Health Departments in the U.S. 1920–1988: Statements of Mission with Special Reference to the Role of
C.-E.A. Winslow

JAMES F. JEKEL, M.D., M.P.H.

C.-E.A. Winslow Professor of Public Health, Yale University School of Medicine, New Haven, Connecticut

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The mission of local health departments in the U.S. is traced from the 1920s to the present through examination of official promulgations of the American Public Health Association and other organizations. As the communicable diseases came under general control, this mission was conceived more broadly. Nevertheless, in effect their public health role was diminished due to the rapid ascendancy of private and not-for-profit medical care, which consistently sought to keep public health out of potential areas of competition.

Thinking both within the public health field (as represented by C.-E.A. Winslow) and outside the public health field (as represented by the American Medical Association), had created boundaries limiting public health’s role to preventive medical services. This restriction, in turn, largely excluded the public health field from participation in the tremendous expansion of medical care since World War II. The public health role was further limited in 1970 by the removal of much of environmental pollution from its purview. The sum of these and other forces has left the public health field weakened and in considerable confusion about its role at a time when the resurgence of infectious disease (e.g., AIDS and Lyme disease), environmental hazards, and medical care institutions requires a strong public health presence.

As a part of The Yale Journal of Biology and Medicine’s tribute to the memory of Arthur J. Viseltear, Ph.D., this article will describe the development of ideas about the mission of local health departments in the United States from the 1920s to the 1988 Institute of Medicine report, which was entitled The Future of Public Health [1]. The linkages of this subject to Arthur Viseltear are several. First, he was one of the leading public health historians of our time. Second, he had been active in public health in his own town of Guilford, Connecticut. Third, public health was not only a subject of scholarly study for Arthur, it was a passion, as he showed in his commencement address to the graduates of the Yale University School of Public Health in May of 1989 [2]. Fourth, he authored the definitive studies of the role of C.-E.A. Winslow in the development of the public health program at Yale [3,4], and, at the time of his death, he was writing a biography of Winslow’s wider contributions.

Abbreviations: AMA: American Medical Association APHA: American Public Health Association C & Y: Children and Youth (projects) CAP: Committee on Administrative Practice (of the APHA) CCMC: Committee on the Costs of Medical Care CDC: Centers for Disease Control (Atlanta) CHP: Comprehensive Health Planning EPA: Environmental Protection Agency IOM: Institute of Medicine of the National Academy of Sciences MCH: Maternal and Child Health MIC: Maternity and Infant Care (projects) NIH: National Institutes of Health RMP: Regional Medical Programs SSA: Social Security Act of 1935 WHO: World Health Organization

Address reprint requests to: James F. Jekel, M.D., Dept. of Epidemiology and Public Health, Yale University School of Medicine, 60 College St., New Haven, CT 06510-3333

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to the field of public health. Central among Winslow's concerns was the mission of local health departments. Winslow also provided the philosophical base for the activity of local health departments with his 1920 definition of public health practice, which is the best known of all such definitions:

Public health is the science and art of preventing disease, prolonging life, and promoting physical and mental health and well-being through organized community effort for the sanitation of the environment, the control of communicable infections, the organization of medical and nursing services for the early diagnosis and prevention of disease, the education of the individual in personal health, and the development of the social machinery to assure everyone a standard of living adequate for the maintenance or improvement of health [5].

Arthur Viseltear loved this quotation and used it often in conversation and in teaching. Winslow's concern for local public health practice is best illustrated by his role on the Committee on Administrative Practice (CAP) of the American Public Health Association (APHA).

Winslow, however, also influenced the direction of local health departments by what appeared to be an even greater interest of his, the development of concern for the rational organization and administration of medical care. The best illustration of this influence was Winslow's seminal role in the creation of the Committee on the Costs of Medical Care (CCMC), which operated from 1929 to 1932, and which was staffed by Winslow's protegé, Isidore Falk. The CCMC's final report was both controversial and influential in its strong call for medical care to be organized as prepaid group practice organizations [6]. One noteworthy aspect of the work of this committee is that its work and recommendations were essentially independent of any reference to the responsibilities of public health departments. Perhaps that should not be surprising, given the seldom-noticed emphasis in Winslow's famous definition of public health, quoted above, where he maintained that the responsibility of public health in medical care was [limited to]: "... the organization of medical and nursing services for the early diagnosis and prevention of disease ...", i.e., preventive medical care services only.

