New York State Dept. of Health

Allegany County Health Service

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A Report to the Board of Supervisors
on the Establishment and Coordination of

County Health Department
County Public Health Laboratory
County General Hospital
Services

NEW YORK STATE DEPARTMENT OF HEALTH

and the

JOINT HOSPITAL BOARD
of the
POSTWAR PUBLIC WORKS PLANNING COMMISSION

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FOREWORD

A committee of the staff of the New York State Department of Health and of the Joint Hospital Board has prepared this prospectus for the organization and development of coordinated health services in Allegany County.

The proposed plan represents an unusual opportunity to promote public health and related laboratory and hospital facilities and services in a sound and effective manner in Allegany County.

There are assembled in the prospectus, as a guide for further consideration and detailed planning, such facts, laws, regulations, and sources of materials as may seem relevant. There are also presented broad objectives that should be considered in such planning. Consideration is given, insofar as current conditions will permit, to the more important matters of procedure and cost, and steps are suggested for the further consideration and clearance of plans as they are developed.

The establishment and development of the services as recommended would definitely place Allegany County in the vanguard of national and state progress.

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INTRODUCTION

Throughout the State and the Nation, there are evidences of a growing public interest and concern in matters relating to the provision of adequate public health and medical services. In consequence, there has been an accompanying increase in proposals for state and national surveys, studies by commissions, and legislation. Much of this has been of a controversial nature, but two distinct trends have taken shape and appear to be meeting with public acceptance and the general support of the professional groups concerned. These are:

(1) the establishment of full-time health departments operated as county units or large city units, as recommended by the American Public Health Association and supported in principle by the American Medical Association and the New York State Medical Society; 1/

(2) national and state sponsored surveys of hospital needs seeking to bring about an orderly development of hospital and related health services which have been given impetus by recent federal legislation, namely, the Hospital Survey and Construction Act, Public Law 725 (1946) (Appendix E). This measure provides financial aid administered by the state for hospital and health center construction. It has the support of the American Medical Association as well as the American Public Health Association and the American Hospital Association.

There are other related trends of national significance, such as the rapid growth of voluntary hospital insurance plans and voluntary medical care insurance plans, which provide a partial answer for certain groups to some of the economic problems of hospital and medical care; the interest in and growth of the principle of paying hospitals on an operating cost basis for patients hospitalized at public expense, as has been established in connection with the Federal Emergency Maternity

1/ New York State Journal of Medicine, July 15, 1946, page 1608.
Journal of the American Medical Association, July 4, 1942, page 811.
American Journal of Public Health, December 1942, page 1421.

and Infant Care program; and the widespread recognition of the advantages of group medical practice in its several forms, including the affiliation of outlying hospitals with medical centers in the interest of establishing and maintaining an improved quality of medical care.

Without exception, these national trends have had their counterparts in New York State. Great encouragement for the development of full-time county and city health departments has been given by the state aid provisions of Chapter 1000 of the Laws of 1946 (Appendix A-1) and by other important legislation, such as Chapter 999 of the Laws of 1946 establishing a greatly accelerated program for the control of tuberculosis. Recognition in New York State of the other major trends is reflected in the establishment of the Joint Hospital Board which has been conducting a survey of hospital and health center facilities (Appendix E); by the establishment of the Interdepartmental Health Council composed of the State Commissioners of Education, Health, Mental Hygiene and Social Welfare with the advisory services of the chairman of the Health Preparedness Commission of the New York State Legislature; by the increasing operation of medical and hospital insurance plans; by the planning for the care of the chronically ill being undertaken by the Health Preparedness Commission; by the development of a plan for regionalization of medical services promoted by this same commission and serving as a basis for state-wide planning; 1/ and by the studies of the New York State Legislative Commission on Medical Care. 2/

Throughout the development and planning of these activities in New York State, particular emphasis has been placed upon the importance of maintaining local authority and responsibility to the highest degree compatible with economical and efficient health and medical care services. Under such a policy, the establishment of facilities and services comprehensive in scope and yet sensitive to the needs and situations prevailing in the communities concerned may be expected to result.

1/ Planning for the care of the Chronically Ill in the New York State - Regional Aspects. New York State Commission to Formulate a Long Range Health Program, also known as New York State Health Preparedness Commission. Legislative Document (1945) No. 78 A..

2/ Medical Care for the People of New York State.. Report of the New York State Legislative Commission on Medical Care, February 15, 1946.

CHARACTERISTICS OF ALLEGANY COUNTY

Allegany County is essentially rural in character. In 1940, eighty-five per cent of its population lived in areas classified by the U. S. Bureau of the Census as rural, i.e., outside cities or other incorporated places having 2,500 or more inhabitants. Only Wellsville village, population 5,942, is classified as urban. Other incorporated villages with more than 1,000 inhabitants are Cuba (1,699), Bolivar (1,344), Andover (1,290), Friendship (1,148), and Belmont (1,146). There has been little change in the total population of the County since 1900 when the population was 41,501. There was a decrease to 36,842 in 1920, followed by an increase to 38,025 in 1930, and a further slight increase, to 39,681 in the following decade. The 1946 estimate is 39,821.1/

Agriculature, which in 1940 engaged one-quarter of the employed workers in the County, is the most common occupation of Allegany County residents. An additional thirteen per cent of the workers are employed in manufacturing, and eleven per cent in the production of crude petroleum and natural gas. 2/

Essential public health services are provided at present through part-time local health officers serving the county's 32 local health districts, and by the full-time staff of the district state health officer at Hornell, which serves Allegany, Chemung, and Steuben counties. Public health laboratory service is provided by the approved county laboratory at Belmont. The county employs, under state aid, three public health nurses who provide public health nursing services under the general supervision of the district state supervising nurse; two registered nurses, who have not had public health training, are employed by the New York State Department of Health under the supervision of the District State Supervising Nurse and supplement the work of the public health nurses by providing bedside nursing care; twelve school nurses provide service only to school children in limited areas within the county. Tuberculosis hospitalization is provided by the Mt. Morris State Tubersulosis Hospital at Mt. Morris, Livingston County.

The infant mortality rate, which is considered as one of the best available single indices of health conditions, is approximately 40 per 1000 live births in Allegany County (Average annual rate, 1940 to 1944; Appendix F). This is 13 per cent higher than the infant mortality

1/ New York State Department of Health, Vital Statistics Review, Vol. 27, No. 1, March 1946.

