Changes in Organization and Services of Local Health Departments

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A RECITAL of the need for changes in organization and content of public health services is commonplace in public health discussions. Population growth, shifts in age distribution, and changes in morbidity patterns are referred to as factors that are producing or should produce changes in local health department organization and services.

That there has been some change is shown by the following national data on personnel in local health departments, taken from published (*1*) and unpublished material of the Public Health Service:

	1947	*1960*
All employees	29,589	44,007
Selected personnel categories:		
Physicians	1,422	1,402
Public health nurses	9,608	14,384
Sanitarians	5,257	6,932
Clerks	6,472	9,878
Social workers	54	417
Psychologists	41	104
Physical therapists	73	158

The change, however, has not all been favorable. From 1947 to 1960, the total number of physicians in local health departments decreased. Although the number of social workers and psychologists increased, there were in 1960 still only 521 for all local health departments, hardly an adequate staff to provide community mental health services. Public health nurses at the local level increased about 50 percent, but a recent review in Pennsylvania (*2*) shows that school health nursing services absorbed most of the increase in that State with little change for other official agencies and a net decrease in voluntary agencies.

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Examples can be found of changes in administrative structure, notably the combination of city and county health departments in Miami and Dade County, Seattle and King County, and Pittsburgh and Allegheny County. But in the broad national picture, general observation, supported by the personnel data quoted, suggests that State and local health services are provided by staffs of approximately the same professional composition giving much the same range of service in the same kind of State and local agency.

In the future, however, major change in structure and function of local health agencies appears more likely as changes in medical care financing and metropolitanization add their force to the other factors already cited. All the forces tending to produce change have complex interrelationships. Consideration of several factors together and of their effects on several agencies complicates discussion. But the increase in the number of the aged, for example, influences developments in medical care, and health departments are or should be working with planning, welfare, and other official and voluntary agencies in community health programs.

Public policy decisions necessary to establish or change health services will be made by legislators and others in a community setting where health needs compete with other demands. The public policy issues require that the public health worker take account of such factors as financial aspects of medical insurance or industrial development in metropolitanization. The primary responsibility and unique contribution of the health worker is, of course, to identify health needs, develop programs to meet them, and interpret the health implications of

various actions to specialists in other fields and to legislators. This contribution is likely to be most effective if the relationship between the public health needs and these other factors is taken into account.

Medical Care Changes

Some architects maintain that in building design "form follows function," and for health services it is important to ask whether major changes in functions can be expected. Change in financial and administrative patterns of providing medical care has the greatest potential to change existing health services. Federal and State medical care legislation could be most dramatic, but legislation is not the only factor which could produce change. There will also continue to be medical care developments in union contracts and in Blue Cross and other insurance plans. In the United States, the medical care complex of hospitals, private practice, medical insurance, drug manufacture and distribution, all together is big business. Greater government involvement which may have a minor effect on the medical care complex as a whole could exert a major effect on structure and function of local or State agencies.

Government responsibility could increase even though Congress were to refrain from encouraging medical and hospital services. State legislation or regulation, for example, can be expected to increase government responsibility in supervision of insurance plans. State insurance commissions are becoming progressively more critical in their review of medical care insurance. A number of States, Pennsylvania among them, have recently undertaken surveys of public and private hospital costs (*3*) and are hoping to develop programs for control of costs. If change were to be restricted only to fiscal management of medical care insurance, there would be little or no effect on health agency organization. But the increasing concern to control costs must ultimately result in increased interest in medical care quality and organization.

The question, Why does this program cost so much and how can costs be reduced? may lead, for example, to adoption of the policy that prescriptions state the generic or chemical name for a drug rather than the proprietary or patented name. But much more important consequences follow from such cost-related questions as, Are we making the most economical and effective use of the various medical resources in the community? It is often possible to choose between two or more different medical care facilities to meet the needs of the individual patient. The range of facilities for consideration obviously includes ambulatory care at a clinic or office, use of a bed in a general or specialized hospital, home nursing care, inpatient or outpatient rehabilitation unit services, and placement in a nursing home. Action based on an evaluation of cost and patient benefit of the various facilities for patient care could not only lead to shifts and developments in the facilities themselves but also to executive reorganization of government agencies involved in medical care administration.

If medical care administrative responsibilities are to include interest in diagnosis of disease and clinical management of patients, the health department, the welfare department, or the insurance commission which develops the program must have appropriately trained clinical and related professional staff. And, of course, the public health worker with his community orientation will be required in medical care administration quite as the epidemiologist is required to complement the clinician's role in communicable disease management.