THE COMMITTEE ON ADMINISTRATIVE PRACTICE

C.-E.A. Winslow was the first chairman of the Committee on Administrative Practice of the American Public Health Association. For decades, beginning in the 1920s, this committee sought to define the mission of official public health agencies by means of a series of studies and proclamations [7].

Local official health agencies in the U.S. developed out of local boards of health, which first began to appear in U.S. cities in the late eighteenth century [8]. Baltimore is generally given credit for developing the first health department, in 1798. The subsequent development was somewhat haphazard until 1910–11, when a series of severe epidemics of typhoid fever around the country, especially one in Yakima, Washington, led to a strong recommendation from the U.S. government that full-time local health departments be created. Their growth began in earnest in the following decade, but still most of these departments were developed without the benefit of any kind of formal structure imposed from above. In 1915, another of America's great figures in public health, Charles V. Chapin, wrote, "There is
probably not a single large municipal health department in the country which is operated along strictly logical lines. They are mostly ill-balanced” [7]. Therefore, by 1920 the situation in the U.S. was somewhat confused.

THE 1933 STATEMENT

One of the first tasks of the new committee was to find out what, in fact, local and state health departments in the 1920s actually were doing. This the CAP accomplished by means of questionnaires and on-site surveys. From these studies, the CAP developed the first in a series of documents, which were to be published by the APHA. That document appeared in 1933, under the wordy title of “An Official Declaration of Attitude of the American Public Health Association on Desirable Standard Minimum Functions and Suitable Organization of Health Activities” [9].

This declaration listed two primary goals for public health agencies: (1) the control of communicable diseases and (2) the promotion of child health. By tacitly accepting a fundamental cleavage between preventive services and medical care, both in the institutions responsible and in the funding thereof, this declaration supported rather than challenged the idea of two worlds of health care, one largely private and curative, the other mostly public and preventive in orientation.

To accomplish the two primary public health objectives listed above, the document listed “Other Essential Aids”: (1) laboratory service, (2) sanitation, (3) public health education, (4) public health nursing, (5) vital statistics, and (6) research in disease prevention. It also mentioned that the local official health agency should assume leadership in the community in health matters and should work closely with private physicians in the process, but the document stopped short of implying that health departments were in any way responsible for assessing the adequacy of, or assuring the availability of, medical care for their constituents. This fact is not surprising because of the committee’s desire to enlist voluntary support and cooperation from private physicians rather than to antagonize them by suggesting in any way that health departments had an oversight role. The planners of public health at this time lived under the shadow of the dispute over “The Boundaries of Public Health,” as Starr has put the matter [10]. Moreover, this period was the time of the CCMC and its advocacy of prepaid group practice as the primary solution to real or potential ills of medical care.

The 1933 Statement was signed by Haven Emerson, who chaired the Subcommittee on Essentials of Health Organization of the CAP, which had developed the Statement, and by the other members of the subcommittee, including C.-E.A. Winslow.

The two major categories in that declaration reflected the basic public health needs of the time, which mostly concerned the prevention of infectious diseases by sanitation, by immunization, or by diagnosis, isolation, and, when possible, treatment of infected persons. Children suffered the most from infectious diseases.

The initial effect of the 1933 Statement is difficult to ascertain, because for the most part it gave a stamp of approval to what health departments were already doing. It did, however, help to give official support to the important role of local health departments, and the Statement undoubtedly assisted in the passage of Title VI of the Social Security Act of 1935 (SSA), which established federal aid for local public health departments [8]. It surely is no accident that Title VI of the SSA, as well as Title V, which concerned grants for maternal and child health, were initially drafted
by C.-E.A. Winslow's student and protegé, Isidore Falk. Only Title V hinted that there should be public responsibility for medical care, and even then only for "crippled children," the concern for whom was growing because of recurrent epidemics of paralytic poliomyelitis.

The 1930s were difficult years for public health, due to the Depression, which brought both great human needs and a diminished capacity of governmental agencies to provide for these needs. At the same time, the 1933 Statement concerning health departments, the 1935 SSA grant-in-aid support for health departments, and the active and outspoken Surgeon General, Thomas Parran, helped to make the 1930s also a creative time for health departments. Many of the brightest physicians were going into public health for both idealistic and financial reasons, which helped to ensure strong public health leadership in the post-World War II years.

