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A Study of the District Health System in New Mexico

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A STUDY OF THE DISTRICT HEALTH SYSTEM IN NEW MEXICO

By

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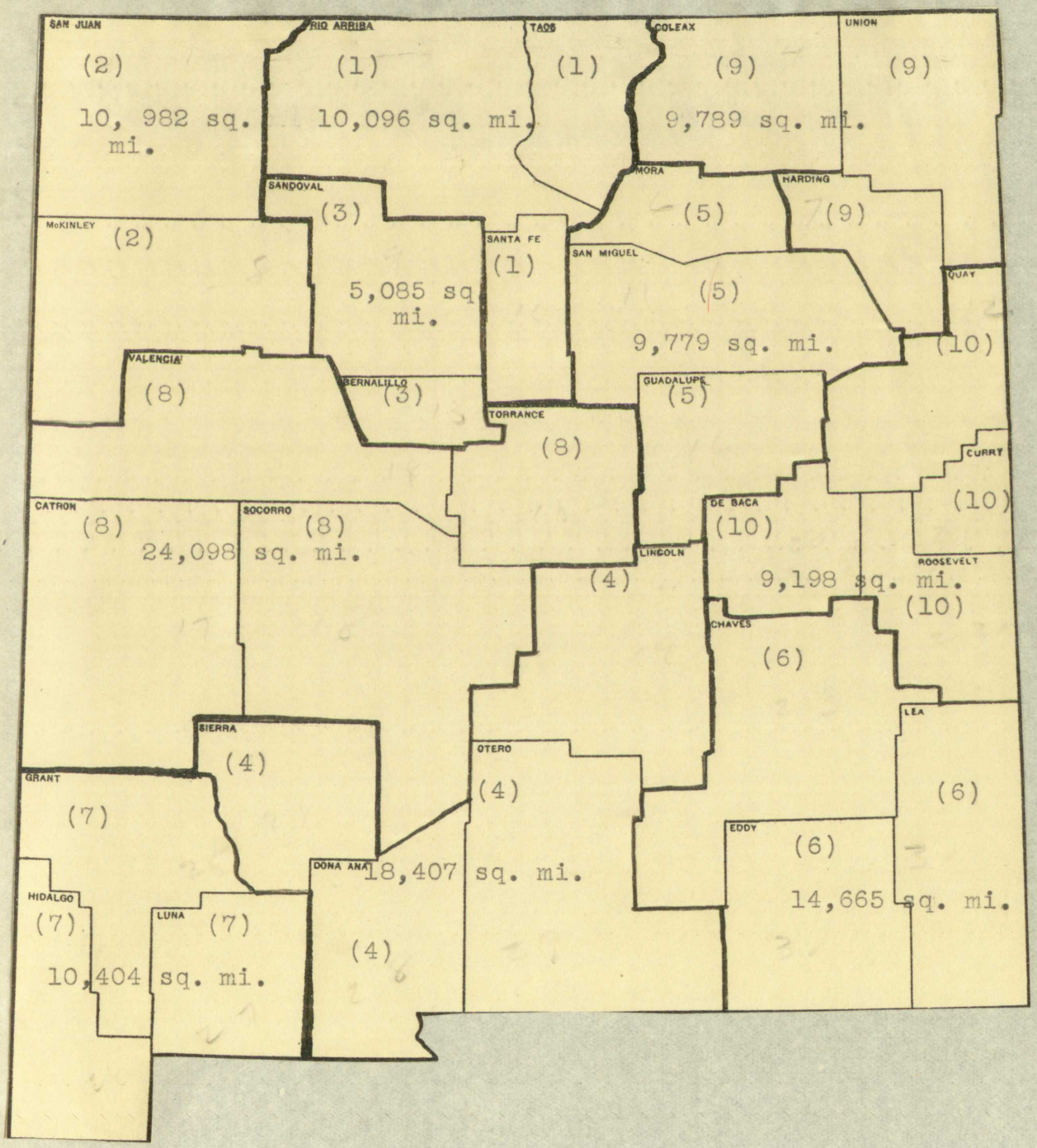

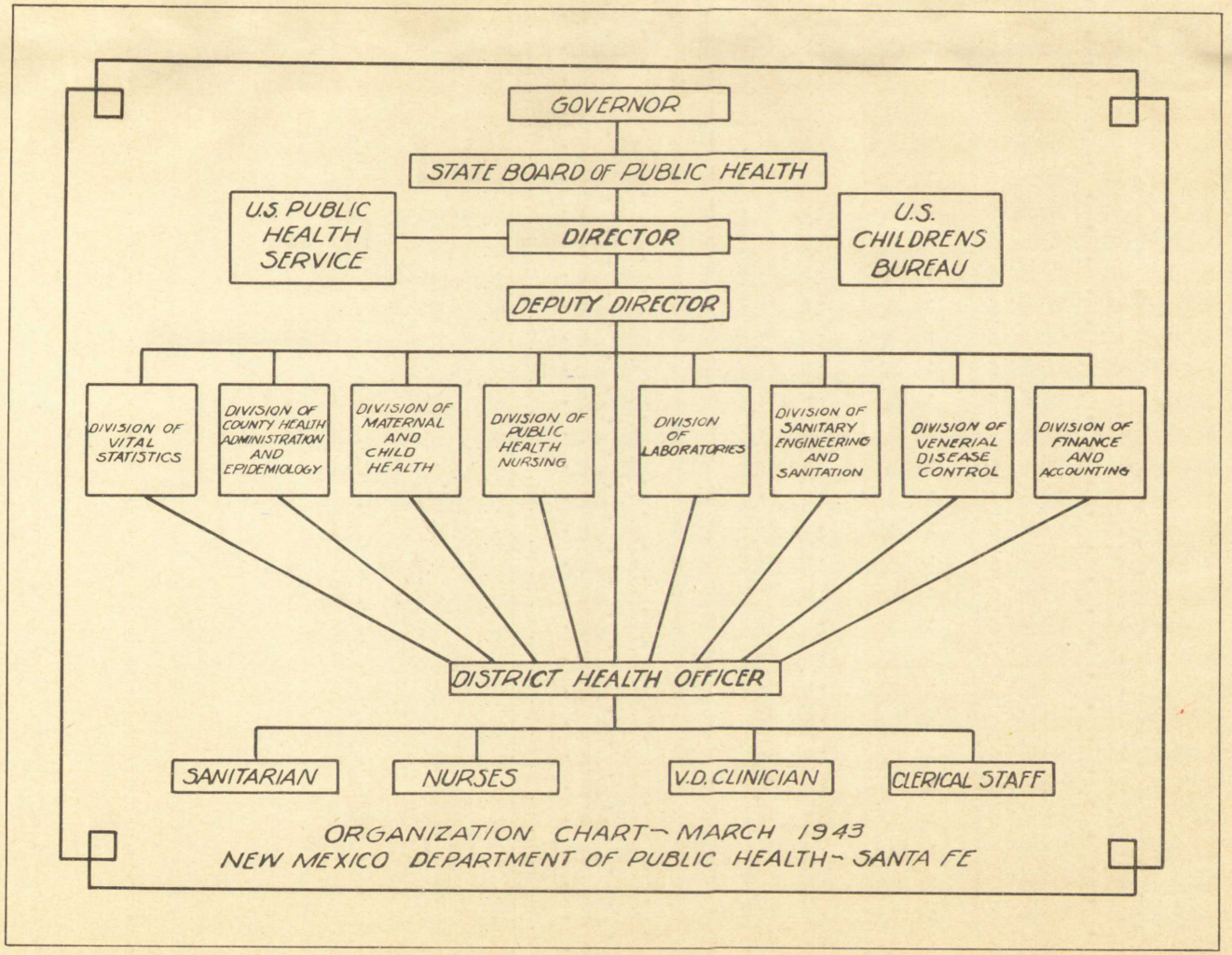

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CHAPTER I

INTRODUCTION

For many years there has been a difference of opinion regarding the administration of the District Health Act in New Mexico. There have been repeated efforts to repeal this act, and it has been subjected to much criticism. The purpose of this study is to examine the criticisms leveled against the Act of 1935, and to make an objective analysis of the administration of the district health system, with a view to determining whether the criticisms are valid in terms of organization and administration, or whether, if valid, it is due to certain factors not inherent in the district system of administration itself.

Importance of the study. Public health has been considered a function of government since early colonial days, when the first laws of the towns included those on sanitation. The question is constantly arising regarding the best or most effective method of administration. Although there is a great difference in the methods which should be employed in urban and suburban areas, and the methods best suited to a more rural region, certain minimum standards have been devised by authorities in the field

of health administration. The administration of the New Mexico district health system will be analyzed with these standards in mind, to determine whether the principles set forth in the laws of this state are in accord with principles which have grown out of the best experience in public health administration.

Organization of the thesis. Before an examination of the administration of the district health system is made, some of the background will be discussed; that is, the factors leading to the establishment of the act. Many of the objections which were raised at the time are still heard and some new ones have been voiced since the system has been active. These will be outlined. The analysis of the system will be made by examining (1) the problems of the state in terms of geographic, economic and social factors, (2) the functions of the personnel engaged in administering the service of the public health program, (3) the relative merits of this over some of the other systems which might be devised to take its place, (4) the problems and needs of the future in promoting the purposes of public health.

