Local Health Organization

—A Progress Report—

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IN the 46 years since the first county health department was organized, the local health unit idea has spread, and today 2,197 counties are served by 1,365 full-time health units—county, city, local district, or State district organizations (*1*). Figure 1 shows this coverage by type of department as of June 1953.

The growth of local units did not occur at a steady rate, but fluctuated widely over the years and in different sections of the country. The idea was slow to take hold at first. Then came periods of rapid acceleration interspersed with periods of slow expansion or even contraction. Recently there has been a sharp decline in the rate of expansion. During the past 5 years there has been a net increase of only 46 units.

It is appropriate, therefore, to take stock at this time of the progress achieved in building local health services and to survey the problems still to be met in extending services to additional areas.

Measuring Growth of Local Services

The growth of local health services can be measured in a number of ways in addition to geographic coverage. Staffing and financing patterns are more accurate indexes of the intensity of services, and program expansion can indicate whether health departments are adapting their services to meet present-day needs.

Although the number of persons employed in State and local health agencies has increased considerably since the end of World War II (fig. 2), this growth has been uneven, both geographically and on the basis of the professional categories in which the increases have occurred. For local health department personnel, 40 percent of the overall increase between 1947 and 1952 was reported by 3 States. A State-by-State analysis reveals increases ranging from less than 3 percent in 1 State to 100 percent or more in 4 States. Decreases ranging from less than 1 percent to almost 25 percent were reported in 6 States.

Variations in the growth of professional staffs are also great with respect to categories of personnel. While the increase in the number of physicians in local health agencies amounted to only 4.5 percent, other professional groups increased markedly. For example, the number of dentists increased by 68.7 percent; health educators, 51.9 percent; engineers, 64.6 percent; and nutritionists, 90.7 percent. Comparable figures for medical and psychiatric social workers are not available for the 1947–52 period; however, their numbers increased by 270 percent between 1948 and 1952.

Staff Shortages and Expenditures

Despite the general improvement in the number of personnel employed, there are serious shortages to be considered. Of the 1,365 health

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organizations, 380 reported that the position of health officer was vacant or being temporarily filled on a part-time basis. A recent study (*2*) showed that about 10 percent of the budgeted positions in local health departments were vacant. Analysis of the number of additional personnel needed to staff existing organizations with the minimum personnel recognized as being essential may point up the situation more effectively. Of the more than 1,200 organizations reporting to the Public Health Service (*3*), 670 units need a total of 1,216 physicians in order to reach a minimum standard of 1 physician for every 50,000 persons—an essential according to pooled professional judgment—or 1 for every local health unit, whichever is less. More than 11,600 nurses are needed by 1,189 of these health units in order to reach the standard of 1 nurse per 5,000 population; and an additional 2,000 sanitarians and other sanitation personnel are needed by 736 organizations to attain the standard of 1 per 15,000 population.

It should be emphasized that these figures do not express total needs even for those organizations included in the count. These standards reflect what is considered to be the minimum staff needed for providing the more or less traditional services which any health department should supply. Any enrichment of program to meet the newer health problems would require either additional staff or a realinement of duties of present staff in these categories. Services of a variety of other professional groups would also be required to supplement those of the basic staff.

Measures of growth based on expenditures are likely to be misleading because of the changes in the value of the dollar. In addition, there have been varying estimates of the amount of money which will provide adequate public health services at any particular time. The amounts spent by local health departments are, on the average, below the lowest of the present estimates. The expenditures of local health departments as reported to the Public Health Service totaled approximately $150 million in 1952. This equals less than $1.00 per person in the United States as a whole, and about $1.10 per person when only that part of the population living in areas served by full-time health units is considered.

The total expenditures for State and local health services vary from more than $3.00 per capita to less than $1.00. (These figures exclude the costs of construction and operation of hospitals.) The States with the lowest per capita incomes are spending a larger proportion of their available resources on health than are States with the highest per capita incomes. When the States are divided into quartiles according to per capita income, the lowest income group spends an average of $1.00 for every $1,000 of individual income paid within the State, while States in the highest income group average about 71 cents per $1,000 (fig. 3). Of the 5 States which rank highest according to the proportion of income spent for health services, 4—Georgia, Kentucky, Mississippi, and North Carolina—are among the States lowest in per capita income, ranking 42d, 43d, 49th, and 46th, respectively.

