's job, his family life, his housing, his recreation must all be assayed for their impact on health and disease. In other words, we must now not only put emphasis on the individual and his needs, but also consider him in relation to his whole complex socioeconomic environment.

This brief review of the major trends in the historical development of public health in this country suggests a conclusion that is already well known, that public health is dynamic and progressive. It develops at different rates of speed, depending upon differences in time, place, and problem. And, up to the present at least, the solution of one problem has only sharpened our awareness of needs in new or neglected areas.

Limitation by Definition

The progressive nature of public health makes any restricted definition of the functions and responsibilities of health departments difficult. More than that—there is a real danger in attempting to narrow down a moving and growing thing. To tie public health to the concepts that answered our needs 50 years ago, or even a decade ago, can only hamstring our contribution to society in the future.

Consider the results if the public health profession had fixed or solidified its responsibilities during any of the earlier periods just noted. Perhaps we would still be concentrating on gross environmental sanitation or, if our program became static at a later period, we would still be limited to placarding and fumigating. Even if our responsibilities had crystallized as much as a decade ago, we would have practically no cancer control or mental health programs today. These and many other recognized activities would be ruled out if we truly limited public health programs to the so-called basic six—the minimum functions which have been suggested for local health departments; nor would there be any room for an aging or a hygiene-of-housing program in the future.

In allowing itself to be guided by a limited definition, public health may fall into the error of substituting the symbol for the job, of mistaking the contrived concept for the actual responsibilities that the people want met. This becomes the start of a descent. The next step,

the one that is far more dangerous, is to live down to the artificial symbol instead of living up to the actual job.

If a public organization or agency is not alert to changing needs, if it grows insensitive to the desires of the people, it becomes rigid and actually falls behind the times. It not only tends to lose popular support but fails to attract the kinds of professional personnel it needs to carry on its programs. Moreover, a narrow outlook constitutes an open invitation for new programs to spring up under other auspices, which may be less well equipped in terms of professional competence and technical experience.

For example, how many health programs have gone by default to other governmental agencies because the health department was not ready to modify or redirect its efforts? A 1950 sample survey of the distribution of State health services (*2*) reveals that in at least one State, 23 State agencies are administering important health functions and that in no State are these activities administered by less than nine. This extreme dispersion is even more pronounced when we examine some of the newer programs individually. For example, in a single State as many as seven different agencies are engaged in some kind of accident prevention programs. Similar situations exist in such fields as water pollution control, hospital planning and construction, mental health, and the administration of medical care programs.

I am not suggesting that all public health services need be the exclusive province of the official health department. Far from it. In our complex civilization, many organizations—voluntary as well as official—have an important role to play. But I think the figures are significant in that they reveal the health department's reluctance to sponsor new services or to accept new areas of interest, despite the fact that these services fill a demonstrable void on the local scene.

A Modern Concept of Services

The question may still be asked: Are there any guidelines which we can use in determining current services and responsibilities of health departments and at the same time avoid being restrictive? The answer is "yes," provided the guidelines are kept flexible and leave room for future modification of program content. In its recent revision of the functions and responsibilities of the local health department, the American Public Health Association (*3*) noted that the rapid development of health services has caused the definitions of local health services and responsibilities "based on limited categories of activity" to become "quickly outdated." They recommended instead that "optimal" responsibilities be identified and that health department services be expressed in general terms. Seven general types of service are listed, namely, the recording and analysis of health data, health education and information, supervision and regulation, provision of direct environmental health services, administration of personal health services, operation of health facilities, and coordination of activities and resources.

On looking at this list, one's first impulse is to say that seven services have now been substituted for six. But the differences are far more important than the addition of a new responsibility. The earlier statements identified specific programs or functions whereas the new listing indicates general areas of service, under which one or several programs may be included. The term "basic" or "essential" may imply that other services are little more than frills; and as a result minimum functions soon become the major or the sole activities of the health department. The broader approach opens up the road for a thrust in any direction, depending on where the greatest need exists.

The transition from a concept of "basic" services to one of "optimal" services is an extremely important one. It raises our sights far above the routine and static activities that still characterize too many health departments. It means a recognition of the realities of the day. And it implies the readiness, the willingness, and the competence to step in and take some positive action wherever a health problem exists and is being neglected.

