Providing Adequate Public Health Services

A TALE OF TWO CITIES

KENNETH I. E. MACLEOD, M.D., M.P.H.

Dr. Macleod draws on his day-to-day experiences as commissioner of public health of Worcester, Mass., and former commissioner of health of Cincinnati, Ohio, to plead for the primacy of the local health department in an era of bigness and centralization. The paper is based on his speech at the New England Public Health Association meeting in Boston on June 15, 1967.

AS A LOCAL health officer, I define public health in the broadest sense, encompassing Disraeli's dictum on public health, Winslow's all-embracing definition, and the World Health Organization's interpretation. In other words, I define public health as all health.

I have not hesitated, therefore, to nose my way into health situations and discussions in which angels might fear to tread. I can get quite upset to learn that health planning or health developments are afoot in which I have not been consulted.

Perhaps this message got around in both my cities, Worcester and Cincinnati, because I have been consulted on most public health matters, although the advice I may have offered at a particular time was not taken. For this reason I have found myself on the boards of many health agencies and occasionally on the boards and committees of welfare agencies.

In Canada and in some States health and welfare go hand in hand. I think that this is good. In the United States at the national level, health, education, and welfare go hand in hand, which I believe is logical. To the outsider it looks as if this arrangement works well enough; yet one cannot wear comfortably a hundred hats at once. Some selectivity is necessary.

I believe that communities have their own blessed individualities and, indeed, peculiarities which make the local situation, often complex but always interesting, exciting and challenging. It is for this reason that I have opposed the wholesale takeover of public health functions by the State, primarily because the State may not feel as urgently the need for action to correct a local problem as citizens on the local level might wish. I agree, however, that the State will be more objective and may act when localities will not act. But there are other ways for States to achieve this same desirable end, such as through setting minimum standards and enforcing them.

The Challenge

In regarding public health as all health and not merely a selected series of activities approved by the public health pundits and the American Medical Association, I found in each of my cities very special situations which required very special approaches for their betterment.

In environmental health, for example, there has been in each city a different parceling out of responsibilities within the city's official family. In Cincinnati, where interest in the development of an adequate housing code stemmed directly from the enthusiasm of the city's first health officer, Dr. William Clendenin, the major responsibility was given in time to the division of housing in the department of safety. In recent years the city health department has had a relatively small responsibility related only to the encouragement of good sanitation. Similarly in Cincinnati, the division of air pollution control was placed in the department of safety, the theory being that the engineering phase takes precedence over the health aspects.

In Worcester, however, prompted by the passage of a State law in 1954 encouraging health departments to secure housing fit for human habitation, housing has been very much a primary concern of the Worcester Department of Public Health. Air pollution control is also a major activity of the health department's bureau of environmental health.

In each city, however, problems have arisen in securing a true coordination of effort between several departments. Indeed, not until the civil rights movement got underway in Cincinnati did the safety department, itself under new direction, recognize the need to coordinate efforts with the health department in enforcing the housing code. In Worcester, we are still trying to secure a meaningful and happy relationship between the buildings and fire departments on one hand and the law department on the other. We hope through new approaches to secure a truly cooperative effort under the overall direction of the city manager.

Enforcement

Trends in enforcement of reasonable public health laws seem to be changing. Formerly, law enforcement was relaxed and permissive. The pundits advised securing compliance through sweet and honeyed words. They called the process health education. Without becoming a haranguer on this point, I believe that enforcement within well-defined limits is also most educational.

The subject of enforcement leads me to reflect on the need for better reporting of designated diseases and conditions, communicable and otherwise, because both physicians and hospitals still cooperate only indifferently in reporting these.

When I first became a district health officer, I was given the book of health laws of the Commonwealth of Massachusetts to read. I remember being impressed with the comprehensiveness of these laws, especially those in chapter III, but when I got out in the field I found out that the words were one thing, the performance another.

