That all is not well in public health today is the theme of the President's address. What is wrong and what can be done to remedy the situation is stated clearly and forcefully. This is a call to action to be heeded by all concerned with the future of community health.

PUBLIC HEALTH IN A TROUBLED WORLD

Dwight F. Metzler, C.E., F.A.P.H.A.

The year 1965 sees us renewing our efforts to abolish poverty and disease, with a new program of health insurance for the aged, expanded medical care for recipients of public assistance, and a strengthened attack on child health problems. The organization and efforts to do this have changed since the days of the public health pioneers. The reduction of environmental hazards and control of the communicable diseases comprised the programs of the early health departments. The role of the federal government was limited to quarantine and the medical care of merchant seamen. The health officer needed to make the diagnosis between chickenpox and smallpox, and, too, he might be called upon to administer diphtheria antitoxin. The engineer, with the aid of crude tools of bacteriology, was expected to find the environmental factors contributing to an outbreak of typhoid fever and to keep water pure by makeshift methods for adding chlorine.

With the passage of the Social Security Act in 1935 came major changes in the organization and financing of public health. Grants were provided which permitted the states to expand their services and many new local health departments to be organized. This step marked a big milestone in the federal-state partnership for the protection and promotion of health, although such a pattern had been developing since the early 1900's. Other federal laws were enacted during the next decade giving special attention to venereal disease, malaria, tuberculosis, mental health, hospitals, heart disease, dental health, water pollution, arthritis, and the metabolic diseases. Each of these represented an emergency response to a public recognition of a threat to public health.

Timed and funded as it was, with its humanistic appeal, public health attracted some of the most competent professionals from medicine, nursing, and the other professions. Their vision was great and public health agencies made remarkable progress in controlling the communicable diseases and improving the quality of the environment. But as the definition of "public health" has grown, and as the public concern for it has been sharpened, we have witnessed increasing fragmentation of health services and the dispersal of public health services among many agencies of government.

The seriousness of fragmentation is illustrated by comparing the situation in 1930 when 72 per cent of all health programs in the states were conducted by health departments, while in 1950 only 27 per cent were in state health departments. Comparable figures are not available for more recent years, but
the percentage has surely continued to decline. Today, the state health departments spend less than one-sixth of the amount appropriated for state health activities.

Prior to 1946, this fragmentation was generated within the states. Beginning with the enactment of the Hill-Burton and the mental health legislation, laws which require the designation of state agencies to administer the programs, the Public Health Service had an opportunity to support consolidation of programs in state health departments. Its failure to do this, in effect, seemed to endorse fragmentation and has hastened the proliferation of services.

The organization of mental health outside of most public health programs marks one of public health’s greatest failures. The assumptions that mental disease was something special, that mental illness was such a major problem that state health departments could not cope with it, that it was controversial, that the basic principles of preventive medicine did not apply to it, led to the formation of separate state mental health authorities. Consequently, mental health programs until recently have been institutionally centered with less emphasis upon positive mental health and the prevention of disease. As experience has shown, the people have been the losers. This is but one example of the failure of public health administrators to accept their professional responsibility. It also highlights the tendency to compartmentalize public health programs into neat boxes with more than forty labels such as heart, cancer, venereal diseases, tuberculosis, radiological health, and water pollution abatement, rather than dealing with all the factors needed in a program to improve the public health.

As a result of this failure on the part of public health administrators to respond to a great public need, state mental hygiene authorities were established and staffed. Now our professional colleagues from mental health agencies are heard referring to public health as “an anachronistic dinosaur being increasingly limited in its power and range of activities because it has lost its ability to change. The team concept of the nurse-sanitarian-public health physician and their ancillary retinue, including the definition of their roles, is a jealously guarded historical tradition more suited to medicine and public health of the nineteenth century than the twentieth.”