THE 1940 STATEMENT

In 1940, the APHA brought out another statement of basic minimum functions for health departments [11]. Although the 1940 Statement was fundamentally the same as the 1933 Statement, it was clearer and more forceful, primarily because it rearranged the items in the 1933 Statement into what were then considered the "basic six minimum functions" of local health departments. This neat, clean, non-hierarchical listing of the six basic functions of local health departments was easy to remember, and the list quickly became known as the "basic six." They provided a self-identity and guide to local health workers and were quickly incorporated into the national public health thinking in a way that the 1933 Statement was not. These "basic six" minimum functions were: (1) vital statistics, (2) environmental sanitation, (3) communicable disease control, (4) public health laboratories, (5) maternal and child health, and (6) public health education (refer to Table 1).

In the majority of cities and counties in the U.S., the routine task of receiving, copying, and sending to the state governments certificates of birth, death, marriage, and divorce was given to the local health department, usually because it was (appropriately) thought that this allocation would give health departments easy access to birth and death certificates for the purposes of analyzing these vital statistics to define public health trends and needs.

Environmental sanitation was initially viewed primarily as one branch of the police power of the states, which, through the state public health codes, required proper public and private water supply systems and sewage disposal, restaurant inspections, insect and rodent control, housing inspections, and response to environmental complaints. Although the police power of the state lay behind most of the activities of the environmental health divisions of health departments, they usually considered their role primarily as one of education rather than enforcement, and they tended to use legal means only as a last resort.

The category of communicable disease control included: (1) provision of immunizations, which were increasingly becoming available; (2) surveillance of disease, including investigation of infectious disease reports and, when indicated, quarantine or treatment of affected individuals; (3) outbreak investigation and epidemic control; (4) screening for disease or infection, such as tuberculin testing; and (5) regular clinics for sexually transmitted diseases and tuberculosis control.

Public health laboratories were a necessary adjunct to the infectious disease control
mandate for health departments in the early decades of this century. Laboratories assisted the environmental sanitation efforts by culturing water, food, milk, and other environmental sources, and they helped the communicable disease control program by culturing for throat pathogens (especially streptococcus and diphtheria), sputum cultures for *M. tuberculosis*, stool cultures for enteric pathogens in applicants for food-handling positions as well as in samples from diarrhea outbreaks, and specimens related to sexually transmitted diseases.

**Maternal and child health** (MCH) included clinics for prenatal and postpartum care; home visitation by public health nurses following delivery to make sure that the home was equipped to care for the new child; well-child conferences, including immunizations, dietary advice, and growth and development counseling for mothers; and school health services, including screening for certain diseases and health education.

**Public health education** was regarded as an important part of the activities of health departments. At this time, health education was understood as giving the public appropriate information about (1) the principles of personal hygiene and nutrition, (2) the available methods of preventing disease, (3) the symptoms of disease and when people should come for treatment, and (4) when and where people should come to obtain public health services.

As the media possibilities expanded, so did the expectation that health educators would be expert in utilizing them to publicize the public health message. More recently, the emphasis in health education has broadened to include a community development role for health educators, and an expectation that the health educator will represent the concerns of the community when major health decisions are to be made.

The 1933 and 1940 Statements also dealt with other issues, which often were forgotten due to the subsequent focus on the "basic six." They emphasized the role of **public health nursing** in several of the functions of the health department, especially in communicable disease control and MCH. Second, they strongly emphasized the importance of **research** in health departments, a recommendation which, had it been better followed, might have made a major difference in the ultimate future of health departments.

The 1940 Statement also emphasized the central role of local health departments in providing preventive services to the poor people within the health department's jurisdiction. It said:

> Health departments should also be prepared to accept responsibility for planning or for supplying needed preventive services for persons who are unable to pay for them on an individual basis.

Local and state health departments have seldom had the resources to carry out this mandate adequately, but the importance of this "indigent clause" is felt even today. Also apparently unnoticed, or at least not criticized, was the division of the world of health into a preventive side, which was the responsibility of public health agencies (at least to the extent that it was not adequately carried out by the private sector of medical care), and a curative side, for which public health agencies were given no mandate.
LOCAL HEALTH UNITS FOR THE NATION

One of the chief concerns of the CAP was the fact that many cities and counties in the U.S. still lacked full-time health departments. Under the leadership of Haven Emerson, in 1945 the CAP produced a monumental work entitled Local Health Units for the Nation [12]. This book examined every state in the U.S. and tried to show how, by creating district health departments, every person in the U.S. could be covered by basic full-time health services sufficient to provide the "basic six" services.

