Chapter 2

Organizations That Help Shape Community Health

Chapter Outline

Chapter Objectives

1. Explain the need for organizing to improve community health.
2. Explain what a governmental health organization is and give an example of one at each of the following levels—international, national, state, and local.
3. Explain the role the World Health Organization (WHO) plays in community health.
4. Briefly describe the structure and function of the United States Department of Health and Human Services (HHS).
5. State the three core functions of public health.
6. List the 10 essential public health services.
7. Explain the relationship between a state and local health department.
8. Explain what is meant by the term *coordinated school health program.*
9. Define the term *quasi-governmental* and explain why some health organizations are classified under this term.
10. List the four primary activities of most voluntary health organizations.
11. Explain the purpose of a professional health organization/association.
12. Explain how philanthropic foundations contribute to community health.
13. Discuss the role that service, social, and religious organizations play in community health.
14. Identify the major reason why corporations are involved in community health and describe some corporate activities that contribute to community health.

SCENARIO

Mary is a hardworking senior at the local university. She is majoring in physical education and looking forward to teaching elementary physical education after graduation. Mary has always been involved in team sports and has been a lifeguard at the local swimming pool for the past four years. Mary has a fair complexion with honey-blonde hair and blue eyes. She has always tanned easily and so has not bothered very much with sunscreens. For the past few weeks, Mary has noticed a red, scaly, sharply outlined patch of skin on her forehead. She has put creams and ointments on it, but it will not go away and may be getting larger. Her roommate, Clare, suggests that she should make an appointment with the campus health services office. Mary lets it go another week and then decides to see the doctor.

After looking at the patch of skin, the doctor refers Mary to a specialist, Dr. Rice, who is a dermatologist. The dermatologist suggests a biopsy be taken of the lesion to test for skin cancer. The specialist tells Mary that if it is cancer, it is probably still in its early stages and so the prognosis is good.

A potential diagnosis of cancer often raises a lot of questions and concerns. Are there any resources in the community to which Mary can turn for help?

INTRODUCTION

As noted in Chapter 1, the history of community health dates to antiquity. For much of that history, community health issues were addressed only on an emergency basis. For example, if a community faced a drought or an epidemic, a town meeting would be called to deal with the problem. It has been only in the last 100 years or so that communities have taken explicit actions to deal aggressively with health issues on a continual basis.

Today's communities differ from those of the past in several important ways. Although individuals are better educated, more mobile, and more independent than in the past, communities are less autonomous and are more dependent on state and federal funding for support. Contemporary communities are too large and complex to respond effectively to sudden health emergencies or to make long-term improvements in public health without community organization and careful planning. Better community organizing and careful long-term planning are essential to ensure that a community makes the best use of its resources for health, both in times of emergency and over the long run.

The ability of today's communities to respond effectively to their own problems is hindered by the following characteristics: (1) highly developed and centralized resources in our national institutions and organizations, (2) continuing concentration of wealth and population in the largest metropolitan areas, (3) rapid movement of information, resources, and people made possible by advanced communication and transportation technologies that eliminate the need for local offices where resources were once housed, (4) the globalization of health, (5) limited horizontal relationships between/among organizations, and (6) a system of **top-down funding** (money that comes from either the federal or state government to the local level) for many community programs.[1]

top-down funding a method of funding in which funds are transmitted from federal or state government to the local level

In this chapter, we discuss organizations that help to shape a community's ability to respond effectively to health-related issues by protecting and promoting the health of the community and its members. These community organizations can be classified as governmental, quasi-governmental, and nongovernmental—according to their sources of funding, responsibilities, and organizational structure.

GOVERNMENTAL HEALTH AGENCIES

Governmental health agencies are part of the governmental structure (federal, state, or local). They are funded primarily by tax dollars and managed by government officials. Each governmental health agency is designated as having authority over some geographic area. Such agencies exist at the four governmental levels—international, national, state, and local.

governmental health agencies health agencies that are part of the governmental structure (federal, state, or local) and that are funded primarily by tax dollars

International Health Agencies

The most widely recognized international governmental health organization today is the **World Health Organization (WHO)** (see Figure 2.1). Its headquarters is located in Geneva, Switzerland, and there are six regional offices around the world. The names, acronyms, and cities and countries of location for WHO regional offices are as follows: Africa (AFRO), Brazzaville, Congo; Americas (PAHO), Washington, DC, United States; Eastern Mediterranean (EMRO), Cairo, Egypt; Europe (EURO), Copenhagen, Denmark; Southeast Asia (SEARO), New Delhi, India; and Western Pacific (WPRO), Manila, Philippines.[2]

World Health Organization (WHO) the most widely recognized international governmental health organization

Although the WHO is now the largest international health organization, it is not the oldest. Among the organizations (listed with their founding dates) that predate WHO are the International D'Hygiene Publique (1907), which was absorbed by the WHO; the Health Organization of the League of Nations (1919), which was dissolved when the WHO was created; the United Nations Relief and Rehabilitation Administration (UNRRA); the United Nations Children's Fund (UNICEF) (1946), which was formerly known as the United Nations International Children's Emergency Fund; and the Pan American Health Organization (PAHO) (1902), which is still an independent organization but is integrated with WHO in a regional office. Because the WHO is the largest and most visible international health agency, it is discussed at greater length in the following sections.

World Health Assembly a body of delegates of the member nations of the WHO

History of the World Health Organization

Planning for the WHO began when a charter of the United Nations was adopted at an international meeting in 1945. Contained in the charter was an article calling for the establishment of a health agency with wide powers. In 1946, at the International Health Conference, representatives from all of the countries in the United Nations succeeded in creating and ratifying the constitution of the WHO. However, it was not until April 7, 1948, that the constitution went into force and the organization officially began its work. In recognition of this beginning, April 7 is commemorated each year as World Health Day.[2]

FIGURE 2.1
The emblem of the World Health Organization.
Source: Courtesy of World Health Organization. Use of logo does not imply endorsement.

Organization of the World Health Organization

Membership in the WHO is open to any nation that has ratified the WHO constitution and receives a majority vote of the World Health Assembly. At the beginning of 2006, 193 countries were members. The **World Health Assembly** comprises the delegates of the member nations. This assembly, which meets in general sessions annually and in special sessions when necessary, has the primary tasks of approving the WHO program and the budget for the following biennium and deciding major policy questions.[2]

The WHO is administered by a staff that includes a director-general and nine assistant directors-general. Great care is taken to ensure political balance in staffing WHO positions, particularly at the higher levels of administration.

Purpose and Work of the World Health Organization

The primary objective of the WHO as stated in the constitution is

the attainment by all peoples of the highest possible level of health.[2] The WHO has six core functions:[2]

- Articulating consistent, ethical and evidence-based policy and advocacy positions
- Managing information by assessing trends and comparing performance; setting the agenda for, and stimulating research and development
- Catalyzing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable national and inter-country capacity
- Negotiating and sustaining national and global partnerships
- Setting, validating, monitoring and pursuing the proper implementation of norms and standards
- Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management, and service delivery

The work of the WHO is financed by its member nations, each of which is assessed according to its ability to pay; the wealthiest countries contribute the greatest portion of the total budget.

Although the WHO has sponsored and continues to sponsor many worthwhile programs, an especially noteworthy one was the work of the WHO in helping to eradicate smallpox. In 1967, smallpox was active in 31 countries. During that year, 10 to 15 million people contracted the disease, and of those, approximately 2 million died and many millions of others were permanently disfigured or blinded. The last known case of smallpox was diagnosed on October 26, 1977, in Somalia.[2] In 1980, the World Health Assembly declared the global eradication of this disease. Using the smallpox mortality figures from 1967, it can be estimated that well over 40 million lives have been saved since the eradication (see Box 2.1).

As noted in Chapter 1, the current work of the WHO is guided by two documents—the *11th General Programme of Work*[2] and the United Nations Millennium Declaration, which

BOX **2.1**

THE KINDEST CUT

Once I was in Geneva at the World Health Organization researching a book on communicable diseases. I met Donald Henderson, M.D., director of the smallpox eradication effort.

Not long ago, smallpox was one of the worst diseases anyone could have. About six of every ten who contracted it died. In the United States, even a single known case was regarded as an epidemic.

There is no smallpox known anywhere today. Credit the WHO smallpox vaccination effort. There is still no cure, only prevention; that is, vaccination. At that time, WHO was ready to vaccinate the world, if necessary, to eradicate the disease.

Henderson had been in one high-incidence smallpox region in South America. But few people there were coming to the WHO field station for vaccinations. The warnings about this disease were ho-hum, even though people were seeing smallpox deaths every day.