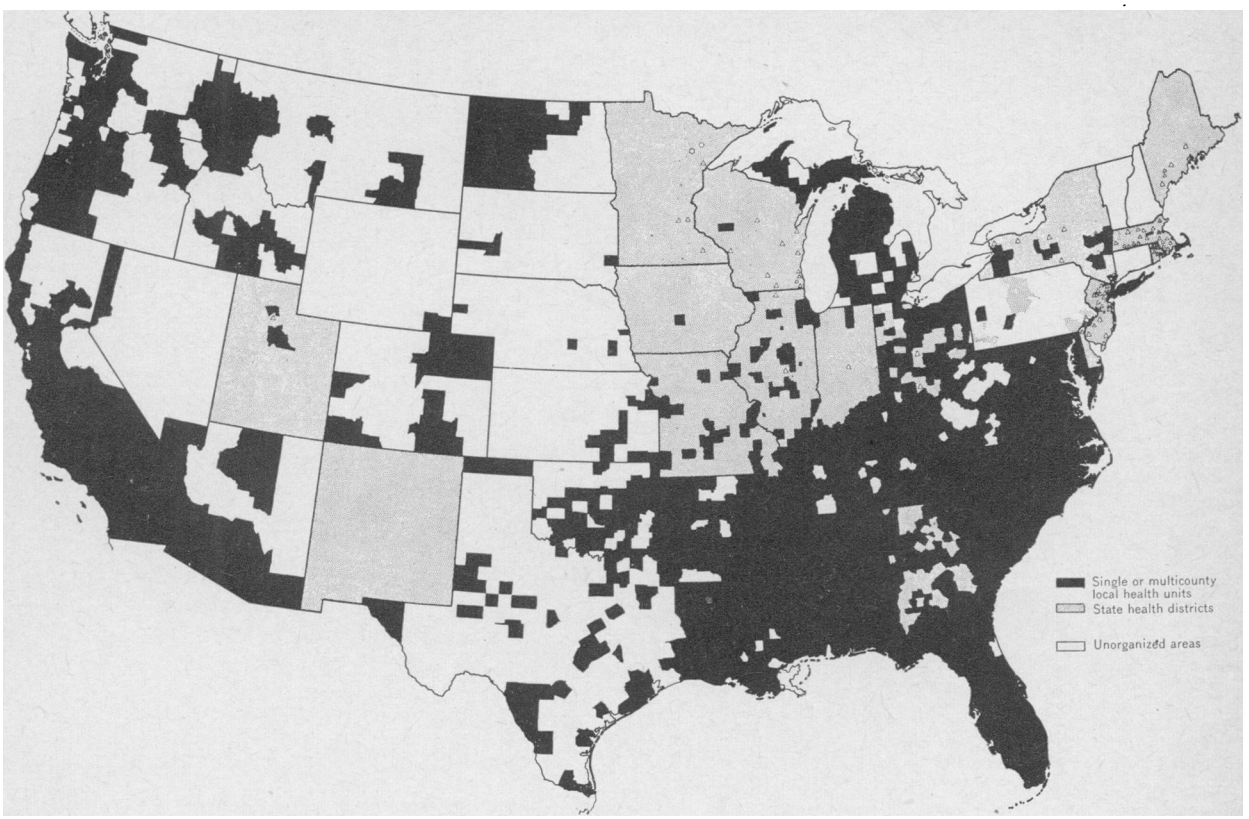
Distribution of Services

While the variety of health services being offered by health agencies of all types is steadily increasing, two facts are important in evaluating the change. First, these services are concentrated in cities. This is not unexpected since the facilities and professional skills needed for conducting such programs are largely concentrated in urban areas. For example, one-third of the jurisdictions reporting mental hygiene clinics were cities which comprise only about 16 percent of the total organizations reporting (*3*).

Second, these newer services have been developed to a large extent under the sponsorship of voluntary agencies. For example, about 60 percent of the cardiovascular clinics reported were operated by voluntary agencies, as were 53 percent of the diabetes clinics. In contrast, only about 7 percent of the tuberculosis clinics and 8 percent of the well-child conferences were operated by voluntary groups. These circumstances provide the health department with an opportunity to play a vital role in encouraging the coordination of the services of voluntary and official agencies.