A basic module or unit of public health services was proposed by this report, which would be replicated for every 50,000 persons. Each module consisted of one public health physician, one sanitary engineer, one sanitarian, ten public health nurses, and three clerical persons. This goal could all be accomplished for what was, even in those days, the modest sum of one dollar per capita. A district of 100,000 persons should approximately double the standard module, getting two public health physicians, one sanitary engineer and three sanitarians, 20 public health nurses, and six clerical staff, and so on. Obviously, as the population to be covered became larger, health department staffs could have specialists, and provision was made for variation in this model if local reasons for doing so existed.

The authors of Local Health Units for the Nation hoped it would bring about a rejuvenation of public health by assuring full-time health department coverage sufficient to provide the "basic six" services for every area of the U.S. Instead, this document had the effect of "hardening the categories" at the very time health departments needed to reconsider their functions and move away from looking only at infectious diseases. As the infectious diseases came under better control after World War II, health departments could have begun to consider such things as chronic non-infectious diseases, injuries and occupational health, pollution of the environment, a host of social problems, and the organization and financing of medical care. Instead, Local Health Units for the Nation was a clarion call for the old public health just when a call for a new public health began to be needed.

In addition, after World War II, Congress decided to discontinue funding local public health efforts by terminating Title VI of the SSA. In 1948, the National Institutes of Health (NIH) was formed, beginning more than four decades of federal commitment to build a biomedical research structure in the U.S. that was to be the strongest in the world [8]. It is significant that no "National Institute of Public Health" was included in the NIH, either when it was created or at any time since. Part of the reason may have been that the Centers for Disease Control (CDC) was considered as a kind of NIH for public health, or at least for epidemiology. Another reason was that the NIH was a totally separate unit within what is now the U.S. Public Health Service, created for biomedical research. The separation, even tension, between the "public health" and the "biomedical research" branches of the federal health effort became most visible in 1965, when each of the two branches was given its own separate agency for health planning: the Comprehensive Health Planning (CHP) agencies for the Bureau of State Services (the public health branch) and the Regional Medical Programs (RMPs) for the NIH. The CHP agencies worked mostly with public and community health agencies, and the RMPs worked primarily with hospitals and medical schools.

After World War II, the environment of medical practice became more entrepreneurial, and medical practitioners began to look at local and state health departments as competitors for patients. This concern led the House of Delegates of the
American Medical Association (AMA) to pass a resolution in 1950 stating “...that the services of public health departments should be limited to [the basic six minimum functions],” which put local health departments in the uncomfortable position of feeling they were enemies of, rather than colleagues of, medical practitioners [13]. The uneasy truce that existed between public health agencies and medical practitioners was now brought into the open, with this declaration that essentially all medical care belonged in the sphere of influence of private practitioners. As late as 1990, the AMA acknowledged that “Tensions remain between physicians in private practice and those in public health . . .” [14].

THE 1950 STATEMENT

During the 1950s and 1960s, the new excitement of bench research and the financial, social, and personal attractions of private practice were so great that few physicians chose public health careers, and those who did often were not the most gifted physicians. Thus, by 1950 an identity crisis had begun to hit public health, and local health departments were among those agencies most affected. To clarify the situation, in 1950 the APHA passed another statement of basic minimum functions for local health departments [15].

The task for the developers of the new statement was not an enviable one. First, they needed to broaden the mission of public health well beyond the “basic six” to include all of the new, developing possibilities. In fact, Winslow’s definition of public health, written as far back as 1920, was far advanced conceptually over the basic six. Briefly, the new statement had an implied mandate to displace the “basic six” thinking that had become standard among local health workers. Second, especially after polio vaccine became available, the public had a growing sense of security, of having been protected from infectious diseases, and the new statement should have helped to convince public representatives of the importance of giving adequate support to official health agencies [16].

The new mission statement also needed to (1) allay the fears of the AMA and private practitioners, (2) convey a sense of excitement to rejuvenate public health work, and (3) assist in recruiting new public health workers (particularly physicians). This task required projecting a vigorous new image to the public.