2/ U. S. Bureau of the Census, Characteristics of the Population (New York State), 1940.

rate for the upstate area and nine per cent higher than that for the rural population in the state as a whole. Five per cent of all births in Allegany County, or between 35 and 40 per year, are premature and these premature infants should have long periods of hospital care. Although infant mortality has been declining gradually in Allegany County during the past several years, as in other parts of the state, the Allegany County rate has continued to remain at a somewhat higher level than the average for upstate. It is pertinent to note in this connection that the proportion of births occuring in hospitals in Allegany County (90 per cent) is third lowest of the eleven counties in the so-called Rochester region.

The death rate from all causes, 11.9 per 1000 of the population also has remained at a higher level than that for upstate New York and reflects to some extent the slightly older age distribution of the population in Allegany County. Even when allowances are made for age differences, however, the death rate is slightly higher in Allegany County than the rate for upstate New York. In striking contrast is the death rate from tuberculosis. Allegany County, which has been served for the last ten years by one of the state tuberculosis hospitals, has one of the lowest, if not the lowest, tuberculosis death rates in the state.

THE COUNTY HEALTH DEPARTMENT

A frequently quoted definition of public health is that of Dr. C.-E. A. Winslow, editor of the American Journal of Public Health and formerly Dean of the Yale School of Public Health:

> "Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organized community effort for the sanitation of the environment, the control of community infections, the education of the individual in the principles of personal hygiene, and the organization of medical and nursing service for the early diagnosis and preventive treatment of disease; organizing these benefits in such fashion as to enable every citizen to realize his birthright of health and longevity."

The functions of the Health Department, some of which are described below, can only be carried out with the cooperative effort of official (tax-supported) and non-official agencies, doctors, hospitals, nurses, and the people themselves.

Constant effort is necessary to prevent the spread of diseases such as typhoid and dysentery through contamination of water and food supplies, and through improper disposal of human wastes. The health department is the agency which is responsible, through its specially trained sanitation personnel, for inspecting water supplies, milk-producing herds, pasteurization plants, and the manner in which the milk and cream are handled from the cow to the consumer, restaurant and other food-handling establishments, certain hotels and boarding houses, farm labor camps, children's camps, and swimming pools and bathing beaches, and assisting in correcting any practices or conditions which are a menace to the public.

Such inspections can only be conducted properly if a sufficient number of trained workers are made available locally. As a necessary part of this inspection service these workers must have readily available a laboratory to analyze the samples which they collect so as to determine if contamination has occurred or if some purification process has been performed properly. For example, a milk sample cannot be sent a long distance to a laboratory, as changes will occur during the time spent in travel which will make the laboratory examination worthless.

These sanitation examinations and inspections are principally to prevent communicable diseases. The control of communicable diseases is helped by other procedures performed by the health department. Physicians are required to report promptly acute communicable diseases which

they diagnose in their patients. These reports are watched carefully by the county health officer and if they suggest that an epidemic is starting he investigates immediately so as to determine the source of the infection and to take steps to prevent further spread. For example, a group of scarlet fever case reports may be received all at one time by the county health officer. Each of the physicians reporting these cases may have seen only one or two cases and not be aware that there is anything unusual, but the county health officer, noticing that all of these patients have become ill within a few days of each other, realizes that it is unusual, and he and his staff will be competent to make a proper investigation. This investigation may trace the outbreak to infected milk, and prompt action would be taken to prevent more cases, thus eliminating much unnecessary suffering and deaths. Time is extremely important in such a situation; adequate health services immediately available in the county will save time in recognizing and controlling such an outbreak.

In certain other diseases, such as typhoid fever, every case reported is carefully investigated to determine the source and prevent additional cases occurring from that source. Here again the availability locally of properly trained full-time personnel and availability of adequate laboratory service to help in these investigations may mean the prevention of much unnecessary suffering and premature death.

An ounce of prevention, of course, is worth a pound of cure, and the health department will devote much of its time in preventing communicable diseases rather than putting into effect control measures after such diseases have already appeared in the community. This means, in addition to the sanitation services already outlined, emphasis on specific immunization against diphtheria, smallpox, and whooping cough, as well as against other diseases under special circumstances. This means a constant campaign on the part of the health department to inform the people of the need for such immunization, to persuade them to take their children and themselves to their physicians to be immunized, and to conduct clinics for such immunization of those individuals who will not go to their own physicians for this purpose.

There are one or two communicable diseases which are particularly important because of the large number of cases which occur in every community and the seriousness of these diseases. Tuberculosis is one of them. It is a serious, "catching" disease, but it can be cured if discovered early, and its spread to others can be prevented if each infectious case is found early, goes to a hospital promptly, and stays there until he is no longer infectious. Prompt hospital care thus is best for the patient himself and for everyone else in the community. The trouble is that in the early stages there are no symptoms, or they are so slight that the individual does not know that he has tuberculosis.

In order to detect such cases, all individuals who are known to have been exposed to a person with tuberculosis must have chest x-rays periodically; and a new development is providing free chest x-rays to <u>all</u>

adults in a community, so-called "mass x-ray surveys". Although the State Department of Health, because of the size and the cost of the program, necessarily must take the lead in much of this tuberculosis control program, it will be successful only if there is wholehearted assistance locally in arranging for groups to be x-rayed, arranging for people who are found to have tuberculosis to receive hospitalization and arranging for members of their families who have been exposed to be examined periodically. The personnel of a county health department are trained to do this job.

The other special communicable diseases are the so-called "venereal" diseases, principally syphilis and gonorrhea. If a person has one of these diseases, and he is treated early and adequately by the new methods recently made available, not only is he promptly made incapable of spreading the disease to others but he will not develop later the terrible crippling and even fatal after-effects which often occur in a non-treated case. Thus, here again prompt diagnosis and prompt and adequate treatment are best, both for the patient with the disease and the people in the community. And once again, to do a proper control job there should be properly trained public health physicians and nurses working every day in the county to see that patients receive treatment promptly; to see that they stay under treatment until they are no longer infectious and are not likely to relapse; to see that those who have been exposed to them are examined to find out if they have caught the disease, and if so, to arrange for them to receive medical treatment; to make readily available expert help in diagnosis in cases in which it is difficult to tell whether or not the patient is suffering from the disease; and to cooperate with the local police authorities in closing and keeping closed houses of prostitution, which are such prolific sources of these particular infections. Here, too, readily available adequate local laboratory service is essential to doing a good job.

There is nothing quite so tragic as the death of a mother in childbirth. Here again organized community effort can help reduce the frequency of such tragedies. They may be reduced through having the expectant mother come under the care of a physician early in pregnancy and continue under such care throughout pregnancy, and by having delivery take place in a properly equipped and maintained hospital or maternity home. The health department public health nurses can assist in having the pregnant woman place herself under the care of a physician early and report to the physician in accordance with the schedule which he outlines.