It is clear that the problems facing the pub-

Figure 1. Areas reporting full-time local health service as of June 1953.



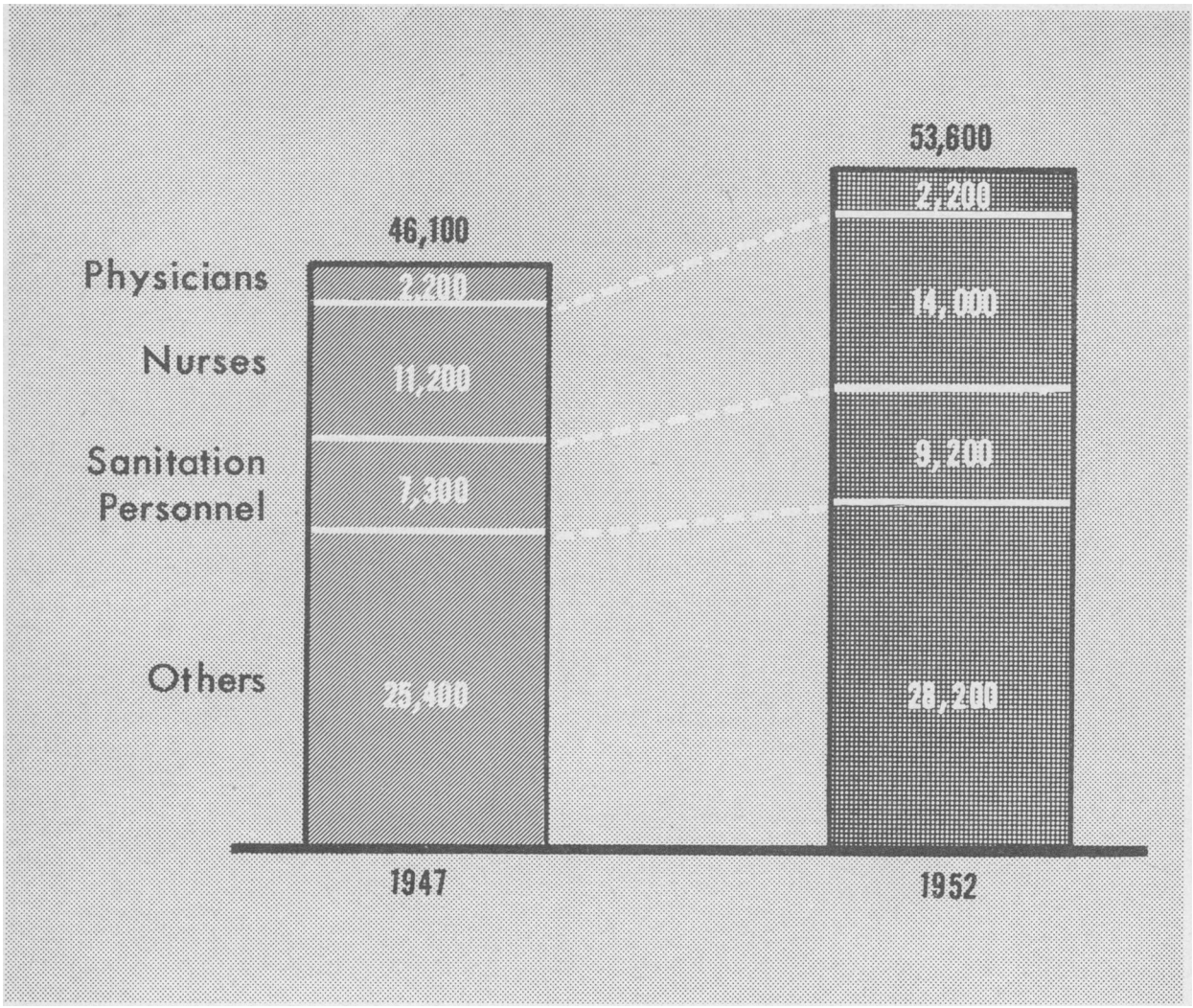
lic health administrator concerned with expansion and improvement of health services are manifold, and that new ideas and imaginative planning are necessary for their solution. A close look at the kinds of communities outside the existing local health organizations further supports the view that some change in thinking is desirable. Two-thirds of the counties without full-time official health services as defined earlier have populations under 15,000. Of the 14 States in which more than 25 percent of the population is in the unorganized areas, 6 have a population density of less than 10 persons per square mile. Only 2 counties have more than 100 persons per square mile. Within the sparsely populated States, most of the urbanized areas have some full-time health organization. Thus, the uncovered areas are generally those with a population density considerably less than that of the State as a whole. This fact points up the difficulty of applying the usual organizational pattern in these areas.