So, Henderson said, they tried bribery. Not money or goods. They substituted ordinary sewing needles for the standard stainless steel stylets, used to prick under the skin. Then the WHO people spread the word that anyone who came for immunization could keep the needle. Women wanted them for sewing and working of cloth. Men saw them as fine tips for hunting darts.

The sudden fervor and turnout for vaccination rivaled that at any Christmas Eve mass at St. Patrick's Cathedral in New York. Henderson's lesson in resourcefulness for the common good did indeed involve some low-road seduction with rewards, but it was a clear lesson, and one with merit. "Get people to come in for vaccination any way you can. But get them," he said that day in Geneva. "First get them healthy. Then there's time enough to try to educate them about staying healthy."

Source: Gallagher, R. (1993). "Resourcerer's Apprentice." *Living: The Magazine of Life,* 22(3): 12.

was adopted at the Millennium Summit in 2003.[3] Because the *11th General Programme of Work* was discussed in detail in Chapter 1, the discussion here focuses on the Millennium Declaration. The declaration set out principles and values in seven areas (peace, security, and disarmament; development and poverty eradication; protecting our common environment; human rights, democracy, and good governance; protecting the vulnerable; meeting special needs of Africa; and strengthening the United Nations) that should govern international relations in the twenty-first century.[3] Following the summit, the *Road Map* was prepared, which established goals and targets to be reached by 2015 in each of the seven areas.[4] The resulting eight goals in the area of development and poverty eradication are now referred to as the Millennium Development Goals (MDGs). More specifically, the MDGs are aimed at reducing poverty and hunger, tackling ill-health, gender inequality, lack of education, lack of access to clean water, and environmental degradation.

As can be seen from this description, the MDGs are not exclusively aimed at health, but there are interactive processes between health and economic development that create a crucial link. That is, better health is "a prerequisite and major contributor to economic growth and social cohesion. Conversely, improvement in people's access to health technology is a good indicator of the success of other development processes."[5] As such, "three of the eight goals, eight of the 18 targets required to achieve them, and 18 of the 48 indicators of progress are health-related"[5] (see Table 2.1).

To date, progress on the MDGs has been slow, and it appears that many of the targets will not be reached by 2015. Five major challenges to meeting the goals have been identified: (1) strengthening health systems, (2) ensuring health is recognized as a priority within development and economic policies, (3) developing appropriate strategies to address the diverse needs of the countries, (4) mobilizing more resources for health in the poor countries, and (5) improving the quality of health-related data in order to track progress toward the goals.[6,7] Much work lies ahead, by all people of the world, to improve the health of those most in need.

National Health Agencies

Each national government has a department or agency that has the primary responsibility for the protection of the health and welfare of its citizens. These national health agencies meet their responsibilities through the development of health policies, the enforcement of health regulations, the provision of health services and programs, the funding of research, and the support of their respective state and local health agencies.

In the United States, the primary national health agency is the Department of Health and Human Services (HHS). HHS "is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves."[8] It is important to note, however, that other federal agencies also contribute to the betterment of our nation's health. For example, the Department of Agriculture inspects meat and dairy products and coordinates the Women, Infants, and Children (WIC) food assistance program; the Environmental Protection Agency (EPA) regulates hazardous wastes; the Department of Labor houses the Occupational Safety and Health Administration (OSHA), which is concerned with safety and health in the workplace; the Department of Commerce, which includes the Bureau of the Census, collects much of the national data that drives our nation's health programs; and the Department of Homeland Security (DHS) deals with all aspects of terrorism within the United States. While information about the DHS was presented in Chapter 1, each of these other departments or agencies will be discussed in greater detail in later chapters. A detailed description of the Department of Health and Human Services follows.

Table 2.1
Health-Related Millennium Development Goals, Targets, and Indicators

Goal: 1. Eradicate Extreme Poverty and Hunger
Target: 2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Indicator: 4. Prevalence of underweight children under five years of age
5. Proportion of population below minimum level of dietary energy consumption[a]

Goal: 4. Reduce Child Mortality
Target: 5. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
Indicator: 13. Under-five mortality rate
14. Infant mortality rate
15. Proportion of 1-year-old children immunized against measles

Goal: 5. Improve Maternal Health
Target: 6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Indicator: 16. Maternal mortality ratio
17. Proportion of births attended by skilled health personnel

Goal: 6. Combat HIV/AIDS, Malaria, and Other Diseases
Target: 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS
Indicator: 18. HIV prevalence among young people aged 15 to 24 years[b]
19. Condom use rate of the contraceptive prevalence rate
20. Number of children orphaned by HIV/AIDS
Target: 8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
Indicator: 21. Prevalence and death rates associated with malaria
22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures
23. Prevalence and death rates associated with tuberculosis
24. Proportion of tuberculosis cases detected and cured under Directly Observed Treatment, Short-course (DOTS)

Goal: 7. Ensure Environmental Sustainability
Target: 9. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources
Indicator: 29. Proportion of population using solid fuel
Target: 10. Halve by 2015 the proportion of people without sustainable access to safe drinking-water
Indicator: 30. Proportion of population with sustainable access to an improved water source, urban and rural
Target: 11. By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers
Indicator: 31. Proportion of urban population with access to improved sanitation

Goal: 8. Develop a Global Partnership for Development
Target: 17. In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries
Indicator: 46. Proportion of population with access to affordable essential drugs on a sustainable basis

[a]Health-related indicator reported by the Food and Agriculture Organization only.
[b]Indicators from the MDG list reformulated by WHO and United Nations General Assembly Special Session on HIV/AIDS.

Source: World Health Organization (2003). *World Health Report 2003: Shaping the Future.* Geneva, Switzerland: Author, 28. Used with permission of the World Health Organization.

Department of Health and Human Services

The HHS is headed by the Secretary of Health and Human Services, who is appointed by the president and is a member of his or her cabinet. The Department of Health and Human Services was formed in 1980 (during the administration of president Jimmy Carter), when the Department of Health, Education, and Welfare (HEW) was divided into two new departments, HHS and the Department of Education. HHS is the department most involved with the nation's human concerns. In one way or another it touches the lives of more Americans than any other federal agency. It is literally a department of people serving people, from newborn infants to persons requiring health services to our most elderly citizens. With an annual budget in excess of approximately $698 billion (representing about 25% of the federal budget), HHS is the

largest department in the federal government, and it spends approximately $195 billion more per year than the Department of Defense.[8,9]

Since its formation, HHS has undergone several reorganizations. Some of the more recent changes have been the addition of the Center for Faith-Based and Community Initiatives and an Assistant Secretary for Public Health Emergency Preparedness. Currently, the HHS is organized into 11 operating divisions (see Figure 2.2) whose heads report directly to the Secretary. In addition, the HHS has 10 regional offices (see Table 2.2). These offices serve as representatives of the Secretary of HHS in direct, official dealings with the state and local governmental organizations.

