

# Governmental Public Health In The United States: The Implications Of Federalism

To address the new threats of bioterrorism, the United States needs a coordinated public health response at the national, state, and local levels.

by **Bernard J. Turnock and Christopher Atchison**

**ABSTRACT:** Governmental public health activities in the United States have evolved over time as a result of two forces: the nature and perceived importance of threats to the population's health and safety, and changing relationships among the various levels of government. Shifts toward a more state-centered form of federalism in the second half of the twentieth century weakened key aspects of the governmental public health enterprise, including its leadership and coordination, by the century's end. These developments challenge governmental public health responses to the new threats and increased societal expectations of the early twenty-first century.

Many are the exercises of power reserved to the States wherein a uniformity of proceeding would be advantageous to all. Such are quarantines and health laws.<sup>1</sup>

*Thomas Jefferson, 1807*

THE FEDERALIST SYSTEM of American government, marked by the distribution of responsibilities among its national, tribal, state, and local components, is an essential contributor to our public health aspirations. Each component contributes in various ways, and to varying degrees, to assessing, addressing, and assuring conditions in which people can be healthy. Although constitutional and legal frameworks define the basic functions and roles of the various levels of government, an even more complex web of intergovernmental relationships characterizes the operational aspects of federalism.<sup>2</sup> These operational relationships influence the ability of the overall governmental public health enterprise to protect and promote the health of the public.

To a large degree, the organization, financing, and delivery of public health ser-

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*“The distribution of authority limits the ability to assure a consistent approach to advancing the public good.”*

vices reflected the operational dimensions of federalism through the nineteenth and twentieth centuries in the United States. The shift toward a more state-centered form of federalism, often termed “New Federalism,” in the second half of the twentieth century amplified weaknesses within the governmental public health enterprise, including its leadership and coordination. The twenty-first century brings new public health threats and societal expectations that will challenge government at all levels, requiring leaders in government and public health to adopt and implement new systems of public health practice. This paper examines the forces that have contributed to the current status of the governmental public health enterprise and suggests strategies for remediation.

## **Influences Of Federalism On Public Health Practice**

■ **Distribution of power and authority.** The American form of government was born out of its founders’ desire to limit the powers of centralized and national governments. Their actions were undertaken within a context of a far-off king issuing proclamations that affected daily life in the colonies. Their extreme reaction against the monarchy is suggested in their initial plans for American governance. The Articles of Confederation, the nation’s initial charter for national authority, proved unworkable by providing little remedy for interstate conflicts and no framework for a national agenda. Its successor, the current U.S. Constitution, clarified the importance of the national agenda but maintained a central philosophy of distributed power and responsibility. It affirmed this priority of distribution by recognizing vertically based responsibilities, between and among the states and the national government, and by creating horizontal mechanisms at the national level establishing three branches of government with separate and specific powers.

The legacy of these historical initiatives is the nation’s current federal system of government. It is one marked by an array of governmental units including those at the national, tribal, state, and local levels. Within each of these units are further distributions of authority that mimic in many ways the national government’s branches of government. Estimates are that there are more than 86,700 of these units, resulting in more of a patchwork of conflicting powers and turf concerns than integrated initiatives addressing regional problems.<sup>3</sup>

Although the pursuit of liberty through the distribution of authority may be a valid and appropriate strategy for public policy, this goal and process limit the ability to assure a consistent approach to measures intended to advance the public good. The operational aspects of this distributed system also inhibit the development of seamless and consistent approaches across the country and within the states. To achieve its goals within this federal system, public health must be

viewed as a national public good supported by coherent strategies and methodologies that enable the coordination of intergovernmental efforts.

■ **Operational federalism.** If public health is a fundamental public trust on a par with public safety and public defense, the powers and authority of the federal government for public health purposes appear quite limited based on a strict interpretation of the U.S. Constitution. Public health was not one of those powers (as was international diplomacy, defense, printing currency, and regulating commerce) explicitly bestowed upon the federal government. Consequently, the federal government moved to acquire power and influence in public health through less direct means, including its powers to regulate commerce, promote the general welfare, and raise substantial revenue through a national tax on income.

