

Commentary

History Will Be Kind

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The seeds of the national accreditation program for local health departments (LHDs) showcased in this special issue of the *Journal of Public Health Management and Practice* were sown in 1850 with the visionary *Report of the Sanitary Commission of Massachusetts*.¹ They took root in an American Medical Association (AMA) sponsored examination of state health agencies in 1914 and spread slowly over the next four decades largely through the efforts of the American Public Health Association (APHA). Only after the 1988 Institute of Medicine's (IOM's) report on *The Future of Public Health*² did foliage begin to appear above ground. In 2007, those seeds appear ready to bear fruit due to the concerted efforts of national public health organizations in a project jointly funded through a unique public-private partnership.

Winston Churchill, the British Prime Minister during World War II, often boasted that history would likely be kind to him. His rationale for this immodest assertion was that he planned to write that history himself. In that light, public health history should be kind to the many that have made it possible for a national accreditation for LHDs to become a reality in the very near future. Indeed, it was they who wrote this history. Details of these accomplishments are more fully chronicled elsewhere,³ but the public health figures, the landmarks, and the lessons of this saga merit a brief revisiting at this time.

● The First 100 Years: Building the Infrastructure, Measuring Progress

In 1850, Lemuel Shattuck, the original architect of the governmental public health infrastructure, provided a blueprint for the development of state and local public health activities in his *Report of the Sanitary Commission of Massachusetts*.¹ Unfortunately, Shattuck's report sat on the shelf for several decades before beginning

to influence the development of state and local public health agencies toward the end of the 19th century. With state and local governments serving populations of various sizes and at widely varying stages of development, some established for more than a century and some for less than a decade, a variety of different governance structures and statutory frameworks appeared. By 1900, there were health departments in nearly all states and many large cities; in 1911, the first county-based health departments appeared.

With the rise of state health departments, the AMA Council of Health and Public Instruction commissioned Charles Chapin in 1914 to conduct a survey of the public health activities in state health departments. The study's primary intent was to identify ways for state health agencies to improve the public's health and better support the efforts of LHDs. Each state health department was rated by the type and quantity of services offered and was assigned a numeric value. Findings were somewhat discouraging, with Chapin concluding that the needs and demands of the public were beyond the capabilities and resources available to these agencies.⁴

Within a decade, Chapin's efforts prompted the APHA's interest in measures and standards for local public health practice.⁴ The association's first initiative occurred in 1921 when the Committee on Municipal Health Department Practice reported information on activities and resources at the local level to identify characteristics that produced promising results.^{5,6} Led by Winslow, Chapin, and Frost, the Committee

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surveyed LHDs in more than 80 large metropolitan areas promoting the notion that a consistent set of public health services should be available in all jurisdictions.

Soon after completing this report, the newly renamed committee (now the Committee on Administrative Practice, or CAP), created a self-assessment (known as the Appraisal Form) to characterize the health services provided in both metropolitan cities and county-based health departments.⁷ The name change and expanded focus of the committee was due in part to the rapid growth of county-based LHDs.

The Appraisal Form measured human, financial, organizational, and clinical resources. Ratings were used to leverage resources and to improve programs while providing LHDs recognition of their accomplishments through a National Honor Roll. Although some perceived the process as overemphasizing quantity rather than quality of services, LHDs generally found value in and supported the process.

Several versions of the Appraisal Form were developed throughout the 1920s and 1930s until a new instrument, the Evaluation Schedule, appeared in 1943.⁸ In lieu of using the self-assessment tool, the Evaluation Schedule was designed to compare resources and activities among LHDs of similar sizes and structures. Based on its analysis of the information from these assessment efforts, the Committee's Subcommittee on Local Health Units developed a report (often called the Emerson Report after the Committee's long-serving chairman, Haven Emerson) in 1945 that became the post-World War II blueprint for the structure and services of LHDs.⁹

The Emerson Report identified six core public health activities that were to constitute the minimum services expected from LHDs with a population of 50 000 people or more. These "Basic 6" services (vital statistics, sanitation, communicable disease control, maternal and child health, health education, and laboratory services) were the focus of information reported by LHDs in both the Appraisal Form and the Evaluation Schedule. Despite the continuing rapid growth of LHDs, interest in measuring LHD activities waned and the committee was disbanded in the mid-1950s.