Sources of data. There has been no detailed analysis or description of the local administration of public health in New Mexico. A description of the state public

health movement was written by Donnelly in 1938.[1] Two surveys have been made of the health conditions and administration in the state. One was made in 1931 by Covington, field agent for the International Health Division of the Rockefeller Foundation.[2] The other was made in 1934 by Buck, field director, American Public Health Association.[3] These two surveys were made prior to the enactment of the District Health Law in 1935, and had considerable influence in the development of this law.

In the field of public health in general, constant reference is made to Smillie's work Public Health Administration in the United States.[4] Smillie is an outstanding authority on public health administration, and is professor of public health administration at Harvard University. Reference is also made to publications of other acknowledged

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[1] Thomas C. Donnelly, Public Health Administration in New Mexico (University of New Mexico Bulletin. Albuquerque: University of New Mexico Press, 1938).

[2] Platt W. Covington, Official Public Health Administration in New Mexico (Report to the Rockefeller Foundation, 1931). An abstract of this report was printed in the U. S. Daily News, March 13, 1931.

[3] Carl E. Buck, Health Survey of the State of New Mexico, (Published by authority of the New Mexico State Planning Board).

[4] W. G. Smillie, Public Health Administration in the United States (New York: MacMillan Company, 1935).

authorities on health administration. Although these sources deal with the administrative practices in the field of public health, there is little material on the program of a region with the problems found in New Mexico.

CHAPTER II

THE DISTRICT HEALTH ACT

INTRODUCTION

Under the legislation of 1919 each board of county commissioners was directed to appoint and employ one county health officer, subject to the approval of the state board of public welfare. He was to have the same powers and duties as the state department of public welfare in the protection of public health. This person was to be paid for his services and all necessary expenses incurred, including travel. The burden of financing the program fell upon the county, which was limited in raising a health fund by the provision that no more than "one half of one mill on the dollar of assessed valuation on all taxable property" could be allocated to the health fund. However, the county was permitted to draw from the general fund for health expenses in case of emergency.[5]

The salary which could be paid to the county health officer was limited, with the following provision:

> ". . . No person shall be appointed or employed as a county health officer at a compensation in excess of one thousand eight hundred dollars ($1,800.00)

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[5] New Mexico Statutes, 1929 comp. Chap. 110, Art. 3.

> per annum, unless he shall have had such special training and experience in sanitary science and public health administration as the state board of public welfare shall by regulation prescribe."[6]

The officer appointed in nearly every case was a practicing physician in the county who was able to devote only part of his time to the duties as public health officer. He was not a full-time health officer, nor was he expected to be.

ADVOCATES OF THE DISTRICT SYSTEM

For many years prior to 1935 the suggestion had been made by various authorities that New Mexico adopt the district system of health administration. Luckett, state director of public health until his resignation in 1930, said in his report to the governor in 1938 that "It is becoming more evident, as experience accumulates, that the full time county health department offers the only satisfactory means of providing local health service economically."[7] The law of 1919 had made it mandatory upon each county to appoint a health officer, but not a full-time one. In 1930, only eight of the counties had a full-time health unit. Luckett, in his report to the governor and the legislature in 1931, recommended that:

"Some way must be found to give every county in the

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[6] New Mexico Statutes, 1929 comp. Chap. 110, Art. 3.

[7] Report of the Bureau of Health, 1928, p. 1.

state the services of a trained full time health officer. Eight have already made provision for it, while seven more can do so without undue cost. The remaining sixteen cannot individually meet the full expense, but could unite with neighboring counties to employ a district health officer. A few such districts could cover the entire group. Each county should have its own nurse, and the present part time health officers might be continued as deputies. State aid would be needed for a while in some districts. The law should be amended so that an individual county could not disrupt the district, but would have to act in unison with the others."[8]

When Luckett resigned in 1930, he was succeeded by Earp. In Earp's report to the governor in 1932, he also proposed a district health system.[9] The survey made by Covington in 1931, recommended the passage of "an enabling act permitting two or more contiguous counties to establish a joint health district."[10] The survey made by Buck in 1934, suggested in the summary, the grouping of counties and developing a "plan of District Health Units" and further recommended that the funds furnished by the counties be pooled with those of the State Bureau for the administration of the plan.[11]

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[8] Report of the New Mexico Bureau of Public Health, 1930, p. 15.

[9] Ibid. 1932, p. 12.

[10] P. W. Covington, Report on Health Administration in New Mexico, (Report to the Rockefeller Foundation, 1931).

[11] Carl E. Buck, Health Survey of the State of New Mexico. (Buck stated that this plan should be effected with the objective of finally providing full-time officials in each county.)

These two reports supported the movement for a district health system. Again in 1934 Earp renewed his proposal[12] and in 1935 the bill setting up a district health system was passed by the legislature.

SOCIAL SECURITY ACT

Although the efforts of the various directors of the bureau of health were of importance in the passage of the bill, the influence of the Social Security Act of 1935 is not to be ignored. In this act, funds were made available to local units and to the state bureau, after certain conditions have been met. These conditions include the following:

> 1. Although it is recognized that many state and territorial health departments conduct a number of important specialized health activities, for the purpose of allocation of funds under this act, no state or territorial health department shall be regarded as properly organized which does not provide as a minimum on a full-time basis the services listed below:
>
> a. A qualified full-time state or territorial health officer.
>
> b. Adequate provision for the administrative guidance of local health services.[13]

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[12] Report of the New Mexico Bureau of Public Health, 1934.

[13] J. R. Earp, "The Public Health Program in New Mexico," New Mexico Business Review, V (January, 1936), #1 pp. 120-1.

PROVISIONS OF THE ACT OF 1935

The legislation of 1935 did not change any part of the laws established in 1919 except to add to the services a full-time health officer, and to create health districts. The counties were grouped into districts on the basis of assessed valuation, grouping together one or more wealthy counties with poorer counties. Standards set for the administering of health in such rural areas are as follows:

> "Even in counties with a population of 25,000 to 30,000 people, but with a large, sparsely settled area and a total annual income of less than $10,000,000 ($300.00 per capita) a standard county health unit is not a feasible organization." [14]

> "An ideal health district should consist of a population of about fifty thousand persons and an area not to exceed one thousand square miles, with a ready means of communication." [15]

In New Mexico some of the districts have as high as 24,098 square miles.[16] Yet such a combination of counties has been necessary to provide the minimum annual income of $10,000,000. It would be financially impossible to provide full-time health administration in many of the counties without the assistance of another county. It should be remembered that it was the intention of Buck to establish

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[14] Smillie, W. G. Public Health Administration in the United States, (New York: The MacMillan Company) 1936. P. 318

[15] Ibid., p. 330.

[16] District VIII, Valencia, Catron, Socorro, Torrance.

the district system with the aim of eventually providing full-time county administration.[17] Under the present status of counties in the state, this does not seem to be practicable for some time to come. In many of the counties the land is poor and non-productive. The assessed valuation is very low. The tax limitation imposed upon the counties is "one mill on the dollar of assessed valuation of such property" which is taxable.[18] In some counties nearly sixty per cent of the land is owned by the state and federal governments. This is not liable to taxation, and lowers the income of the counties.

The is the financial problem which confronts the administration of the public health program in the state. Without the district health system no full-time health officer could be employed. With the district health system, the area and population impose distinct limitations upon the service which can be given under even minimum standards. Each district, for the most part, cannot boast of having a ready means of communication. Often the travel is over roads which are closed some of the months of the year, and are very poor the year round. Many small settlements remain

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[17] Buck, Carl E., op. cit., p. 32.

[18] New Mexico Statutes, 1941 comp. Chap. 71, Art. 1.

isolated because of geographic, economic and social factors. They still present a problem of health and sanitation; these problems do not remain confined by such conditions to the area.

In establishing the district health system in 1935, the legislature abolished the county health officer position, transferring the duties to the district officer. If at any time the act should be repealed, some other provision must be made for full-time health coverage for the state. It is not conceivable that all the counties in the state could maintain the best standards of public health with the services of the public health nurse and the district or local sanitarian only. The enactment of a new health bill, providing some system to include health officers would be necessary to comply with the standards set by the Social Security Act and to give the state the service it needs.

The legal right of any county to employ a health officer must come from the legislature. If this right were given, or even made mandatory, it would put the entire system back on the inadequate basis upon which it formerly operated and the possibility is great that the situation would again be as it was prior to 1935. Furthermore, there would be a great loss of funds derived from the Social Security Act and other national sources.

CRITICISMS MADE OF THE DISTRICT HEALTH SYSTEM

For many years there have been concerted efforts to repeal the District Health Act of 1935. These have, in some cases, provided for a return to the county basis and for augmenting the administration at the top level by adding assistant health directors. Different reasons have been advanced for these moves.