*Impact of the Depression.* A century and a half of minimal federal involvement in public health ended with the economic and social chaos of the Great Depression in the 1930s. To meet this national challenge, government at all levels was called upon to play more direct roles in meeting the health and welfare needs of the population. By that time, as well, the shift from an agrarian to an industrial society had changed the nature of the revenue base for governmental resources. Taxes on property gave way to taxes on income, and the federal government's share of total tax resources increased while that of state and local governments declined. The sharing of federal tax revenue resources and, with it, the ability to influence the decisions of state and local governments related to public health activities increased despite the limited authority granted to the federal government in matters related to health.<sup>4</sup>

*Expanded protective powers.* This power and influence steadily expanded during the twentieth century through the federal government's role in directly protecting the public in food and drug safety, environmental protection, and occupational health and safety, among others. Federal influence reached even greater levels as the federal government became a major purchaser of personal health care services through the Medicare and Medicaid titles of the Social Security Act after 1965.

*Fiscal accountability.* Central authority and leadership developed further as the result of concerns for accountability and the potential for misuse of federal funds. National legislation led to the earmarking of federal resources for specific purposes through conditions attached to the sharing of these funds. These "categorical" approaches to problem solving became the federal government's primary strategy for influencing state and local public health efforts. Public health programs were organized to address specific diseases (such as tuberculosis and lead poisoning) and populations (such as mothers and children and migrant workers). Indeed, for some health priorities the federal agencies not only provided financial resources but also detailed federal employees to work in and even manage these programs. Beginning with the National Venereal Disease Program, the assignment of federal "public health advisers" became commonplace for sexually transmitted disease (STD) programs and later for other categorical programs, including tuber-

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culosis, immunization, and childhood lead poisoning prevention.<sup>5</sup>

Few aspects of operational federalism had greater impact on the public health strategic and operational activities of state and local governments than did the attaching of conditions to the receipt of federal funds. This approach contributed to the institutionalization of isolated silos, as opposed to integrated systems, of public health services through the creation of separate categorical programs. As a result, public health practice became identified with specific services, with little attention being paid to the broader system requirements that a public health system ought to reflect. Few resources were provided for discretionary or generalized public health practice concerns. Attempts in the 1970s and 1990s to create block grants by consolidating categorical grants and providing greater flexibility to state and local governments did little to reverse this trend. Categorical programs continued to dominate the federal health landscape.

■ **Public health and federalism at the local level.** The most dramatic change in the structure of public health practice during the twentieth century was the proliferation and maturation of local public health agencies, especially those organized at the county level. As the focus of public health threats shifted from controlling infectious diseases and environmental hazards in the first half of the twentieth century to combating chronic diseases with behavioral antecedents after 1950 and then to battling societal issues with social roots in the final quarter-century, the substance of public health efforts began to place increasing emphasis on local solutions.<sup>6</sup> By century’s end there were more than 3,000 local health units, whereas there had been only a handful of health departments in large cities and none serving any counties before 1911.<sup>7</sup> Beginning in the mid-twentieth century, community factors were increasingly viewed as more important and remediable influences on health than were the policies and activities of federal agencies. Modern public health practice emerged in this environment of expanding federal influence and heightened expectations over addressing local concerns. Yet despite this growing set of responsibilities, public health had yet to establish “standards of practice” that would ensure that essential levels of public health performance were in place in all jurisdictions.

### **Governmental Public Health By The Late 1990s: Vital Signs**

Concerns that the nation was facing major threats to its public health led to the convening of an Institute of Medicine (IOM) panel to study the future of public health. The 1988 report of this group promoted a renewed understanding of and appreciation for public health’s mission, substance, core functions, and unique link with government.<sup>8</sup> Government, as viewed in the IOM report, was an essential component of public health systems because only government could guaran-

tee that public health's mission to assure conditions in which people could be healthy was being addressed and that the necessary components were in place. In articulating the responsibilities to be assigned to the various levels of government, the IOM report identified states as bearing the primary public-sector responsibility for health, with the federal government responsible for coordinating knowledge dissemination, establishing national priorities, providing technical assistance to states and localities, coordinating national policies, and providing resources to strengthen state and local capacity for achieving national objectives.