I remember an outbreak of diphtheria that occurred in a small town in my district. The town's physician, who had a private vendetta with the local board of health, not only failed to report the cases to the board, but failed to notify the district health officer. I suggested to the physician then in charge of communicable disease control that an example could be made of the physician, and reminded him that an example would have been made of him in Britain. I was told quite politely and firmly that "we just don't do things that way in this country." I still wonder why, because it surely seems to me that we make of the law, by not insisting on compliance, a façade and a pretense.

In Cincinnati I ran into a serious instance of nonreporting. By chance, I found out that some physicians were not only not reporting their patients with active cases of tuberculosis but were permitting them to work. A woman physician allowed her elderly patient to continue working in a lumberyard office. When I telephoned the physician she agreed that her patient was infectious to others, but declared that the patient would be retiring in 6 months and that she, personally, saw no harm in permitting her to work out her time. I told her that unless she got her patient out of that office and isolated within 24 hours, I would be the only person standing between her and the many suits for damages which could come from the other clerks and staff in the office. She complied.

This incident prompted me to bring the situation before the local medical society. The society gave me complete support in getting the cooperation of the medical profession both in reporting and in caring for tuberculosis patients in the city. The results were threefold.

1. We had an "epidemic" of tuberculosis that year, more than 100 additional new cases being reported.

2. We established an eradication program which has been reported elsewhere.

3. We secured a much better program for the treatment and care of patients in and out of the sanatorium.

State and Local Cooperation

From my experience there is a real need for communication between, and cooperative efforts by, official State and local health agencies. On paper, in both Ohio and Massachusetts this cooperation exists; in reality, the State and local agencies seem at times to be playing tug-of-war as to which agency does what and why. I can document this, and these examples give some insight into State and local agency conflicts.

In Ohio, the State health department, responding to pressures from the milk interests, and with almost no consultation with local health departments except to hold a number of "we-tell-you-so" type of regional meetings, was party to the enactment of a law which practically speaking pre-empted the entire field for licensing and inspectional control of milk production and processing. The State was, in my opinion, not equipped or staffed sufficiently to do the job; it had to depend upon the strong local health departments continuing to do the day-to-day work. But the State health department through this legislation depleted the power of the local health department and, due to those same pressures, the State set the fees which the milk interests had to pay to the local health department for "quality control" in dairy farms and processing plants at such a low level that, in effect, the local health departments lost considerable revenues. The law was passed in the name of better public health. The real reason was obvious; the industry obtained what it had been seeking for years, the driver's seat, through a uniform but essentially weakened statewide milk control program.

Again in Ohio, the State tried to pre-empt the function of nursing home licensing and inspection, and again, in my opinion, without the tools to do it adequately. If I had not, through a floor vote in the State legislature, succeeded in securing the rights of the local health departments which had adequate local programs, by means of a certification clause, Cincinnati's otherwise excellent program of enforcement and licensing of nursing homes would have been replaced by a weaker statewide program.

It seems a sorry situation when otherwise well-intentioned State health officials allow themselves to be pressured by forces of political interest and by do-gooders in women's groups, in some voluntary agencies, and in too many of the teaching centers. The people in those groups often have no practical knowledge of the realities of local situations. For example, conditions in the great population centers cannot be compared with conditions in the more sparsely populated rural areas. Yet too often the needs of one or the other have urged upon the State do-gooding legislation for the improvement of particular situations which often result in impractical and ineffective programs.

In Massachusetts legislation regulating child day care centers was enacted which, in my opinion, is not doing the job its proponents believed it would do. Worcester, before the law was passed, had 25 day care centers under the eagle eye of the local health department. Now there are only nine. Where are the children? Many are cared for in places that are completely uncontrolled. We shall have to do something about it, and I intend to.

There are other illustrations in this State. Control of water pollution was taken away from both State and local health departments. Worcester's citizens fume about a pond badly polluted with industrial wastes, but we can do nothing about it because it is beyond our present jurisdiction. The State, so far, has done nothing about it, and the State's department of natural resources does not even answer our letters. (Since this speech was given, however, new cooperative action has been secured, with happy results, as a consequence no doubt of our representations.)