But whether as a result of concern for costs or of legislation based on other considerations, or for whatever reason, change in community policy on medical care can be expected. New medical administrative responsibilities for government will not, of course, come in a neat package to be added to some department. Rather they will present tasks of development, complicate existing manpower needs, and shift patterns of relationships among government departments and between them and medical and other community groups. Present American practice shows no clear-cut indication as to the department of government to which administrative responsibility for medical care is to be assigned. One plan which is of distinct interest as a possible administrative mechanism is that developed in the New York City program for medical care of welfare recipients.

In essence the plan provides for a sharing of medical policy decisions by the health and welfare departments through a jointly supported staff headed by a physician appointed as deputy director in each department (*4*). Such a mechanism has the advantage of making available medical and public health knowledge to the welfare department, which in New York as in most other States has major governmental fiscal responsibility in community medical care programs.

The effect of medical care change on the pattern of administration is further complicated by concurrent changes in other medical programs. There are other needs for the aged having an effect on the form of health services; for example, the need for development of screening programs for early detection of chronic disease and the need for nursing home regulation. Among only a few of the most important other concerns receiving increased community attention and currently leading to new program developments are mental health, accident prevention, and addiction control. As with medical care, it is by no means conclusive what government agency is most appropriate to develop these new services. For example, community mental health services may be conducted by either State or local health departments, or departments of welfare, or a separate mental health department. Here again no matter what specific government agency is assigned principal responsibility, that agency must provide clinical medical judgment, epidemiologic knowledge, and skill in community administration.

To discuss only "new" functions, moreover, is not adequate. The basic public health programs of communicable disease, maternal and child health, and environmental health are not less important in determining administrative patterns because they are long established. The past stability of these programs in considerable part reflects their value to the community. The public health administrator must also be concerned now as in the past about the community health protection offered by these programs. To prove the point, it seems that deemphasis of venereal disease control in the early 1950's resulted in some loss of effective control. Now efforts must be made to reestablish the earlier trends of declining incidence of these diseases. If we are to eradicate tuberculosis, control efforts for this disease must be intensified. And, of course, this list of public health functions can be extended. In total, these functions are a conservative force in maintaining present administrative and government patterns. But the point is that a principal determinant of the pattern of service will be the functions which are to be performed.

Metropolitanization

The second major influence likely to produce change in health service patterns is the increasing concentration of population in metropolitan areas. It would be surprising indeed if a social change of this magnitude were not to influence health needs and health services (*5*). H. G. Wells, in 1903, discussed suburban development in Great Britain and wrote an eloquent statement of complaint which could be substituted with little modification for current American writings. Typically, Wells suggested a super metropolitan government. He wished for all of London to be consolidated into a single legislative and executive unit which "would replace county council Board of Guardians, urban and rural district councils and all the rest of them all together" (*6*). Fortunately, however, publications have begun to appear which offer a more sober appraisal and more limited, but probably more practical, recommendations for action. Notable at the national level is the report to Congress, "Government Structure, Organization and Planning in Metropolitan Areas" (*7*) and at the State level, the report by the Rutgers Bureau of Governmental Research reviewing public health legislation in New Jersey (*8*).

A review of voter response to proposals to establish metropolitanwide government shows that such proposals are usually defeated. On the other hand, for several decades the electorate has generally accepted limited special function metropolitan units for water, sewage, and mosquito abatement. Fragmentation into many municipal units is deplored, but it is the mechanism being used as the legal machinery of government in metropolitan areas.

Areawide reorganization is being tested in a few localities, such as Miami and Dade County,

and very likely other "new" government machineries will be tried. However much suburban fragmentation may be deplored, it would appear that the existing pattern of multiple municipal and special function units will continue for some time. These units individually or together will be the local functioning legal powers of metropolitan government.

The existence of many municipalities in a single metropolitan area is by no means always an obstruction to metrowide action. There are, to be sure, metrowide needs which cannot be met by individual municipalities, but cooperation between metropolitan municipalities is in fact not unusual. Experience with committees of municipal officials shows that such groups can often determine municipality response in the same way that conclusions of standing legislature committees are often accepted by a legislature without further debate. Furthermore, it is a basic maxim of public health that groups affected by public health programs should participate in developing public health policy. The central city or suburban municipal unit has a number of advantages as a mechanism to provide community participation, including the unique advantage of possession of legal authority.

There is a preoccupation with bigness in metropolitanization. But how often does one deal with an entire metropolitan area as a single unit? Is there not a practical maximum size as well as a practical minimum size for public health administrative units? My own experience suggests that it is difficult to administer standard public health services from a single central headquarters when the population served exceeds 400,000. In Los Angeles County, Pittsburgh, and Seattle, administrative health districts have been formed with populations of between 200,000 to 400,000. It is not intended here to state definitive conclusions on population size and patterns of decentralization. But breaking up a centralized program in a city of more than half a million population is as deserving of attention as centralizing planning for a central city and its politically independent suburbs.

