# The Role of State Health Departments in Medical Care

*A small group of State health officers, concerned with current and future problems in medical care, requested the assistance of the Division of Community Health Services, Public Health Service, in developing a statement on the role of State health departments in medical care. This statement, presented to the Association of State and Territorial Health Officers by its Committee on Health Services Administration, chaired by Dr. Franklin D. Yoder of Illinois, was approved by the Association at its October 1963 meeting with the following resolution:*

The Association recommends the following statement to its members as a useful description of the role of State health departments in medical care, and as a guide in determining what State health departments can accomplish in assuming their proper role in medical care administration and in the cooperative development of facilities and services with all professional, official, and voluntary agencies concerned.

## STATEMENT

### Introduction

*Definition*

Medical care, in a generic sense, refers to the organization and administration of personal health services. It encompasses the system of arrangements and institutions through which health services of a personal nature are produced and delivered to the population.

*Patterns*

The changing patterns of medical care and the technological, social, economic, and political trends which have influenced its evolution are well documented. In brief, some of these factors are:

1. Increasing technical capacity to prevent disease and to provide effective medical diagnosis, treatment, and rehabilitation.

2. Increasing specialization of health personnel and facilities.

3. Increasing size and mobility of the population and changing age composition, as well as changing morbidity and mortality patterns with increasing emphasis on the chronic diseases.

4. Increasing costs of medical care; expanding economic capacity of the nation collectively and individually; and progressive removal of economic barriers to the receipt of medical care.

5. Increasing involvement of voluntary and official agencies in financing the availability of facilities, personnel, research, and organization of health services.

*Problems*

The principal problems in medical care include the following:

1. An increasing fragmentation in delivery of services; artificial separations between preventive and curative services; and depersonalization of the patient through categorical disease emphasis and medical specialization.

2. A lack of comprehensiveness and continuity in patient care resulting from the fragmentation and depersonalization of services.

3. The maldistribution of health services and

facilities, and shortages of professional and technical personnel.

4. The absence of a defined locus of responsibility for medical care, which would be responsive to the needs and problems, capable of achieving solutions, and publicly accountable for the results.

*Governmental Responsibilities*

Official agency responsibility for health services to the public does not rest exclusively in health departments. A number of governmental units at Federal, State, and local levels have some responsibility for insuring that the environmental, social, emotional, and biological health of the population is improved or maintained. Some of these other agencies have primary responsibilities for categorical health programs, for example, autonomous mental health agencies or Hill-Burton agencies. Others include health in addition to their primary responsibilities, for example, departments of education or welfare.

Only the official health departments, however, have primary responsibility for the general health of all the people. To the extent that personal health services are less than adequate for any of the people, to that extent medical care is important to us as State health officers.

## Principles

The basic principles which should guide the role and function of State health departments in medical care include the following:

*Goal*

The goal of medical care is the provision of a continuum of high quality, comprehensive health services, ranging from primary prevention through rehabilitation, which would be available to each individual when and where he needs them, and without regard to race, color, creed, residence, or economic status, with those able to pay for medical treatment services being expected to do so.

*Leadership*

The achievement of this goal will require the dynamic interaction of private and public organizations and individuals at all levels of responsibility. Creative, professional, and responsible leadership in this endeavor is a prime requisite. Official health agencies should be prepared to assume a leadership role in mobilizing and coordinating all resources to improve the quality, availability, organization, and distribution of health services for the population as a whole.

*Relationships*

We must strive for the establishment of effective relationships among private and public organizations at local, State, and Federal levels, as well as at each level among the various units concerned with medical care. Such relationships should insure that each unit fully utilizes its skills, experience, and resources to strengthen the medical care system and contribute to, but not dominate or fragment, the direction or growth of health services. This should promote the movement of program activity and achievement to that level of responsibility which assures the most effective services, while maintaining an appropriate degree of central leadership, consultation, and coordination.

*Flexibility*

The State health department role and function should insure that the initiative for planning personal health services arises from within the States and their various communities in order that variations in existing authority, responsibility, and capability will be considered in appropriate relation to local needs, resources, and attitudes.

*Priorities*

In establishing priorities, we should endeavor to achieve an integrated balance among the substantive areas of service, research, and resource development; and should be guided by present circumstances while anticipating future progress.

*Methods*

The technical and organizational methods which we develop for any particular medical care activity should utilize and apply the latest in specialized knowledge and skills from the medical, social, economic, and behavioral science fields. The methods should, however, empha-

size program requirements rather than special interests of the individual professions in order to apply the generalist approach necessary to achieve coordination.

*Standards*

The standards of qualitative and quantitative adequacy which we develop for any medical care activity should be defined professionally, implemented realistically, and evaluated objectively.

**Functions**

State health departments have some general responsibility for seven principal functions related to medical care. The scope and type of our specific activities will vary among and within the States, depending upon variations in legal authority, organizational capacity, and historical precedents. However, we all have some degree of responsibility and capability for performance in each of the seven broad functional categories. As new legislation and administrative decisions create the authority for expanded medical care programs and activities, we will be able to use our existing functional capacities as the basis for assuming added responsibilities.