There are those who believe that in this era of bigness—big government, big business, and big education—bigness and centralization are cure-alls. I do not. When a program is nationwide or Statewide, the mistakes often cause damage even more widespread than when the

local jurisdictions are left with the responsibility which was rightly theirs.

The faults of overlarge organizations were pointed out in 1942 by Sir Alexander Cairncross, now head of the economics division of the Treasury of the United Kingdom. His statements still apply today (*1*).

> The bigger an organization grows, the more readily it falls a victim to the diseases of bigness—indecision, apathy, routine and red tape, personal intrigue, confusion of counsel and responsibility. It is difficult to delimit functions; there is therefore duplication of effort, waste of time in establishing responsibility, elaborate consultation, petty sabotage. It is necessary to preserve uniformity, partly as an economy in bureaucratic intelligence, partly to forestall charges of discrimination; there is therefore restricted discretion, irksome adherence to regulations, disregard of personal circumstances. This is just as true in a large business as in a government department.

I would make a strong plea for a return to true State and local cooperation. There is a real need for it, especially in local health matters.

There are many other illustrations of the dangers of centralized power, but none is better than the example of the British National Health Service. It was also to be a cure-all; it is not. A cynical little book "A New Look at Medicine and Politics" by Enoch Powell, Britain's former Minister of Health, explains why (*2*).

> From the point of view of the recipients (patients) Exchequer money is for all practical purposes unlimited . . . the figure on the supply side of the equation (on the other hand) is fixed at any particular time by those complex forces that determine the State's decisions on expenditure. With this figure demand can be brought into balance. Virtually unlimited as it is by nature, and unrationed by price, the demand has nevertheless to be squeezed down somehow so as to equal the supply. *In brutal simplicity, it has to be rationed.* . . .

Some Special Problems

Because provision of medical care is presently in a mighty state of flux, an appalling complex of problems faces public health workers. In Cincinnati, so fragmented are the services and so flimsy the relationships between the providing agencies that patients often have no idea where to go. Agencies which would be better out of business find new reasons for continuing. They obtain the funds to do so from the Federal Government through grants which seem to be dished out wholesale. Even two clearly related agencies, the tax-supported, university-affiliated general hospital and the city health department, until recently handled every transaction between them on a crisis basis—by telephone or messenger. They lacked any planned relationship. Such a relationship now appears to be developing with a change in leadership in the medical center and the immediate pressures of certain federally funded maternal and child health programs. A tenuous footbridge has been erected over which traffic between the two agencies is increasing.

In Worcester, although in theory titles 18 and 19 of Medicare have opened the door for medical care to most, if not all, of the eligible poor and to the medically indigent, in practice the difficulties in communications, in actual availability of services, and in health manpower are serious. It is one thing to say "go to a private physician" and another to find one willing to take the patient on his list. Moreover, physicians who do take on patients do not get paid promptly, due to a natural lag, and they become even more suspicious of the entire set-up.

Congress may enact wonderful-seeming legislation, but the firing line is at the local level. It is not always easy to make the adjustments necessary because of differences in localities.

Teaching and the Health Department

At least in the larger centers, the health department has some relationship to the training of health personnel. The relationships with the teaching centers in Cincinnati, particularly with the University of Cincinnati's Medical School and its College of Nursing and Health, have been strengthened recently. Medical and nursing students come to the health department for field experience. In the summer months medical students have taken positions and done research under the direction of the department's staff.

I hope to see a similar relationship develop between the new medical school of the University of Massachusetts and the Worcester health department. I believe that medical schools have a responsibility also to aid in the planning and development of sound community health programs. I understand from a personal communication that the dean of the school, Dr. Lamar Soutter, is of a similar mind.

Official and Voluntary Agencies

Somewhere else I have described health and welfare in the United States as "a many splendored but many splintered thing." I still believe that; I think also that there is a need to cease the splintering of responsibilities and to meld or weld together more and more health and welfare agencies. I agree that the time is not ripe for the forced disappearance of either particular official or voluntary health agencies. I think, however, that the rationale for their existence—which agency does what and why—should be re-examined at national, State, and local levels. With the availability of more and more Federal grant money and of third-party payments, many voluntary agencies continue to grow.