The public health nurse will also assist the mother in evaluating symptoms which occur during pregnancy and in deciding whether or not they need to be brought to the attention of the physician before the next regular visit. She is able to be of great help to the mother in assembling and making clothes and other materials she will need for the care of the baby after it arrives.

Maternity homes will be regularly inspected by a staff member of the health department to be certain they are being conducted safely and

properly. (Hospitals in most instances are inspected by representatives of the State Department of Social Welfare and the American College of Surgeons. Even here, however, the qualified staff of a county health department can often give helpful advice as to the best procedures to be followed in the maternity wards and new born nursery, as well as in the communicable disease isolation wards and elsewhere in the hospital.)

"As the twig is bent so grows the tree". Within a relatively few years, the nature of the population of a community is changed through the children which have been born into it and their growing up into adults. If these new citizens are given every opportunity for the best possible growth and development - physically, mentally and morally - the community will be a much more happy and prosperous one than if such opportunities are not provided. This actually goes back to before birth, since birth is merely an incident in the development of a person. Thus proper prenatal care of the expectant mother, through proper nutrition and skillful delivery in a properly equipped hospital or maternity home, not only reduces the chances of a fatal outcome in the mother but increases tremendously the possibility of a completely normal infant at birth who is off to a good start in life.

However, assistance is also needed by the mother throughout the infant, childhood and adolescent stages of development in the child. Here again, organized community effort, represented by the health department (particularly by the public health nurses), the physicians in the community, and other groups and agencies, can be of great help in giving this needed assistance. Infants and young children need to be examined periodically by qualified physicians to be sure that they are developing properly, and to correct any defects while they can still be corrected and before doing permanent damage.

The mother needs advice with regard to feeding the family so as to assure optimum growth through proper nutrition, and this will be obtained to a large extent through the local public health nurses who, in turn, will have received expert advice from qualified nutirtionists made available through the State Department of Health.

Regular dental inspection with proper treatment of the teeth when indicated is an important part of this program. The crippled child, whether due to infantile paralysis, cerebral palsy or some other condition, is particularly in need of help, as well as his family, and special services and financial assistance are available, provided by the State Departments of Health and Education in cooperation with the county judges of the children's courts. Here again, however, it is not possible for a community to take full advantage of these services unless it has an adequately staffed health department to develop them in accordance with the needs of that community.

Many other very important activities could be mentioned, such as the early detection and proper treatment of cancer, and the prevention of accidents in the home and on the farm, but these few examples show the kind of public health service every community is entitled to, and which can be

given best through a county health department adequately staffed with specially trained workers.

The work of a county health department may vary from year to year or from day to day according to the particular needs or desires of the communities which it serves. The gains in improving the health of the public in the past have been achieved largely through the combined efforts of health officers, public health nurses, sanitarians, laboratory technicians, health educators and others. Actually, a team of workers such as these, each trained in his special field, makes up the personnel of the health department. As individuals and as a team they should be a part of the community and constantly alert to the health needs of its people.

They should be easily accessible and ready to turn their attention to any problem concerning the health of the public, whether it be the prevention of epidemics, stopping epidemics if and when they get started, saving the lives and improving the health of mothers and children, arranging for people with cancer, rheumatic fever, or other conditions to receive proper care at a time when they may be cured and resume normal lives, or promoting other facilities and resources for meeting the health needs of the people.

The organization of such a team for each individual village and town is not practical, since a small community cannot afford nor does it have a sufficient volume of work to justify the employment of these full-time properly trained workers. Therefore, over the past years, the state has found it necessary to supplement local service by employing and assigning certain trained personnel to district offices to provide health services which should have been provided locally. This has not been entirely satisfactory, however, since the number of state personnel available could not possibly provide the amount of service required for a good and effective local public health service. Generally speaking, the county is the optimum governmental unit for providing such services, through a county health department.

In order to assist the counties in providing for these services an amendment has been made in the public health law to provide for state aid for county and part-county health departments to the extent of 75 per cent of the first $100,000 expended for approved public health work (Appendix A-1). Expenditures above $100,000 are reimbursable on a 50 per cent basis. State aid for county health work in counties not organized as county health departments is continued on the same 50 per cent basis as heretofore. Towns and villages are not eligible for state aid for public health work.

Under the public health law, the retention of boards of health and health officers of the individual towns and villages is permitted when local opinion so directs. Such health officers continue to be paid by the local municipality rather than by the county, although they become deputies of the county health officer and perform such duties as may be delegated to them in the towns or villages which they serve.

As regards Allegany County, the minimum public health personnel required to staff the county health department and the estimated cost thereof would be as follows:

Personnel	Annual Salary Range 1/	
Health Commissioner	$6,000	$7,000
Clinic physician fees	2,500	2,500
Director of Public Health Nurses	3,360	4,020
8 Public Health Nurses at $2,280 - $2,880 2/	18,240	23,040
Public Health Engineer	4,500	5,500
Sanitary Inspector	2,400	3,000
Milk Sanitarian	3,600	4,350
Veterinarian, part-time	1,600	2,000
Dentist, part-time	1,600	2,000
2 Dental Hygienists at $2,000 - $2,500	4,000	5,000
Health Educator	2,600	3,225
Office Manager	2,520	3,120
4 stenographers or clerks at $1,200 - $1,700	4,800	6,800
Total	$57,720	$71,555
Annual Maintenance and Operating Costs	14,500	14,500
Total 3/	$72,220	$86,055

1/ It is difficult to recommend definite salaries because of the rapid changes in the cost of living and corresponding salary levels. These ranges are suggested as those currently in force for public health personnel. It is recognized that some modifications may be indicated in a particular county to provide salaries in line with local salary levels.

2/ This does not provide for sufficient instructive bedside nursing care of the sick nor sufficient school nursing. If it is planned to increase this service additional nursing personnel will be required as described on page 13.

3/ The cost of original equipment is not included in this estimate, since the amount required would be dependent on an evaluation of existing equipment which might be used.

If these salaries are accepted, the annual cost for salaries and maintenance and operation will vary between a minimum of $72,220 and a maximum of $86,055. For preliminary planning purposes, $75,000 is suggested. State aid reimbursement on expenditures of this amount would be $56,250, leaving $18,750 as the amount to be raised by county taxation. Of this amount, $6,025 is already provided for as the county's share of the cost of nursing service, exclusive of the purchase of new cars, in the 1947 budget. Therefore the net estimated increase in the total budget would be $12,725, or 19 cents per $1000 over the county tax rate of $8.74 in 1945. 1/

There is much to recommend the combination of school medical, school dental, and school nurse teacher services with the general health program of the county health department. Such an integrated service would be not only in the interest of economy, but also would result in an improved opportunity for continuity of health work as the preschool child passes into school age, or as the school child is found in need of health services or related medical care, which can be provided through the public health program.