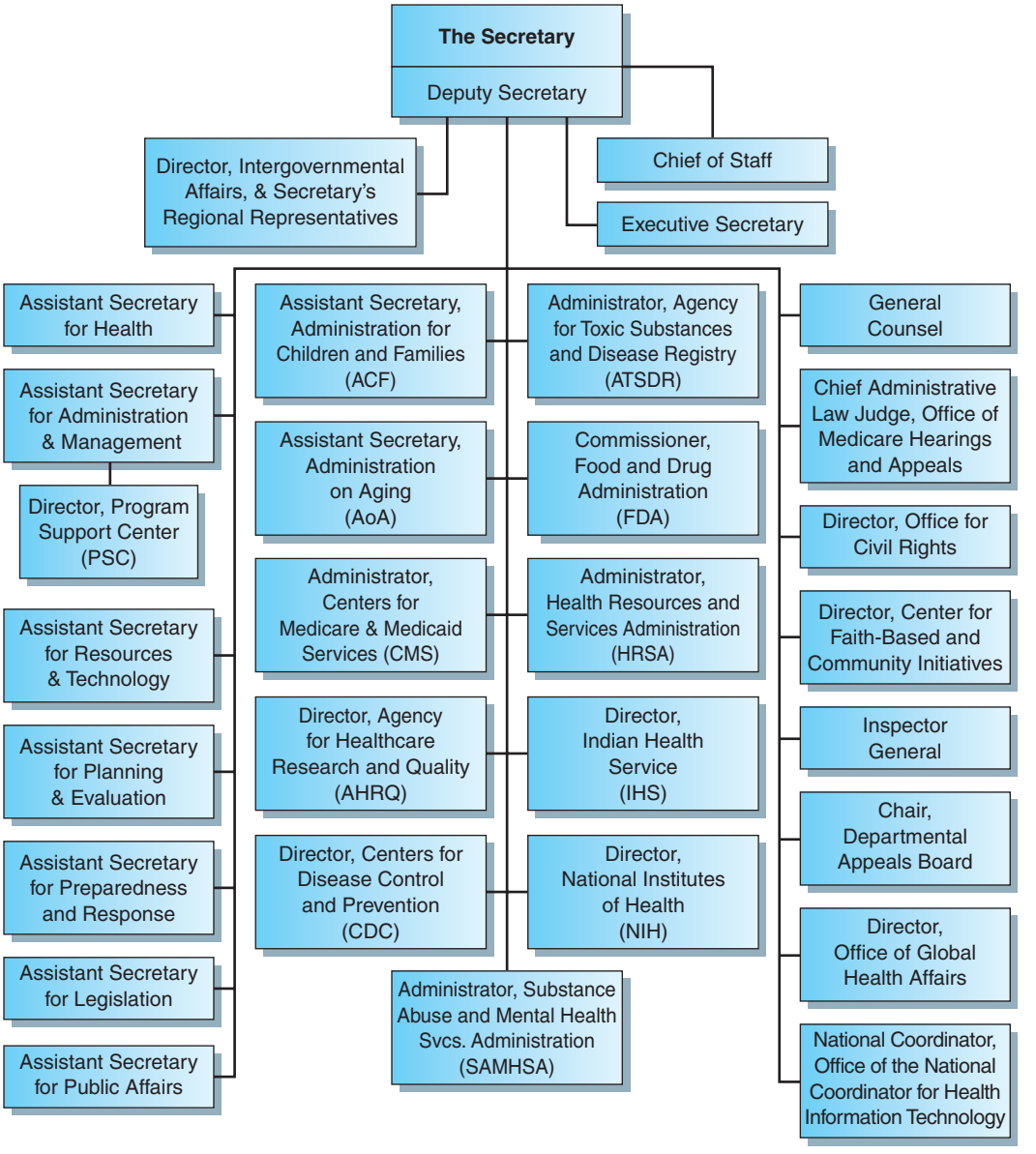

FIGURE 2.2

Organizational chart for the U.S. Department of Health and Human Services (HHS).

Source: U.S. Department of Health and Human Services (2007). Available at http://www.hhs.gov/about/orgchart.html.

Although it appears in Figure 2.2 that the Public Health Service (PHS), a long-standing federal health agency, was eliminated from HHS, this is not the case. Eight of the 11 operating divisions of HHS now constitute the PHS (AHRQ, CDC, ATSDR, FDA, HRSA, IHS, NIH, and SAMHSA). Another three operating divisions (CMS, ACF, and AoA) comprise the human services operating divisions.

Administration on Aging (AoA)
This division of the HHS is the principal agency designated to carry out the provisions of the Older Americans Act of 1965. (See Chapter 9 for more information on this act.) This agency tracks the characteristics, circumstances, and needs of older people; develops policies, plans, and programs to promote their welfare; administers grant programs to benefit older Americans; and administers training, research, demonstration programs, and protective services for older Americans. One exemplary program supported by the AoA is Meals on Wheels.

Administration for Children and Families (ACF)
The ACF is composed of a number of smaller agencies and is responsible for providing direction and leadership for all federal programs for needy children and families. One of the better-

Table 2.2
Regional Offices of the U.S. Department of Health and Human Services

Region/Areas Served	Office Address	Telephone Number
Region 1: CT, MA, ME, NH, RI, VT	John F. Kennedy Bldg. Government Center Boston, MA 02203	(617) 565-1500
Region 2: NJ, NY, Puerto Rico, Virgin Islands	Jacob K. Javits Federal Bldg. 26 Federal Plaza New York, NY 10278	(212) 264-4600
Region 3: DE, MD, PA, VA, WV, DC	Public Ledger Building 150 S. Independence Mall West Suite 436 Philadelphia, PA 19106	(215) 861-4633
Region 4: AL, FL, GA, KY, MS, NC, SC, TN	Sam Nunn, Atlanta Federal Center 61 Forsyth Street, SW Atlanta, GA 30303	(404) 562-7888
Region 5: IL, IN, MI, MN, OH, WI	233 N. Michigan Avenue Chicago, IL 60601	(312) 353-5160
Region 6: AR, LA, NM, OK, TX	1301 Young Street Dallas, TX 75202	(214) 767-3301
Region 7: IA, KS, MO, NE	Bolling Federal Building 601 East 12th Street Kansas City, MO 64106	(816) 426-2821
Region 8: CO, MT, ND, SD,UT, WY	Bryon G. Rogers Federal Office Building 1961 Stout Street Room 1076 Denver, CO 80294	(303) 844-3372
Region 9: AZ, CA, HI, NV, American Samoa, Guam, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, Republic of Palau	Federal Office Building 50 United Nations Plaza San Francisco, CA 94102	(415) 437-8500
Region 10: AK, ID, OR, WA	Blanchard Plaza Bldg. 2201 6th Avenue Seattle, WA 98121	(206) 615-2010

known programs originating from this division is Head Start, which serves more than 900,000 preschool children. Other programs are aimed at family assistance, refugee resettlement, and child support enforcement.

Agency for Healthcare Research and Quality (AHRQ)
Prior to 1999 this division of the HHS was called the Agency for Health Care Policy and Research, but its name was changed as part of the Healthcare Research and Quality Act of 1999. AHRQ is "the Nation's lead Federal agency for research on health care quality, costs, outcomes, and patient safety."[10] AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use, and access. The information helps health care decision makers—patients and clinicians, health system leaders, and policy makers—make more informed decisions and improve the quality of health care services.

Agency for Toxic Substances and Disease Registry (ATSDR)
This agency was created by the **Superfund legislation** (Comprehensive Environmental Response, Compensation, and Liability Act) in 1980. This legislation was enacted to deal with the cleanup of hazardous substances in the environment. ATSDR's mission "is to serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and disease related to toxic substances."[11] To carry out its mission and to serve the needs of the American public, ATSDR evaluates information on hazardous substances released into the environment in order to assess the impact on public health; conducts and sponsors studies and other research related to hazardous substances and adverse human health effects; establishes and maintains registries of human exposure (for long-term follow-up) and complete listings of areas closed to the public or otherwise restricted in use due to contamination; summarizes and makes data available on the effects of hazardous substances; and provides consultations and training to ensure adequate response to public health emergencies. Although ATSDR has been responding to chemical emergencies in local communities across the country for the last 25 years, like many of the other federal health agencies its work has taken on new meaning since 9/11. For example, some of the projects the agency's staff have worked on or continue to work on include sampling dust in New York City residences after 9/11; working with New York health agencies to create a registry of people who lived or worked near the World Trade Center (WTC) on 9/11 to collect health information on those most heavily exposed to smoke, dust, and debris from the collapse of the WTC; conducting environmental sampling at anthrax-contaminated buildings; and disseminating critical information to agencies and organizations with a role in terrorism preparedness and response.[12]

Superfund legislation
legislation enacted to deal with the cleanup of hazardous substances in the environment

Centers for Disease Control and Prevention (CDC)
The CDC, located in Atlanta, Georgia (see Figure 2.3), "is the nation's premiere health promotion, prevention, and preparedness agency and global leader in public health."[13] The CDC serves as the national focus for developing and applying disease prevention (including bioterrorism) and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.[13] Once known solely for its work to control communicable diseases, the CDC now also maintains records, analyzes disease trends, and publishes epidemiological reports on all types of diseases, including those that result from lifestyle, occupational, and environmental causes. Beyond its own specific responsibilities, the CDC also supports state and

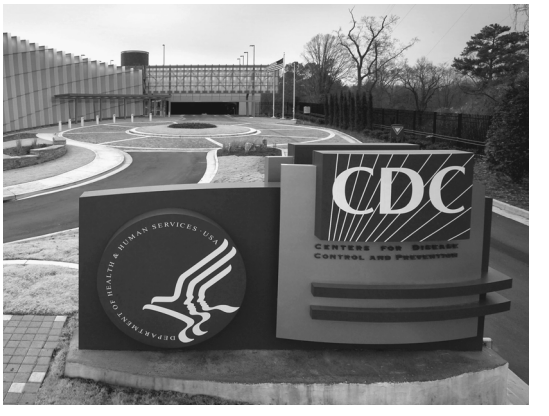

FIGURE 2.3
The Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, is one of the major operating agencies of the Department of Health and Human Services (HHS).

local health departments and cooperates with similar national health agencies from other WHO member nations.