This year the national water pollution control program has been moved from the U. S. Public Health Service into a separate agency. Thus, Congress is following an example set in some of the states where the sentiment is growing to set up separate water pollution control agencies. The arguments for this action occur with monotonous regularity and include such statements as the following: “Water pollution programs will never be successful in the public health agency. Public health is concerned only with water which is good enough so people don’t get sick. Public health officials don’t care about fish and recreation. They’re afraid to enforce the law against industry.”

Engineers in health agencies must bear some of the responsibility for these charges. While the majority of states were carrying out effective programs, in enough states there were engineers and their health officers who did not enforce the existing laws to give substance to the accusations of the conservationists. In pointing out that a good job had been done in many states by public health officials, we have always been on the defensive. We have been cast in the role of impeding progress.

When, in 1964, with a supreme effort, public health leaders working through

* George, Don, M.D. Unpublished remarks, 1965 meeting of Kansas Public Health Association.
the American Public Health Association stopped legislation which would have removed water pollution control from the health direction, Public Health Service officials could not—or did not—make the changes for which the public was clamoring. These changes were so universally supported, incidentally, that not a single vote was cast against them in the House of Representatives, when it passed the proposed legislation of the previous year in March, 1965. Nor was a single voice raised against the bill when the Senate passed the compromise version in September.

One of the most effective arguments of proponents for moving water pollution control out of health agencies was the policy position of the Association of State and Territorial Health Officers until the mid-1950’s. This position was that water pollution which affected health should be under the jurisdiction of state public health agencies, but that pollution control administration for the protection of fish and wildlife might be done better elsewhere.

We in public health have resorted to all kinds of excuses for permitting the use of septic tanks, leaching pits and cesspools along with individual water supplies in the fringes and in urban centers. We have yielded to political and economic pressure in permitting the indiscriminate use of wells and septic tanks; this practice has encouraged urban sprawl while directly endangering the public health. The 25 million septic tanks have put sewage in countless backyards, down streets, and into roadside ditches. In addition, they have contaminated the drinking water of hundreds of thousands living in suburbia.

In growing numbers, health-centered programs such as alcoholism, drug addiction, air pollution, occupational health, and vocational rehabilitation have been organized in agencies other than public health. Until very recently, state and local public health agencies have shown a remarkable aversion to attacking problems associated with public medical care. Even today, the record is not one to which we can point with pride.

We have not solved the problem of providing public health services to the rural areas, where one-third of our people still live. Large areas of the country have no organized public health departments, nor do they have the protection of health services from district or regional public health departments. We have followed the slogan “Local health units for the nation,” even when large areas demonstrated their conviction that local health units on a town or county basis could not be financed or staffed.

We have been only partially effective in encouraging people to improve their own health and that of their community. Health education programs have lacked adequate support in finances, staff, and organizational placement. The pronouncements and materials of health educators need the clarity, the concise, crisp, understandable appeal of the public health leaders of half a century ago. They have not always met these criteria and all too frequently have been verbose and stuffy. A comparison of infant and maternal mortality, over-all death rates and death rates of aged males in this country with those of other economically developed countries, emphasizes the need for the very best in bridging the gulf between health knowledge and its use by people.

In preparing for this meeting, I read the messages of many governors to their 1965 legislatures. Their infrequent and brief references to public health left the impression that little ferment or controversy was occurring. Programs for mental health and medical care, on the other hand, were generously mentioned. This observation prompted a search for the elected local or state
officials who were talking of public health as a major issue of public concern. While there may be a few, their very scarcity indicates the need for public officials filled with a vision of the mission of public health.

That only a few officials have this view is an indictment of all of us. Some are frank to say that public health has been struck in epidemic proportions by hardening of the arteries acquired from a rich diet when society moved at a slower pace and people multiplied less rapidly.