On the other hand, this approach is not one of unlimited expansionism. It is not a matter of simply adding one job on top of another until we amass a long string of impressive responsibilities. At least two factors should militate against such a mushroom type of growth.

The first is that public health is and should continue to be subject to social controls which will effectively prescribe our areas of responsibility. It is one thing to say that public health should not be impeded by definitions that are designedly restrictive. It is another to recognize that public health must adapt itself to the will of the community. Such practical matters as budget and fiscal considerations—sometimes looked on as the bane of our existence—actually provide the opportunity for considered review of our activities. On these occasions, too, representatives of the people reflect the community's needs, problems, and desires for service. In a democratic society, we can rely on social controls for the guidance and advancement of public programs, but only if these controls are allowed to operate freely.

The second factor involves the recognition by public health agencies of an important obligation. They owe it to society to modify or reduce those activities which may be marked as finished business or as business that offers only limited returns on the investment. For example, many commercial organizations as well as consumer groups are now deeply aware of health and sanitation measures and put them into daily practice. Restaurants and food establishments are beginning to undertake programs to supervise their own sanitation. The housewife insists on a clean butcher shop and grocery store. Because this is so, health department staffs no longer need conduct the same kinds of detailed inspection and regulatory programs that were formerly the rule.

Food-borne outbreaks of disease must undoubtedly be guarded against vigorously. In fact, a great many such outbreaks still occur each year. But health departments might prevent these occurrences by a program of general education and standard setting and by the training of food handlers, supplemented by judicious law enforcement. Particularly where they are operating within a limited budget, they might rely on spot checks and on more precise information about outbreaks now taking place rather than on the general purpose inspection. In such a manner, they might meet the problem more effectively and at less cost and, by the same token, make more time and money available for other activities. Sanitarians could devote more of their energies to contemporary problems in food sanitation and to other new fields, where their experience and training can be put to good use. They might, for example, be working on such broad social problems as community planning, housing, control of air pollution, and accident prevention.

Somewhat the same situation holds true for the programs designed to improve individual and family health. Many of the time-consuming activities involved in controlling some of the infectious diseases may be modified to a holding type of operation—that is, maintaining vigilance against localized outbreaks of disease. On the other hand health departments must turn more attention to other types of personal health services.

Opportunities Unlimited

Preventive health work no longer means solely safeguarding the physical environment or curbing the spread of infection. Today it has a personal connotation and, even more, it means preventing the complications of disease or the further deterioration of one who already has a disease or disability. In the words of the official APHA statement (*3*): "Because of the marked changes in the age distribution of the population and in the spectrum of our health problems, the theory and practice of public health has expanded to include not only prevention of the onset of illness, but also prevention of the progress of disease, of associated complication, and of disability and death."

Perhaps because there are relatively few primary preventive measures against the chronic impairments, the role of the health department in this field has not yet been clearly established. There are, however, many ways in which the actual or potential resources of the health agency may be utilized. These vary all the way from providing auxiliary services for physicians in private practice to operating the facilities which may be established under public auspices for general or specialized care.

Medical care is also beginning to exhibit many of the elements which are identifiable with a general health service. This is so partly because of the increased effectiveness of therapeutic measures which can be used to combat

certain diseases on a mass basis. The effects of modern therapy on scarlet fever and pneumonia demonstrate graphically how these diseases have been robbed of most of their terrors. There are other, if less dramatic, examples. The new "wonder drugs" not only reduce mortality strikingly but also abort many incipient cases of disease; almost without exception they shorten morbidity and reduce complications. Thus, the health department must be increasingly concerned with the character and availability of medical facilities and services within its geographic area.

Even with our limited knowledge today, much can be done not only to stabilize chronic illness but also to rehabilitate its victims and to help them make necessary adjustments. In light of the social goals of public health, it is our responsibility to play an active part in restoring an individual to his family, his job, and his community. Any recovery or any gain that will make a person in any measure more self-sustaining than he was will mean some degree of improvement, not only for the individual but for society. Even if an individual is rehabilitated from the hospital bed to the wheel chair at home, it represents that much of a social gain in relieving the community of the burden, the expense, and the responsibility of care. If the person is able to return to productive employment, the gains are multiplied many times over.