One of the criticisms is that the district health officer is not "performing his duties." It must be remembered that under the old county system part-time county officers were appointed who were practicing physicians. They combined their private practice with their duties as county health officers, and also with their treatment of charity patients paid for through the county indigent fund. The confusion of purposes of the new health system stem from this multiplicity of functions. Many persons felt that since the district officer did not take care of charity patients, he was not performing his duties. Others have stated that the officers in some districts were also carrying on a private practice and that this was not right. This is true, in one instance, where there was no physician in a small town and the health officer was given special authorization to help out whenever possible.

Another criticism has come from counties which were previously able to provide adequate medical care. These

counties have expressed some dissatisfaction at being combined with other poorer counties. The feeling has been that it is unjust for them to have to assist in providing health services to neighboring counties. They have stated that in so doing their own services have been curtailed. This may be justified, since the area to be served by the officer is much greater, and there is a lack of available personnel, particularly during the war years. This is clearly shown by the statement of McIntyre in 1943 report of the State Department of Public Health:

> "The value of a district scheme of operating several venereal disease diagnostic and treatment facilities is perfectly obvious to those familiar with existing conditions in the State of New Mexico. New Mexico is the fourth largest state in the Union. It comprises an area of 122,503 square miles, approximately twice the combined area of all the New England states. It embraces a population of half a million residents, widely scattered as evidenced by individual county population densities, varying from 0.5 persons to 11.2 persons per square mile, in the thirty-one counties comprising the state, except Bernalillo, which has a population density of 38 persons per square mile. Approximately 60% of the total population are Spanish American and the Spanish language is still the predominant tongue spoken in many parts of the state, especially in rural areas. Facilities for medical care prior to the war were very limited and for the most part restricted to the larger centers of population, 75% of the total number of physicians practicing in the state being concentrated in Albuquerque. As a result of this concentration, medical attention in rural areas was hopelessly inadequate, a trip of fifty to one hundred miles or more, by automobile, wagon, and occasionally horseback, being necessary for the inhabitants of many communities to reach the nearest source of medical care. The inaccessibility of medical care created by great distances is further complicated by environmental factors. While the climate of

> New Mexico is dry, the mean annual rainfall varies from twelve to sixteen inches in different localities and at times is heavy enough to make travel even on the few improved highways difficult, if not impossible. Moreover, during the winter months the precipitation in the higher mountainous areas of the state frequently results in heavy snows that make the roads impassable for weeks. Also, during recent months the difficulties of transportation have been increased due to the effects of gasoline rationing and rubber shortage in a state with extremely limited public transportation facilities. Conditions attending our present wartime emergency have further curtailed the availability of medical services due to the absorption of a comparatively large number of New Mexico physicians into the armed forces. In some areas, the enlistment of one physician has resulted in the total loss of all professional medical service; whereas in other areas, it has forced a tremendous burden on the remaining physicians, usually limited in capacity to serve in the armed forces by reason of health or age and who, because of these limitations, are forced to distirbute their services to meet the emergency needs only at the expense of neglecting the less alarming and frequently more devastating venereal infection. Hospital facilities are even more limited and the operation of several larger private institutions has actually been discontinued due to lack of available professional personnel."[19]

Without considering many of these factors involved, many have asserted that the system of district administration has not been working. The criticisms have come from the following factors, basically: (1) misunderstanding of the purposes of public health, and the duties of the district health officer; (2) inability of some of the counties to carry their full share of the district expenses; (3) isolated

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[19] New Mexico Health Officer, 1943. p. 69.

communities coupled with vast areas and distances and poor roads; and (4) limited available personnel.

Probably no one will dispute the fact that the system has not been operating with top efficiency, especially during the war years, but the reasons for the situation should be carefully analyzed in order to find the best way to correct it. In the following chapters the administrative structure of the system will be discussed. The duties, method of selection, qualifications, and activities of the personnel actively engaged in the administration of public health, will be analyzed in accord with the accepted standards of practice. The personnel considered will be the district health officer, the district sanitarian, and the public health nurses.

CHAPTER III

THE DISTRICT HEALTH OFFICER

QUALIFICATIONS

The standards of personnel and service under a district system of health administration differ little from standards set under county or other forms of rural administration. The type of personnel needed is the same. The problems which create the need for a district health system are also the same as those which make necessary any public health system.

The standards which have been set for the selection of a district health officer in this state follow closely the remarks of Smillie:

> "The ideal training for a health officer includes collegiate training, a medical degree, and at least one year's hospital interneship. The hospital interneship should include, if possible, special work in communicable diseases and pediatrics. This basic training should be followed by an academic year of formal training in a school of public health."[20]

The laws of New Mexico state that the district health officer shall have experience as a full-time county or municipal health officer, or as assistant to such an

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[20] Smillie, op. cit., p. 417.

official, a diploma from a special course of training with instruction in sanitary science, and public health administration, or that he complete a written examination with a grade of 70% or more.[21]

SELECTION

It has been recommended by some authorities that the selection of the district health officer be made by the state director of public health and that he assign the official to his jurisdiction. This would be the method in a highly centralized administrative system, but would very likely be received with a strong objection in a state where the principle of local autonomy is strong. The most common method of appointment is the method discussed by Mustard as follows:

> "State laws should set forth the method of appointment of the health officer, his tenure of office, and the method of removal from office. The exact method which is best to follow will depend to some extent upon the relationship of the health department to the local government. The former may appoint the local health officer subject to confirmation by a local board of health of the properly organized body, or the local group may nominate or appoint the local health officer subject to approval of the state health officer. It is probable that the latter method is the one of choice for, since the health officer is to serve in a local capacity, the local government is less likely to be

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[21] New Mexico Statutes, 1941 comp. Chap. 71, Art. 2

critical of one whom it chooses, and will probably be more interested in his work, than when he is chosen by a somewhat remote state health department." [22]

The method of selection in New Mexico follows the latter of the methods suggested above; that is, District Health Boards select their choice, and he must be approved by the state director, after having passed the examination. These boards are representative of all the counties in the district. They are composed of two members from each county in the district, appointed by the county commissioners. They serve without pay.[23]

Salary. The salary of the district health officer is fixed by law at $3600.00 per annum, with travel allowance not to exceed $1200.00 per annum.[24] This salary is provided by the district, with the amount from each county prorated in accordance with its assessed valuation. Each county must provide adequate office facilities for the health department and bear the expenses incurred in the county.[25] The fund raised in the county and the district for the expense of the district health officer is sent to the state treasury and from there sent to the health department to be disbursed on vouchers to the district officers.

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[22] Mustard, Harry S., Rural Health Practice, (New York: The Commonwealth Fund, 1936) p. 32.

[23] New Mexico Statutes, 1941 comp. Chap. 71, Art. 2.

[24] Ibid.

[25] Ibid.

DUTIES OF THE HEALTH OFFICER

The duties of the district health officer are the same as the duties prescribed for the state board of public health and the state director. The legal bases for his activities are found in the state laws which provide that they must perform the functions assigned to the state board. Their position is described by Tobey as follows:

> "All local health officers are, furthermore, officers of the State. Their jurisdiction is, of course, confined to their own communities or to the area designated by law, but they are, nevertheless, official agents of the state since they are officers of political sub-divisions of the state." [26]

In the state of New Mexico the officer is responsible to the state board and is under the direct supervision of the state director of public health. His powers described in the laws[27] are:

1. Supervise the health of the people of the state.
2. Investigate, control, and abate the causes of disease, especially epidemics, sources of mortality and effects of localities, employment, and other conditions on public health.

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[26] Tobey, James A., Public Health Law. (New York: The Commonwealth Fund, 1939) p. 98.

[27] In 1937 the State Bureau of Public Health was taken out of the jurisdiction of the State Board of Public Welfare and put under a separate board. It is now the State Department of Public Health and is under an independent board, with all the powers and duties pertaining to public health which were part of the public welfare department.

3. Inspect public buildings, institutions, premises and industries and to regulate the sanitation thereof in the interest of public health.

4. Regulate the sanitation of schools, hospitals and sanitoriums, maternity homes, asylums, orphanages, hotels, restaurants, lodging houses and tenements, factories, workshops, industrial and labor camps, recreational resorts and camps, barber shops, swimming pools and public baths, places of public amusements, and public conveyances and stations.

5. Establish, maintain, and enforce isolation and quarantine.

6. Close theatres, schools, and all public places and forbid gatherings of people when necessary for the protection of public health.

7. Abate nuisances endangering the public health.

8. Regulate plumbing, drainage, water supply, sewage and waste disposal, lighting, heating, ventilation, and sanitation of public buildings, in the interest of public health.

9. Collect, compile, and tabulate the reports of marriages, births, deaths, and morbidity and to require the submission of such information as may be required for such purposes.

10. Cooperate with the health agencies of the Federal Government and other health agencies in carrying out measures for the protection of public health.

11. Receive such gifts, subsidies, donations, allotments or bequests as may be offered to the state, by the Federal Government or any department thereof, or by any public or private foundation or individual for the purpose of promoting public health.