To better meet the challenges of public health for the twenty-first century, in 2003 the CDC began a strategic planning process called the *Futures Initiative.*[13] As a part of the Futures Initiative, the CDC adopted new overarching health protection goals and a new organizational structure. The goals that were adopted included the following:

- *Preparedness:* People in all communities will be protected from infectious, environmental, and terrorist threats.
- *Health promotion and prevention of disease, injury, and disability:* All people will achieve their optimal lifespan with the best possible quality of health in every stage of life.
- *Healthy places:* The places where people live, work, learn, and play should protect and promote human health and eliminate health disparities.

The reorganization of the CDC created a structure that included the Office of the Director, the National Institute for Occupational Safety and Health (NIOSH) (see Chapter 18 for a discussion of NIOSH), and six coordinating centers/offices. The coordinating centers are as follows:

- Coordinating Center for Infectious Diseases: Includes the National Center for Immunization and Respiratory Diseases (NCIRD); the National Center for Zoonotic, Vectorborne, and Enteric Diseases (NCZVED); the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP); the National Center for Preparedness, Detection, and Control of Infectious Diseases (NCPDCID); the Strategic Business Unit (SBU); and the Strategic Science and Program Unit (SSPU).
- Coordinating Center for Health Promotion: Includes the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP); the National Center for Birth Defects and Developmental Disabilities (NCBDDD); and the National Office of Public Health Genomics.
- Coordinating Center for Environmental Health and Injury Prevention: Includes the National Center for Environmental Health (NCEH)/Agency for Toxic Substances and Disease Registry (ATSDR); and the National Center for Injury Prevention and Control (NCIPC).
- Coordinating Center for Health Information and Services: Includes the National Center for Health Statistics (NCHS); the National Center for Health Marketing; and the National Center for Public Health Informatics.
- Coordinating Office for Global Health (COGH): This office provides national leadership, coordination, and support for CDC's global health activities in collaboration with CDC's global health partners.
- Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER): This office has the responsibility to protect health and enhance the potential for full, satisfying, and productive living across the lifespan of all people in all communities related to community preparedness and response.

Food and Drug Administration (FDA)

The FDA touches the lives of virtually every American every day. It "is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable; and helping the public get the accurate, science-based information they need to use medicines and foods to improve their health."[14] Much of this work revolves around regulatory activities and the setting of health and safety standards as spelled out in the Federal Food, Drug, and Cosmetic Act and other related laws. However, due to the complex nature of its standards and the agency's limited

resources, enforcement of many FDA regulations is left to other federal agencies and to state and local agencies. For example, the Department of Agriculture is responsible for the inspection of many foods, such as meat and dairy products. Restaurants, supermarkets, and other food outlets are inspected by state and local public health agencies.

Centers for Medicare and Medicaid Services (CMS)
Established as the Health Care Financing Administration (HFCA) in 1977, the CMS is responsible for overseeing the Medicare program (health care for the elderly and the disabled), the federal portion of the Medicaid program (health care for low-income individuals), and the related quality assurance activities. Both Medicare and Medicaid were created in 1965 to ensure that the special groups covered by these programs would not be deprived of health care because of cost. In 2005, about 87 million Americans were covered by these programs.[8] In 1997, the State Children's Health Insurance Program (SCHIP) also became the responsibility of the CMS. Medicare, Medicaid, and SCHIP are discussed in greater detail in Chapter 14.

Health Resources and Services Administration (HRSA)
The HRSA is the principal primary health care service agency of the federal government that provides access to essential health care services for people who are low-income, uninsured, or who live in rural areas or urban neighborhoods where health care is scarce.[8] It "provides national leadership, program resources and services needed to improve access to culturally competent quality healthcare."[15] HRSA "helps prepare the nation's health care system and providers to respond to bioterrorism and other public health emergencies, maintains the National Health Service Corps and helps build the health care workforce through many training and education programs. HRSA administers a variety of programs to improve the health of mothers and children and serves people living with HIV/AIDS through the Ryan White CARE Act programs. HRSA also oversees the nation's organ transplantation system."[8]

Indian Health Service (IHS)
The goal of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.[16] To attain its goal, the IHS:

1. Assists tribes to develop their health programs through activities such as health management training, technical assistance, and human resource development.
2. Facilitates and assists tribes in coordinating health planning, in obtaining and using health resources available through federal, state, and local programs, and in operating comprehensive health care services and health programs.
3. Provides comprehensive health care services, including hospital and ambulatory medical care, preventive and rehabilitative services, and development of community sanitation facilities.
4. Serves as the principal federal advocate in the health field for Indians to ensure comprehensive health services for Indian people.[16]

Though health services have been provided sporadically by the United States government since the early nineteenth century, it was not until 1989 that the IHS was elevated to an agency level; prior to that time it was a division in HRSA. (See Chapter 10 for more information on the IHS.)

National Institutes of Health (NIH)
Begun as a one-room Laboratory of Hygiene in 1887, the NIH today is one of the world's foremost medical research centers, and the federal focal point for medical research in the United States.[17] The mission of the NIH "is to uncover new knowledge that will lead to better health for everyone."[17] Although a significant amount of research is carried out by NIH scientists at NIH laboratories in Bethesda and elsewhere, a much larger portion of this research is conducted by scientists at public and private universities and other research institutions. These scientists receive NIH funding for their research proposals through a competitive, peer-review

Table 2.3
Units within the National Institutes of Health (NIH)

National Cancer Institute (NCI)
National Eye Institute (NEI)
National Heart, Lung, and Blood Institute (NHLBI)
National Human Genome Research Institute (NHGRI)
National Institute on Aging (NIA)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institute of Allergy and Infectious Diseases (NIAID)
National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)
National Institute of Biomedical Imaging and Bioengineering (NIBIB)
National Institute of Child Health and Human Development (NICHD)
National Institute on Deafness and Other Communication Disorders (NIDCD)
National Institute of Dental and Craniofacial Research (NIDCR)
National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
National Institute on Drug Abuse (NIDA)
National Institute of Environmental Health Sciences (NIEHS)
National Institute of General Medical Sciences (NIGMS)
National Institute of Mental Health (NIMH)
National Institute of Neurological Disorders and Stroke (NINDS)
National Institute of Nursing Research (NINR)
National Library of Medicine (NLM)
Clinical Center (CC)
Center for Information Technology (CIT)
National Center for Complementary and Alternative Medicine (NCCAM)
National Center on Minority Health and Health Disparities (NCMHD)
National Center for Research Resources (NCRR)
John E. Fogarty International Center for Advanced Study in the Health Sciences (FIC)
Center for Scientific Review (CSR)

Source: National Institutes of Health (2006). "Institutes, Centers and Offices." Available at http://www.nih.gov/icd/.

grant application process. Through this process of proposal-review by qualified scientists, NIH seeks to ensure that federal research monies are spent on the best-conceived research projects. Table 2.3 provides a listing of all the institutes and centers located in NIH.

Substance Abuse and Mental Health Services Administration (SAMHSA)
The SAMHSA is the primary federal agency responsible for ensuring that up-to-date information and state-of-the-art practice is effectively used for the prevention and treatment of addictive and mental disorders. "SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness."[18] Within SAMHSA, there are three centers—the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS). Each of these centers has its own set of missions that contribute to the overall mission of SAMHSA (see Chapter 11 and Chapter 12 for more information on SAMHSA).

State Health Agencies

core functions of public health
assessment, policy development, and assurance

All 50 states have their own state health departments (see Figure 2.4). Although the names of these departments may vary from state to state (e.g., Ohio Department of Health, Indiana State Department of Health), their purposes remain the same: to promote, protect, and maintain the health and welfare of their citizens. These purposes are represented in the **core functions of public health,** which include *assessment* of information on the health of the community, comprehensive public health *policy development,* and *assurance* that public health services are provided to the community.[19] These core functions have been defined further with the following 10 essential public health services.[20]

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Ensure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal- and population-based health services.
10. Research for new insights and innovative solutions to health problems (see Figure 2.5).

The head of the state health department is usually a medical doctor, appointed by the governor, who may carry the title of director, commissioner, or secretary. However, due to the political nature of the appointment, this individual may or may not have extensive experience in community or public health. Unfortunately, political influence sometimes reaches below the level of commissioner to the assistant commissioners and division chiefs; it is the commissioner, assistant commissioners, and division chiefs who set policy and provide direction for the state health department. Middle- and lower-level employees are usually hired through a merit system and may or may not be able to influence health department policy. These employees, who carry out the routine work of the state health department, are usually professionally trained health specialists such as microbiologists, engineers, sanitarians, epidemiologists, nurses, and health educators.

Most state health departments are organized into divisions or bureaus that provide certain standard services. Typical divisions include Administration, Communicable Disease Prevention and Control, Chronic Disease Prevention and Control, Vital and Health Statistics, Environmental Health, Health Education or Promotion, Health Services, Maternal and Child Health, Mental Health, Occupational and Industrial Health, Dental Health, Laboratory Services,

FIGURE 2.4
Each of the 50 states has its own health department.