In Cincinnati an almost defunct voluntary health agency providing maternal and child health care services has found new reason for existence and new federally derived resources to make its existence possible. Yet the official agency finds it difficult to carry its expected load because of lack of staff and funds. The private agency has little difficulty in getting volunteers, specialized staff, public plaudits, and now money.

So in Worcester, the Visiting Nurse Association has gone from strength to strength both in money and support as well as in quality of staff, but our little nursing force in the health department remains at the same level it was nearly 30 years ago. I have established a committee to examine the relationships of the two programs.

Perhaps a realist would accept the closing down of the nursing service in the official agency and would seek and obtain the same service from the VNA, by contract. Whether this is feasible is nevertheless wrapped up in origins, traditions, legalisms, and other factors, but we are looking into it. All over the United States, locality after locality and State after State will have to face such problems and work for a better division of these overall responsibilities.

The Future

In the forefront of concern for the future are the environmental needs of the United States, especially our polluted air and water. The skills necessary and the study required to deal with them offer new challenges to the environmentalists. It is not surprising therefore that in Worcester, while the nursing service in the health department remains at the same level, the environmental health services are increasing in scope and a greater number of persons are engaged in this work.

Despite the fears I have expressed about the dangers of centralization, in my crystal ball I see more and more centralization as the order of the days ahead, with the Federal Government probably pre-empting the field in both air and water pollution.

Irrespective of these trends, I see also a great deal of sense in the regionalization of public health programs with the strengthening of local health services where they can be strengthened, the States providing subsidies, and both taking the responsibility for localities which either cannot or will not supply the services or meet the needs. This formula I would encourage and would hope will be encouraged by those in a position to make the ultimate decisions.

The fact that highly centralized, State-managed programs will vary just as locally established and locally managed programs must vary was clearly brought out to me when I visited the Soviet health exhibit in Cincinnati a year or two ago. The chief exhibitor agreed that, although on paper the services in Siberia were of the same order as those in Moscow or Leningrad, in reality they could not possibly be of such high quality, because the staffs in the big centers were so much better and the necessary resources were immediately to hand.

Conclusion

Whether a better public health day will dawn depends on so many factors that it is anyone's guess where we'll be in the year 2001. But if we do not secure better control of population growth and supply the real needs of the people, we may well have passed the zenith of human progress. Nevertheless, I call myself an optimistic pessimist, because there is much beyond the horizon of which we cannot reckon now.

REFERENCES

(*1*) Cairncross, A.: The higher civil service after the war. Public Administration 20: 16–67 (1942).

(*2*) Powell, J. E.: A new look at medicine and politics. Pitman Publishing Company, New York, 1966, p. 37.

Public Health Service Staff Appointments

William R. Berry has been appointed director of the Data Systems Development Staff, Office of the Surgeon General, Office of Administrative Management. This staff was established as part of the Public Health Service reorganization on January 1, 1967.

The primary responsibility of the Data Systems Development Staff is to plan, develop, and implement a management information system throughout the Service which will assist the Office of the Surgeon General in program planning, directing, and controlling the Service's activities.

Mr. Berry, who received his bachelor degree in business administration from the University of Maryland in 1951, worked in private industry for 10 years in the field of modern information technology. He began his career in data automation in 1957 with IBM. He was employed by the Electronic Data Processing Division of the Radio Corporation of America from March 1959 to February 1966. During the last 3 years of this period he was branch manager in charge of RCA systems design operations in the District of Columbia, Maryland, Virginia, and portions of West Virginia. Mr. Berry was Federal program manager for the MAI Equipment Corp. of New York from February 1966 until his appointment with the Service.

Dr. James E. Banta has been appointed director of the Public Health Service's Office of International Health. He succeeds Dr. Charles L. Williams, Jr., who is being detailed to the Pan American Health Organization. Dr. Banta was formerly chief of the office's Technical Resources Staff.