12. Regulate the disposal, transportation, interment, and disinterment of the dead, to such extent as may be reasonable and necessary for the protection of public health.

13. Operate and maintain laboratory facilities for the investigation of public health matters.

14. Disseminate information on public health matters.

15. Aid and advise in the prevention of infant mortality and infant blindness.

16. Promote child hygiene.

17. Regulate the sanitation and safety for consumption of milk, meats, and other foods and drugs.

18. Regulate the practice of midwifery.

(18½) To prescribe the minimum professional qualifications of public health nurses, school nurses, and sanitarians.

19. Establish, maintain and enforce such rules and regulations as may be necessary to carry out the intent of this and to publish the same.[28]

The New Mexico public health system has been acclaimed one of the nation's best.[29] In order to see how it stands today, it should be compared with the standards set by the authorities on the administration of public health. Smillie divides the activities of the health officer into six fields. They are:

1. Administrative duties.

2. Communicable disease and epidemiology.

3. School hygiene.

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[28] New Mexico Statutes, op. cit. Chap. 71, Art. 1.

[29] Luckett, G. S., "Health Work in New Mexico is Five Years Old," The Nation's Health, November, 1924.

4. Tuberculosis clinics.

5. Vaccination and immunization.

6. Infant and maternal hygiene.[30]

ADMINISTRATIVE DUTIES

> "The health officer is the executive for the Board of Health, and administers the work of the department, planning and coordinating the activities of each of its members. . . The various members of the unit are responsible to him for performance of their duties." [31]

The New Mexico district health officer has the power to supervise the activities of the personnel in his district, and to coordinate their activities, even though they may be placed in the field by one of the divisions such as the division of sanitation. He approves the appointment of the nurses and other local personnel employed by the county,[32] supervises the reporting of the county health department, and directs the activities of the sanitarian. His administrative powers are granted him through the provision in the act of 1935 which transfers the duties and powers of the county officer to the district officer. It states, in reference to the county officer, that:

> "He shall possess the same powers with the respect to the preservation of the public health and the ad-

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[30] Smillie, op. cit. pp. 321

[31] Smillie, op. cit. pp. 321-322.

[32] The Merit System has been extended to cover this to some extent. It covers nurses and clerical workers. See the New Mexico Health Officer, 1943, pp. 83-84.

ministration and enforcement of the health laws as those conferred upon the state department of public welfare (state department of public health), except that said powers shall be exercised within his jurisdiction only and in subordination to and with the approval of the state department of public welfare (state department of public health). He shall be charged with the execution within his jurisdiction of the health laws and all rules and regulations promulgated by the state board of public welfare (state board of public health), be under its supervision and control and make such reports to the state department of public welfare as it may direct." [33]

These administrative duties extend to every phase of the public health program within the district. The officer must be directly responsible to the state board for the exercising of his powers, for the activities of the entire district, and for the reports made by the county departments of health. Furthermore, in the absence of other personnel, or the lack of local practicing physicians, he must perform the other activities personally, besides supervising other work. If it is possible to send other doctors out, such as the venereal disease clinicians, the officer is relieved of some of the duties, and has the time to devote to administrative work. When possible, local practicing medical men are enlisted to devote some of their time to the clinics and other preventive measures.

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[33] New Mexico Statutes, 1929 comp. Chap. 110, Art. 3. Throughout the laws of 1929 the department of public welfare was charged with the health responsibilities. When the change was made in 1937, the duties described were under the health department. The parentheses were inserted by the author.

COMMUNICABLE DISEASES AND EPIDEMIOLOGY

> "The health officer must be an expert in the diagnosis of contagious diseases. He should be available to all the physicians in the county for consultation in diagnosis." [34]

In the field of communicable diseases, the health officer has a problem of time and personnel. The communicable diseases include all the "reportable" diseases, tuberculosis, venereal disease, and other infectious diseases. The reportable diseases include such illnesses as chickenpox, measles, rabies, as well as occupational diseases, and food poisoning, or even cancer. The work in connection with the tuberculosis clinics and the venereal diseases will be discussed under separate headings.

The objectives of the system of investigating and reporting communicable diseases are: (1) discover the focus, or the source through which the disease was contracted; (2) prevent the spread of the disease.[35] In performing these duties, the officer must have the time to visit the case when necessary, to go out in the community and the outlying districts to examine the sources of water and food, and to make a thorough investigation of the contacts the patient had before and after the disease was reported. He must have available to him the necessary

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[34] Smillie, op. cit. p. 322.

[35] Mustard, op. cit. p. 373.

TABLE I

COMMUNICABLE DISEASE CONTROL

Table Showing the Number of Immunizations and Number of Cases for a Five Year Period (1939-1943)

YEAR	SMALLPOX		DIPTHERIA		TYPHOID	
	Vaccinations	Cases	Immunizations	Cases	Immunizations	Cases
1939	14,776	33	13,737	107	9,492	136
1940	15,791	14	13,090	73	8,180	148
1941	15,031	4	12,169	64	17,960	112
1942	14,978	4	17,894	86	12,629	116
1943	14,424	4	17,646	50	10,544	85
Totals	75,000	59	74,536	380	58,805	597

Source: New Mexico Health Officer, 1943.

personnel to help enforce the quarantine properly and to make a good investigation of the sanitation.

Obviously under any system of public health, with the possible exception of a large city with a large health staff, some cases are not followed through to the same extent as more serious ones. In such cases as mumps the epidemiological investigation is not stressed to the extent that smallpox or typhoid fever would be. The need for swift investigation is great. The more serious diseases should be given preference over all other work because these are emergencies. Since there is delay in calling the family physician, and delay in reporting, little time can be allowed to pass before control measures are introduced.[36]

Sometimes the relationship of the health department, and the health officer, with the local physicians is subjected to considerable strain in the follow-up visits. These visits are necessary in cases of the more serious diseases, and are forced upon the health officer by the public, or by the laws on quarantine and isolation. The visits to the home can be made by the nurse much more conveniently and with less criticism or suspicion than by the officer.

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[36] Mustard, op. cit. p. 373 ff.

The reporting of the disease requires a good system in the health office. The card files, and the weekly and monthly reports must be kept up, in order to plan the needs and to tell the success of the program. This is done by the clerk in the local department but is the responsibility of the health officer. Every disease reported is entered on the records. If the officer investigated every "lead" on disease and possible contacts and carriers, he might well find himself devoting his entire time to this activity alone. The responsibility cannot be shifted, and the need for adequate and responsible personnel is great.

SCHOOL HEALTH PROGRAM

> "In the smaller counties, the health officer will make all physical examinations of school children. In larger counties, the Health Department may employ some of the physicians of the county on a part-time basis to aid in the medical examination of the school children."[37]

The state laws require that the school authorities see to the compliance of the children with the laws on vaccination and immunization. This is the duty of the county school superintendent, who acts trough the teachers, the school nurse, if any, and the public health nurse. In this state this is largely the function of the nurse, although the health officer sometimes is called in to vaccinate. The law states:

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[37] Smillie, op. cit. p. 323.

> "The state department of public welfare (state department of public health) shall make suitable provision for the innoculation of the inhabitants of this state with cowpox vaccine, under the direction of the county (district) health officers." 38

It further provides that all school children must be vaccinated before they can be permitted to attend school. The school superintendent is required to see that each child has a certificate of vaccination.[39] When vaccination is given by the health officer, no charge can be made, but the county must pay the expense. In cases where the service is performed at the county health department, under the clinical service for pre-school children, the county provides the vaccine; if the service is part of the yearly school program, the school provides the vaccine. While the county system was still being used, an attorney general's decision was made, stating that the officer was not required by law to be present at the vaccination, but that he was charged with the responsibility of directly supervising the program.[40]

In this field, as well as the physical examination of school children, an effort is made to see that there is

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[38] New Mexico Statutes, 1929 comp. Chap. 110, Art. 3.

[39] Ibid. (See Chap. 71, Art. 3, 1941 comp.)

[40] Attorney General's Decision, April 3, 1933.

some local doctor to devote some of his time to the program. He may be paid for his service by the school or the county. This relieves the health officer of the duty of performing the service, but he still is directly responsible for the administration. At the present time, with the lack of medical personnel in the communities in the state, the health officer is present during both the vaccination and the examination.

TUBERCULOSIS CLINICS

Tuberculosis clinics are one of the more important fields in the public health problems of New Mexico. The objectives of the clinics are:

> "The rural health department may best express its immediate goals in terms of (a) case finding, (b) facilities for diagnosis, (c) facilities for treatment, and supplementing these, (d) an effective program of public health nursing."[41]

The incidence of tuberculosis in New Mexico is comparatively high. Because of the climate, which is favorable to persons with tuberculosis, fifty per cent or more of the cases reported are of out of state origin.

Case finding is one of the tasks, because it is necessary to check contacts of the patients in order to control the spread of the disease. This is done by holding clinics, where x-ray, skin tests, and patch tests are given.

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[41] Mustard, op. cit. p. 489.

