

FOUR YEARS OF DISTRICT HEALTH ADMINISTRATION IN NEW YORK CITY

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CITY health departments were created as a device through which the community, by taxation, could attain health improvement and protection. As the public became convinced of their usefulness they developed and advanced. Until shortly before the Great War they followed in general a uniform pattern of centralized control regardless of the size of the population served. During the last quarter of a century has come a recognition of the obvious geographical advantage of establishing localized service for many of the health departments' functions. The desirability of shifting from centralized to localized administration seemed especially evident in metropolitan areas. Thus was born the health center idea.

The "health center" is a term popularly applied to a wide variety of health undertakings, ranging from a small unit, where a handful of people receives some type of health service from a voluntary source, to a cooperative effort of public and private agencies undertaking to provide health service for a large population area.

In New York City we now think of a "health center" not as an isolated unit giving special services in a city "sore spot," but as one of the focal points of a city-wide administrative setup which localizes the work of a large department of health in districts of 200,000 to 300,000 population. The center makes it possible to bring together at one point the strength of all the health resources of the area for a common understanding, a united program, and an effective attack on the special health problems of that district as well as those that are common to the entire city.

Pioneer experiments to test the usefulness of health centers in

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selected areas had been going on for nearly a quarter of a century before the present broad district health administration program was launched in January, 1934, by the Department of Health.

Two broad general objectives were defined:

First, the health center as an administrative device, geared into the existing machinery of the Health Department, should make more effective the work of the functional bureaus of the Department.

Second, the health center as a district unit must become a vital and integral part of the community in which it is situated; it should serve as a focal point for informed community opinion and support in the field of public health.

Only as the first objective begins to be realized does the full meaning of the second become apparent, but the two are so closely interwoven as to form one pattern.

To initiate and build a structurally sound official program of district health administration on a city-wide basis has been a tremendous task. Changing from one type of departmental administration to another in a city so large as New York presents many problems. Ordinarily four years would be considered too short a period in which to attempt an evaluation of so fundamental and complex a new procedure. However, the existence of a large amount of demonstration data available for guidance, and the extraordinary speed with which the Department's health center program has forged ahead, due to the leadership and constant support of Mayor LaGuardia, makes the beginning of 1938 a suitable time at which to present a progress report and to look toward the future.

Our guidance in setting up this program was the experience of early health districts, started by Dr. S. S. Goldwater (Health Commissioner during 1914) in 1914 and carried on during 1915-1917 by Dr. Haven Emerson (Health Commissioner during 1915-1917) and of the health demonstrations conducted during the war and post-war periods.

The health districts of 1914-1917, while cooperating with the voluntary health and welfare agencies, were, in the main, branches of the Health Department. The health demonstrations were independent units, with no concern about adjusting their activities to a city-wide health program, and no need to balance their efforts with twenty-nine others in the same family group.

In the official city-wide plan, inaugurated in 1934, district health administration had to take its place as one part of the general public health program. It had further to observe the limitations of city budget. On the other hand it gained immeasurably by being recognized as an accepted official plan strongly supported by the City Administration.

To introduce so radical a change in administration into a static department would have been complicated. To accomplish this change in a dynamic department, which was constantly changing and expanding, was much more difficult. For example, the establishment of two new bureaus, tuberculosis and social hygiene, stimulated big advances in the control programs in their fields which was reflected in district work.

ORGANIZATION

The first step in organization was to set up the machinery for localized service and to create within the Health Department a Bureau of District Health Administration, with a full-time director. This Bureau was charged with the responsibility of mapping out the program and policies. The district health officers, working under the guidance of the Bureau of District Health Administration, were made responsible for carrying out in their districts the policies of the various bureau directors of the Health Department, for administrative supervision of the local services, and for suggesting program changes to make the work in the districts more effective.