Health administrators in many parts of the country are devising methods for meeting some of these problems. New administrative arrangements for provision of health services are being worked out. Two States, for example, are developing plans whereby the local community may obtain services from the State health agency on a contract basis. In this way the sparsely settled community may procure the kinds and amount of services which it considers necessary. Such a procedure should prove more effective and economical than would an attempt to maintain a local health department of the traditional type. It is possible that availability of such services will stimulate community interest in providing additional services as the need for them is recognized. Other States are experimenting with strengthening and regionalizing their State consultant services in order to make technical assistance available to larger areas of the State.

Recruiting and Utilizing Personnel

The problem of the chronic shortage of professional personnel must be faced with the

Figure 2. Increase in public health workers, State and local health departments.

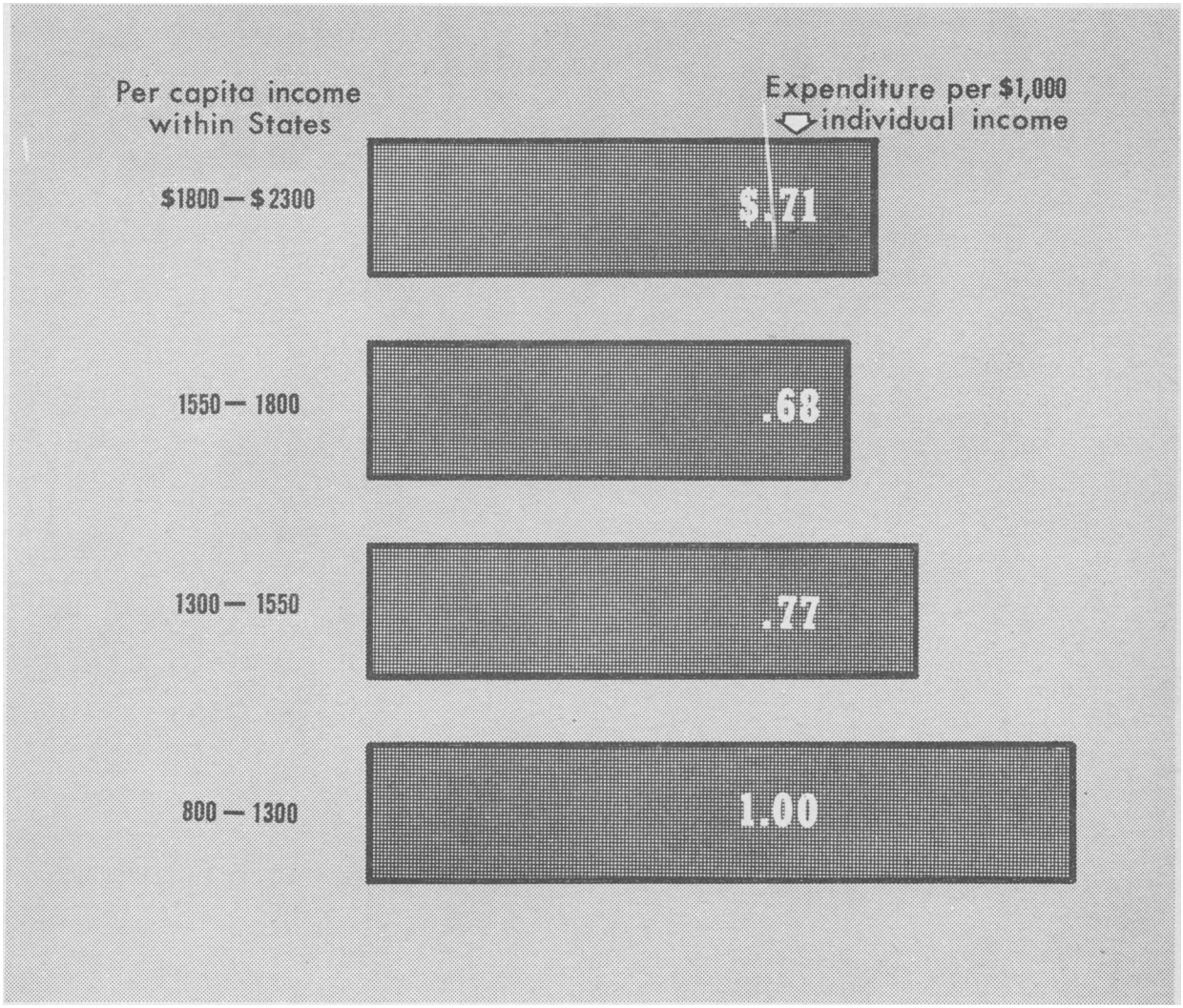


realization that there probably will not be enough personnel available to staff health departments in accordance with the accepted minimum standards. Professional schools at present are not supplying enough graduates to meet future military and civilian needs as they are now estimated (*4*). Active, imaginative recruiting will certainly help to attract desirable personnel if the challenge and personal satisfactions inherent in public health work are clearly shown. Financial rewards and opportunities for advancement, however, must be made commensurate with those of private employment if able, well-qualified persons are to be expected to remain in public service. Most important, perhaps, those who are already in the field must do the kind of job that makes public health a profession one would be proud to choose.

Here it may be well to reemphasize the fact that the professional knowledge and skills possessed by those already engaged in health work are not being fully used. A study made by the committee on professional education of the American Public Health Association (*5*) showed that many duties carried out in the past by professional personnel are being delegated to administrative personnel. However, there must be a continuing effort to relieve the professional staff of clerical and administrative duties which can be effectively performed by personnel with training in those fields.

In any plan for health services, it is imperative that full advantage be taken of all

Figure 3. State and local will to spend, in relation to financial capacity, 1952.



community resources for improvement of the public health. Part of the evolution of public health practice has taken place through the recognition of the increasing importance of the public health physician's function as a community leader and the corresponding decrease in his role as a law enforcement officer. Under such leadership the health department can act as a catalyst in bringing together the services of official and voluntary agencies for the improvement of the community health program. When the health department is able to fulfill this responsibility successfully, it may be possible to reduce the estimates of personnel needs and to extend a different sort of service to the "uncovered" areas.