Unfortunately, the 1950 Statement (published in 1951) was not adequate to meet the many demands placed upon it. In part, the new statement tried to incorporate the “basic six” into broader language, as well as to add some new functions. The result was seven basic minimum functions. (Refer to Table 1.)

Fundamentally, the new mission statement sought to broaden and enrich the existing functions; for example, “Vital Statistics” was extended to become “The Recording and Analysis of Health Data,” and the like. At any rate, the new “basic seven” list had neither the simplicity and coherence of the “basic six,” nor did it possess a central theme that could become a rallying cry for a new public health. The 1950 Statement did not help public health workers to visualize their jobs or to communicate their roles to legislators and the public.

This situation was unfortunate because, in terms of defining a broad, meaningful role for local public health, the 1950 Statement was a definite improvement on the previous statements. It walked a fine line between the specificity and rigidity of the 1940 Statement, and the vague generalities of the 1963 Statement that was to follow. But it was not memorable; it had no “sound bites,” and so it failed.
### Summary of the Basic Minimum Functions of Official Health Departments, as Given in the 1940, 1950, and 1963 Statements of the American Public Health Association

| 1940 Statement                                                                 |
|--------------------------------------------------------------------------------|
| 1. Vital Statistics                                                             |
| 2. Environmental Sanitation                                                     |
| 3. Communicable Disease Control                                                 |
| 4. Public Health Laboratories                                                   |
| 5. Maternal and Child Health                                                   |
| 6. Public Health Education                                                      |
| Source: [11]                                                                   |

| 1950 Statement                                                                 |
|--------------------------------------------------------------------------------|
| 1. Recording and Analysis of Health Data                                       |
| 2. Health Education and Information                                           |
| 3. Supervision and Regulation                                                  |
| 4. Provision of Direct Environmental Health Services                          |
| 5. Administration of Personal Health Services                                 |
| 6. Operation of Health Facilities                                              |
| 7. Coordination of Activities and Resources                                   |
| Source: [15]                                                                   |

| 1963 Statement                                                                 |
|--------------------------------------------------------------------------------|
| I. General Responsibilities of the Local Health Department                    |
| 1. Medical Care                                                                |
| 2. Regional Planning of Health Services                                        |
| 3. Effective Use of Natural Resources                                         |
| 4. Efficient Delivery of Traditional Services                                 |
| II. Functions of the Local Health Department                                  |
| 1. Promotion of Personal and Community Health                                 |
| 2. Maintenance of a Healthful Environment                                      |
| 3. The Attack on Disease, Injury, and Disability                               |
|   a. Communicable Disease                                                      |
|   b. Operation of Certain Services and Facilities                             |
|   c. Improved Use of Existing Services and Facilities                         |
|   d. Development of Services for Primary Prevention, Prevention of Progression |
|     of Disease, and Rehabilitation of Patients                                |
| 4. Research, Development, and Evaluation                                       |
| Source: [19]                                                                   |

The 1950s became a difficult time for public health, as interest in and funding for it declined. Even the most dramatic health advance of the decade, polio vaccine, was regarded as a triumph for medical research rather than for public health, causing even more money to be channeled into biomedical research, often at the expense of public health services. The plight of public health was desperate enough that even the AMA relaxed its policy regarding public health (which it no longer viewed as much of a threat) and passed a new resolution saying that the duties of "... public health departments should include at least [the basic six]" [17]. This change was a step in the right direction, albeit a small step.

**THE WORLD HEALTH ORGANIZATION STATEMENT**

In 1960, the World Health Organization (WHO) promulgated seven basic health services as constituting an integrated health program for a local area [18]. These services were strongly influenced by the previous U.S. statements but also added...
"public health nursing" and "medical care," while leaving out the laboratories section.

THE 1963 STATEMENT

The APHA was sufficiently worried about the status of local health departments that, in 1963, it passed still another statement on the mission of health departments [19]. This Statement bore almost no resemblance to the previous statements. Where the "basic six" was a rather narrow and specific statement, this one was general and nonspecific. Categories were totally regrouped, so that one could no longer find traces of the "basic six." (Refer to Table 1.) This Statement was so general as not to be helpful, and even the "basic six," though limited, formed a better guide to agency policy.