TABLE II

TUBERCULOSIS CASES IN NEW MEXICO

1939 to 1943

Year	Total	Origin Within State	Per Cent	Origin Outside State	Per Cent	Per Cent
1939	871	407	44.2	464	57.8	100
1940	938	387	41.2	551	58.8	100
1941	931	398	42.8	533	57.2	100
1942	905	315	34.8	590	65.2	100
1943	1,013	436	43.0	577	57.0	100
Total	4,658	1,943	41.7	2,715	59.2	100

Source: New Mexico Health Officer, 1943.

In the school program tests are given the students as part of the physical examination. Referrals are made to the department by the Public Welfare Department and other charitable organizations. The health officer must take the responsibility for the operation of clinics within his district. He must serve as public relations agent, mobilize the community, and stimulate interest in the clinic.

Case finding is also operated by investigating contacts in families, where a death from tuberculosis has occurred. The nurse, in her home visits for other reasons, may report a possibility of the disease in the family and follow-up is done by the health officer and his staff.

VACCINATION AND IMMUNIZATION

Probably the best way to see that the most people are reached in the vaccination and immunization program is through clinics. Smillie recommends that vaccination and innoculation be free and that the health officer perform this function if so requested.[42] It has been pointed out above, in the discussion of school health, that the state laws require that the health officer see that the people of the state have the opportunity to be vaccinated. Again the problem lies in organization and education of the

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[42] Smillie, op. cit. p. 323

community. Through the school program and contacts with families much can be accomplished. Vaccination is done free in the clinics, or if the family requests the health officer to vaccinate the child and bears the expense of the serum. In the case of those unable to pay for the service, the county may be asked to provide the vaccine.

In larger towns and cities, the civic organizations may be enlisted to help with a campaign to see that all families are vaccinated. This is done in such a way as to encourage them to go to their own physician if at all possible. This action is the responsibility of the officer of the district, who must at all times utilize the clubs and groups of the community in promoting the program of health.

When a situation arises making it necessary to do so, the health officer may permit the nurse to vaccinate children in the clinics and the schools. In many districts this may be necessary, but if at all possible, the officer prefers to attend to that function personally. In whatever way it is done, the health officer is responsible for the work and must devote much of his time seeing that this is done. He must also see that accurate reporting is done, and that as much information as is possible is given to the community in order that the public will understand the value of the program.

INFANT AND MATERNAL HYGIENE

The program of infant and maternal hygiene has been less a function of the health officer than of the nurse, in direct administration. Smillie has suggested that the nurse take the principle responsibility for this phase of the health program of the county or district.[43] In New Mexico that has been the practice. For that reason the topic will be given greater emphasis in a later discussion on the activities of the Public Health Nurse.

One statement which should be discussed in making the analysis of the position of the district health officer is:

> "In many county health departments, there is a tendency developing to set aside funds from the budget for medical treatment phases of the public health program, and to employ the practicing physicians of the county to do this type of work for the health department. This plan is not feasible in the small units with a very limited budget."[44]

In the New Mexico laws, provision is made for additional health officers to be employed by the county. This officer must meet the requirements for district health officer, and serve as assistant to the district officer. There is some use made of the private physicians in the public health

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[43] Smillie, ibid.

[44] Ibid.

program also. In case of the latter procedure, the county must reimburse the private physician for his time. In the former the county must employ the officer out of county funds; he has other duties than those set above. Either method used would be a great asset to the administration of health in the districts, since the district officer would then have more time to devote to his other duties as supervisor.

Wherever it is possible, it is advisable to enlist the assistance of the local doctors, since this would help the relationship between the local medical profession and health department.

> "So far as the present is concerned, it may be said that seldom does the health officer play other than an administrative part in maternity service, and unless he is willing to set himself up as a many-sided specialist, it is probably unwise for him to attempt to do more."[45]

The division of infant and maternal health in the state department in New Mexico conducts clinics and places special nurses in the field. They try to get local physicians to devote one day a week to the clinic for examinations. Where this is not possible the district health officer must give as much time as possible to the clinic. The personnel of the clinic is responsible to the health

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[45] Mustard, op. cit. p. 258.

officer, even though he may not have to work directly in the clinic. All reporting is done through his office and he must closely supervise the work. Since there are conditions of eligibility for the maternal care program, he must see that such rules are adhered to. Under this program the education of midwives is conducted, and the certificates given. This is a duty of the health officer.

VENEREAL DISEASE CLINICS

The state of New Mexico has had unusual results for a state of its size and economic resources in establishing successful venereal disease clinics. Private physicians have attempted to give their time at least one day per week to one of the clinics in the district, and reporting and treatment has been highly successful. Although wartime conditions made it difficult to maintain the desired staff, more recently there have been new appointments made and the services of several more clinicians have been added. These persons have been engaged exclusively for the venereal disease program, and to conduct treatment and investigation clinics within the county or districts to which they are assigned.

Private physicians have been engaged on a part-time basis to assist in the treatment. The necessary medicines have been provided through the venereal disease division of

TABLE III

VENEREAL DISEASE CONTROL

Showing the Source of Funds for the Years
1942-43 and 1943-44*

Source	1942-43	1943-44
Federal		
Lanham Act [1]	54,400	60,300
USPHS [2]		156,390
		8,300
State	11,040	12,000
County	6,831	16,165
Cities	120	4,455
Private	240	
Totals	72,630	257,610

[1] Lanham Act Funds, F.W.A. for Intensive Treatment Hospital. May, 1943 to May 15, 1944.

[2] Estimated to be amount of services received through personnel provided by USPHS.

* Source: New Mexico Health Officer, 1943.

the health department. In 1943 there were thirty-six such clinics throughout the state. Eleven clinicians and numerous nurses have been appointed to attend them. They were organized under the direction of the venereal disease division. The district health officer has had little responsibility in this field, except in planning needs, and in working with the community to stimulate interest. In one or two places it has been necessary for the officer to attend the clinic work personally. This was done in the absence of other professional assistance.[46]

> "The division of venereal disease control, recognizing the inestimable value and importance of education, encourages health officers, venereal disease clinicians and nurses to conduct venereal disease educational programs and cooperates with them in this activity by furnishing literature, equipment, films and other educational material. It acts in an advisory capacity to the district health officers who are immediately responsible for planning and directing educational programs, and whenever possible and limitations placed on divisional staff personnel permits, it actively participates in these programs."[47]

The quarantine and isolation regulations in regard to the venereal diseases are enforced by the district officer. He must see that all persons known to be infectious are quarantined, even to the extent of isolating them in the jails. He has sole authority to see that no one may enter

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[46] New Mexico Health Officer, 1943, p. 70.

[47] Ibid. pp. 75-76.

the place where the patient is excepting the nurse and the attending physicians. It is with his permission that the quarantine is lifted.[48]

During the war period, the federal government has encouraged the field of treatment of venereal diseases by direct aid. The Lanham Act funds and the physicians furnished by the United States Public Health Association have augmented the services given by the state. When a United States Public Health Service physician is in charge of the treatment center, he is responsible to the health officer. In Clovis, for example, the physician was an Army doctor, who was engaged directly by the United States Public Health Service. The facilities were provided by the state, as well as providing the personnel. The health officer for that district was the administrative director for the clinic.

SUMMARY

Under present conditions in New Mexico, the health officer has had to schedule his trips to the different towns in his district so that he could make frequent trips to each of them. He has had little time to give to direct service under the various programs he has planned and directed. The major divisions of the state department of

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[48] New Mexico Statutes, 1941 comp. Chap. 71, Art. 3

public health have provided staffs for the various clinics and have advised the health officer in his work in connection with these. The ultimate responsibility, however, is his. He is the administrative chief of all the health activities which have taken place in his district.

Whenever possible he has had to add to his duties as supervisor and coordinator the tasks of directly performing health operations in the clinics and the other emergencies which arose. He has had to plan his time and arrange the work to cope with emergent situations, and still has the trips of fifty to two hundred miles to make to visit other towns.

The task of education alone is one which could easily take up much of his time. In order to facilitate his own work, he must see that the community understands, and actively participates in the program by caring for their own health and sanitation. He must make speeches, contact different organizations, organize vaccination campaigns and other activities. In making the public see the needs of the community, and attempt to correct them as much as possible, he is able to devote his time to other activities.

The administrative duties are those of supervising all public health activities in the district, coordinating, advising and planning. Then further, he must constantly be organizing activities to serve the new needs, or the situations which have not yet been touched.

He is the only full-time health official in the district, and is the sole authority over the activities. He is responsible directly to the state director, and in fact, is responsible for the same activities in the local jurisdiction as the state director is for the state. Without such an administrative head in the districts, the funds provided by the federal agencies, and some of the private endowments, might be seriously curtailed. These funds now amount to fifty per cent or more of the total expenditures in health in the state.

CHAPTER IV

THE DISTRICT SANITARIAN

In addition to the district health officer, there is one other district official, the district sanitarian. This position is almost entirely supported by the United States Public Health Service, with some funds coming from the state. The district sanitarian is employed by the district, and acts as sanitary inspector or engineer. In the administration of the state health department there is a division of sanitary engineering. The division director, a commissioned sanitary engineer in the army, is detailed by the United States Public Health Service to the State Department of Public Health for the period of the war emergency.[49] He is a fully trained civil engineer with additional training in public health administration.