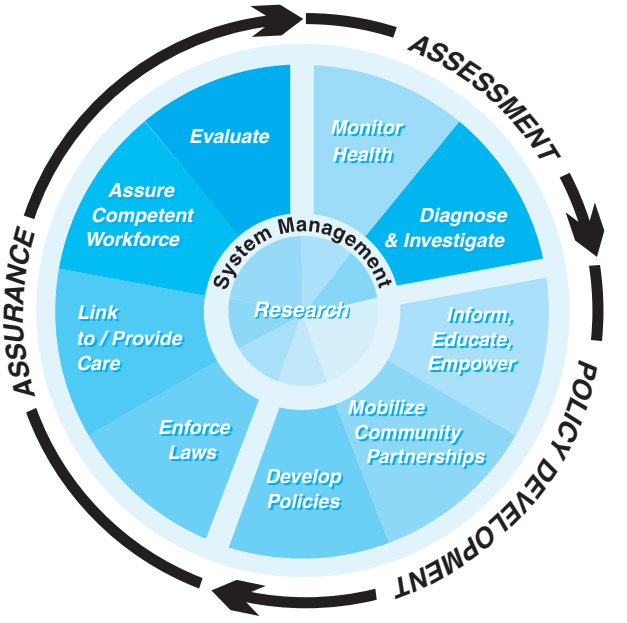

FIGURE 2.5
Core functions of public health and the 10 essential services.
Source: Office of Disease Prevention and Health Promotion (2006). "Public Health in America." Available at http://web.health.gov/phfunctions/public.htm.

Public Health Nursing, Veterinary Public Health, and most recently, a division of Public Health Preparedness to deal with bioterrorism issues.

In promoting, protecting, and maintaining the health and welfare of their citizens, state health departments play many different roles. They can establish and promulgate health regulations that have the force and effect of law throughout the state. The state health departments also provide an essential link between federal and local (city and county) public health agencies. As such, they serve as conduits for federal funds aimed at local health problems. Federal funds come to the states as block grants. Funds earmarked for particular health projects are distributed to local health departments by their respective state health departments in accordance with previously agreed upon priorities. State health departments may also link local needs with federal expertise. For example, epidemiologists from the CDC are sometimes made available to investigate local disease outbreaks at the request of the state health department. State health departments usually must approve appointments of local health officers and can also remove any local health officers who neglect their duties.

The resources and expertise of the state health department are also at the disposal of local health departments. One particular area where the state health departments can be helpful is laboratory services; many modern diagnostic tests are simply too expensive for local health departments. Another area is environmental health. Water and air pollution problems usually extend beyond local jurisdictions, and their detection and measurement often require equipment too expensive for local governments to afford. This equipment and expertise are often provided by the state health department.

Local Health Departments

Local-level governmental health organizations, referred to as local health departments (LHDs), are usually the responsibility of the city or county governments. In large metropolitan areas, community health needs are usually best served by a city health department. In smaller cities with populations of up to 75,000, people often come under the jurisdiction of a county health department. In some rural counties where most of the population is concentrated in a single city, a LHD may have jurisdiction over both city and county residents. In sparsely populated rural areas, it is not uncommon to find more than one county served by a single health department. In 2005, there were approximately 2,864 LHDs; of that number, 62% were located in nonmetropolitan areas and 38% were in metropolitan areas (see Figure 2.6).[21]

FIGURE 2.6
The common logo of public health created by the National Association of County and City Health Officials (NACCHO).

Source: National Association of County and City Health Officials (2007). "The National Identity for Local Health Departments." Available at http://www.naccho.org. Used with permission.

It is through LHDs that health services are provided to the people of the community. A great many of these services are mandated by state laws, which also set standards for health and safety. Examples of mandated local health services include the inspection of restaurants, public buildings, and public transportation systems, the detection and reporting of certain diseases, and the collection of vital statistics such as births and deaths. Other programs such as safety belt programs and immunization clinics may be locally planned and implemented. In this regard, local health jurisdictions are permitted (unless preemptive legislation is in place) to enact ordinances that are stricter than those of the state, but these jurisdictions cannot enact codes that fall below state standards. It is at this level of governmental health agencies that sanitarians implement the environmental health programs, nurses and physicians offer the clinical services, and health educators present health education and promotion programs.

Organization of Local Health Departments

Each LHD is headed by a health officer/administrator/commissioner (see Figure 2.7). In most states, there are laws that prescribe who can

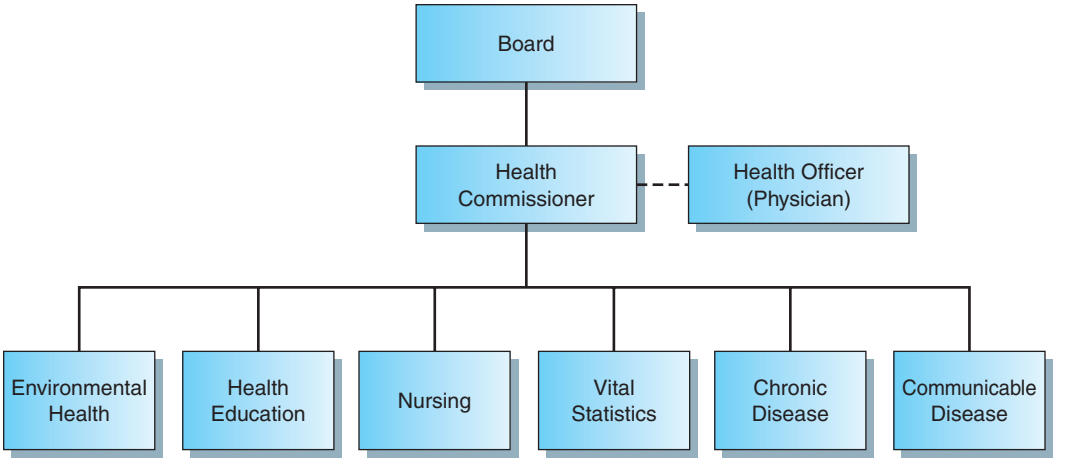

FIGURE 2.7
Organizational chart of a local public health agency.

hold such a position. Those often noted are physicians, dentists, veterinarians, or individuals with a master's or doctoral degree in public health. If the health officer is not a physician, then a physician is usually hired on a consulting basis to advise as needed. Usually, this health officer is appointed by a board of health, the members of which are themselves appointed by officials in the city or county government or, in some situations, elected by the general public. The health officer and administrative assistants may recommend which programs will be offered by the LHDs. However, they may need final approval from a board of health. Although it is desirable that those serving on the local board of health have some knowledge of community health programs, most states have no such requirement. Oftentimes, politics plays a role in deciding the make-up of the local board of health.

The local health officer, like the state health commissioner, has far-reaching powers, including the power to arrest someone who refuses to undergo treatment for a communicable disease (tuberculosis, for example) and who thereby continues to spread disease in the community. The local health officer has the power to close a restaurant on the spot if it has serious health law violations or to impound a shipment of food if it is contaminated. Because many local health departments cannot afford to employ a full-time physician, the health officer is usually hired on a part-time basis. In such cases, the day-to-day activities of the LHD are carried out by an administrator trained in public health. The administrator is also hired by the board of health based upon qualifications and the recommendation of the health officer.

Local sources provide the greatest percentage of LDH revenues (29%), followed by state funds (23%) and federal pass-through funds (13%).[21] A limited number of LHD services are provided on a fee-for-service basis. For example, there is usually a fee charged for birth and death certificates issued by the LHD. Also, in some communities, minimal fees are charged to offset the cost of providing immunizations, lab work, or inspections. Seldom do these fees cover the actual cost of the services provided. Therefore, income from service fees usually makes up a very small portion of any LHD budget. And, it is not unusual to find that many LHDs use a **sliding scale** to determine the fee for a service.

sliding scale the scale used to determine the fee for services based on ability to pay

Coordinated School Health Programs

Few people think of public schools as governmental health organizations. Consider, however, that schools are funded by tax dollars, are under the supervision of an elected school

board, and include as a part of their mission the improvement of the health of those in the school community. Because school attendance is required throughout the United States, the potential for school health programs to make a significant contribution to community health is enormous. In fact, Allensworth and Kolbe have stated that schools "could do more perhaps than any other single agency in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives."[22] Yet coordinated school health programs have faced a number of barriers, including the following:[23]

1. Insufficient local administrative commitment
2. Inadequately prepared teachers
3. Too few school days to teach health in the school year
4. Inadequate funding
5. The lack of credibility of health education as an academic subject
6. Insufficient community/parental support
7. Concern for the teaching of controversial topics (i.e., sex education)

If communities were willing to work to overcome these barriers, the contribution of coordinated school health programs to community health could be almost unlimited.