The Pioneering Spirit

Can health departments assume these new responsibilities without undergoing a major upheaval? I think they can, provided there is a recognition of the need, a reorientation of thinking, and a willingness to tackle the job. The new approach will call for a great deal of administrative and technical pioneering. For example, from our experiences in controlling the diseases of bacterial origin, we are used to dealing with specific, almost rigid, control techniques. For our purposes today, however, we may have to revert once more to the rather general approach reflected in the Shattuck report (*1*). In such programs as health promotion for older people or mental health, we are dealing with a new kind of social pathology, much of which is still vague and ill-defined. Thus, we may very well turn to empirical and general methods, at the same time seeking constantly for refinements and for more precise techniques.

The health department can begin preparing for its new responsibilities by surveying the resources and facilities already available in the community and by being ready to adapt or to apply them to health purposes. It must seek and train a wide variety of new competencies and make liberal use of consultants. Cardiologists, psychologists, medical social workers, nutritionists, even economists and sociologists, all have a place in modern health service programs. Although not all of them can or should be employed directly on the staff of every local health department, an interchange of personnel can be made possible through the regionalization of health services. In addition, a progressive program of staff education should be instituted to give professional personnel the broad perspective and well-rounded knowledge they need to conduct the newer health programs. Training should be given not only in the traditional health field but in a variety of related disciplines and particularly in the social and administrative fields.

Moreover, the health agency should call for consultation and advice from people both within and outside the health professions. Engineers and safety consultants as well as epidemiologists, psychiatrists, health educators, and public health nurses have much to contribute to a program in the prevention of home accidents. Social workers, recreational personnel, industrial and labor groups, and housing officials all have to play a part in programs designed to promote the health of older people.

It would seem clear, therefore, that the health department today is only one of a number of agencies—official and nonofficial—which can contribute toward better health. Many of the newer programs must be based on suitable working arrangements between health departments, hospitals, private physicians, and others who actually perform various services.

Other types of administrative reforms and organizational improvements will undoubtedly suggest themselves to health workers once they take the initiative in developing the new programs. What is important to remember is that

a variety of activities are already under way. Excluding health departments by definition merely precludes them from participating in many services where they have much to offer. If health workers remain wedded to concepts unrelated to current needs, health department programs will inevitably be sterile and narrowly restricted. If, however, they not only meet these needs but also keep in mind the broader objectives—improving individual satisfaction and community life—they will be ready to make their maximum contribution to society.

For despite all the health activity that is going on today and despite all the real progress that is being made, there is a greater need than ever for a community organization to spearhead the work and to provide the technical and administrative guidance. That organization should be the focal point of the community's health activity. It should contain the social perspective and the wealth of competency to be able to perceive the need; and it should have the ability and the courage to take whatever action is necessary.

The people expect the health department to be that organization. They look to it as the community agency which will help find the answers to their pressing health problems. It is to this trust that public health must be truly dedicated.

REFERENCES

(1) Shattuck, Lemuel, and others: Report of the Sanitary Commission of Massachusetts, 1850. Cambridge, Harvard University Press, 1948, p. 10.

(2) Mountin, Joseph W.: Changing patterns of State health services. Am. J. Pub. Health 41: 516–521 (1951).

(3) American Public Health Association: The local health department—Services and responsibilities. Am. J. Pub. Health 41: 302–307 (1951).

Parrot Fever Quarantine Revised

Revisions in the Federal quarantine regulations for the foreign importation and interstate shipment of parrots, parakeets, lovebirds, and other psittacine birds have been announced by the Public Health Service.

Changes in the foreign quarantine regulations went into effect December 15, 1951. They remove the 8-month minimum age limit on birds imported for use by zoos and research; reduce from 2 years to 4 months the time birds imported as pets must be in the owner's possession prior to entry into this country, and remove the requirement that imported pet birds must be transported to the owner's residence immediately upon arrival in this country. An added requirement is an affidavit that birds imported as pets are not to be resold and that the owner has brought no other birds into the country during the preceding year.

Changes in the interstate quarantine regulations, which went into effect November 15, 1951, remove all Federal restrictions on shipments of psittacine birds from psittacosis-free areas in the United States, but they prohibit the shipment of the birds from areas where the Public Health Service has determined that psittacosis infection is dangerous to the public health.

None of the changes affect the standing requirement that interstate shipments of psittacine birds must be covered by a permit when it is required by the health department of the State of destination.

Changes in the quarantine regulations followed a Public Health Service study which disclosed that psittacosis is no longer a major public health problem in this country and that the disease is found among birds which do not belong to the psittacine family.

985891—52——2