Public Health for Today

The times demand that public health officials be in the forefront discussing and taking positions on the most controversial issues of the day. We should be complaining about the pollution of our air, soil, and water; about the substandard housing and crowding in our cities; the overbuilding of hospitals; and the extravagant and inefficient use of highly trained personnel should be exposed where it occurs. We should be raising our voices for better services, vigorously administered, to the poor, disabled, chronically ill, aged, industrial workers, mothers, and children. We should be impatient as we work with schools of medicine, private practitioners, and hospitals to make the findings of research on the disabling and killing diseases really accessible and acceptable to the general public. We should be outraged at the 5,000 maternal deaths which occur annually from abortions, and all the resources of health authorities should be marshalled to deal with child abuse.

In an age when more than 6 per cent of the gross national product is spent for the enhancement of health, one has only to read the daily papers to observe that the public is crying for new and extended health services. This clamor is well into its second decade, and the cries have not been stilled by providing more communicable disease control. This generation is ready, as no generation has ever before been ready, to work actively for an improved environment, for the relief of poverty and for high quality medical care.

Where health agencies are not responsive to the public demand, people are turning to other agencies, or creating new ones. We must convince the mayors and the governors, the city councils, and the state legislatures that we are ready to take on new responsibilities, while recognizing that the most convincing argument lies in demonstrated competence. We must be able to guide public opinion in the support of programs which are economically and professionally sound. We must continually assure people that public health professionals are interested in problems which concern the public. Insistence that the public fit its problems into our tidy compartments is suicidal.

The responsibility to give this assurance is one we all share. Like trial lawyers, our charge is to plead effectively the cause of health improvement before boards of health, hospital boards, city councils, county commissioners, state legislatures, and Congress. But the Supreme Court—the tribunal of last appeal—is the people. Therefore, it is our duty to speak plainly and candidly to those who are the judges of their own cause on the important issues which face us today.

In pleading the case, we need to follow the scientific discipline of public health. We have the responsibility to seek out the facts and make them known, free from the bias of selfish interest. As professionals, we cannot escape the obligation to call attention to the current flood of partial truths which deluge us on every hand with the implied promise of easy solutions.

Beginning today, I challenge you who are the American Public Health Asso-
ciation to make the public health agency the energizer and coordinator for all community health activities, recognizing that many health activities will be carried on outside the health department. The public cares little how government organizes to provide health services, but it is vitally concerned with the results. People are interested in full health protection, not whether it comes from social welfare, vocational training, mental health, agriculture, labor, public health, the medical school, or any of 53 other agencies which are operating health programs in one or more states.

To meet its responsibility, public health must be integrally involved in comprehensive community health planning as one of its major responsibilities. I propose that state health departments establish the legal basis and set up a research and planning division whose role is to work with other health-oriented persons and agencies, private and public, to develop services for protection of the environment and for comprehensive health care. The development of such a plan requires working jointly with the private practitioners, related health professions, the schools of medicine, voluntary agencies, official agencies, and community leaders. This plan would set forth the long-range goals of the state in the conservation of the health of its citizens. While some will disagree, I believe it not only can but should be adopted by the legislature and subjected to regular updating, with the goals based upon the anticipated future needs for health services. The plan would, for example, seek to achieve an integrated balance in services to people, plan to protect them from communicable diseases, assure distribution of health services to both urban and rural residents, prevent the waste of resources, implement and apply the findings of research, and coordinate the development of health resources with the human and economic resources of the state.

General goals and objectives could then be developed as the second part of the plan for at least 20 years in the future. These would be for the achievement of the purposes set forth in the long-range goals. They might include specific guidelines for the maintenance of air and water quality. Certainly they would set goals for locating and providing hospitals, clinics, and nursing homes. Realistic targets for control of the communicable diseases would be included. The sources of health manpower would need to be considered and the numbers of personnel estimated for each specialty. With our present capacity for predicting, these needs should be convertible into requirements for medical personnel of teaching hospitals, laboratories, and schools. The National Commission on Community Health Services has been studying the future needs. Its three years of study, aided by the suggestions of some 1,200 persons who attended four regional conferences last month, have revealed many objectives for the future. We can expect a doubling of public and private expenditures for health in the next decade. The impact of this conclusion on health resources is obvious.