■ **National public health objectives.** The IOM report's conclusions and recommendations stimulated long-overdue interest in examining how well the governmental public health enterprise was performing. The first national health objective relating to public health system performance was fashioned early in the 1990s as part of the process for establishing national health objectives to be achieved by the year 2000 (there were none among the 227 objectives established for 1990). Objective 8.14 called for 90 percent of the population to be served by a local health agency that was effectively carrying out the core functions articulated in the IOM report. Associated with the IOM effort, the Public Health Functions Steering Committee of the U.S. Department of Health and Human Services (HHS) added specification to the core-function framework by delineating the "essential public health services" that constitute a comprehensive public health presence.<sup>9</sup>

■ **Performance measurement.** The proposal that the field of public health should recognize a consensus set of essential services was an important step in the effort to adopt standards of practice that could transcend the jurisdictional limitations of the federal system. However, efforts to further implement management strategies for public health coordination were only sporadic in the period between 1988 and 2002. The Health Resources and Services Administration (HRSA) commissioned an enumeration of the public health workforce that was completed in 2000, and the Centers for Disease Control and Prevention (CDC) compiled a status report on the public health infrastructure in 2001, although both reports relied heavily on previous studies and data.<sup>10</sup> There were no comparable efforts to quantify national public health expenditures or measure key aspects of public health system performance. Scattered efforts contributed useful data and insights related to these questions but did not result in consensus about the key dimensions of the governmental public health enterprise and where the nation stood in relation to its year 2000 target. Even with the Government Performance and Results Act (GPRA) of 1993, little ground was gained in establishing a consistent platform for public health performance measurement.<sup>11</sup>

As a result, at the onset of the twenty-first century, only limited information is available to assess the vital signs of the governmental public health enterprise. Such information would include the outcomes or results of public health efforts and the extent of the economic investment in governmental public health activities. Ideally, outcomes would provide the prime measure of the system's perfor-

mance and demonstrate its value to policymakers across all levels of government authority. For example, despite growing concerns over disparities in health status among many racial and ethnic groups, the broad measures of U.S. population health show steady improvement in recent decades for indicators such as infant mortality and other age-specific mortality rates and many cause-specific death rates. Most measures of morbidity and self-reported health status also have improved. However, there is little ability to directly relate populationwide outcomes to specific activities of the governmental public health enterprise.<sup>12</sup> As a result, to affirm the public health contribution to this public good, there is a need to examine these questions through a different lens.

■ **Spending assessment.** Another approach to assessing public health performance could be through its economic dimensions. However, official estimates of current national spending for essential public health services are lacking. A crude estimate is that governmental agencies spent an estimated \$38 billion in 1995 to carry out public health's essential services.<sup>13</sup> State and local governments were responsible for about two-thirds of these expenditures, and the federal government supported the remaining one-third. Only about 30 percent of these expenditures was for population-based public health services. Seventy percent was directed toward linking people to needed services or providing services that would otherwise not be available. The population-based component, primarily funded through governmental public health agencies, amounts to little more than ten cents per person per day, the approximate economic value placed on governmental public health promotion and protection in the United States.<sup>14</sup> These estimates indicate that governmental public health resources are meager and that state and local governments shoulder the major share of the burden.

■ **Influx of federal funding.** A substantial influx of federal funding for state and local public health agencies, more than one billion dollars annually, arrived in 2002 as a result of bioterrorism-related legislation enacted by Congress after the events of fall 2001. Key activities to be funded include emergency response planning, epidemiological expertise, rapid communications, information and surveillance systems, laboratory support, risk communication capabilities, and workforce readiness. Congress also provided funding for epidemiological and information capacity and for laboratory support at the federal level. Such funding levels would increase the federal share of population-based prevention and public health protection by about 20 percent and increase the total amount available for these public health roles by another penny per person per day. The deployment of these resources began in late 2002. However, funds to public health agencies were only one stream in the national response to terrorism. It is expected that future Congresses will carefully scrutinize these expenditures to determine which efforts are most effective in addressing the national threat. Expenditure and performance measures are needed, as is consensus on the units of measurement within any standardized system.