Where the school health service is administered as part of the general health program of the county, the program must be planned in conjunction with the school authorities and the work in each particular school district must be approved by the appropriate school authorities under the provisions of the Education Law and under the regulations prescribed pursuant thereto.

Nursing care for the sick is an important service related to public health nursing. The purpose of such service is to teach a responsible member of the family or a practical attendant the procedures of home nursing care and the methods of carrying out the treatment ordered by the private physician. Visits for this purpose average about one hour in length and are spaced in accordance to the needs of the patient. Calls for the nurse may be received from physicians or families, but the nurse only gives her services where there is a physician in attendance whose orders for treatment are followed.

This is a worthwhile and popular service and has economic values to the individual citizen and to the public budget. It is directly related to efficient use of hospital facilities.

Where it is planned as part of the public health nursing service, registered professional nurses should be employed part-time or full-time to assist the public health nurse. It has been determined that a population of 5000 would need, on an average, one public health nurse assisted by a registered professional nurse for sickness care and for certain aspects of clinic work. A practical nurse as an extra assistant to the public health nurse may be thought of later wherever the care of chronics is included and where the case load is heavy.

1/ Proceedings of the Board of Supervisors of Allegany County, 1945, p. 268

Since public health laboratory services constitute an essential part of a comprehensive health program, it is preferable that such services be included in the county health department. Under the existing Public Health Law, Sections 20-c to 20-h, (Appendix A-2) - separate provision is made for state aid for public health laboratory services. This supersedes the general provisions for state aid for county health services previously referred to. This unit of service must, therefore, be financed separately.

In addition to the services of the county health department for which provision is made above, certain supplemental specialized public health services would be provided on a cooperative basis by the state. These would deal with specialized or advisory functions in which the requirements of Allegany County would be insufficient to justify the full-time employment of highly trained technical personnel. Examples of the service which might be provided by the state are orthopedic nursing service, specialized consultation and diagnostic service in orthopedics, obstetrics, pediatrics, tuberculosis, the venereal diseases and other communicable diseases, and consultation services in nutrition and medical social service, but it is hoped that in the future counties may find it possible to employ the part-time services of some of the foregoing specialists.

THE COUNTY PUBLIC HEALTH LABORATORY

Adequate laboratory services are a fundamental of good medical care and a public health program. They are essential as an aid to diangosis, to communicable disease control, to certain forms of therapy, and to the practice of preventive medicine. No plan can be considered complete that does not make ample and adequate provision for such.

Under the provisions of the Public Health Law, Sections 20-c -- 20-h, inclusive (Appendix A-2), the board of supervisors of any county is empowered to establish therein a laboratory or laboratories which shall serve the whole or part of the county. Under certain conditions specified in the law, they may apply for state reimbursement of 50 per cent of the cost of maintaining each laboratory in an amount not to exceed $7,500 per annum. In addition, state aid may be received not to exceed $2,500, toward the initial installation and equipment of each laboratory. Laboratories receiving such aid must fully meet the standards of the Commissioner of Health for approval as a public health laboratory.

As far as Allegany County is concerned, an ideal opportunity presents itself to develop further and operate the public health laboratory as a part of the coordinated county hospital and health department plan. It is suggested that the main county laboratory be located in the proposed general hospital at Wellsville with branch facilities at Cuba, and the present county laboratory in Belmont be discontinued.

The two laboratories at Cuba and Wellsville should be under one qualified Director who would be a competent pathologist and would be available for consultation in the laboratory phases of medical problems.

The estimated annual budget and method of financing for the laboratory service is as follows:

Expenses		
Personnel		
Director	$9000	
Wellsville		
Assistant bacteriologist	2500	
Senior technician	2200	
Junior technician	1500	
Helper	1200	
Secretary	2000	
Cuba		
Senior technician	2200	
Junior technician	1500	
Total		$22,100
Supplies and maintenance		3,900
Total		$26,000
Method of Financing		
Income from fees paid by private patients		8,000
State aid reimbursement (50 per cent of $26,00 less income from fees received from private patients) 1/		9,000
Net cost to county		9,000
Total		$26,000

The floor space recommended for the laboratories to serve the two hospitals as well as the county laboratory would be 1500 square feet at Wellsville and 500 square feet at Cuba. Since it is recommended that the laboratories be housed in the proposed county general hospitals, the additional expense would be that of supplying an additional 1500 square

1/ Up to maximum of $7,500 for each of the two proposed laboratories.

feet of construction to the Wellsville plant and an additional 500 square feet to the Cuba general hospital plant. Provision has been made for this in the estimated cost of construction of the county hospitals in Section IV of this prospectus.

The equipment now in the laboratory at Belmont could be transferred to one of the proposed new laboratories. Additional equipment would be needed, however, for which an additional $2500 of state funds would be available under the provisions of 20-h of the public health law.

THE COUNTY GENERAL HOSPITAL

This plan is developed upon the premise that in the public interest the preventive, diagnostic, and curative fields of medicine must be readily available to all members of the community. The provision of such services and facilities, particularly in rural areas, is recognized, however, as one of the major problems confronting the country.

There has been a continuing decline in the number of physicians in rural areas. While economic conditions are in large measure responsible for this situation, they are not the only factor. The young physician has been educated and trained to use and depend upon the modern hospital and laboratory as essential tools for the use of his scientific knowledge and skill in a manner satisfying to him in discharging his obligation to his patients. Furthermore, in his training he has become aware of the advantages of consultations with specialists in problem cases, and such readily available consultation service is provided in the modern hospital. Thus, the medical school graduate of today will not elect to go to rural areas without adequate hospitals and laboratories. Therefore, the community that wishes to have adequate medical services must have the foresight to provide the physical equipment that will attract the efficiently trained physician.

INTEGRATION OF PUBLIC HEALTH AND HOSPITAL SERVICES

In recent years, there has been a growing realization that there can be no hard and fast lines between the health of the mass of the people, such as sanitation and quarantine (public health), and the health of the individual. In the past, the general hospitals have been thought of entirely as places where acutely ill individuals were taken to get well. Health department activities, on the other hand, have dealt primarily with the prevention of disease in large groups of people.

The prevention of disease and maintenance of good health begins with the individual and it is important for the physician to give much of his attention to preventive measures and to the maintenance of optimum health of his patients. Large opportunities exist for the collaboration of the physicians, hospitals, and public health authorities in the conduct of effective health education, collection and analysis of mortality and morbidity statistics, case-finding and control in tuberculosis and the venereal diseases, and other health services. In fact, it may be said that only through such combined action can there be developed an adequate health service for the people.