The services which were already operating through field units, such as tuberculosis, child hygiene, etc., were first chosen to par-

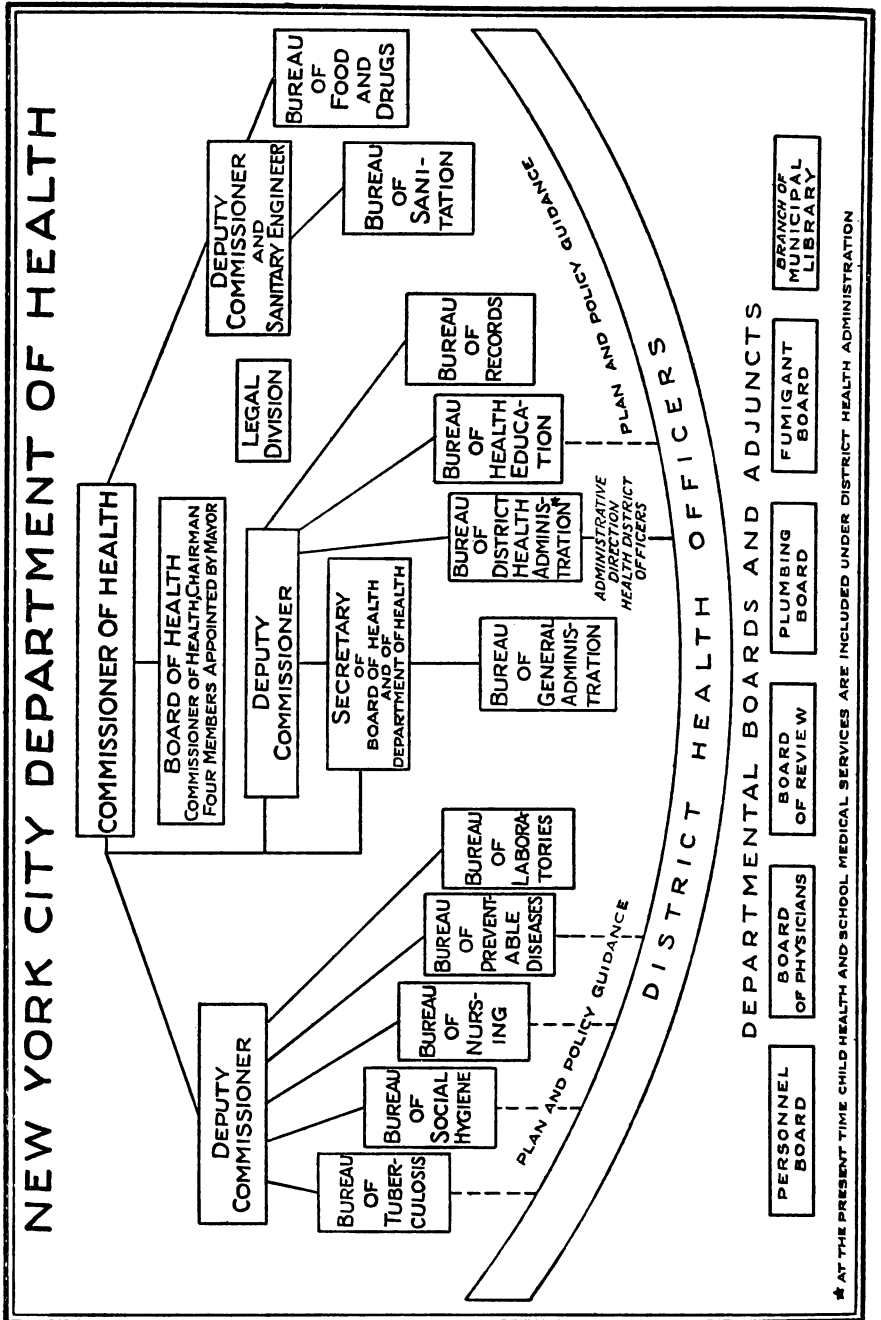


Fig. 1. Organization chart of the Department of Health of the City of New York.

ticipate in the localized program. (See Fig. 1). Later, the Bureau of General Administration participated by the assignment of custodial staff on a district basis and the Bureau of Laboratories by establishing local pneumonia-typing stations in some health centers.