## Structure And Infrastructure

■ **State and local levels.** Without the unifying force of a central framework for public health practice in either structural or performance terms, the benefits of public health are poorly understood and underappreciated. For example, the lack of comprehensive assessments makes it difficult to either support or refute characterizations of governmental public health as inadequate, eroding, and outdated. These characterizations are often targeted at state and local public health systems, with evidence offered in anecdotal form. Reorganization of state public health responsibilities and closure of local health departments are examples of events that trigger concerns over infrastructure erosion. At the state level, several state health departments moved out of umbrella human service agencies to become freestanding agencies, while several others moved from freestanding status into umbrella agencies or saw service provision programs removed and centralized in other agencies. At the local level, health department closures and consolidations raised concerns over lack of coverage and an eroding local public health infrastructure. Although many of these changes were contentious, there is little empirical evidence that there was any real impact on public health activities in these jurisdictions.

On the positive side, there is evidence of a willingness at the state and local levels to apply even greater resources to the public health mission. For example, the number of full-time-equivalent (FTE) public health workers employed by state and local agencies has increased at twice the rate of the overall population through the 1990s, and the number and proportion of local health jurisdictions engaged in the basic business of public health (as described by the core functions and measures of core-function performance) has steadily increased over the past decade.<sup>15</sup>

■ **Federal versus state workforce.** Federal public health activities, however, show little evidence of structural improvement. Federal government civilian employment for health functions declined by about 10 percent during the 1990s. There were about 130,000 total employees, including 120,000 full-time federal civilian employees assigned to health functions in 2000.<sup>16</sup> The composition of the federal public health workforce differs markedly from those at the state and local levels. More than two-thirds of federal public health workers fall into the professional category, compared with only 45 percent of state and local public health workers. There are differences in the composition of the professional category as well. Compared with the composite national public health workforce, physicians and lab professionals make up a larger share of the federal professionals, while public health nurses and health educators make up a larger share of the composite professional category.<sup>17</sup> Differences between federal public health professionals and those working in state and local governments will likely grow in terms of disciplines and levels of formal training as federal agencies reduce overall staffing while increasing the proportion of professional staff.

■ **Federal restructuring.** The period 1988–2002 witnessed several reorganizations within HHS. The restructuring that was completed in 1996 was the most sig-

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nificant in recent decades. The changes made were undertaken as part of the federal Reinventing Government Initiative to bring expertise in science and public health closer to the HHS secretary. In the restructuring, the line authority of the assistant secretary for health over the eight agencies of the Public Health Service was abolished, with those agencies now reporting directly to the secretary on an equal basis with the Centers for Medicare and Medicaid Services (CMS), the Administration for Children and Families, and the assistant secretary for aging.

Coordination of public health issues and activities across federal health agencies occurred through much of the 1990s through the Public Health Functions Steering Committee. However, after securing consensus for the essential public health services framework among the national public health organizations, the committee ceased its activities. This body included the leadership of the various federal agencies and served as the mechanism to address broader public health systems issues. Even with this steering group, coordination across the various federal health agencies was a persistent problem with not infrequent turf battles among agencies. For example, despite the fact that the CDC and HRSA had collaboratively begun to undertake a strategic planning process for public health workforce development, there has been no delineation of roles between them in terms of strategies and programs to develop the public health workforce. In 2002 both agencies were funding public health training through projects based in schools of public health, with most grantees receiving funding for similar activities from both federal agencies.

Throughout the 1990s a series of initiatives, largely within the CDC’s Public Health Practice Program Office, cast a more intense spotlight on public health systems and their infrastructure, in part as a result of congressional interest in bioterrorism preparedness. The rationale for these strategies was based on the premise that categorical programs would operate more effectively if built on a strong foundation of basic public health practice. There were also concerns that categorical programs limit flexibility and elasticity within the public health system, resulting in suboptimal performance when resources are redeployed in response to an emergency. However, efforts to articulate the interdependence between the long-standing and relatively well funded categorical programs and the more generalized initiatives to build public health capacity (such as leadership development institutes, national performance standards, and Health Alert Network funding) did little to alter the balance of power; as a result, categorical strategies continued to predominate at the CDC and the other federal agencies.

■ **Changes in performance.** As form follows function, structural changes within the governmental public health enterprise portend complementary changes

in functional performance during the 1990s. The evidence, although incomplete, suggests that this may have been the case.