SELECTION OF THE SANITARIAN

Environmental sanitation is a very vital part of the entire public health program. It was first emphasized by the United States Public Health Service in 1914.[50] Although great importance is attached to the work of the

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[49] New Mexico Health Officer, ibid. p. 59.

[50] Ehlers, Victor M. and Ernest W. Steel, Municipal and Rural Sanitation. (New York: McGraw-Hill Company, Inc. 1937.)

district sanitarian, there has been a neglect throughout the country in establishing high standards of training for the position.

> "The qualifications for sanitary inspector have not been up to the standards of other services. It is generally agreed that he should be at least a high school graduate with not less than the equivalent of 1 years theoretical training in sanitary procedure." 51

The test given in New Mexico is for the purpose of measuring the applicant's standing in sanitary procedure. However, due to the personnel shortage during the war, many allowances had to be made in order to fill the positions at all. It is highly desirable that the standards of this position be raised, especially in rural areas where sanitary work is one of the vital needs.

In this state the appointment is made by the health department, with the approval of the district health officer. The test is given the applicant, and the formal requirements do not specify any special training.

THE SANITARIAN AND THE DISTRICT HEALTH OFFICER

The sanitarian and the health officer must work closely on the program in the district. Many of the communicable diseases have their origin in unsanitary conditions.

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51 Smillie, op. cit. p. 319.

Environment is an all-important factor in the health of the community. In many communities sanitary conditions are paramount to any other phase of the health problem. The elimination of disease cannot be brought about without going to the source. The importance of environmental sanitation has come to be an accepted fact in more densely populated areas. In this state, however, there is still need for education in the matters of local sanitation. It is necessary to show the people living in remote settlements that the conditions which exist in their own little community can have a direct effect not only on their health but upon the health of the people who live miles away.

The sanitarian must work with the health officer in making his epidemiological investigations, and in the elimination of causes of disease. Because of the difficulty of completely covering the vast areas of some of the districts, the entire staff must be more vigilant when in some of the areas and report back to their co-workers any conditions which they feel are likely to be a problem at the moment or in the future. The sanitarian is under the supervision of the health officer and must report to him.

DUTIES OF THE SANITARIAN

The duties of the district sanitarian include the

following:

1. Inspection of water supplies.
2. Inspection of milk and food.
3. Inspection of public places.
4. Inspection of sewage and waste disposal in public and private places.
5. Investigation of nuisances.
6. Education in matters of sanitation and environment.

Although these duties are directly assigned to the state board and to the health officer in each district, they are given to the district sanitarian in order that the work may be concentrated and handled by one expert. The health officer is the supervisor of this activity.

It is important that the state laws deal directly with each of these fields, and they do, for example, in regulating the milk and water supply. In New Mexico it is fortunate that the laws expressly give the authority needed to regulate these matters.

Inspection of water supply. Many cities provide for the inspection of their plants and sources in the effort to assure clean and healthful water for the citizens. However, there are many small villages and settlements which do not have such a service, and it is provided by the health department. The sanitarian inspects sources, such as springs and rivers; he inspects private wells and cisterns, and

public storage facilities. He is required to check the water sheds for contaminating articles which would eventually reach the streams and rivers.

His authority in inspecting and controlling private water supplies is expressly given in the laws on sanitation.[52] This is an especial need in the rural areas, since the use of cisterns and wells is prevalent even in many towns. The water supplies may be furnished by the incorporated villages in most cases; but since there are so many mineral and chemical substances in the water from city supplies, many people prefer to store water for domestic and drinking uses.

Inspection of the milk supply. There is much milk sold within the small communities which comes from purely local dairies and farms. The laws are definite on the sanitary standards of this type business, just as they are on the large dairies and farms. Tests must be taken of the livestock, the milk, and the environment in which it is produced.

In New Mexico there is a dairy commissioner who is required to see that all dairy products consumed in the state are inspected and sanitary.[53] This relieves the sanitarian

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[52] New Mexico Statutes, 1941 comp. Chap. 71, Art. 1.

[53] Ibid. Chap. 49, Art. 21.

of a great bulk of the work, and makes the investigation of diseases suspected of coming from the milk supply a much simpler process.

Inspection of public places. Under the codes which define nuisances, wide powers are given to the health department to control the sanitation of public places. Also in the list of powers and duties of the health department, the inspection of public businesses is mentioned specifically. In separate laws governing restaurants, beauty shops, barber shops, and theatres, provision is made for cleanliness and sanitary facilities. The power of inspection is given the health department.[54]

Inspection of sewage disposal. The principle need in New Mexico for inspection and advice in sewage disposal is in the small rural settlements, where there is no public service and each family or group of families provide for their own needs. The unscientifically constructed outdoor toilet facilities and the lack of understanding of the use of disinfectants is a menace to the health of the entire community. The right of the sanitarian to inspect the facilities on private property, where needed, and the right to enforce the regulations, is a great asset to the health

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[54] Ibid. Chap. 71, Art. 1.

program.[55] While enforcing the rules, however, the sanitarian must do all he can to explain the need for such provisions.

Investigation of nuisances. The definitions and the laws on nuisances in the New Mexico statutes are most complete. In the administration of health in the districts and counties, there is much need for constant investigation to discover the source of disease. In giving such authority as the laws do to the health officials, the work of environmental sanitation is greatly aided. The laws on nuisances cover deposit of filth, sanitary disposal of waste, garbage and other offensive matter, and the pollution of water. The authority is given the official in charge of this field to enter and inspect property. He has the power to see that the nuisance is removed and this is done at the expense of the offender.[56]

Education. Throughout his travel and work, the sanitary inspector must be continuously teaching the public the value of the rules he is enforcing. It is not enough to tell the offender to cease certain practices, he must be told why, and made to see the value of the regulations as they pertain to him and to the community.

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[55] See New Mexico Statutes, 1941 comp. 71-113 especially

[56] New Mexico Statutes, op. cit., Chap. 41, Art. 35.

"Whenever it becomes general knowledge that our sanitary regulations have been drawn for the health and safety of the public and that violation of these regulations will be prosecuted regardless of alibis, political connections, etc., then and only then will our regulations receive the cooperative compliance they deserve." [57]

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[57] New Mexico Health Officer, op. cit. p. 58.

CHAPTER V

THE PUBLIC HEALTH NURSE

One of the most important positions in the health program is that of the public health nurse. When the program is planned, or established, the nurse must carry out much of it. In the New Mexico statutes provision is made that the county must employ public health nursing personnel deemed necessary by the state board of public health, and that the nurses must be paid by county funds. In cases where there is need for additional personnel, it is provided by other funds. Consequently, there is at least one public health nurse in each county, and in some there are more; namely, the school nurse, the nurse employed by the children's bureau and those in the venereal disease clinics.[58]

Public health nursing has high qualifications. They include, in rules and regulations governing the employment of nurses, certain educational and experience requirements. They also include many intangible things, such as the ability to work with all types of people with understanding and to gain the confidence of the public.

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[58] A study of the Public Health Nurse in Bernalillo County was made by Helen Kinnaird. It is used as a source for this chapter, since it was largely a field study personally made. The study is an unpublished paper of the Department of Government of the University of New Mexico.

The formal requirements set up in the rules of the state board of health are:

> "No person shall be employed as a public health nurse in the state of New Mexico who shall not have the following qualifications; to-wit:
> (a) Graduate of an accredited nursing school.
> (b) Four months of instruction under one of the recognized public health nursing courses and one year's experience; or an eight months' course in public health nursing and six months' experience, part of this experience being in school nursing service.
> (c) Registration in the state of New Mexico by examination or reciprocity, after employment.
>
> No nurse shall be paid from the health fund appropriated under the provisions of Section 110-532, Code of 1929, unless she shall have satisfied the Director of Public Health that she holds the qualifications enumerated in Section 1 above."[59]

The selection is made by the county health department with the advice and approval of the state board. This usually consists of the approval of the district health officer and the advice of the supervisor of nurses. Necessary office space is provided by the county, usually in the court house. The number of nurses in the health department when the staff is complete, is fifty-four; besides this figure, there are fourteen school nurses.[60]

FUNCTIONS OF THE NURSE

The functions of the county health nurse may be

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[59] Kinnaird, op.cit

[60] New Mexico Health Officer, 1943, p. 27

divided into seven different categories. These are:

1. Maternity
2. Infant and pre-school health
3. School health
4. Communicable diseases
5. Vital statistics
6. Sanitation
7. Health education[61]

Maternity program. The following excerpts from the report of the Division of Public Health Nursing in 1943 describe the activities of the nurse in this field:

> "A program giving direct service by a nurse-midwife was inaugurated in Pecos.
>
> "To serve this community there is only one regular physician and an osteopathic physician, both having a rather large obstetrical practice. Three Spanish midwives live in the village and care for those not wishing, or not able, to secure other service.
>
> "Since December 22, 1943, the roads in and surrounding Pecos have been impassable. For days, even the paved highway was dangerous. On three different occasions cases listed for delivery by the nurse-midwife had to be attended by the local midwife, who tried to send for help but was unable to get word through to the Pecos Center, which has no telephone.
>
> "Communities visited by nurse-midwife during this period numbered eleven.