What exactly is meant by coordinated school health? Prior to 1998, a coordinated school health program was commonly referred to as a *comprehensive school health program*. However, it was commonly confused with *comprehensive health education*. To eliminate this confusion, the term *coordinated* school health program is used. A coordinated school health program is defined as "an organized set of policies, procedures, and activities designed to protect, promote, and improve the health and well-being of students and staff, thus improving a student's ability to learn. It includes but is not limited to comprehensive school

BOX 2.2

PUBLIC HEALTH IN THE UNITED STATES

Governmental health agencies at the local, state, and national levels make up the backbone of the public health system. The system is there to (1) prevent epidemics and the spread of disease, (2) protect against environmental hazards, (3) prevent injuries, (4) promote and encourage healthy behaviors, (5) respond to disasters and assist communities in recovery, and (6) assure the quality and accessibility of health services.[20] It is a system that has been taken for granted by most Americans, including those who fund it. As Noreen M. Clark, Dean of the School of Public Health at the University of Michigan, stated, "often when public health works effectively, it is invisible. . . . public health is the disease you *didn't* get, the epidemic that *didn't* spread, the environmental disaster that *didn't* occur."[24]

However, the events of 9/11 "highlighted the state of the infrastructure with unprecedented clarity to the public and policy makers: outdated and vulnerable technologies; a public health workforce lacking training and reinforcements; antiquated laboratory capacity; lack of real-time surveillance and epidemiological systems; ineffective and fragmented communications networks; incomplete domestic preparedness and emergency response capabilities; and communities without access to essential public health services."[25] Yet, if the public health system is to be improved, government health agencies cannot do it alone. They will need to partner "with other organizations and sectors of society, working closely with communities and community based organizations, the health care delivery system, academia, business, and the media."[25]

Building on the vision articulated by *Healthy People 2010*—healthy people in healthy communities—the Committee on Assuring the Health of the Public in the 21st Century of the Institute for Medicine has developed 34 recommendations for assuring population health in the United States. The committee's recommendations revolve around (1) adopting a focus on population health that includes multiple determinants of health, (2) strengthening the public health infrastructure, (3) building partnerships, (4) developing systems of accountability, (5) emphasizing evidence, and (6) improving communications. More specifics about the committee's recommendations can be found at the Institute for Medicine's Web site (www.iom.edu).

health education; school health services; a healthy school environment; school counseling; pyschological and social services; physical education; school nutrition services; family and community involvement in school health; and school-site health promotion for staff."[26]

As previously stated, there are three essential components in every coordinated school health program—health education, a healthy school environment, and health services. Health instruction should be based on a well-conceived, carefully planned curriculum that has an appropriate scope (coverage of topics) and logical sequencing. Instructional units should include cognitive (knowledge), affective (attitudes), and psychomotor (behavioral) components. The healthy school environment should provide a learning environment that is both physically and mentally safe and healthy. Finally, each school's health program should provide the essential health services, from emergency care through health appraisals, to ensure that students will be healthy learners. These topics and others will be discussed in much greater detail in Chapter 6.

QUASI-GOVERNMENTAL HEALTH ORGANIZATIONS

The **quasi-governmental health organizations**—organizations that have some official health responsibilities but operate, in part, like voluntary health organizations—make important contributions to community health. Although they derive some of their funding and legitimacy from governments, and carry out tasks that may be normally thought of as government work, they operate independently of government supervision. In some cases, they also receive financial support from private sources. Examples of quasi-governmental agencies are the American Red Cross (ARC), the National Science Foundation, and the National Academy of Sciences.

quasi-governmental health organizations organizations that have some responsibilities assigned by the government but operate more like voluntary agencies

The American Red Cross

The ARC, founded in 1881 by Clara Barton (see Figure 2.8), is a prime example of an organization that has quasi-governmental status. While it has certain "official" responsibilities placed on it by the federal government, it is funded by voluntary contributions. "Official" duties of the ARC include (1) providing relief to victims of natural disasters such as floods, tornadoes, hurricanes, and fires (Disaster Services) and (2) serving as the liaison between members of the active armed forces and their families during emergencies (Services to the Armed Forces and Veterans). In this latter capacity, the ARC can assist active-duty members of the armed services in contacting their families in case of an emergency, or vice versa.

In addition to these "official" duties, the ARC also engages in many nongovernmental services. These include blood drives, safety services (including water safety, first aid, CPR, and HIV/AIDS instruction), nursing and health services, youth services, community volunteer services, and international services.

The ARC was granted a charter by Congress in 1900, and the ARC and the federal government have had a special relationship ever since. The president of the United States is the honorary chairman of the ARC. The U.S. Attorney General and Secretary of the Treasury are honorary counselor and treasurer, respectively.

The Red Cross idea was not begun in the United States. It was begun in 1863 by five Swiss men in Geneva, Switzerland, who were concerned with the treatment provided to the wounded during times of war. The group, which was called the International Committee for the Relief to the Wounded, was led by Henry Dunant. With the

FIGURE 2.8
The American Red Cross was founded by Clara Barton in 1881.

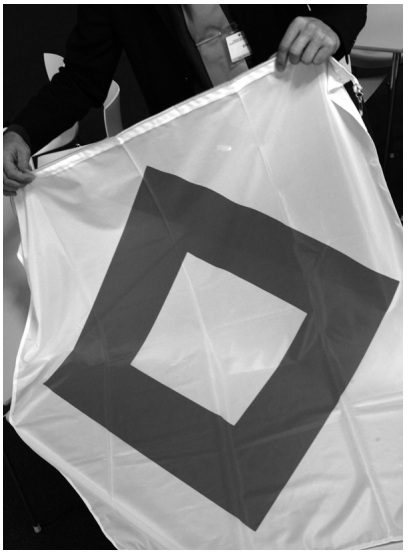

FIGURE 2.9
The red crystal: an additional emblem of the ICRC.

assistance of the Swiss government, the International Committee brought together delegates from 16 nations in 1864 to the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field (now known as the first Geneva Convention) to sign the Geneva Treaty.

The efforts of Henry Dunant and the rest of the International Committee led to the eventual establishment of the International Committee of the Red Cross (ICRC). The ICRC, which still has its headquarters in Geneva and is still governed by the Swiss, continues to work today during times of disaster and international conflict. It is the organization that visits prisoners of war to ensure they are being treated humanely.[27,28]

Today, the international movement of the Red Cross comprises the Geneva-based ICRC, the International Federation of Red Cross and Red Crescent Societies (the red crescent emblem is used in Moslem countries), and the over 180 National Red Cross and Red Crescent Societies.[27] There are a number of other countries that believe in the principles of the Red Cross Movement, but have not officially joined because the emblems used by the movement are offensive. Thus, the ICRC has created a third emblem that meets all the criteria for use as a protective device and at the same time is free of any national, political, or religious connotations. The design is composed of a red frame in the shape of a square on the edge of a white background. The name chosen for this distinctive emblem was "red crystal," to signify purity. The emblem was put into use on January 14, 2007 (see Figure 2.9).[28]

Other Quasi-Governmental Organizations

Two other examples of quasi-governmental organizations in the United States are the National Science Foundation (NSF) and the National Academy of Sciences (NAS). The purpose of NSF is the funding and promotion of scientific research and the development of individual scientists. NSF receives and disperses federal funds but operates independently of governmental supervision. Chartered by Congress in 1863, the NAS acts as an advisor to the government on questions of science and technology. Included in its membership are some of America's most renowned scientists. Although neither of these agencies exists specifically to address health problems, both organizations fund projects, publish reports, and take public stands on health-related issues.

NONGOVERNMENTAL HEALTH AGENCIES

Nongovernmental health agencies are funded by private donations or, in some cases, by membership dues. There are thousands of these organizations that all have one thing in common: They arose because there was an unmet health need. For the most part, the agencies operate free from governmental interference as long as they meet Internal Revenue Service guidelines with regard to their specific tax status. In the following sections, we discuss the following types of nongovernmental health agencies—voluntary, professional, philanthropic, service, social, religious, and corporate.

voluntary health agencies nonprofit organizations created by concerned citizens to deal with a health need not met by governmental health agencies

Voluntary Health Agencies

Voluntary health agencies are an American creation. Each of these agencies was created by one or more concerned citizens who felt that a specific health need was not being met by existing governmental agencies. In a sense, these new voluntary agencies arose by themselves, in much the same way as a "volunteer" tomato plant arises in a vegetable garden. New voluntary

agencies continue to be born each year. Examples of recent additions to the perhaps 100,000 agencies already in existence are the Alzheimer's Association and the First Cradle/SIDS Alliance. A discussion of the commonalities of voluntary health agencies follows.