Efforts to measure the public health system's performance suffer from unequal attention on the various levels of governmental public health entities. The measurement frame for most studies focused on local jurisdictions served by a governmental public health agency. Comparable assessments at the state level, other than through aggregating those done at the local level within a state, or at the national level are virtually nonexistent.

Several studies using measures of core function-related performance found that performance varied among local jurisdictions and that composite national performance fell far short of the year 2000 target, with as little as one-third of the population effectively served in 1995.<sup>18</sup> Overall performance scores in the 1990s based on measures of core-function performance were roughly similar to those identified in the 1940s by an expert panel headed by Haven Emerson, based on their examination of staffing and funding levels at the time.<sup>19</sup> Of course, both the measures used and the context for public health practice differed at these two points in time.

There is evidence that performance levels for activities related to public health's core functions have increased since 1988 and that these changes are linked to core function-related standards implemented at the local and state levels.<sup>20</sup> Inability to link spending on public health activities to effective performance, whether defined by outcomes or by other means, limits efforts to demonstrate the value of the governmental public health enterprise. Until there is a consensus set of definitions for the resources used in practice that can ensure consistent performance across the distributed federal system, coordination of efforts will be difficult to achieve and demonstration of results that will assure the long-term and continued support for public health programming will remain an even greater challenge.

## **Changing Threats And Expectations**

Governmental public health efforts have evolved over time, in part because of changing relationships among the various levels of government and also the nature and perceived importance of threats to the population's health and safety and the public's expectations for governmental preparedness and response. Although far less dramatic than the shift in societal expectations during the 1930s, the transformation of public health practice in the 1990s served to raise public expectations that are generally directed to more proximal levels of government. As a result, within our system of federalism, state and local governments are assuming greater public health burdens without the authority, mandates, and capacity—including funding, constituencies, and leverage—to succeed.<sup>21</sup> Heightened public expectations after the terrorist attacks of late 2001, including the anthrax events, represent the most recent chapter in the story of changing threats and expectations for the governmental public health enterprise.

Key aspects of the federal role in public health had diminished by the time new public health threats and expectations appeared after September 2001. With consensus on the basis for analyzing public health capacity, it may be possible to establish a coordinated, intergovernmental public health response to address these new threats and expectations. Needed are greater incentives to restructure the public health system around the core function and essential public health services frameworks and to create a common taxonomy for practice that will inform public health leaders at all levels of the federal system.

■ **Congressional support and systematic reform.** The opportunities afforded by public interest in and increased expectations for public health have not yet resulted in linking congressional support for public health with systematic reform. Even with the enactment of the Frist-Kennedy legislation and substantial funding for bioterrorism preparedness, there has been little link with systematic reforms such as through the use of national public health performance standards; links with Healthy People 2010 priorities; or any nationally consistent approaches to workforce, information, and organizational resources. The federal agencies with responsibilities for public health must devise a structure that communicates a clear chain of command and responsibility for public health systems and capacity building. The operational aspects of this structural reform should be based on more flexible resource-sharing strategies to states meeting appropriate standards and through these states to local health units meeting specific standards based on public health's core functions and essential services.

■ **“All hazards” view versus categorical approaches.** The first test of public health's new millennium will be whether the substantial levels of funding for bioterrorism preparedness will be effectively deployed to diagnose and treat the problems facing the governmental public health enterprise, especially those exacerbated by more than two centuries of evolving intergovernmental relationships. The “all hazards” view that public health emergency preparedness and response is a vital capacity for all levels of government and all possible threats and hazards must predominate over categorical approaches to addressing the threat of bioterrorism.

THE NEED FOR A MORE EFFECTIVE and efficient public health system persists; however, we cannot achieve such a system without major advances in the organization, financing, and delivery of governmental public health services. This can still occur, but it will require the reworking of the operational aspects of the federal-state-local system of public health responsibilities and taking maximum advantage of bioterrorism and tobacco settlement resources. This is necessary to bring the ability of the federal government into better alignment with the opportunities afforded by an emerging form of local public health practice that is more heavily engaged in identifying and addressing community needs and in exposing itself to the gaps between what is doable and what is now expected.

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