Except for statistics that can be compiled from reports of cases of communicable diseases and cancer, death statistics provide the only reliable guide we have today regarding the general health of the public. It

appears highly desirable for hospitals, which serve over one-tenth of the population annually, to assist in the development of a system of sickness reporting. Such data would furnish a much more reliable basis upon which to measure the health of the people and the effectiveness of health measures than those which are now used. This problem, like most others, would be handled for the greater benefit of the public if hospitals and health departments integrated their facilities in a coordinated program.

Hospitals are in a strategic position for the dissemination of reliable health information. If a program of health education were developed by the hospitals, they would become the focal points for health activities in the community. In view of the fact that so large a proportion of the population (patients, their relatives and friends) are passing through these institutions each year, a large opportunity exists for hospitals to share more extensively in health education work. Education in matters of health is notoriously of little interest to healthy people; but when they fall ill, their curiosity as to cause, cure, and prevention is aroused, and they together with their relatives and friends, show an avid eagerness for knowledge. Hospitals and health authorities have an excellent opportunity for collaboration in this field.

It would be advantageous also if the public health nurses were responsible for follow-up of patients discharged from the hospitals to the care of private physicians and patients receiving out-patient service.

This would require the formulation of a plan by the physicians, hospitals, and health department for the referral of patients, transfer of records, and other pertinent information to provide continuity of nursing care in accordance with patients' needs. The hospitals also should be available as centers for refresher courses and instruction for the field nurses as well as their own nursing staffs. They would serve as the centers for the clinical practice and mobilization of volunteers, auxiliary nursing aides, and practical nurses in an integrated program of community service. There would also be an opportunity for interchange between the hospital nursing staffs and the field nursing staffs which would prove of great value and represent a potential economy in case of emergency.

AFFILIATION WITH MEDICAL TEACHING CENTERS

The affiliation of smaller hospitals and health facilities with larger institutions in which comprehensive and competent service in the special fields of medicine are available has been proposed in order to maintain a proper standard of service in the smaller hospitals and provide for the continuing education of the physicians practicing at these institutions. It has been suggested that the facilities of the medical schools and the teaching hospitals be sufficiently augmented so that qualified instructors and consultants could regularly visit these outlying institutions to assist the local staff, provide postgraduate instruction, and be available upon call for consultation services to the local physician. If we are to be successful in improving medical services in rural

and small urban areas, it is believed necessary that such a system of affiliation be arranged. This action would provide for a more interesting and satisfying medical career for the rural and small urban physician and allow for a larger number of patients to be cared for at their community hospital. Under a system of affiliation it should be possible for the small urban and rural hospitals to develop through their attending physicians the indicated staff of specialists and to provide for the establishment of competent well-organized services in the several departments of medicine and surgery. Affiliation should do much to strengthen the quality of services and bring about full local support of the public.

The consultation and advisory services obtained through the type of affiliation proposed fall into two broad categories, each of which would be financed differently: (1) Consultation and advisory services to the hospital as a whole, such as regularly scheduled conferences with the hospital staff on x-ray problems, surgery, medicine, obstetrics, pediatrics, hospital administration and nursing, which would be services to the entire medical staff, with payment probably considered a part of the operating cost of the hospital and reflected in the daily charge to patients or in the operating deficit. (2) Specialist consultation service rendered in emergencies or in the treatment of individual patients apart from the regularly scheduled conferences, which would be obtained on an individual case basis and charged to the individual patient.

CHRONIC DISEASE HOSPITAL CARE

One of the major problems in medicine today is the control of chronic disease. As a part of long-term planning, consideration should be given in the development of community hospital facilities for the provision of public diagnostic, treatment, and follow-up services for those suffering from chronic diseases as a part of a coordinated health and hospital service. The chronic disease facility should be expected to operate at a lower patient day cost than the general hospital proper.

FEDERAL AND STATE AID

The regulations pertaining to state aid provided through the State Department of Health (Public Health Law, Article II-B; Appendix A-1) in the amount of 50 per cent of the cost of construction and maintenance of a county general hospital are given in Appendix C. In accordance with the provisions of the law, the Commissioner of Health is expected to establish standards for the construction and operation of such hospitals. These are currently under review, but, in general, will be similar to those required for approval by the American College of Surgeons (Appendix C).

Federal aid to the extent of one-third of the cost of construction is administered by the Joint Hospital Board of the Postwar Public Works Planning Commission in accordance with regulations promulgated by the Surgeon General of the United States Public Health Service and the State Agency (Appendix E).

EXISTING HOSPITAL FACILITIES

There are at present three general hospitals in Allegany County with a total bed capacity of 85 beds. The 15-bed hospital at Fillmore (Genesee Country Memorial Hospital) and the 42-bed hospital at Wellsville (Jones Memorial Hospital) are non-fire resistive and were not originally constructed to be used as hospitals. In reality, the county has only one hospital of modern fire-resistive construction. That is the Cuba Memorial Hospital at Cuba with a bed capacity of 28.

The Cuba Memorial Hospital operated with an average daily patient census 66 per cent of its capacity during 1944, which is slightly above the normal percentage occupancy expected for a hospital of its size. The Genesee Country Memorial Hospital operated during the same year with an average daily census of only 32 per cent of its capacity. The Jones Memorial Hospital, on the other hand, operated at 103 per cent of its normal capacity and found it necessary to establish 13 additional beds to meet the demands for its facilities in recent years.

The geographic distributions of patients are available for the hospitals in Cuba and Wellsville in 1944. Of the 729 patients discharged from the Cuba Memorial Hospital in that year, 295 were residents of Cuba; 337 were from the rest of the county; and 97 were from outside the county or the state. Of the 1865 patients discharged from the Jones Memorial Hospital at Wellsville in the same year, 655 were residents of the village of Wellsville; 925 were from the rest of the county; 34 were from other counties and 204 were from outside of the state.

ESTIMATED NEEDS

The number of available general hospital beds in Allegany County is considered inadequate. The formula based on births and deaths 1/ which is currently recommended as an index of general hospital needs, indicates that the average daily general hospital census of Allegany County residents alone might be expected to be 169. Allowances for the referral of patients to the larger medical centers in Buffalo or Rochester and for periods of increased demands because of seasonal or epidemic

1/ Hospital Survey News Letter, Commission on Hospital Care, Chicago, Illinois, July 1946.

increases in illness, emergencies, etc., indicate a final estimated need of 183 general hospital beds in Allegany County, determined as follows:

Expected average daily census	169	
Number of additional beds needed to meet seasonal and other fluctuations in demands.	46	
Total		215
Allowance for referral of patients to larger medical centers for specialized care.		32
Estimated total number of general hospital beds needed in Allegany County.		183

Of this number, as stated above, a total of 85 beds are already available but 57 are in buildings which are not fire-resistive and were not constructed to be used for hospital facilities, leaving only 28 beds that are suitable and safe for use at the present time. Therefore, there is a need for 155 new general hospital beds, or replacements in Allegany County.