FEDERAL INITIATIVES IN THE 1960S AND BEYOND

At this time, the federal government was also becoming much more proactive in health matters. In the early 1960s, the Maternity and Infant Care (MIC) Program was passed (as a part of Title V of the SSA), as was the Community Mental Health Act. Then 1965 brought a landslide of Great Society health legislation that included Medicare, Medicaid, Community Health Centers, the Children and Youth (C & Y) Program, and the planning legislation that authorized both the Comprehensive Health Planning and the Regional Medical Programs. Most of this legislation bypassed the traditional federal → state → local pattern for federal grants-in-aid, and local health departments often were bypassed, either intentionally or because they did not have adequate grant-writing capacity.

One other force kept local health departments from feasting on the new federal health money: philosophical principles. Despite, or perhaps because of, the "indigent clause" in the 1940 Statement, public health departments usually considered their services as something which should be available free of charge to all citizens in their jurisdictions. The Great Society legislation often required means tests of recipients' financial ability before providers would be reimbursed for services, and most local health departments were philosophically opposed to applying means tests to any of their services. Consequently, due both to lack of aggressiveness and of skills at grant writing and to philosophical opposition to the use of means tests, local health departments were further weakened as community health agencies. Suddenly there were "competing" mini-health departments in many communities, such as neighborhood health centers, community mental health centers, and other federally supported community agencies. The development of these agencies confused public health leaders, because, although their natural tendencies were to work cooperatively in a community context, the neighborhood/community health centers tended to want a fairly independent line. They were developed out of a community power/action base with a large degree of community control. Their funding was direct and did not require local (or, in many cases, even state) health department approval, and they tended to go their own way. In many communities, the neighborhood health centers have disappeared or been considerably weakened, and whatever preventive and curative roles that originally were, in effect, transferred from health departments to neighborhood health centers usually were not "returned" to the health departments when these health centers ceased to exist or terminated some of their functions.
In addition, the health departments' planning role, which had never been performed very well, was now largely taken over by the Community Health Planning (CHP) agencies, which were also created by federal legislation in 1965, as a part of the Great Society package. The same legislation also created the Regional Medical Programs to plan for medical education and medical care. Therefore, after 1965, the creation of a new system of community health agencies, the opposition of organized medicine, the lack of governmental funds, and the narrow self-image of local public health workers conspired to limit local health departments mostly to the basic six minimum functions. During this time, many health departments were particularly nervous about trying to become more heavily involved in curative care for fear that might antagonize private practitioners and the new community health centers.

Another change was the removal of much of the responsibility for the environment from the official health agencies. This alteration began with the creation of the federal Environmental Protection Agency (EPA) in 1970, which was followed by the creation of parallel state environmental agencies in many states, although some states refused to diminish the environmental role of public health and assigned the environmental protection role to their state health agencies. Somewhat oversimplified, those environmental responsibilities where microorganisms were the primary concern remained in health departments, and environmental concerns where other forms of pollution and toxins were the primary concern were allotted to the new environmental protection agencies. Whereas this separation may be logical for air pollution, for many other forms of pollution it is not; for example, sewage and solid waste disposal combine both concerns (i.e., microorganisms and toxins). This federal initiative resulted in both a perceived and a real downgrading of the responsibilities of health agencies, with some resulting loss of responsibility and morale.

THE 1975 STATEMENT

As was shown by Miller and Moos, the above picture in many ways is too pessimistic [20]. Often local health departments developed creative new programs, including the provision of medical care. The kinds of creativity found in their study, however, could not be said to be typical for local health departments in the late 1960s and the 1970s.

The APHA decided to give the mission statement approach one last try. Unpublished drafts of proposed new local health department mission statements from the late 1960s and early 1970s show that there was no agreement on an approach [21]. By 1975, however, the APHA had produced another mission statement which was, perhaps, the logical and inevitable culmination of most mission statements in the modern world. It was, in essence, a "laundry list" of all of the possible tasks, functions, and responsibilities that health departments could undertake, either by law or on their own initiative [22]. Tied to this list of possibilities was a strong statement that a public health program must be tailored to the needs of the community, and that, based on needs assessment and local resources, each health department should set priorities for those functions that are most important for the community.

Thus, in their mission statements, health departments had moved from the standardized approach characteristic of industrial-era thinking (the "second wave" in Toffler's challenging analysis of historical trends [23]) to the approach of the post-industrial era (Toffler's "third wave"), which is characterized by individualiza-
tion in all manner of programs, agencies, and products. The problem for many health departments, especially the smaller ones and those headed by persons without public health training, was that the new approach required a major commitment to community needs assessment and institutional planning at a time when funds were becoming difficult to obtain for just the "basic six" and other routine functions.