Early in 1934 seven districts were selected as areas in which the need for more intensive health work was clearly evident. To each of these a full-time civil service health officer and staff were appointed. These first districts included two privately financed demonstration health centers, East Harlem and Bellevue-Yorkville, which were taken over by the City and incorporated in the new official program. The work of the Harlem Health Center, established by the City in 1930, was made the nucleus for the official Central Harlem Health District.

During 1935-1936 much time was spent in working out the new administrative procedures and relationships. The health officers had to gain both an intimate knowledge of the district problems and resources and a familiarity with the broad, general public health program. Many conferences were held between the bureau directors and the health officers so that each might know the assets of the other and how to work easily together. A manual of district health administration was prepared and published in preliminary form in 1936. This did much to clarify procedures.

As the work progressed it became increasingly apparent that district health administration as an administrative procedure would encounter innumerable handicaps unless it could be applied on a city-wide basis. In 1937 it was decided to place the entire City under the district plan.

To accomplish this two things were necessary. First, the small number of available district health officers was augmented by the assignment of physicians, from other services, to district health units under the title of medical-officer-in-charge. At the close of 1937, there were available thirteen district health officers and seven medical-officers-in-charge.

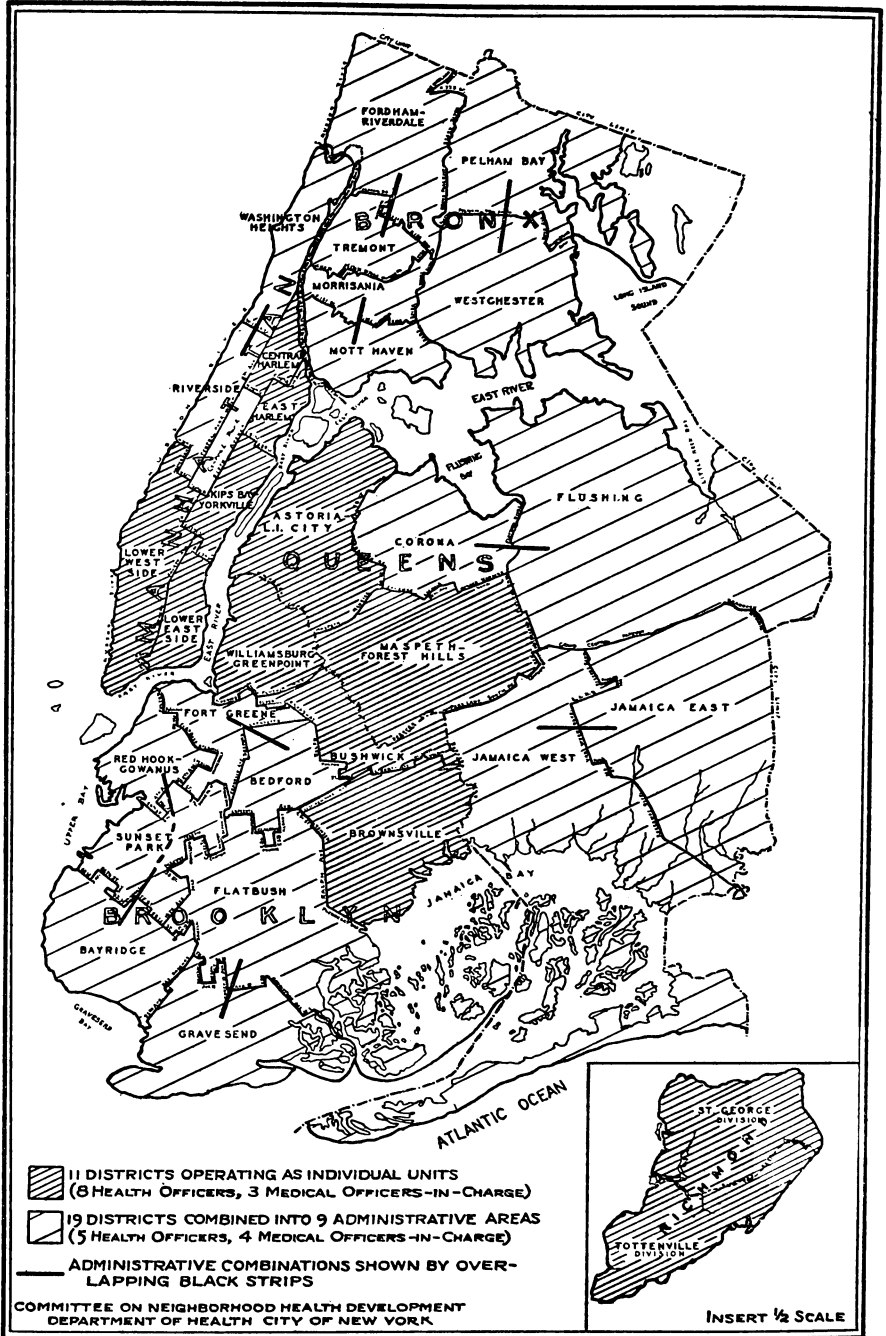


Fig. 2. Map of New York City, showing the health districts.

Second, the thirty districts were divided into twenty administrative units. Eleven districts operate as individual units, while the remaining nineteen are combined into nine areas for administrative purposes. (Fig. 2.) Coincident with this, the five Borough Offices of School and Child Hygiene were discontinued and their staff absorbed into district health administration, reducing duplication of service.

Thus at the end of four years, district health administration has established a framework throughout the City, in which the activities of functional bureaus may be more efficiently administered and render more effective service. The Ten Year Health Center Program contemplates the organization of all thirty districts by the close of 1945, each in adequate headquarters and with a full-time administrative officer.