The Office of International Health advises the Surgeon General on international health activities and programs. It develops Service policies on relationships with bilateral and multilateral health agencies and, with the Department of State, participates in formulating national policies on international health.

Born in Tucumcari, N. Mex., on July 1, 1927, Dr. Banta received his medical degree from Marquette University School of Medicine in 1950. In 1954 he received his master's degree in public health at the Johns Hopkins University School of Hygiene and Public Health. After serving in the Navy, he joined the Commissioned Corps of the Public Health Service in 1960. Dr. Banta served in the Heart Disease Control Program of the Service and in the Peace Corps' medical program, first as deputy director and later as director.

Dr. Banta is a fellow of the American Association for the Advancement of Science, American College of Preventive Medicine, and American Public Health Association. He is a member of the Association of Military Surgeons, New York Academy of Sciences, and American Medical Association and a diplomate of the American Board of Preventive Medicine.

Dr. Charles D. Flagle has been appointed special assistant to the Surgeon General for health applications of modern technology.

Dr. Flagle will coordinate activities of the Public Health Service related to the application of modern systems analysis, computer, and communications technologies to the delivery of health services. The Service today supports approximately $20 million worth of research to improve the delivery of health services by using modern technology in such fields as automated laboratory activities, multiphasic screening, hospital information systems, and computer-aided diagnosis.

Dr. Flagle is on leave of absence from the Johns Hopkins University where he was professor of public health administration, School of Hygiene and Public Health, and a professor in the department of operations research and industrial engineering. He was among the first persons to apply the techniques of operations research to medical and hospital care; in 1956 he became director of the Operations Research Group of the Johns Hopkins Hospital.

Born in Scottdale, Pa., Dr. Flagle received his B.S. (1940), M.S. (1954), and Dr. Eng. (1955) degrees from the Johns Hopkins University. Among other assignments he has served on an Operations Research Office Study for the U.S. Army; as a member of the Health Services Research Study Section, National Institutes of Health; on the Council on Education and Research of the American Hospital Association; and as a visiting associate professor at the Applied Mathematics and Statistics Laboratory, Stanford University. Dr. Flagle is also a consultant to the California Department of Public Health and the Veterans Administration.

phr synopses

SCHWARTZ, JEROME L. (Institute of Social and Personal Relations, Berkeley), and DUBITZKY, MILDRED: *Expressed willingness of smokers to try 10 smoking withdrawal methods. Public Health Reports, Vol. 82, October 1967, pp. 855–861.*

The responses of 386 male smokers aged 25–44 years who answered a questionnaire on smoking were analyzed to determine which methods the men would be willing to try to help them give up cigarettes. Although the great majority of these smokers were concerned about their smoking and wished to quit, many of the 10 methods listed received little support. The methods involving lectures, counseling, groups, and public health clinics received the least positive response. The most popular methods—receiving instructions on how to quit, watching a television series at home, and taking medication—were those which required the least activity and involvement on the part of the subjects and were self-administered (as opposed to requiring the aid of professionals).

Subjects who found many methods acceptable gave somewhat different responses from those who were willing to try only a few, but the most popular techniques were the same for both groups. Of various other factors investigated through the questionnaire, those measuring motivation to stop smoking (attitudes toward smoking, concern about smoking, desire to quit) were most strongly related to the number of methods rated acceptable by the respondents. The results are discussed in terms of their possible significance for planning anti-smoking campaigns and offering withdrawal methods to the general public.

WYLIE, CHARLES M. (Johns Hopkins University School of Hygiene and Public Health): *Measuring end results of rehabilitation of patients with stroke. Public Health Reports, Vol. 82, October 1967, pp. 893–898.*

Montebello State Hospital admitted 1,223 patients with cerebrovascular accidents during 1956–64. Of these, 1,025 patients were studied to determine the validity of the Barthel index in describing disability in stroke patients.

Based on values of 5, 10, or 15 points for each activity, the index allows 0 points for helpless patients, a maximum of 100 points for those performing 10 basic functions without help, and intermediate scores for various states of disability.