The following outline describes the general functions, and gives examples of activities which some State health departments are now or are capable of performing in each category.

*Planning and coordination.* The planning function requires: (1) the exploration of present needs; (2) their projection to the future; and (3) the assessment of capabilities and requirements to meet the obligations through the most effective use of scarce resources. The coordination function is an essential and vital part of planning, especially because a multiplicity of specialized skills is involved within an agency, as well as among the numerous agencies with which the health department relates. Achievement of the goal of comprehensive, continuous medical care demands a high degree of coordinated planning, for which we as State health officers can provide leadership.

Within the health department itself, annual and long-range planning of all activities serves to integrate medical care functions and to coordinate these functions with others of the agency. Because categorical grant programs tend to fragment medical care activities, some State health departments are developing an organizational structure with single lines of authority and administration which facilitates the integration of programs. In some instances, this is accomplished by delegating medical care responsibilities to a single unit whose chief is directly responsible to the department's director; in other cases, a deputy director is assigned to coordinate the medical care activities performed by several departmental units.

In either case, when the internal structure of the State health department defines a single locus of responsibility for medical care, the development of effective relationships with other governmental and nongovernmental agencies is greatly facilitated. We as State health officers are then better able to provide creative leadership for the coordination of all aspects of medical care within our State and with adjacent States and Federal programs.

*Collection, interpretation, and dissemination of information.* Adequate and current information is essential for effective planning. Virtually all State health departments are concerned with the collection of vital statistics, morbidity-mortality data, and other demographic information. When we analyze and interpret this information, it can serve as a basis for defining the population to be served and describing its needs. We perform a valuable service by extending these activities to the collection, analysis, and interpretation of data on the utilization of various kinds of medical care, their costs and financing, and the availability and distribution of manpower, facilities, and services. Statistical data may be supplemented with descriptions or case reports of actual programs which demonstrate how certain functions are being performed in particular situations.

Through the communication of this information, the health department performs a vital medical care function both for its own programs as well as those of other agencies. In some instances, the State health department may be the only source and channel for this information. By serving as such a medical care communications center, we can coordinate data from various sources and thus obviate the necessity for expensive duplication of efforts.

*Research and evaluation.* The epidemiologic skills of health departments are a valuable and necessary resource for conducting research and evaluation in medical care. They provide a basis for identifying the cause and effect relationships among the human, technical, and institutional factors which influence our patterns of medical care. These skills can be applied to the problems of evaluating the capacity of a system for providing services, the quality of performance in a program, and the effectiveness of the medical care provided.

The multiple professional and technical skills which we have available in our departments are well suited for the interdisciplinary approaches necessary for program evaluation, studies and demonstrations of new methods for providing services, and research efforts which can provide new knowledge in the organization, financing, and delivery of services.

State health departments may conduct, participate in, and stimulate research by others to find answers to such questions as: How do people move through the medical care system? How do people go about seeking appropriate care? How does coordination of activities affect patient movement? What is the influence of health education and other channels of information on the use of medical care? How can the quality of care be measured? How can scientific advances best be translated into practice?

*Consultation.* As State health officers, we have been charged with the legal responsibility for maintaining and improving the public's health. Communities, other governmental and nongovernmental agencies, and individuals seeking or needing guidance in health matters look to, or should be able to look to, our departments for the trained and qualified personnel capable of providing professional and technical consultation. Welfare departments, vocational rehabilitation agencies, workmen's compensation commissions, and others frequently turn to our departments for advice and consultation in the development, organization, and evaluation of their medical care programs. In some States, for example, the health department advises these agencies on equitable reimbursement rates for providers of service; or it may develop medically sound guides for evaluation of quality of medical care purchased; or it may advise on or certify the providers of services participating in the program. In some cases, we find it possible to loan professional or technical personnel to other agencies or communities when they require consultative services on a more continuing basis.

Some State health departments provide consultation to individual hospitals, nursing homes, or other community health service programs to assist them in developing needed services, improving fiscal or administrative procedures, or generally improving standards to a level which would enable the institution to qualify for licensure or other purposes. Guides and manuals which set forth uniform methods and procedures for various services, for organization and administration, personnel management, cost accounting, and so forth, are also valuable tools.

*Resource development.* State health departments are increasingly concerned with the development of manpower and facility resources for medical care. Scarcity of these resources demands the most effective use of those available, as well as continuing efforts to improve the quantity and quality of their supply.

Some departments provide scholarships or training grants for postgraduate short- and long-term education in medical care administration. Others provide residency training in preventive medicine and community health for physicians and field training experiences for medical and nonmedical administrators. In-service training is also used to retrain or advance the capacities of health department personnel in this field. Increasingly, we are assuming the responsibility for conducting seminars or workshops for the medical care personnel of other governmental and nongovernmental agencies. Institutes for administrators of nursing homes, home care agencies, and other community health services are also presented.

Administration of the Hospital and Medical Facilities Survey and Construction Program is a responsibility of the health department in most States. When this program is coordinated with activities of voluntary hospital planning associations, community health and welfare councils, and other agencies, we have an effective mechanism for developing needed resources and achieving a rational allocation and organization of scarce facilities and services.