The "health extension" concept of applying community organization techniques to the solution of health problems holds many possibilities. In a few places, individuals skilled in obtaining personal and community participation in public health plans and operation have worked through existing organizations and leaders to stimulate awareness of health problems. They have helped to discover and interpret the steps necessary to solve the problems, and have encouraged the needed individual and group action. Wider use of such techniques would undoubtedly strengthen the programs of local health units and help to increase the effectiveness of services available in areas without full-time health organizations.

Organizational Flexibility

A great deal has been written and spoken regarding the necessity for gearing health programs to the needs of individual communities. It is no less important to maintain the same flexibility in approaching matters of organization. For example, it is probable that not all communities will require the same pattern of organization which has been advocated in the past. It is also likely that the traditional lines of political jurisdictions may not be the best boundaries for health jurisdictions in some areas. In many cases, consolidation of existing health units will provide an organizational base broad enough to permit adequate financing. Combining the resources of several communities may also allow more flexibility in the utilization of professional personnel. Care must be exercised, however, to assure that the combination really achieves the intended purposes. Unless sufficient professional personnel—especially nurses and sanitarians—are available to staff the combined unit, the existing programs may be weakened rather than strengthened. This may happen where the geographic area is large and requires an excess of travel time for field personnel or for those expected to visit the health department clinics or offices.

Summary

Although progress in the development of local health services has been encouraging, there are still many areas where improvement is needed. Many local health organizations, as they are now constituted, cannot cope with today's health problems. This does not mean that local health departments are no longer desirable. It may mean that the present structure should be strengthened, that the organizational pattern of official health agencies should be substantially altered, or that services for the more complex public health problems should come from other sources. Certainly, any possibility of getting more or better services for less money than is now being expended should be continuously explored, and efforts to provide services for those communities presently lacking them should be intensified.

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