BUILDING PROGRAM

To push the roots of this program deep into the soil of the community it seemed vital to have adequate local headquarters for the health officer, the nurses, doctors, and other groups who were to work in the unit. Besides this a solid structure in the district, around which the people of the community could rally and which they could call their own health building, was considered essential. While at first district offices were established on a small scale wherever they could be fitted into already existing city services, by the end of 1937, with the aid of PWA funds, nine new modern well-equipped buildings were completed and occupied.

Two additional buildings financed entirely by the City are now under construction. Funds for three others have been allocated in the 1938 capital outlay budget. In addition, the City purchased and remodeled one building, suitable for a health center. The continuing of the building program—the largest health building program ever undertaken by a city—is a definite part of the general Ten Year Plan.

These health center buildings provide adequate clinic room, offices for the executive staff and nursing units, an auditorium for lectures, and a certain amount of space for district welfare agencies. Free quarters are allocated to voluntary agencies on the understanding that an equivalent amount of additional service will be given to the district by the agency.

SUBSTATIONS

While the health center is the focal point for district work, there is need for a varying number of substations in each district. Some services, such as maternity, child health, and dental, are located at points throughout the area so that they may be easily available to the people. In some districts the case load necessitates more than one central tuberculosis or social hygiene service. Under WPA funds a building program is going forward for twelve new permanent child health stations. Cooperative arrangements with the Housing Authority have been made for allocation of space for health services in two of the new federal housing developments.

RESULTS IN TERMS OF DEPARTMENTAL SERVICE

There is no longer any doubt that the organization of a district under a full-time, competent health officer results in more effective service in that area. All available resources are carefully studied so that they may be used most effectively in relation to the particular needs and conditions of that district. Child health stations, for instance, are re-located so that their service is better adapted to certain transportation problems, population needs or racial customs.