Organization of Voluntary Health Agencies

Most voluntary agencies exist at three levels—national, state, and local. At the national level, policies that guide the agency are formulated. A significant portion of the money raised locally is forwarded to the national office, where it is allocated according to the agency's budget. Much of the money is designated for research. By funding research, the agencies hope to discover the cause of and cure for a particular disease or health problem. There have been some major successes. The March of Dimes, for example, helped to eliminate polio as a major disease problem in the United States through its funding of immunization research.

There is not always a consensus of opinion about budget decisions made at the national level; some believe that less should be spent for research and more for treating those afflicted with the disease. Another common internal disagreement concerns how much of the funds raised at the local level should be sent to the national headquarters instead of being retained for local use. Those outside the agency sometimes complain that when an agency achieves success, as the March of Dimes did in its fight against polio, it should dissolve. This does not usually occur; instead, successful agencies often find a new health concern. The March of Dimes now fights birth defects; and when tuberculosis was under control, the Tuberculosis Society changed its name to the American Lung Association in order to fight all lung diseases.

The state-level offices of voluntary agencies are analogous to the state departments of health in the way that they link the national headquarters with local offices. The primary work at this level is to coordinate local efforts and to ensure that policies developed at the national headquarters are carried out. The state-level office may also provide training services for employees and volunteers of local-level offices and are usually available as consultants and problem solvers. In recent years, some voluntary agencies have been merging several state offices into one to help reduce overhead expenses.

The local-level office of each voluntary agency is usually managed by a paid staff worker who has been hired either by the state-level office or by a local board of directors. Members of the local board of directors usually serve in that capacity on a voluntary basis. Working under the manager of each agency are local volunteers, who are the backbone of voluntary agencies. It has been said that the local level is where the "rubber meets the road." In other words, this is where most of the money is raised, most of the education takes place, and most of the service is rendered. Volunteers are of two types, professional and lay. Professional volunteers have had training in a medical profession, while lay volunteers have had no medical training. The paid employees help facilitate the work of the volunteers with expertise, training, and other resources.

Purpose of Voluntary Health Agencies

Voluntary agencies share four basic objectives: (1) to raise money to fund their programs, with the majority of the money going to fund research, (2) to provide education both to professionals and to the public, (3) to provide service to those individuals and families that are afflicted with the disease or health problem, and (4) to advocate for beneficial policies, laws, and regulations that affect the work of the agency and in turn the people they are trying to help.

Fund-raising is a primary activity of many voluntary agencies. While in the past this was accomplished primarily by door-to-door solicitations, today mass-mailing and telephone solicitation are more common. In addition, most agencies sponsor special events like golf outings, dances, or dinners. One type of special event that is very popular today is the "a-thon" (see Figure 2.10). The term "a-thon" is derived from the name of the ancient Greek city Marathon, and usually signified some kind of "endurance" event. Examples include bike-a-thons, rock-a-thons, telethons, skate-a-thons, and dance-a-thons. These money-making "a-thons" seem to be

FIGURE 2.10
Most voluntary health agencies hold special events to raise money for their causes.

limited in scope only by the creativity of those planning them. In addition, some of these agencies have become United Way agencies and receive some funds derived from the annual United Way campaign, which conducts fund-raising efforts at worksites. The three largest voluntary agencies in the United States today (in terms of dollars raised) are the American Cancer Society (see Box 2.3), the American Heart Association, and the American Lung Association.

Over the years, the number of voluntary agencies formed to help meet special health needs has continually increased. Due to the growth in the number of new agencies, several consumer "watchdog" groups have taken a closer look into the practices of the agencies. A major concern of these consumer groups has been the amount of money that the voluntary agencies spend on the cause (e.g., cancer, heart disease, AIDS, etc.) and how much they spend on fund-raising and overhead (e.g., salaries, office furniture, leasing of office space). Well-run agencies will spend less than 15% of what they raise on fund-raising. Some of the not so well-run agencies spend as much as 80% to 90% on fund-raising. All consumers should ask agencies how they spend their money prior to contributing.

Professional Health Organizations/Associations

Professional health organizations and associations are made up of health professionals who have completed specialized education and training programs and have met the standards of registration, certification, and/or licensure for their respective fields. Their mission is to promote high standards of professional practice for their specific profession, thereby improving the health of society by improving the people in the profession. Professional organizations are funded primarily by membership dues. Examples of such organizations are the American Medical Association, the American Dental Association, the American Nursing Association, the American Public Health Association, the American Association for Health Education, and the Society for Public Health Education, Inc.

Although each professional organization is unique, most provide similar services to their members. These services include the certification of continuing-education programs for professional renewal, the hosting of annual conventions where members share research results and interact with colleagues, and the publication of professional journals and other reports. Some examples of journals published by professional health associations are the *Journal of the American Medical Association,* the *American Journal of Public Health,* and the *American Journal of Health Education.*

Like voluntary health agencies, another important activity of some professional organizations is advocating on issues important to their membership. The American Medical Association, for example, has a powerful lobby nationally and in some state legislatures. Their purpose is to affect legislation in such a way as to benefit their membership and their profession. Many professional health organizations provide the opportunity for benefits, including group insurance and discount travel rates. There are hundreds of professional health organizations in the United States, and it would be difficult to describe them all here.

philanthropic foundation an endowed institution that donates money for the good of humankind

Philanthropic Foundations

Philanthropic foundations have made and continue to make significant contributions to community health in the United States and throughout the world. These foundations sup-

BOX 2.3

A CLOSER LOOK AT ONE VOLUNTARY HEALTH AGENCY: THE AMERICAN CANCER SOCIETY

The American Cancer Society (ACS) was founded in 1913 by 10 physicians and five laymen. At that time, it was known as the American Society for the Control of Cancer. Today, with offices throughout the country and approximately two million volunteers, ACS is one of our largest voluntary health organizations. In spite of its success, its mission has remained constant since its founding. It is "dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy and service."[29]

The mission of the ACS includes both short- and long-term goals. Its short-term goals are to save lives and diminish suffering. This is accomplished through education, advocacy, and service. Its long-term goal, the elimination of cancer, is being approached through the society's support of cancer research.

The American Cancer Society's educational programs are targeted at two different groups—the general public and the health professionals who treat cancer patients. The public education program promotes the following skills and concepts to people of all ages: (1) taking the necessary steps to prevent cancer, (2) knowing the seven warning signals, (3) understanding the value of regular checkups, and (4) coping with cancer. The society accomplishes this by offering free public education programs, supported by up-to-date literature and audiovisual materials, whenever and wherever they may be requested. These programs may be presented in homes, worksites, churches, clubs, organizations, and schools. A few of their better-known programs include I Can Cope, Reach to Recovery, and Man to Man.[29] From time to time, the society also prepares public service messages for broadcasting or televising.

The society's professional education program is aimed at the professionals who work with oncology patients. The objective of this program is to motivate "medical and allied health professionals to use the latest and best possible cancer detection, diagnostic, and patient management techniques."[30] Such education is provided through professional publications, up-to-date audiovisual materials, conferences, and grants that fund specialized education experiences.

The ACS offers patient service and rehabilitation programs that ease the impact of cancer on those affected. The services offered include information and referral to appropriate professionals, home care supplies and equipment for the comfort of patients, transportation of patients to maintain their medical and continuing care programs, and specialized education programs for cancer patients to help them cope and feel better about themselves. There are also rehabilitation programs that provide social support for all cancer patients and specific programs for those who have had a mastectomy, laryngectomy, or ostomy.

The ACS is the largest source of private, not-for-profit cancer research funds in the United States, second only to the federal government in total dollars spent. Since 1946, when the ACS first started awarding grants, it has invested about $3.1 billion in cancer research. The research program consists of three components: extramural grants, intramural epidemiology and surveillance research, and the intramural behavioral research center.[29] The most recent addition to the work of the ACS is in the area of advocacy. Specifically, the ACS works to (1) support cancer research and programs to prevent, detect, and treat cancer; (2) expand access to quality cancer care, prevention, and awareness; (3) reduce cancer disparities in minority and medically underserved populations; and (4) reduce and prevent suffering from tobacco-related illnesses.[29]

All ACS programs—education, service, research, and advocacy—are planned primarily by the society's volunteers. However, the society does employ staff members to carry out the day-to-day operations and to help advise and support the work of the volunteers. This arrangement of volunteers and staff working together has created a very strong voluntary health agency.

port community health by funding programs and research on the prevention, control, and treatment of many diseases. Foundation directors, sometimes in consultation with a review committee, determine the types of programs that will be funded. Some foundations fund an array of health projects, whereas others have a much narrower scope of interests. Some foundations, such as the Bill and Melinda Gates Foundation, fund international health projects, whereas others restrict their funding to domestic projects. The geographical scope of domestic foundations can be national, state, or local. Local foundations may restrict their funding to projects that only benefit local citizens.