The setting of general goals should permit a realistic appraisal of the dispersion of health manpower. If we are to have a continuing shortage of physicians, then the issue of training non-physicians for some administrative posts, such as hospital and public health administrators, can be faced realistically.

Such planning can make the public health agency the focal point for developing full health coverage. It permits the assignment of priorities for governmental expenditures. It gives private individuals and industries guidelines for their decisions—and they will understand a plan which they have helped develop.
Allow me to use an example in the area most familiar to me, but one which demonstrates how this type of planning would function. Assume that one of the goals is to maintain all streams of the state in such condition that they can supply raw water for cities and be used for public recreation. This decision sets the quality of water needed and indicates the degree of waste treatment which the health department will require of any city or industry for a specific reach of stream. It permits the prospective new industry to estimate its waste treatment costs, as well as guaranteeing the quality of its raw water. The water resource planners can calculate from this the quantity of storage to include in upstream reservoirs for the maintenance of water quality, and they can set the limits on how much water can be withdrawn for consumption. Even in this simple example the decisions of at least three and probably five or six public agencies are coordinated through a single goal in the plan which centers around human health.

While state health departments bear a primary responsibility to provide leadership in community health planning, area-wide planning in large urban areas is equally important. The overlapping jurisdictions and the multiplicity of agencies in metropolitan areas clearly lead to lost effort and duplication.

The second challenge lies in public involvement to gain support for and to guide health policy decisions. With people demanding more health services, an unparalleled opportunity awaits us to use every means at our command to encourage citizen participation in health matters through advisory committees, health councils, medical societies, women’s auxiliaries, service groups, farm organizations, labor unions, and boards of voluntary agencies. We need more spark plugs in our communities. The challenge is to find and energize them.

The third challenge lies in the area of recruitment and personnel development. The dimensions of public health are far greater than ever before and are still expanding. It therefore offers more diverse opportunities and a longer list of possibilities than ever before.

These opportunities and their concurrent responsibilities are coming at a time when the competence to meet them is threatened by obsolescence from the rapid development of new knowledge. Each member of the Association has a responsibility to counter this obsolescence by continuing education.

The expanding profession and the challenge to meet its demands with competence based upon the findings of research offer an exciting future for public health professionals. Recruiting the outstanding young, disciplined minds and giving them, along with those already in public health, the opportunity to develop and use their talents is one way to reach this challenge. What I have in mind might be demonstrated by an imaginary staff meeting of the state health officer of the 51st state, Sasnak, and his division directors.

"We are starting on a new program of recruitment," he announces. "I want your help in recruiting for our department the keenest minds of graduates of our schools today." To a query about more guidelines, he said, "The kind of person I’m seeking has greater mental capacities, is more highly motivated, and likes people better than any of us here. I envision these persons being superior ten years from now to any of us today." "No," in answer to another question, "their graduate degrees are not too important, other than they should represent a rigorous course of study heavily weighted to theory in a biological, physical, or social science.
We might even be able to use someone from political science. The legislature has approved four unclassified positions with the salaries to be set by our board of health.”

To attract this kind of person, we must change the image which many persons have of public health. They must understand that a career in public health does not offer a secure, peaceful, or easy life; nor does it have a nine to four o’clock workday for either its workers or its leaders. To achieve leadership is demanding, fatiguing, and hazardous. A career in public health does offer a life of interest with a potential for service to mankind exceeding that of most other professional pursuits. It has a variety and complexity to challenge the most brilliant minds. We must get the message through to graduates in medicine, nursing, engineering, and the related professions that public service demands the best.