When a new district service is to be established, the health officer assists the director of the functional bureau of the Health Department by recommendations based on local experience. He is in a position to know the best time and place for the work and he can attend to the necessary administrative details. As far as possible staff assignments from the Central bureaus are made on a district basis. This results in better working relationships, greater flexibility

of staff time within the district, and a greater interest on the part of the staff in district problems.

Along with the general knowledge and opinions gained by intimate contact with local work, goes a critical study of related basic data. Current records and basic statistics are readily available for use in program planning. Facts concealed by City or Borough figures show up clearly when data are segregated by districts or health areas. For example: In one district with a good economic status as a whole and few health problems, in terms of its customary morbidity and mortality rates, there seemed to be little need for any additional health service. However, in studying the neighborhood, the health officer found three health areas within the district with infant mortality rates of 51, 72, 65 for the period 1932-1936 compared with 47 for the district as a whole. Further study showed that a very high proportion of these deaths were neonatal, and that the maternal mortality rates for these three areas ranged from 8 to 16 (1932-1936) compared with 4 for the City as a whole. The health officer immediately started to search for the causes of this condition and to ascertain what steps could be undertaken for improvement.

Again, the tuberculosis mortality rate for New York City during a five-year period (1929-1933) was 66. Only by studying individual districts could we have discovered three districts in Manhattan with rates of 131, 155, and 247. In breaking down these three districts into health areas we found such startling rates as 372, 319, and 262. Obviously local statistical studies must be the guide for program planning.

The statistical data form the basis, but with this must go a knowledge of how to adapt the general program to the local problem. In the one district, for example, with a tuberculosis mortality rate of 131, four health areas had rates of 220, 208, 168, 130. These four areas represented a concentration of Puerto Rican and Negro population who did not use the tuberculosis service available in another part of the district where the population was largely Italian.

To remedy this situation a new convenient clinic service, with emphasis on Spanish speaking personnel, was established; a tuberculosis survey was conducted among home relief clients in the area; and intensive educational measures were begun. In the past year, 386 cases of pulmonary tuberculosis in these four areas have been discovered and placed under care, and the tuberculosis mortality rates are decreasing.

To further the use of current data by all members of the staff, the Bureau of District Health Administration in collaboration with the other bureaus, sends out each month to all those concerned, a six-months' study of some phase of the district work of one bureau. Questions are raised as to why deviations from the normal expectancy for that service have occurred. The district health officers, in consultation with the staff, prepare an answering report and discuss the problems. This device is new and needs to be developed further. However there is already apparent a keen interest in this phase of the work and suggestions for items to be included in these studies are coming in from district officers and bureau directors.

It has been possible through outside assistance during the past year, to make a study of the cost of services by bureaus and by districts for the year 1936. A pattern has been established so that cost analyses and service analyses can be correlated. So many pertinent facts have come to light in a preliminary analysis of this material that an extension of the study has been planned.

The general foundation of district health administration has been well laid, but many details of procedures and relationships must still be worked out. In a sense we are working in a pioneer field. Often in the early demonstrations that preceded our official district health administration program, a procedure would be introduced promptly as an experiment. Gearing new procedures into official machinery on a city-wide basis is much more difficult. Whole-hearted acceptance is gained by leadership rather than by authority. This requires time and patience and flexibility.

TEACHING CENTERS

In looking to the future, a large scale cooperative teaching program has been planned by the department and the five medical schools located in the City. Using five health centers for training purposes, this program will afford medical students an opportunity to learn about practical public health procedures and give department personnel the opportunity to secure post-graduate training. This is a program of great significance in its own right and will be the subject of later reports.