Shattuck, Chapin, and Emerson were unusual public health leaders in many ways. Shattuck was a bookseller with an interest in statistics. After being elected to the Boston City Council, he used his statistical skills in analyzing the city's birth and death records. His reputation as a meticulous information gatherer and analyst resulted in the state legislature commissioning his sanitary survey of the state. Chapin, a physician, came to his position as health officer in Providence with no real background or training. He saw value in emerging concepts of sanitary and hygienic practices and found ways to harness these in the services offered through his agency. Emerson's inauguration into pub-

lic health was as a deputy to Hermann Biggs at the New York City Department of Health, where he later served as Health Commissioner. Much of his work with the APHA and the Committee on Administrative Practice occurred while serving on the medical faculty at Cornell and Columbia universities. Certainly, these were not the only public health notables making substantial contributions over this 100-year period, but they personify the qualities of commitment, curiosity, and perseverance that allow us to view their remarkable professional accomplishments as landmarks on the public health landscape even today.

Much was accomplished between 1850 and 1950, especially after 1915. The governmental public health infrastructure expanded considerably, especially in terms of the number and scope of LHDs. Considerable information became available as to the structure of those agencies and the services they offered in their communities. Throughout this period, measuring and establishing standards for LHDs was high on the agenda of influential national professional organizations. Initially, the AMA played a leadership role and the APHA's interest was critical for more than three decades. In the reports developed by Shattuck, Chapin, and Emerson, measurement for measurement's sake was never the intent. Each landmark effort sought to use information from these assessments to improve public health services and community health outcomes. The difficulty in using this information without understanding the relationship between services and outcomes eventually led to the recognition that a new approach was necessary. After CAP disbanded, the flame of interest in LHDs and local public health activities sputtered for several decades, only to reignite in the fourth quarter of the 20th century.

● The Last 50 Years: Improving Performance, Enhancing Accountability

A few voices, especially Terris and Mountin,^{10,11} raised concerns over the plight of LHDs in the 1950s and 1960s, and the APHA maintained an interest at a policy rather than a measurement level during this period. LHDs became increasingly involved with filling gaps in the medical care system and providing mental health, substance abuse, and environmental protection services. In the 1970s, Hanlon¹² challenged the public health community in asking whether LHDs indeed had a future.

Arden Miller picked up the gauntlet, extending the strategies and methods of previous decades to resurrect interest in local public health practice. For some LHDs, community health planning became an important activity. Other than the steadfast efforts of Miller, tracking and understanding the effects of these changes for

LHDs received little attention. With wider recognition that LHDs often served a unique role as the governmental presence in health, Miller's studies of LHDs helped shape an understanding of the important role played by LHDs in their communities. Remarkably, his efforts extended across four different decades and inspired several generations of practitioners and researchers. The breadth and depth of his inquiries are reflected in a virtual library of work products, beginning with his 1977 survey of LHDs and their directors¹³ and continuing through the 1990s.

By the time the landmark report of the IOM on *The Future of Public Health*² appeared in the late 1980s, LHDs increasingly viewed their role as that of the governmental presence in health at the local level, a concept that emerged in 1979 from a group of public health leaders working on model standards for community preventive services.¹⁴ The committee authoring the 1988 IOM report included many leading public health practitioners and academics. Seizing the opportunity to characterize its findings in near shocking terms such as "disarray," activists on the committee fashioned a document that would serve as a wake-up call for the public health community.

Exemplifying this approach was committee member Hugh Tilson, a former local and state health officer then working as an epidemiologist for a large pharmaceutical company. Tilson and other activist committee members assured that the report would receive widespread attention and continued to push for periodic reassessments of whether real progress was being made. A second IOM report¹⁵ in 2003 identified strategies to engage the governmental public health presence described in the first report with other key players and stakeholders in the community. This set the stage for governmental public health entities to become more accountable for what they do and more open to functioning through collaborations and partnerships.

The 1988 IOM report and its follow-up study 15 years later generated new conceptual frameworks and tools, including the essential public health services framework, which, in turn, spawned national public health performance standards¹⁶ and efforts at several levels to reform and improve state-local public systems. Kristine Gebbie's leadership for public health workforce development and Bobbie Berkowitz' coordination of the National Turning Point Project funded by the Robert Wood Johnson Foundation are prime examples.