*Development and maintenance of standards.* State health departments are vitally concerned with functions to insure that the health services provided the population meet at least a minimum standard of quality. We have responsibility for developing and maintaining standards for the quality of medical care provided or purchased by our own programs. In some instances, the standards we develop and maintain may be accepted as the basis for participation by providers of service in welfare department, rehabilitation, Blue Cross, and other programs. When such a situation exists, expensive duplication of efforts is avoided and the providers of services are spared inconvenience and conflicting requirements of multiple inspections for identical purposes.

The majority of State health departments have responsibility for examination, inspection, and licensing of health facilities; some also are responsible for licensing health professional personnel. In some States, we extend these functions to other community health services, such as laboratories, home care programs, and ambulatory services. In at least one State, the health department has been given responsibility to undertake confidential medical audits to determine the quality and availability of medical care in the State.

*Provision of services.* The scope and type of State health department activity in providing or purchasing direct personal health services varies widely among and within the States.

The equalizing role of State health departments is recognized in some States through their financing, in whole or in part, the services and medical care programs of local health units. Direct personal health services are provided to special population groups, as in maternal and child health programs, crippled children's programs, and school health programs. Some health departments provide services for persons with special diseases, such as venereal diseases, tuberculosis, mental illness, or other chronic diseases. State formula grants, Hill-Burton grants, and categorical grants subsidize such medical care activities for the population in general as areawide planning, hospital construction, multiple screening programs, specialized laboratory or diagnostic services, home care services, and others.

In those States where the crippled children's service program is administered by the health department, it may have a direct concern in providing care as well as in purchasing medical care from those providers which meet the Federally prescribed criteria for participation in the program. In a few States, health departments administer the public assistance medical care programs under contract with welfare departments and thus have either direct or indirect responsibilities in the purchase of personal health services for indigent and medically indigent persons.

**Conclusions and Recommendations**

The goal of medical care is based upon a dynamic concept which will change and adapt with new knowledge, methods, and techniques. Achievement of the goal in any one place or time is predicated upon social, economic, and political forces which, in a democratic society, are shaped and given direction by the people. The people, however, must depend upon an enlightened and competent leadership to inform them of alternatives, to guide their choice, and to implement their decisions. They expect, and have a right to expect, that leadership in medical care will come from the official agency which has responsibility for the general health of all the population.

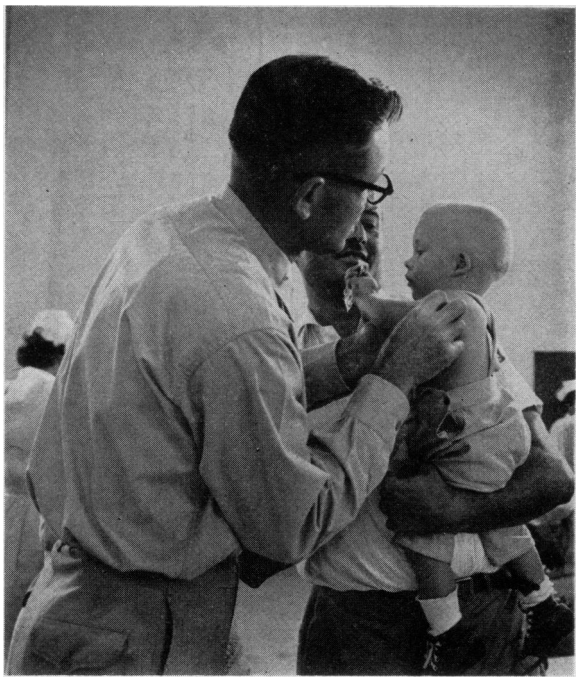
Whatever the amount and source of funds the nation collectively or individually allocates to medical care, problems of organization, distribution, quality, and administration of personal health services will remain to be solved. We in State health departments should accept our responsibilities for leadership in achieving solutions to these problems, using to the fullest extent our existing and potential resources and establishing close and effective working relationships with other governmental and nongovernmental agencies and individuals at local, State, and Federal levels.

## SMALLPOX VACCINATION

Although so far as is known, there is no smallpox in Cuba, the regulation requiring vaccination applies to Cuban refugees as to all travelers from abroad. Only a small proportion of the Cuban refugees lack vaccination. Those vaccinated by Public Health Service officers are released with others to the emergency center where they remain under observation.

Ordinarily, if a traveler from an infected area requires vaccination, he may, after inoculation, receive a surveillance order requiring him to appear before a health officer each day for a maximum of 14 days; or, after vaccination he may be isolated for a maximum of 14 days if there is a possibility that he was seriously exposed.

Outbreaks of smallpox in Sweden and Poland in the past year have alerted the Public Health Service to the hazard of smallpox carried by travelers. Both the Swedish and Polish outbreaks were traced to persons who had returned from South Asia.



*All Cuban refugees requiring vaccination, including this small boy, are vaccinated.*

*A Spanish-speaking employee (right) of the Catholic Welfare Agency interprets for a quarantine inspector checking for recent evidence of vaccination.*