The determination of the best size of hospital is a difficult problem in rural areas. Hospital facilities should be accessible to those in the most distant points in the community. Yet, each hospital should be large enough to make it possible to maintain adequate standards and efficient operation.

The construction and operation of a general hospital of less than 50 beds is not considered good modern practice from a financial or medical staff standpoint. As hospitals decrease in size below 100 beds, it is increasingly difficult to provide the necessary balanced medical staff of specialists. If hospital care of high standards is provided, there will be a sharp increase in the patient-day cost, and the percentage occupancy possible during normal periods will be materially reduced. In other words, smaller hospitals will have a larger proportion of vacant beds for longer periods if they are planned to meet peak loads.

The present trend in design is toward a compact multi-storied plan, since such a structure is less expensive to build, operate, and maintain. Because of hospital insurance and the rise in living standards there is a trend today which indicates that the future public demand will be for more semiprivate facilities and fewer ward-type facilities than in the past. (See Appendix D for reference)

The ideal hospital plan for Allegany County would be one 150 bed hospital preferably located at Wellsville and containing the physical facilities for the activities of the full-time county health department and the county laboratory. Because of the existing facilities and interests, however, the alternative of a 100-bed hospital at Wellsville to replace the existing non-fire resistive plant and an expansion of the Cuba Memorial Hospital to 50 beds is suggested.

It is suggested that these projects should be carried out at the earliest opportune date and that consideration be given in future planning to modern replacement of the Genesee Country Memorial Hospital at Fillmore to serve as a branch unit of the Wellsville hospital. The branch unit should have interchange with and supervision from the Wellsville Hospital so far as administrative facilities and services are concerned.

The plan for the Jones Memorial Hospital at Wellsville should include facilities for the main office of the county health department and facilities for its activities, including clinic and health education. A branch of the county health department is suggested for the Cuba Hospital. The county laboratory also should have its headquarters at the Wellsville hospital with a branch at the Cuba hospital.

Cuba Memorial Hospital

The plan for a 50-bed hospital and health center would require a total of approximately 43,000 square feet of floor space, 1/ including the existing plant. This would provide ten one-bed private rooms, 12 two-bed semiprivate rooms and four four-bed wards, plus two single isolation rooms and a nursery with eight bassinets. It would provide two operating rooms, one delivery and one labor room. 2/

The floor space of 43,000 square feet would be apportioned as follows: 27,750 square feet, or 555 square feet per bed for hospital facilities and approximately 15,250 square feet for public health administration, public health clinics, laboratory, social service, and related activities. If it appears desirable, certain out-patient services and

1/ Exclusive of office facilities for lease to private physicians who are members of the attending staff.

2/ For the details of requirements in floor space for the various branches of hospital service, reference should be made to "Planning Suggestions and Demonstration Plans for Acute General Hospitals" by MacDonald and Schaffer, reprinted from HOSPITALS, July 1943.

follow-up clinical services could be held in the clinical spaces of the branch health department wing. If it is desired not to have a branch of the County Health Department at Cuba, the estimated square footage for the floor plans given above can be decreased accordingly.

Jones Memorial Hospital at Wellsville

The city might consider turning the present plant over to the county but a complete replacement of the plant should be considered with a capacity of 100 beds including housing facilities for the county health department and for the county laboratory service.

For a 100-bed hospital there would be required 61,950 square feet of floor space apportioned as follows: 46,700 square feet for hospital facilities 1/ and approximately 15,250 square feet for public health administration, public health clinics, laboratory, social service, and related activities.

The new hospital should be planned to provide for one-third of the beds on a private basis, one-third semiprivate, and one-third in four-bed wards. It would be necessary for the present hospital to function during the period of new construction so that the selection of an additional site might have to be considered.

1/ For the details of requirements in floor space for the various branches of hospital service, reference should be made to "Planning Suggestions and Demonstration Plans for Acute General Hospitals", by MacDonald and Schaffer, reprinted from HOSPITALS, July 1943.

ESTIMATED COST AND SUGGESTED METHOD OF FINANCING THE CONSTRUCTION PROGRAM

Cost

It is very difficult to arrive at a sound estimate of the cost, in view of the uncertain conditions of material and labor. The following figures are conservative and are based on pre-war costs plus one-third. Since the project is of considerable scope, the county should not undertake construction at a time when high existing costs would place an excessive expense upon the taxpayers.

a.	Replacement of Wellsville hospital, 100-bed capacity estimated at $7,500 per bed, including standard equipment, health center, health department, and county laboratory.	$750,000
b.	25-bed addition to the Cuba Memorial Hospital at $7,500 per bed 1/, including standard equipment and branch facilities for the county health department and laboratory.	187,500
		$937,500

Method of Financing

Federal grant through the State under provisions of Public Law 725, Federal Hospital Survey and Construction Act, 1946 (one-third of total cost - Appendix E).	$312,500
State aid for architectural planning through the Postwar Public Works Planning Commission (50 per cent of cost of preparing plans, specifications and estimates, but not to exceed two per cent of the total cost of construction.)	18,750
State aid for construction under provisions of Article II-B, Section 19, Public Health Law - 50 per cent of total cost less federal aid and state aid for architectural planning (Appendix A-1)	303,125
Cost to county 2/ (total cost less federal and state aid)	303,125
Total	$937,500

1/ It is anticipated that certain changes would be necessary in the central services of the hospital to provide for the increased capacity.

2/ It would be possible for both existing hospitals to undertake a subscription drive and turn the proceeds over to the County Treasury for the purpose of meeting the planned hospital construction costs. Likewise, any endownments available through the Board of Trustees of the Cuba Memorial Hospital could be handled accordingly.

Hospital Operating Deficit

It is assumed that the cost of caring for patients approved for care by the public welfare officials would not be charged back to the county, towns, or villages, and that such costs would be cared for as part of the annual operating deficit which would be eligible for 50 per cent state aid through the State Commissioner of Health. Based on the average operating deficit of State aided hospitals of a similar size to that which is recommended for Wellsville and Cuba, a reasonable estimate might be as follows:

Cuba Memorial Hospital, 50 beds	$36,300
The Jones Memorial Hospital, Wellsville, 100 beds	37,400
Total Estimated Annual Operating Deficit	$73,700
50 per cent State aid to the county	36,850
Estimated Annual Operating Deficit Cost to the County	$36,850

No cost has been included for a branch emergency hospital at Fillmore. This is a project which might receive consideration at some future date.