The activities of these foundations differ from those of the voluntary health agencies in two important ways. First, foundations have money to give away, and therefore no effort is spent on fund-raising. Second, foundations can afford to fund long-term or innovative research projects, which might be too risky or expensive for voluntary or even government-funded agencies. The development of a vaccine for yellow fever by a scientist funded by the Rockefeller Foundation is an example of one such long-range project.

Some of the larger foundations, in addition to the Bill and Melinda Gates Foundation, that have made significant commitments to community health are the Commonwealth Fund, which has contributed to community health in rural communities, improved hospital facilities, and tried to strengthen mental health services; the Ford Foundation, which has contributed greatly to family-planning efforts throughout the world; the Robert Wood Johnson Foundation, which has worked to improve access to medical and dental care throughout the United States and lessen the impact of tobacco on health; the Henry J. Kaiser Family Foundation, which has supported the development of health maintenance organizations (HMOs) and community health promotion; the W. K. Kellogg Foundation, which has funded many diverse health programs that address human issues and provide a practical solution; and the Milbank Memorial Fund, which has primarily funded preventive-medicine projects.

Service, Social, and Religious Organizations

Service, social, and religious organizations have also played a part in community health over the years (see Figure 2.11). Examples of service and social groups involved in community health are the Jaycees, Kiwanis Club, Fraternal Order of Police, Rotary Club, Elks, Lions, Moose, Shriners, American Legion, and Veterans of Foreign Wars. Members of these groups enjoy social interactions with people of similar interests in addition to fulfilling the groups' primary reason for existence—service to others in their communities. Although health may not be the specific focus of their mission, several of these groups make important contributions in that direction by raising money and funding health-related programs. Sometimes, their contributions are substantial. Examples of such programs include the Shriners' children's hospitals and burn centers, the Lions' contributions to pilot (lead) dog programs and other services for those who are visually impaired, such as the provision of eyeglasses for school-aged children unable to afford them, and the Lions' contributions to school health programs via the educational program named "Lions Quest."

FIGURE 2.11
Community service groups contribute needed resources for the improvement of the health of the community.

The contributions of religious groups to community health have also been substantial. Such groups also have been effective avenues for promoting health programs because (1) they have had a history of volunteerism and preexisting reinforcement contingencies for volunteerism, (2) they can influence entire families, and (3) they have accessible meeting-room facilities.[31] One way in which these groups contribute is through donations of money for missions for the less fortunate. Examples of religious organizations that solicit donations from their members include the Protestants' One Great Hour of Sharing, the Catholics' Relief Fund, and the United Jewish Appeal. Other types of involvement in community health by religious groups include (1) the donation of space for voluntary health programs such as blood donations, Alcoholics Anonymous, and other support groups, (2) the sponsorship of food banks and shelters for the hungry, poor, and homeless, (3) the sharing of the doctrine of good personal health behavior, and (4) allowing

community health professionals to deliver their programs through the congregations. This latter contribution has been especially useful in black American communities because of the importance of churches in the culture of this group of people.

In addition, it should be noted that some religious groups have hindered the work of community health workers. Almost every community in the country can provide an example where a religious organization has protested the offering of a school district's sex education program, picketed a public health clinic for providing reproductive information or services to women, or has spoken out against homosexuality.

Corporate Involvement in Community Health

From the way it treats the environment by its use of natural resources and the discharge of wastes, to the safety of the work environment, to the products and services it produces and provides, to the provision of health care benefits for its employees, corporate America is very much involved in community health. Though each of these aspects of community health is important to the overall health of a community, because of the concern for the "bottom line" in corporate America, it is the provision of health care benefits that often receives the most attention. In fact, many corporations today find that their single largest annual expenditure behind salaries and wages is for employee health care benefits. Consider, for example, the cost of manufacturing a new car. The cost of health benefits for those who build the car now exceeds the cost of the raw materials for the car itself.

In an effort to keep a healthy workforce and reduce the amount paid for health care benefits, many companies support health-related programs both at and away from the worksite. Worksite programs aimed at trimming employee medical bills have been expanded beyond the traditional safety awareness programs and first aid services to include such programs as substance abuse counseling, nutrition education, smoking cessation, stress management, physical fitness, and disease management. Many companies also are implementing health promotion policies and enforcing state and local laws that prohibit (or severely restrict) smoking on company grounds or that mandate the use of safety belts at all times in all company-owned vehicles. (See Chapter 18 for more on safety and health in the workplace.)

CHAPTER SUMMARY

- Contemporary society is too complex to respond effectively to community health problems on either an emergency or a long-term basis. This fact necessitates organizations and planning for health in our communities.
- The different types of organizations that contribute to the promotion, protection, and maintenance of health in a community can be classified into three groups according to their sources of funding and organizational structure—governmental, quasi-governmental, and nongovernmental.
- Governmental health agencies exist at the local, state, federal, and international levels and are funded primarily by tax dollars.
- WHO is the largest and most visible governmental health agency on the international level.
- The Department of Health and Human Services (HHS) is the U.S. government's principal agency for the protection of the health of all Americans and for providing essential human services, especially for those who are least able to help themselves.
- The core functions of public health include the assessment of information on the health of the community, comprehensive public health policy development, and assurance that public health services are provided to the community.
- Quasi-governmental agencies, such as the American Red Cross, share attributes with both governmental and nongovernmental agencies.
- Nongovernmental organizations include voluntary and professional associations, philanthropic foundations, and service, social, and religious groups.
- Corporate America has also become more involved in community health, both at the worksite and within the community.

REVIEW QUESTIONS

1. What characteristics of modern society necessitate planning and organization for community health?
2. What is a governmental health agency?
3. What is the World Health Organization (WHO) and what does it do?
4. What federal department in the United States is the government's principal agency for protecting the health of all Americans and for providing essential human services, especially to those who are least able to help themselves? What major services does this department provide?
5. What are the three core functions of public health?
6. What are the 10 essential public health services?
7. How do state and local health departments interface?
8. What is meant by the term *coordinated school health program?* What are the major components of it?
9. What is meant by the term *quasi-governmental agency?* Name one such agency.
10. Describe the characteristics of a nongovernmental health agency.
11. What are the major differences between a governmental health organization and a voluntary health agency?
12. What does a health professional gain from being a member of a professional health organization?
13. How do philanthropic foundations contribute to community health? List three well-known foundations.
14. How do service, social, and religious groups contribute to the health of the community?
15. Why has corporate America become involved in community health?

ACTIVITIES

1. Using a local telephone book, list all the health-related organizations that service your community. Divide your list by the three major types of health organizations noted in this chapter.
2. Make an appointment to interview someone at one of the organizations identified in Activity 1. During your visit, find answers to the following questions:
   a. How did the organization begin?
   b. What is its mission?
   c. How is it funded?
   d. How many people (employees and volunteers) work for the organization, and what type of education/training do they have?
   e. What types of programs/services does the organization provide?
3. Obtain organizational charts from the U.S. Department of Health and Human Services (a copy is in this chapter), your state department of health, and your local health department. Compare and contrast these charts and describe their similarities and differences.
4. Call a local voluntary health organization in your community and ask if you could volunteer to work 10 to 15 hours during this academic term. Then volunteer those hours and keep a journal of your experience.
5. Carefully review your community newspaper each day for an entire week. Keep track of all articles or advertisements that make reference to local health organizations. Summarize your findings in a one-page paper. (If you do not subscribe to your local paper, copies are available in libraries.)

SCENARIO: ANALYSIS AND RESPONSE

After having read this chapter, please respond to the following questions in reference to the scenario at the beginning of the chapter.

1. What type of health agency do you think will be of most help to Mary?
2. If this scenario were to happen to someone in your community, what recommendations would you give to him or her on seeking help from health agencies?
3. The Internet has many sources of information that could help Mary. Use a search engine (e.g., Google) and enter the word "cancer." Find the Web site of one governmental health agency at the national level and one voluntary health agency that might be able to help her. Explain how these agencies could be of help.
4. If Mary did not have Internet access, how would you suggest she find out about local health agencies in her area that could help her?

COMMUNITY HEALTH ON THE WEB

The Internet contains a wealth of information about community and public health. Increase your knowledge of some of the topics presented in this chapter by accessing the Jones and Bartlett Publishers Web site at **http://health.jbpub.com/book/communityhealth/6e** and follow the links to complete the following Web activities.

- World Health Organization
- Department of Health and Human Services
- Association of State and Territorial Health Officials

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