The most complex piece of this puzzle was the development of a set of national public health performance standards for states, local public health agencies, and local boards of health. The Centers for Disease Control and Prevention's Public Health Practice Program Office undertook this challenge in the mid-

1990s under the leadership of Ed Baker, with the specific duty falling to Paul Halverson. National performance standards would have several applications, including tracking trends in public health practice, providing accountability to stakeholders and constituencies, benchmarking performance for improvement efforts, and increasing the scientific base for public health practice. Halverson envisioned standards as applying to public health systems, not just public health agencies. Such standards could be used by public health agencies to assess broad needs within the community. Halverson had worked as a hospital administrator, before obtaining his doctoral degree in public health with Miller as his mentor. Working with Baker provided a unique opportunity to affect public health practice at a high level and prepared him well for his later move to become a state health officer. Despite longstanding fears and suspicions among LHDs as to how national standards might be implemented and enforced, the National Association of County and City Health Officials (NACCHO) embraced the inclusion of the national standards in the development of the *Mobilizing for Action Through Planning and Partnerships* process.¹⁷ Paul Wiesner guided the birth of this process with strong contributions from many NACCHO and Association of State and Territorial Health Officials colleagues. The final frontier for preparing for LHD accreditation was breached in 2005 with the development of standards characterizing an operational definition of a functional LHD¹⁸ shepherded by Patrick Lenihan on behalf of the NACCHO.

The *Exploring Accreditation* Project,¹⁹ the groundbreaking partnership coordinated by the Association of State and Territorial Health Officials and the NACCHO that examined the desirability and feasibility of a national public health accreditation program for both state and local health departments, became the beneficiary of this chain of developments. An outgrowth of the 2002 IOM report, this effort builds on the experience of public health leaders, including local public health officers and administrators, to prompt improvement in the nation's health through a more comprehensive approach. Several elements of the public health agency accreditation were carefully considered, including governing structures, standards and measures, financing, and research and evaluation of the voluntary accreditation program. Within 14 months, the steering committee and its work groups developed an initial model and crafted several revisions on the basis of comments received from the public health community. As a result, the committee concluded that a program is feasible and desirable, and recommended moving forward with its implementation.¹⁹

The ever-expanding agenda of and shifting expectations for governmental public health in the United

TABLE 1 ● Key figures and landmarks in the history of public health agency accreditation, 1850–2007

Figures	Landmarks
Lemuel Shattuck	<i>Report of the Sanitary Commission of Massachusetts</i> (1850)
Charles Chapin	<i>A Report on State and Local Public Health Work Based on a Survey of State Boards of Health</i> (1915)
Haven Emerson	<i>Local Health Units for the Nation ("The Emerson Report," 1945)</i>
Arden Miller	<i>Survey of Local Public Health Departments and Their Directors</i> (1977)
Hugh Tilson	<i>The Future of Public Health</i> (1988) <i>The Future of the Public's Health in the 21st Century</i> (2003)
Paul Halverson	<i>National Public Health Performance Standards</i> (2002)

States since the end of World War II underscore the need for leaders such as Shattuck, Chapin, Emerson, Miller, Tilson, and Halverson, and many have risen to that challenge. To acknowledge only a few may seem arbitrary, although it is not possible to even briefly identify the many whose work has made public health agency accreditation a reality. With some trepidation, this historical review identifies only a few sentinel figures and landmarks, and spotlights even fewer in summary fashion in Table 1.

The lessons since 1950, in large part, repeat and extend those from the preceding 100 years. Leaders have arisen to examine the key questions and guide the development of additional landmarks. National organizations have again been key, although the NACCHO, the Association of State and Territorial Health Officials, and the Centers for Disease Control and Prevention have replaced the AMA and the APHA as prime movers of the public health improvement agenda. A broader view of public health systems and clearer role for the governmental presence in health has developed, allowing for consensus around the conceptual framework for modern public health practice.

● Implications and Conclusions

For much of the 150-year period described in previous sections, public health professionals held different perspectives as to what public health is and how it works, although there has long been an appreciation of why it is important. State public health systems were the initial focus, but since the days of Emerson, LHDs have been at the center stage. While local public health has always been where the rubber meets the road, greater direct involvement of states and state health agencies in a national accreditation program will be necessary for the program to succeed.