CONCLUSION

The above is a brief outline for co-ordinated health and medical care facilities and services for Allegany County, a rural county of 39,585 population. It is expected that considerable savings can be effected through such a joint medical care and public health undertaking, and at the same time supply needed services to the public and the medical profession.

It would appear desirable for the recommended facilities to affiliate with the Rochester Regional Hospital Council, for the provision of specialized medical, surgical, and pathological diagnostic and therapeutic services which are not available in the county. Such arrangements should make it possible for certain patients who must now go to Rochester or Buffalo for their hospitalization to remain near their own homes.

RECAPITULATION OF COSTS

	Total Cost	Source of Funds		
		Federal	State	County
Hospital construction 1/				
Replacement of 100 beds at Wellsville and 25 bed addition at Cuba	$937,500	$312,500	$321,875 2/	$303,125
Annual maintenance and operation				
County health department	75,000	-	56,250	18,750
Hospital operating deficit	73,700	-	36,850	36,850
Laboratory operating deficit	18,000	-	9,000	9,000
Total	$166,700	-	$102,100	$64,600

1/ Including floor space for the county health department and laboratory, but exclusive of new equipment and offices for lease to private physicians who are members of the attending staffs of the hospitals.

2/ Two per cent through the Postwar Public Works Planning Commission for architectural planning plus 50 per cent through the State Department of Health toward the total cost of construction less federal aid and state aid for architectural planning.

SUGGESTED SEQUENCE OF STEPS RECOMMENDED IN PLANNING AND OBTAINING STATE APPROVAL

The following suggested steps are intended to clarify what may seem to be a complicated and confusing process of clearance. Certain State approval is required under the law for the construction of the proposed general hospital facilities. Other types of clearance or approval also are required in obtaining state aid.

Under existing law and administrative regulations, the three chief elements of service concerned, i.e. the establishment of the county general hospitals, county health department and the expansion of county public health laboratory, need not all be undertaken at once. However, in the interest of an efficient and economical medical and health service for the county, all three are strongly recommended, and the steps recommended are based on such an integrated program.

It would be possible to establish a county health department alone and to obtain state aid. Similarly, it would be possible to expand the county laboratory service alone and obtain state aid within the limitations prescribed. Under the existing regulations, however, it is no longer possible to obtain state aid for the construction and operation of the county general hospitals except as they are a part of, or closely coordinated with, the services of a full-time county health department. This restriction, however, does not apply to the possibility of obtaining federal assistance under the Federal Hospital Survey and Construction Act.

RECOMMENDED STEPS

1. State assistance up to 50 per cent of the cost of preparing plans, specifications, and estimates for building programs by counties but not to exceed two per cent of total cost of the project, is available through the Postwar Public Works Planning Commission. Application should be addressed to that agency. Governor Alfred E. Smith State Office Building, Albany, New York.

2. Before construction is undertaken, the county is required to submit its plans for the hospital to the State Department of Social Welfare for approval (Appendix A-4). This should be done through the Rochester Area office, 45 Exchange Street, Rochester 4, New York.

3. If assistance through Federal funds (Public Law 725) for the hospital construction is to be requested, application for approval of the project and plans should be filed with the Postwar Public Works Planning Commission, since such approval is requisite to the granting of Federal funds. This approval is in the interest of good overall State planning

and integration of hospital services. Procedures for application for Federal funds are not available as yet but will be released within the next few months.

4. If state aid under Article II-B, Section 19, of the Public Health Law is to be requested, the following steps should be taken:

a. A county health district must be established. Assistance and advice in the necessary steps will be provided by the District State Health Officer, Dr. D. P. McMahon, Federation Building, 42 Broadway, Hornell, New York. This county health district must embrace the entire area of the county. For the approved expenditures of such a county health department, the county may receive reimbursement in the amount of 75 per cent of the first $100,000 spent annually and 50 per cent of any amounts expended in excess of $100,000.

b. A county general hospital may then be established in accordance with the provisions of Sections 126 to 133 of the General Municipal Law (Appendix A-3). If the hospital is so established and operated that it meets with the regulations and standards established by the Commissioner of Health and is operated as a part of, or is satisfactorily coordinated with the county department of health (Appendix C), the county may apply for state aid of 50 per cent for moneys expended in the construction and operation of such hospital. If such state aid is to be requested, clearance with the District State Health Officer through all stages of organization and planning is desirable in order to protect the interest of the county.

5. The county public health laboratory must, under the current provisions of law (Appendix A-2), be financed as an independent unit since separate application for state aid must be made to the State Commissioner of Health. The District State Health Officer can advise and assist with this.

6. Should the county be in receipt of voluntary contributions for the construction and/or operation of the county general hospital and health department facilities, such moneys, if expended by the county, may be considered as county funds and are creditable for establishing a claim for State reimbursement, provided such funds are accepted and appropriated by the county board of supervisors.

It would be highly desirable for the powers and duties of the Board of Managers of the county laboratory to be conferred upon the county board of health as permitted under paragraph 8, Section 20-b, (Appendix A-2) of the Public Health Law. Early revision of the law to permit the greater unification and coordination of all three boards, i.e. the Board of Health, the Board of Managers of county general hospitals and the Board of Managers of public health laboratories is being considered by the legislature currently in session.

APPENDIX

APPENDIX A

1. Public Health laws relating to county health districts and state aid to counties for public health work.

2. Public health laws relating to public health laboratories and state aid for public health laboratories.

3. General municipal law relating to the establishment and operation of public general hospitals.

4. Social welfare law relating to inspection and supervision of hospitals.

APPENDIX B

Effective Units for Health Service in New York State
by V. A. Van Volkenburgh, M.D.

APPENDIX C

1. Official notice to boards of supervisors on state aid for public health purposes.

2. New York State Department of Health rules for state-aided county general hospitals.

3. Standards for approval of hospitals by the American College of Surgeons.

APPENDIX D

References on hospital and health center planning and construction.

APPENDIX E

1. Abstract of the Federal Hospital Survey and Construction Act.

2. New York State Plan for Survey of Hospital Facilities and Program for Regional Hospital Planning for Postwar Hospital Construction, New York State Postwar Public Works Planning Commission Joint Hospital Board.

3. Hospital Survey and Planning in New York State,
by John J. Bourke, M.D.

APPENDIX F

Map showing average annual Infant Mortality Rates by counties, New York State exclusive of New York City, 1940-1944.