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[61] Op. cit.

"A midwife conference was held in the nurse-midwife's quarters every third Friday in each month. The attendance was very good when the roads were passable. The midwives have expressed a desire to have these conferences continued." [62]

This report was concerned with the period from August 1, 1943, to February 1, 1944. In that time the nurse reported the number of cases handled in the state through this service as 271.[63]

Due to the high infant mortality rate in the state, the maternity service is of great importance. Each county tries to have a pre-natal clinic, which carries the service through from early pregnancy to the time the child is born, and if necessary, after delivery for a short period. These clinics encourage medical examinations, and when the mother requests, give the examination. The education of the mother is essential, and the nurse must teach her how to prepare for the baby, and how to tend the baby in matters of diet and sleeping and other habits.

There has been much work done toward the education of midwives since many of the births in this state are attended only by them. The nurse makes home visits to the prospective mothers, encourages them to take advantage of the health service and to attend the classes. She also

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[62] New Mexico Health Officer, p.33.

[63] Ibid., p. 33.

tries to encourage them to have a physician attend; but in the event they are unable or unwilling to do so, she asks the midwife to offer his services. There is a definite program of education and certification given the people who act as midwives. They must agree to certain practices, learn certain essentials of sanitation and be able to tell when a doctor's service is essential.

Infant and pre-school health. The "Well-Baby Clinic" is well known throughout the country. New Mexico counties have made much use of them, since a realization of the high mortality rate among the very small children has penetrated each community. Again home visiting is the first step toward getting the mothers to take advantage of them. Then the nurse must begin the process of education, of seeing that the children are examined (usually by a local practicing physician) and that the diet of the children is nourishing and adequate. One of the problems most frequently encountered is the diet. To quote the report of the Maternal and Child Health Division in 1943:

> "General malnutrition is still reported with regularity from observations on school children as well as being a frequent finding at maternal and well child medical conferences." [64]

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[64] Ibid., p. 49.

Some of the reasons for this situation is the lack of knowledge about diet among the people living in remote areas, or with limited education. Another reason is economic: the lack of certain foods; the desire to utilize the foods produced on small farms; the scarcity of some foods at a price level many families feel they cannot reach. The nurse must instruct the people in ways to prepare certain foods, the kinds of foods which may be substituted, and in cleanliness in food habits.

School health. In many counties school health is supervised by the school nurse. This is a desirable practice, when possible, since it provides more constant care, and relieves the county nurse of the added duty. In counties where this is not done, the county nurse must try to give as much time as possible to the school. Ane one of her duties may conceivably take all of her time, but since there are many phases to the work, she must plan her time in proportion to the immediate needs and the importance of the task.

In school health programs, the activity is much like that of the infant hygiene program. However, the school system requires certain standards of health, and the program is more or less compulsory. The major tasks are examining the students, checking on quarantine and communicable diseases, teaching classes in hygiene, and conducting

first aid and home nursing classes.

Home visiting is one of the essentials of the program, in case there is a symptom of trouble which shows up in the examination or later in the school year. There is much responsibility attached to this position, and the school must see that the program is carried on. If at all possible, the school authorities engage the services of physicians at the examinations. The entire health organization is greatly augmented by the school nurse or the county nurse.

Communicable diseases. Again the need for education absorbs much of the nurses' time. She must see that the rules of isolation and quarantine are followed, that the parents or attendants understand the methods of caring for the patient. She is the one directly responsible to see that the quarantine is posted, and that the report is made. She contacts the schools, and investigates all possible contacts of the person to prevent possibility of new outbreaks of the disease. It is not the field of the public health nurse to do nursing. This is impracticable because of the time element and the type work for which she is engaged. She must see that the child is getting the proper care, and that the isolation period is observed, but must be very careful in her contacts to see that the family does not misunderstand her approach as that of a practicing nurse.

In cases of tuberculosis and venereal diseases, the state health department has tried to furnish additional personnel to handle the clinics and cases. The nurse has the duty of finding cases and seeing that they are treated. Usually the county nurse does not do this, since almost all communities are served by the venereal disease and the tuberculosis clinics. The nurse attached to this program gives tests, administers the work as planned by the health officer and keeps the records of cases. An important thing to note in connection with the venereal disease clinics is that the cases are not easily found, due to the social fears of the patients, and the records must be and are kept with the utmost secrecy. If this were not possible, it is doubtful that the progress would be as commendable as it is.

The tuberculosis work is aided by the funds from the National Tuberculosis Association. Those funds are sometimes used to employ a nurse for the county, who administers the program of the clinic. In many counties, however, this is not done, and the county nurse must carry out the work in this field also. In this phase of health work, again the case finding and the treatment and education of the patient and his family is the essential function. Community education may be carried on as part of the program, making the education program broad enough to cover all these phases of work.

For the benefit of the tuberculosis patient, care and treatment must be emphasized. Often the financial resources of the family do not permit adequate care. It is not mandatory for the patient to be treated, as in the case of venereal diseases. It is difficult to get the patient to admit the disease, or to make some effort to get medical attention. The harm done to the family and associations as a consequence of this attitude makes the job of the nurse an important one. She must work with the patient and with his family to see that there is emotional acceptance of the illness, and a will to do something about it.

Vital statistics. The use of vital statistics is important in planning the activities of the health department.

> "Statistics are facts expressed in figures. For example, a birth report recorded officially is not a vital statistic, but a vital fact. These facts may be expressed by figures, classified, tabulated, and arranged in various ways for study and comparison. These tabulations and classifications may be visualized by the use of graphs. The various mathematical processes that are used in analysis of the vital facts make it possible to formulate generalizations and to draw logical conclusions or inferences." [65]

Reporting in the health departments of the counties is done by the nurse, and by the sub-registrar. The nurse attempts to make some investigations while on her regular duties, and

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[65] Smillie, op. cit., p. 70.

to show the need of prompt and adequate reporting to the people with whom she comes into contact. Other reports are made directly to the department. The nurse must combine the figures and make her report to the state office through the district health officer.

Sanitation. The most frequent contact with the home is made by the nurse. The sanitary engineer has much more territory to cover, and is not so often in close contact with the family. While on her regular duties, the nurse notes the sanitary conditions of the home, and the surrounding homes as well. She notes the ventilation, the lighting, the sanitary facilities. She must also see that personal habits of cleanliness are emphasized, thereby arousing interest on the part of the individual in his surroundings.

Other activities. Other phases of the public health nursing activities are mental hygiene and orthopedic service. As Smillie says, the mental hygiene program "permeates all phases of her work." [66] She must understand the principles of psychology well enough to discover the possibility of some mental trouble of the child or patient, and handle the situation insofar as it affects the health program. She must also make referrals to any other agency or department which handles that sort of case. Unfortunately, New Mexico

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[66] Smillie, op. cit., p. 188.

has no psychiatric clinic nor child guidance program to which mental health cases might be referred.

Through examinations in the schools and the clinics for children, the nurse is able to keep rather complete records of crippled children within her area. She must give advice and aid to the parent and the school about the program of the state and federal government in caring for handicapped children. If possible, she must see that they are hospitalized or given the braces and care they need. The Department of Public Welfare usually takes over the functions in the orthopedic care, but many cases are found and referred by the health authorities.

Throughout the entire health program, the primary function is public health education. This function the nurse must combine with all her other activities. She is constantly practicing education in the clinical activities; she organizes the special lectures, the classes, and shows individuals the reasons behind every action of the health department.

Rules and standards may be promulgated by the top authorities and the divisions, but they are valueless if not enforced and recognized by the public. The public in general, and the individuals contacted in particular, must understand that the standards are for their own protection, and that enforcement comes only when voluntary effort is

lacking on the part of the public. Health rules are not successful with passive acceptance, but must be activated by the community with the aid and advice of persons who are informed on the subject.

Every action on the part of the nursing staff must be carried on with a view to educating the person contacted as well as performing the task at hand. The public health nurse has definite programs of education which run along with her other activities. These classes and meetings serve to create an understanding and a desire to act on the part of the community in general.

Additional county personnel. In addition to the health nurse in the county health department, there is the clerical staff. The county health clerk is employed by the county board of commissioners. She is in the county health department all of the time, and is the clerical aide to the nurse. This employee must keep the records on all cases treated, receive certificates, and perform other duties in the office. The calls which are made for the nurse are recorded and reported to her. The clerk must also make the reports which go to the health officer and later to the state office.

One other person who is employed in the county health department is the sub-registrar. There are several persons

in each county employed on a part-time basis in this capacity. This employee registers all deaths and births in the area, reporting them to the county office. These vital statistics are required by law; and many rural areas, it is difficult to enforce the legislation. The importance of vital statistics cannot be over emphasized, since they are the source of information which demonstrates the success of the public health program.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The purpose of this final chapter is to analyze the criticisms made against the district health system, and to examine the needs of the health department in carrying on its assigned functions.