The basic legal position of the State in the American governmental system provides both a greater responsibility and a greater opportunity for State agencies than they have so far exercised in metropolitan government. Legislative and administrative mechanisms already exist which would enable States to influence development of needed metropolitanwide services. For example, State agencies could insure greater cooperation in metropolitan areas by requiring local officials to coordinate planning before applying for State or Federal financial grants-in-aid, a recommendation which has been formally proposed to Congress by the Advisory Commission on Intergovernmental Relations (*9*). To be fully effective such a program requires that the State or Federal agency make a policy commitment and devise a specific plan for the kind of metropolitan government that it wishes to see developed. There is a need to decide: What municipalities in what delineated area would be required to participate? To what municipality or group of municipalities should some function be delegated?

As another example, State agencies could further metropolitanwide programing by delegating to local agencies functional responsibility for State programs conducted within the metro area. In many instances State responsibility is delegated to local health departments as a regular policy. Extension or modification of such arrangements could insure that the delegated service is performed for the entire metropolitan area. In particular, greater attention may be given to use of formal contractual agreements between various governmental units within the metropolitan area, and between municipal jurisdictions and the State and Federal governments. Such contracts have been used effectively to achieve coordination of public health services in Los Angeles County and in St. Louis County, Mo. The formal contract deserves more consideration by health agencies not only as a technique of coordination within counties but also for use in Federal-State-municipal efforts to develop metropolitanwide services.

As one turns to consideration of mechanisms other than charter revision, it is apparent that there are indeed a variety of legislative and other mechanisms available to modify existing health service patterns in the metropolitan area. New Jersey, for example, provides three different mechanisms for establishing local health units, and the Rutgers report realistically en-

dorses selective use of these several legislative methods to modify patterns of health services. There are then easily identified opportunities for State action to improve metropolitan area coordination.

Certainly, of course, municipal or county governments also must accept responsibility for program planning and action. There is dissatisfaction with the initiative taken by local units, and it is frequently assumed that the deficiency stems from a lack of a metropolitan area government. The single greatest obstacle to program development at the local level, however, is not organizational but financial. Review of tax revenue indicates that "cities are getting a much smaller share of the total tax dollar than previously. Before World War I, local governments captured close to 60 percent of the tax dollar; today, they get less than 20 percent" (*10*). Local tax problems are such that increases in local appropriations to finance new kinds of programs frequently cannot be obtained. This fiscal aspect of Federal, State, and local relationships is receiving increasing attention, and there have been recommendations for change. It is important, however, in this discussion to recognize that this fiscal pattern is severely limiting so far as development of local initiative is concerned. The grant-in-aid programs of the Federal and State governments in part redress the disadvantage, but the existing tax structure provides real obstacles to local staff and local program development.

Similarities and Interrelationships

In general, as with many of the important public policy issues in medical care, the organizational and fiscal questions reviewed for metropolitanization are not decided within health agencies. It is significant that these two major, presumably unrelated, community developments—medical care and metropolitanization—are similar in their implications for health agency change and the difficulties they present to legislators or health executives.

For neither of these is it clear which department of government is to be assigned responsibility. For medical care should it be health or welfare? In housing programs what shall be the relationship between urban renewal agencies, and planning, and health departments? Housing programs have their legal base in the relationship between health and housing. But a decision for some neighborhood to proceed with a housing rehabilitation program or to raze and reconstruct requires not only knowledge of housing status but of community needs for transportation, industrial location, and other factors of planning and urban design having little relation to health. Both medical care and metropolitanization are difficult to delimit as they are considered in program planning. Medical care and aging are interrelated. In metropolitanization, there is the interrelation to the environmental health program. It is noteworthy that the first major reorganization of the Public Health Service in 20 years followed a review of that agency's programs in environmental health (*11*).

Conclusions

For both medical care and metropolitanization, the extension of health concerns into associated social or economic processes may seem to diffuse or obscure responsibility for the health agency or official. But in both situations, the function of the public health worker and the primary role of the health official is to focus on health. There are agencies of government better equipped than the health department to manage the financial aspects of medical care, as there are also other agencies of government better equipped to deal with planning and urban renewal.

Changes in public health agencies and programs are inevitable, but the changes can be expected to result in greatest public health benefit when they are based on adequate health data.

Planning for health service change requires that the metropolitan area be developed as an important dimension of interest in epidemiology. Information regarding health relations of housing, industralization, population density, and other features of metropolitanization is necessary in public health administration. And for medical care there also is need for reorganization of known material and development of new kinds of health data. Such data will provide the best guide to the changes to be recommended for health services.

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