THE HANLON-TERRIS DEBATE

In the 1970s, two of the twentieth century's most prominent public health leaders, John Hanlon and Milton Terris, engaged in a debate in professional journals regarding the essence of the mission of health departments (especially local departments) [24,25]. Hanlon started the debate by calling attention to the fact that health departments increasingly were relegated to sweeping up the unfinished health business that other health agencies didn't want or were not able to accomplish. He proposed an orderly, data-oriented "master planner" and "guarantor of health" role for health departments. Rather than providing personal health services, local health departments should primarily be the agency that "assures" good health for everyone. He was less specific as to how public health agencies, which, at the three governmental levels, receive less than 3 percent of the total health dollar, could obtain the leverage to assure good health for all. Hanlon basically accepted the view that medical care is not a direct obligation of public health agencies.

Terris responded that Hanlon's approach was not sufficiently cognizant of the second epidemiologic revolution, because of which it was now possible to prevent many of the chronic diseases as well as the infectious diseases. He criticized the Hanlon approach as one which was "hardly compatible with a future of consequence," because, in giving up the provision of direct services, including at least the direct provision of preventive health services, health departments were also losing their most important political constituencies. Each of these authors had made valid and important points, but they were quite far apart on one of the critical continua that public health had to use in order to decide the appropriate functions for a specific health department: the importance of providing personal health services.

After the 1975 Statement, whatever creative energies the APHA may have had left for promulgating mission statements for local health departments were channeled into the new Institute of Medicine (IOM) report on The Future of Public Health [1]. The APHA followed the development of this report with great interest and relief that another organization was willing to reconsider the entire issue.

The IOM's report took what could only be described as a strong Hanlon-oriented perspective. It stated that health departments (at all levels) should focus on their "assurance" role and leave the direct provision of services to others, whenever possible. Its definition of the public health mission was "... fulfilling society's interest in assuring conditions in which people can be healthy." It went on to interpret this mission as consisting of the roles of "... assessment, policy development, and assurance." The rationale was that "... programs for providing medical care to poor persons inevitably will consume a large proportion of the resources of health departments and detract from the departments' efforts to protect the populace at large." This point of view was much to the liking of the AMA, which strongly supported the IOM report [14].

Law, ethics, medical technology, communications, social and administrative sciences, and both epidemiology and biostatistics, in addition to the increasing complex-
ity of diseases (such as AIDS), environmental problems, and socioeconomic and political problems (including illicit drugs), all have made the field of public health, including the administration of health departments, more complicated by an order of magnitude than it was in the 1930s.

Health departments are, in varying degrees, enlarging the "basic six" mentality and are trying, with limited resources, to address the complex problems of the day with modern tools. The history of mission statements for health departments illustrates both the advantages and disadvantages of trying to standardize an approach during a time of rapid change. It may produce a better product for a while, but, over the long run, it cannot adapt quickly enough to stave off partial obsolescence and irrelevance, such as was suffered by public health agencies in the 1950s and 1960s.

Thus, from 1920 to 1988, public health agencies moved away from the relative simplicity of infectious disease control, as shown by the "basic six" approach to local public health work, and also largely moved away from the provision of direct preventive and curative medical care to individuals, both for philosophical and financial reasons.

Some of the seeds for this dichotomy between medical care and public health are found in the statements and the activities of C.-E.A. Winslow, although these also gave a much-needed positive impetus to both public health and medical care at the time they were written. This dichotomy, however, has left public health agencies weakened at a time of renewed threats from infectious diseases such as AIDS and Lyme disease, increasing threats from environmental and occupational health hazards, and greater need for the monitoring of the safety and quality of care in long-term care agencies and other community health settings. Many health departments are trying valiantly to accomplish these tasks while desperately short of resources to carry them out adequately, while other health departments appear to have given up the struggle to accomplish a global mission and have retreated back into the shell of the "basic six" and the state public health code, or some variant of these.

The simplicity of the early public health mission is being replaced by the complexity of the 1990s and by a new national statement of mission, which has directed public health departments to address the complex issues of planning and policy development and to avoid, when possible, the direct provision of services. Terris's warning may come back to haunt the writers of the IOM report: a health department that does not provide direct services will lose constituencies, and such a mission may be "... hardly compatible with a future of consequence" [25].

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