The recruitment of the best brainpower is not simply the best theoretical course to take; it makes political sense. For example, President Johnson has drawn high praise for his 300 nonjudicial appointments. This success is due, in part, to a search which is organized by a talent hunter, John Macy, the chairman of the U. S. Civil Service Commission, whose criteria are high intelligence, relative youth, good academic qualifications, professional recognition, and a willingness to be loyal.

To recruit this type of person, public health must offer the opportunity to accomplish, to make decisions, to be promoted to the top. The opportunity to conduct research, to participate in the shaping of programs, to tackle difficult problems, and to attend professional meetings are necessary ingredients to job satisfaction for these outstanding people. Bringing such people into public health may mean a change in undergraduate and graduate education to include more public health content, or extensive on-the-job supervision and training. It will result in more non-medical administrators in a decade.

The fourth challenge lies in reorganizing the agencies and units responsible for the delivery of health services at the federal level. The ad hoc response to this or that suddenly perceived health threat, often with accompanying “whoopla,” has resulted in a multiplicity of federal agencies with health responsibilities which sometimes function at cross-purposes with each other.

The establishment of a means for long-range health planning is a responsibility of the executive department of the federal government. Perhaps this can best be done in the office of the secretary of Health, Education, and Welfare making liberal use of professionals and members of the concerned public as advisers. A policy-level commission reporting directly to the President might supply guidelines and provide leadership. I am inclined to think, however, that the establishment of a department of health with three basic services—the environment, medical services, and research—may provide the most practical and politically acceptable organization for coordinating and supplying community health services from the federal level. Some solution must be found or fragmentation of health programs will continue to occur nationally, in the states, and in the communities.

Conclusion

These are troubled times in public health. The pressures for fragmentation and duplication are greater than ever before. Heraclitus, the Greek philosopher, 2,500 years ago, observed that “Nothing is permanent except change.” This axiom applies to public health today and the changes are disturbing.

The future holds many new opportunities as change continues, perhaps
even accelerates. We must recruit the best minds, assure the best education, improve our administrative organizations and methods, be willing to consider not only new programs, but new organizational forces and modalities, and involve people in creative long-range planning. We must control our impulses, harness our prejudices, and follow scientific discipline to rise above traditional thought and action. Our responsibility is to shape the change, not merely to await it.

You who are the American Public Health Association have provided much of the leadership to unify public health and to encourage experimentation, innovation, and change. In the Association you can find a fertile field for professional development out of which can come the new leaders of tomorrow, dedicated as you are to that high ideal—the service of mankind. This is the challenge of public health. Here is the opportunity each person seeks to serve the society which brought him to life. This each of us must do if, in the words of the Association's motto, "the leaves of the tree are to truly serve for the healing of the nation."

Mr. Metzler is executive secretary of the Kansas Water Resources Board, and professor of civil engineering, University of Kansas, Lawrence, Kans.

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New Alcoholism Courses for Public Health Workers

Rutgers University recently announced that the Summer School of Alcohol Studies is revising and expanding its public health course offerings in 1966.

The first change will be a new emphasis upon the work of qualified public health educators in the course: "Organizing and Developing Alcoholism Programs in a Public Health Setting." This will include a review and evaluation of current public health experience, throughout the United States and Canada, in organizing and promoting alcoholism education.

Also to be offered is a new course exclusively for public health nurses on "Public Health Nursing Services to Alcoholic Patients and Their Families."

In addition to these basic courses, each student is expected to participate in a second course of his choice, and to attend the general lectures, given to the entire student body.

The 1966 Summer School of Alcohol Studies will be held on the campus of Rutgers-The State University, New Brunswick, N. J., June 26 to July 15. This will be the 24th annual session since the establishment of the School at Yale in 1943.

The total cost for this three-week school, including tuition, room and board (except week-end meals), will be $300. A number of scholarships will be available. For further information about the courses and available scholarships, write: Summer School of Alcohol Studies, Rutgers-The State University, New Brunswick, N. J. 08903