The total score was shown to be a valid reflector of disability in several ways. As the average score of newly admitted patients rose, (*a*) their rate of immediate death fell, (*b*) the numbers of patients discharged alive and improved increased proportionately, and (*c*) patients with high initial scores were more rapidly discharged than those with lower scores.

Average age of all newly admitted patients was 63.8 years, their average initial score was 42.5, and scores of older patients usually were lower. White patients were more numerous, older, and usually had higher scores than their nonwhite counterparts. White women were older and had lower scores than white men. Among nonwhite patients over 65 years, women had higher scores than men.

GETTING, VLADO A. (University of Michigan School of Public Health): *Michigan community health services study. Public Health Reports, Vol. 82, October 1967, pp. 925–932.*

The Michigan Community Health Services Study, begun in 1963, is financed by grants from the W. K. Kellogg Foundation and the Public Health Service. Participating in this study are 246 persons classified as "influential persons" or "decision makers" organized into one statewide and six regional task forces. Each task force has studied health services in its geographic area. In preparing their reports, the task force committees averaged seven meetings and held many subcommittee meetings. The committees studied local and State health departments, other official agencies concerned with health, voluntary agencies, medical services including hospitals, nursing homes, and home care. Provisional reports with recommendations have been submitted to the statewide committee which has prepared a consolidated report.

Experience in Michigan indicated that it is possible to get top decision makers and influential persons in various social-action fields to participate in comprehensive studies and plans to improve regional and statewide health services. These persons will take an active part if they have a meaningful role which leads to action.

The State subsidy to local health departments has increased 300 percent. Members of committees have supported pending health legislation in Lansing and in Washington. For the first time, Michigan has full-time health departments in all counties. As a demonstration project, a regional office of the State health department is now operating in the Upper Peninsula.

phr synopses

CONSTANTINE, DENNY G. (Naval Biological Laboratory): *Bat rabies in the southwestern United States, Public Health Reports, Vol. 82, October 1967, pp. 867–888.*

Data on rabies observed in bats in California, Arizona, New Mexico, and Colorado for periods from 3 to 12 years were examined. Diagnoses of rabies were confirmed by the fluorescent antibody or serum-virus neutralization test.

Rates of rabies virus infection in clinically normal bats usually were no greater than 1 percent in resident bats but 2 to 3 percent in migratory bats. Highest rates were detected in autumn. Available evidence does not support the belief that bat rabies mortality has increased since rabies in bats was discovered in the United States. When mortality was examined with allowances for annual activity patterns of the hosts, a gradual increase in mortality was evident from spring to autumn. Considerable nonrabies mortality was observed, particularly in migratory bats.

Persons who encountered live bats infected with rabies experienced bites in a ratio of 14.2 bites per 100 live bats. Contacts between pets and bats occurred in a ratio of 29.8 pets per 100 infected bats. Bite rates were highest for bat species of smaller sizes, species making the few confirmed, unprovoked attacks.

Captive bats died of rabies infection after periods as long as 90 days, indicating that migratory bats would have carried the virus great distances, concurrently providing an overwintering mechanism in some instances. Nonmigrant bats, collected as they were about to awaken naturally from hibernation, died of rabies-virus infection several months later, illustrating another overwintering mechanism of the virus.

Rabies virus was present in the brains of all infected bats. Virus inactivation before death was observed in some tissues of bats infected in nature and in experiments. Bats frequently survived experimental exposures, some with no disease signs, some after recovering from rabies signs, and others with sequelae. Differences in bat rabies virus isolates were characterized by the responses of mice and Carnivora to infection.

In addition to the aerosol route of rabies virus transmission observed in bat caves, certain bats, under experimental conditions, transmitted infective doses of virus to Carnivora by biting them. Transmission of rabies virus to Carnivora species by bites of certain bat species could occur in nature, particularly when such animals investigate ill bats. Transmission of virus to Carnivora appears to be tangential to the cycle in bats but, if it occurs, it may prove to be significant.