One of the criticisms made against the system is that the district health officer is not performing his duty. This criticism is based on the assumption that the officer is engaged as a physician. Under the county health system, the health officer spent part of his time in treatment of charity patients, the remainder in performing his duties as a public health officer. Since this arrangement did not give the county a full-time health officer, as required in order to receive funds under the Social Security Act, the system had to be revised. Under the old system that preceded the present one, many of the counties could not or would not provide a full-time public health officer. Therefore, the various officials on public health recommended that counties be grouped to provide one officer for each district. In doing this the administrative districts created were large enough to prevent the health officer from personally attending to many tasks that the county officer had formerly been expected to do. The district

health officer was to be the administrative chief, planning, coordinating and supervising health work within his area. The lack of sufficient personnel in each county of the district has made it necessary for him to perform many of the tasks personally and as a result divide his time between his administrative duties and other activities.

Misunderstanding of the purposes of public health is another source of criticism. The purposes of public health are preventive, and designed to protect the health of the citizens of the state by elimination of the sources of disease. It does not imply treatment except in cases where necessary to prevent the spread of disease. The principle underlying need in any public health system is education. Health education is perhaps the main functions of public health authorities. The lack of sufficient personnel has curtailed this important phase of the work in New Mexico. If the district health system were functioning with a full quota of personnel, the district officer could devote much of his time to education. Under present conditions, the amount of work to be done and the lack of adequate staffs in counties make it necessary for all the members of the health department to devote their energies to emergency situations. This does not appear to be a fault of the administrative system but of the lack of enough personnel. Until it is possible to provide enough workers, the

organization of the administrative units will suffer.

The need for additional personnel is realized by everyone in almost every field today. This is especially true of the public health services. In order to assist the district health officer, some counties have employed an assistant health director for their county. If this were done in all counties, the amount of public service performed by the health organizations could be greatly increased. There is a dire lack of medical care and medical facilities in the small communities. In many counties there is no hospital, and some towns and villages are more than sixty miles from hospital service. Furthermore, the lack of technical facilities in the clinics of some of the smaller communities greatly curtails the service that can be given privately or publicly.

Another objection to the district health system sometimes come from counties which had a full-time health officer before the district system was established. These counties, of which there were eight, objected to being grouped with a poorer county which had no health officer. The feeling has been that they were required to pay for public health activities for some other county and in doing so have curtailed their own services. The financial arrangement under which the district health act operates is that each county pays into a general fund according to

the wealth of the county. This fund was arranged so that each district contributed $4800.00, making a total of $48,000.00. The total amount is distributed by the state department to the health officer in each district. Any county which wishes to employ a health officer in addition to the one jointly engaged by the several counties is encouraged to do so.

Approximately the same financial arrangement obtains in other financial matters in the state. The taxes to support public education is one example. This is set up so that each county contributes to a general fund which is distributed where needed over the state. This is the basis of equalizing educational opportunities throughout the state. In health matters, where no condition can remain localized in its effect, this is of vital importance. An additional advantage to the centralization process is the removal of political patronage. Because the health officer is appointed by a board composed of representatives from each county in the district with approval to be made by the central administrators, this position may remain free from local patronage.

Principally, the district system is the most acceptable one for the allocation of federal funds. The only alternative to the district system which would satisfy the requirements for federal funds would be provision for a

full-time health officer in each county. If this were done, there would be thirty-one rather than ten health officers. In the past, it has been proven impossible for each county to bear the expense of a complete health department. Even at the present time, it is impossible to employ nurses in some of the counties due to lack of available personnel. It has been difficult and in some cases impossible to employ a health officer for some of the districts. To get thirty-one health officers on a full-time basis would be even more difficult, if not impossible.

If the federal funds are dependent upon the form of administration, which they are in almost every case, the standards of the agency allocating the funds must be followed. In New Mexico over fifty per cent of the money spent on public health comes from federal sources. Loss of these funds would cripple the activities of the health department considerably.

It appears that the district health system meets the needs of the state more nearly than any other system for the following reasons:

1. It provides a full-time health officer for each district.

2. It meets the standards of the Social Security and other boards allocating funds for health protection.

3. It provides a system which equitably insures health services to all counties.

4. Without such a system, many counties would have little or no public health service.

Before the health system can function adequately and prove its value as an administrative system, it appears that several things are needed. They are:

1. Additional personnel including nurses, clinicians, and clerical staff.

2. Increased facilities for testing, diagnosing, and treating preventable diseases.

3. A health education staff consisting of persons trained to promote interest in and knowledge of preventive health measures through public meetings, publications and classes.

In the latest published study on public health administration[67] the summary of findings are as follows:

"1. The delivery of the half-dozen essential, primary services of public health should be a function of local government responsive intimately and personally to the needs of each community. These services are: (a) vital statistics; (b) communicable disease control; (c) environmental sanitation; (d) public health laboratory services; (e) hygiene of maternity, infancy, and childhood; (f) health education.

"2. One-third of the nation lives under sub-standard local health organization ill-equipped to give basic minimum health protection at all times and to meet public health emergencies quickly and efficiently.

"3. Approximately 20,000 local governmental units, in addition to some 70,000 school boards, are currently responsible for local health service in the United States.

"4. The failure of local government in some states to organize workable administrative units of local health service is gradually removing the intimate and personal

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[67] Emerson, Haven, Local Health Units for the Nation, New York: The Commonwealth Fund, 1935. Summary of Findings.

service of local health protection from the sphere of local to that of state government.

"5. In order to provide the organization of workable administrative units of local health jurisdiction each state should have enabling legislation, either permissive or preferably mandatory, whereby cities and counties may unite to form districts of suitable size for local health administration. Except for special reasons these districts should be made up of existing or combinations of existing governmental units in order that existing tax and appropriating machinery may be utilized.

"6. For approximately one dollar per capita every person in the United States could have minimum basic local health services under a professionally trained full-time medical health officer, with appropriate associated professional and technical personnel and equipment.

"7. This county-wide coverage could be achieved through 1,200 local health units.

"8. Essential characteristics of these units are:

a. Population of at least 50,000. Smaller populations can only in rare instances either support or justify an adequate local health organization.

b. Include no unit or local government below the county (except in certain states where the county is unimportant as an administrative subdivision of government).

c. Include both the urban and rural areas of a county.

d. Where counties have smaller populations than 50,000, as is true of 85 per cent of the 3,070 counties of the 48 states, they should join with one or more neighboring counties to form local health districts following natural trade and transportation areas.

"9. The minimum staff required by such a local health unit is:

a. One full-time medically trained administrative health officer.

b. One public health nurse per 5,000 population, one of each ten of the nurses to be of supervisory grade.

c. Two workers in environmental sanitation per 50,000 population, one to be professionally trained, preferably as a sanitary engineer.

d. One clerk per 15,000 population.

e. Part-time clinicians and dentists, and laboratory workers, dental hygienists, health educators, and other workers as local conditions require.

"10. To staff the 1,200 units the following workers are recommended as a minimum:

2,060 full-time administrative health officers and directors of medical divisions. No part-time health officers are recommended.

6,145 local practicing physicians for part-time clinical service.

26,400 public health nurses, nearly twice as many as were reported employed by local official agencies in 1942.

5,800 workers in environmental sanitation of who one-third should be professionally trained. Only 10 per cent of those employed in 1942 were so trained.

8,930 clerical and secretarial workers including those with statistical training and representing an increase of two-thirds over the number employed in 1942.

3,535 laboratory workers - 12 per cent professional, and 44 per cent each technical and unskilled to serve 766 units, the remainder to be served by the state laboratories. In all units of less than 100,000 population both professional supervision and assistance in the more complicated diagnostic procedures will be given by the state laboratory.

3,790 dentists - 12 per cent on a full-time basis and 4,265 dental hygienists to carry on a public health dental program in the schools and the general community, a program with notable exceptions, generally lacking in 1942.

540 health education specialists in the most populous 261 units with 60 per cent of the nation's population. In 1942 only 44 were reported employed and were confined to 12 states.

2,390 messengers, maintenance workers, laborers, and other unskilled workers.

"10a. To staff the 10 units suggested for New Mexico the following workers are recommended as a minimum:

18 full-time administrative health officers and directors of medical divisions. No part-time health officers are recommended.

32 local practicing physicians for part-time clinical service.

107 public health nurses, representing an increase of nearly 45 per cent over the number reported employed by local official health agencies in 1942.

32 workers in environmental sanitation; more than twice the number reported employed in 1942.

46 clerical and secretarial workers, an increase of about one-fifth over the number reported employed in 1942.

14 technical and unskilled laboratory workers for seven units, with professional supervision in these and all service in three units to be provided by the state laboratory.

14 part-time dentists and 27 dental hygienists; in 1942 no dental service was reported except one part-time dentist in each of two counties.

1 health education specialist to be shared by two adjoining units; the other units must depend for service on the state department of health unless more than minimum resources are available.

5 unskilled workers."

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