Effective intervention strategies depend on an intricate web of relationships and resources in the environment in which public health problems reside. Public expectations are another important elements of public health practice. The history of governmental public health in the United States is marked by often lengthy periods of relative obscurity and inattention interrupted by highly visible events that result in increased attention, opportunities, and expectations. The first decade of the 21st century is but the latest iteration of this cycle. Fears of bioterrorism and identification of public health as a national and personal security asset raise the bar for public health agencies. Accreditation is viewed as a means to demonstrate that public health agencies can meet those expectations.

The torch now passes to a new cohort of public health leaders. A national accreditation program for LHDs appears a solid contender for inclusion on the next public health landmarks list.²⁰ The *Exploring Accreditation* initiative that proposes this approach will require leaders of the caliber of Shattuck, Chapin, Emerson, Miller, Tilson, and Halverson. Based on the progress made to date, the *Exploring Accreditation* leaders will likely soon join that list.

The foundation for a national accreditation is strong, with the work and work products of many evident in its structure. On this foundation, national standards and a voluntary national program to assess and recognize LHD performance now stand. The lessons from this 157-year odyssey evolved slowly but will likely determine whether the current proposal will succeed or fail. Should it succeed, history will indeed be kind to those who helped make it happen.

REFERENCES

1. Chapin CV. *A Report on State Public Health Work Based on a Survey of State Boards of Health*. Chicago: American Medical Association; 1915. <http://www.deltaomega.org/ChapinClassic.pdf>; <http://www.deltaomega.org/classics.htm>. Accessed September 21, 2006.
2. Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academies Press; 1988.
3. Turnock BJ, Handler AS. From measuring to improving public health practice. *Annu Rev Public Health*. 1997;18:261–282.
4. Vaughn HF. Local health services in the United States; the story of CAP. *Am J Public Health*. 1972;62:95–108.
5. American Public Health Association, Committee on Municipal Health Department Practice. First report; part I. *Am J Public Health*. 1922;12(2):7–15.
6. American Public Health Association, Committee on Municipal Health Department Practice. First report; part II. *Am J Public Health*. 1922;12(2):138–147.
7. American Public Health Association, Committee on Administrative Practice. Appraisal form for city health work [abstract]. *Am J Public Health*. 1926;16(1)(suppl):2–4.

8. American Public Health Association, Committee on Administrative Practice. *Evaluation Schedule for Use in the Study and Appraisal of Community Health Programs*. New York: American Public Health Association; 1947.
9. Emerson EH, Luginbuhl M. *Local Health Units for the Nation*. New York: Commonwealth Fund; 1945.
10. Terris M, Kramer NA. Medical care activities of full-time health departments. *Am J Public Health*. 1949;39:1129–1135.
11. Mountin JW. The health department's dilemma. *Public Health Rep*. 1952;67(3):223–229.
12. Hanlon JJ. Is there a future for local health departments? *Health Serv Rep*. 1973;88(10):898–901.
13. Miller CA, Brooks CF, DeFriese GH, Gilbert B, Jain SC, Kavaler F. A survey of local public health departments and their directors. *Am J Public Health*. 1977;67(10):931–939.
14. American Public Health Association, Association of State and Territorial Health Officials, National Association of County Health Officials, US Conference of Local Health Officials, and Centers for Disease Control and Prevention. *Model Standards: A Guide for Community Preventive Health Services*. 2nd ed. Washington, DC: American Public Health Association; 1985.
15. Institute of Medicine. *The Future of the Public's Health in the 21st Century*. Washington, DC: National Academies Press; 2003.
16. Centers for Disease Control and Prevention. *National Public Health Performance Standards*. Atlanta: Centers for Disease Control and Prevention; 2002.
17. Centers for Disease Control and Prevention. *Mobilizing for Action Through Planning and Partnerships*. Washington, DC: National Association of County and City Health Officials; 2001.
18. National Association of County and City Health Officials. *Operational Definition of a Functional Local Health Department*. Washington, DC: National Association of County and City Health Officials; 2005.
19. Exploring Accreditation. Final recommendations for a voluntary national accreditation program. <http://www.exploringaccreditation.org>. Accessed November 24, 2006.
20. Beitsch LM, Thielen L, Mays G, et al. The Multi-State Learning Collaborative, states as laboratories: informing the national public health accreditation dialogue. *J Public Health Manag Pract*. 2006;12(3):217–231.