HEALTH EDUCATION

Of all the district services the one which is probably best suited to localization is health education. Effective teaching of health work must be based on an intimate understanding of the people to be taught. Subject matter must be adapted to many interests, traditional thought patterns and levels of intelligence. Health education seems also to be the field of public health which is least thoroughly geared into public health programs throughout the country. Too often it is the thing to be done if any money is left over. Trained personnel, tested procedures, and funds are inadequate. Four years of district experience have shown both the urgent necessity for organized health education among the people and some of the effective ways in which this can be done on a localized basis. Development of this work is one of the outstanding plans in the district program.

COMMUNITY ORGANIZATION

Four years' experience has shown that district administration can be and is an effective administrative device. There is also an accumulation of evidence that district health centers have already taken an integral and vital place in their communities.

The Department, through the health officer, offers to the community a variety of service planned with consideration for the needs

of that particular community. Medical services are efficiently administered and are carried out by competent doctors and nurses. Equipment is modern and adequate. Confidential information concerning patients is respected. Ethical relationships are maintained with the medical and dental professions. Up-to-date information on public health is made available to the public by health talks to selected groups, by lectures by qualified specialists to professional groups, by case conferences and round table discussions for workers in special fields, by the distribution of health literature, and by the courteous attention of the staff to requests for information.

Further, the Department has deliberately invited the advice and participation of the community in planning the district program. Community participation is effected through two district committees in each organized district: a District Medical Advisory Committee and a District Health Committee.

The District Medical Advisory Committee consists of from two to fifteen physicians who live or practice in the district. These members are recommended by the County Medical Society and are appointed by the Commissioner of Health. The medical committee has a twofold responsibility. It meets regularly with the health officer and advises with him concerning community health problems. It also reports back its opinions concerning district work to the County Medical Society. These district medical committees come under the direction of the Committee on District Cooperation with the Medical Profession (one of the standing committees of the Committee of Neighborhood Health Development). (*See Fig. 1.*) Advising the members of this latter group are two official representatives of each of the five county medical societies. This close relationship between the Health Department and the medical leaders, with its resultant understanding and tolerance, has become a most valuable asset to the district program.

The District Health Committee offers a similar opportunity for participation to workers in the district in various fields of health

and welfare, public spirited citizens, and representatives of civic, religious, and social groups. Members of this committee are appointed by the Commissioner. They meet monthly with the health officer to consider program planning and district problems. They, too, interpret to their own groups the policies and objectives of the Department, and present to the Department the needs of the district. Active subcommittees study, make recommendations, and help to solve the problems in special fields of district work, such as maternity and child hygiene, school health, health education, tuberculosis, and social hygiene. These committees have proved so effective and of such value to the Department that one of the most active standing committees is the one on community organization. This group is the parent body of the district committees and provides the services of a secretary and three field assistants for the development of this program.

Participation by the dentists of the districts is not yet as extensive as that of the medical profession but the same cordial spirit exists. Two or three local dentists are recommended by the Committee on District Cooperation with the Dental Profession and appointed by the Commissioner to membership on the District Health Committee or the Medical Advisory Committee.

A unique opportunity to present the health center philosophy and program to the community was found in the opening of eight new health center buildings during 1937. The Health Department and the Committee on Neighborhood Health Development conducted a most successful campaign for interpreting district health centers to the public through the press, the radio, opening and dedication ceremonies, and various other devices. A real civic pride was developed.

This vital integration of the local health center with its community has been possible because, through the Committee on Neighborhood Health Development, the entire program of health center development has been for nearly ten years a vital part of the

thinking of health and welfare leaders throughout the City. The Committee on Neighborhood Health Development, organized in 1929 with the Commissioner of Health as chairman, consists of leaders in the field of medicine, public health, social welfare, and allied groups. Its work has been of inestimable value. Its members have given substantially of their time and interest in advising with the Health Department and assisting in working out the program.

District health administration is now generally recognized throughout the City as a successful policy of the Department of Health. That other public departments and voluntary agencies are thinking along district lines for their own activities is a tribute to the painstaking, substantial foundation on which the centers have been built.