LAWS OF NEW YORK.—By Authority

CHAPTER 1000

AN ACT to amend the public health law, in relation to state aid for public health work and the organization, establishment and operation of certain health districts

Became a law April 24, 1946, with the approval of the Governor. Passed, three-fifths being present

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The article heading of article two-b of chapter forty-nine of the laws of nineteen hundred nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," such article having been added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three, is hereby amended to read as follows:

ARTICLE 2-B

State Aid for Public Health Work[1]

§ 2. Section nineteen of such chapter, as added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three and last amended by chapter seven hundred twenty-two of the laws of nineteen hundred thirty, is hereby amended to read as follows:

§ 19. **State aid to counties and certain cities[2] engaging in public health work.** 1. As used in this article:

(a) "County" means any county of the state other than one wholly embraced within a city.

(b) "City" means each city of the state having a population of fifty thousand or more, according to the last preceding federal census, but does not include any such city which is included as a part of a county health district pursuant to section twenty-b of this chapter.

(c) "Municipality" means a county or city.

(d) "Governing body" means the board of supervisors of a county or the common council, city council or other legislative body of a city.[3]

2. Whenever the board of supervisors of any county shall appropriate and expend moneys for the construction, establishment or maintenance by such county of a county, community, or other public hospital, clinic, dispensary or similar institution, or for the purpose of defraying the expenses of such county in any public enterprise or activity for the improvement of the public health, or any public health work undertaken by such county, within limits to be prescribed by the state commissioner of health, such county shall receive state aid in the manner and subject to the conditions pre-

scribed in this article unless state aid is otherwise specifically provided for any such purpose by this chapter or any other law.[4]

3. Whenever any city shall appropriate and expend moneys for the purpose of defraying the expenses of such city in any public enterprise or activity for the improvement of the public health, or any public health work undertaken by such city, within limits to be prescribed by the state commissioner of health, such city shall receive state aid in the manner and subject to the conditions prescribed in this chapter unless state aid is otherwise specifically provided for any such purpose by this chapter or any other law.[5]

§ 3. Section nineteen-a of such chapter, as added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three and amended by chapter two hundred seventy-eight of the laws of nineteen hundred twenty-four, is hereby amended to read as follows:

§ 19-a. **Approval of state commissioner of health.** It shall be the duty of the state commissioner of health to formulate standards of construction, equipment, service, administration and work which must be complied with by such municipalities[6] in order to be entitled to state aid, and no state aid shall be given to any municipality unless the state commissioner of health, after inspection and examination by him or his representative, shall make his certificate that such construction, equipment, service, administration or work is necessary to the public health and conforms to the standards so established therefor, and to the limits prescribed by him as required by section nineteen of this chapter.

§ 4. Section nineteen-b of such chapter, as added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three and last amended by chapter seven hundred thirty-two of the laws of nineteen hundred forty, is hereby **repealed,** and such chapter is hereby amended by inserting therein in lieu thereof a new section, to be section nineteen-b, to read as follows:

§ 19-b. **Amount of state aid; procedure.** 1. The board of supervisors of each county or the common council or other body exercising similar powers of each city desiring to make application for state aid under this article shall on such dates as may be fixed by the state commissioner of health submit to him the request of such county or city for such state aid and shall support such request with such information as the state commissioner of health may require. The state commissioner of health shall prescribe the form in which such information shall be submitted.

2. State aid reimbursement shall be granted under the provisions of this article in accordance with the following schedule: Fifty per centum of the amount of money expended or to be expended by a county not organized as a county department of health; fifty per centum of the amount of money expended or to be expended by a department of health of a city having a population of fifty thousand or more, according to the last preceding federal census; where a city or cities each having a population of fifty thousand or more, according to the last preceding federal census, contained in a county which is organized as a county health district exclusive of such city or cities as specified in section twenty-b of this chapter, takes or take

joint action with such county for the establishment of an integrated health service, such city or cities and such county shall each be entitled to receive reimbursement in the amount of seventy-five per centum of the first one hundred thousand dollars expended or to be expended by each for such health service, and in the amount of fifty per centum of all money so expended in excess of one hundred thousand dollars; on account of money expended or to be expended by a county department of health, reimbursement in the amount of seventy-five per centum of the first one hundred thousand dollars and fifty per centum of all money expended in excess of one hundred thousand dollars.

3. Reimbursement of the state's share of expenditures made by counties prior to the first day of January, nineteen hundred forty-seven shall be made in accordance with the provisions of former section nineteen-b of this chapter as it existed immediately prior to such date.

§ 5. Section twenty-b of such chapter, as added by chapter five hundred nine of the laws of nineteen hundred twenty-one, as amended, is hereby amended to read as follows:

§ 20-b. **County and part-county health districts.** 1. Definitions. Whenever used in this section the term "county health district" shall mean a health district comprising the entire county heretofore or hereafter established pursuant to the provisions of this section; the term "part-county health district" shall mean all that part of a county outside of a city or cities having a population of fifty thousand or more heretofore or hereafter established as a health district pursuant to the provisions of this section; the term "county department of health" shall mean that division of the county government having jurisdiction over the public health of a county or part-county health district; the term "board of health" shall mean the board of health of such county or part-county health district; the term "county health commissioner," shall mean the executive officer of such county department of health; and the term "health district", unless otherwise designated, shall mean either a county health district or a part-county health district.

2. The board of supervisors of any county, with the approval of the state commissioner of health, shall have power to establish a county or part-county health district and in such event shall appoint a board of health for such county or part-county health district. No city or any part thereof shall be included as a part of any such health district unless the mayor and common council of such city or the officials exercising similar powers shall have consented thereto and, in respect of cities having a population of fifty thousand or more, according to the last preceding federal census, unless the supervisors representing that part of the county outside such city shall have consented thereto.

In a county containing one or more cities having a population of fifty thousand or more, according to the last preceding federal census, which are not to be included in a county health district, the supervisors representing that part of the county outside of such city or cities may petition the board of supervisors to establish such

part of the county as a part-county health district and, upon receiving such petition, the board of supervisors shall forthwith file a certified copy of such petition with the state commissioner of health. If after a reasonable period of time following such petition to the board of supervisors, a part-county or county health district has not been established in such county, which district, in the opinion of the state commissioner of health, meets the standards of administration, service and work necessary to qualify for state aid, he may refuse state aid reimbursement of expenditures made by such city or cities until such a part-county or county health district has been established or until such petition has been withdrawn.

Whenever the provisions of this section shall have been proposed to be adopted in any county, and proceedings have been taken to establish a county or a part-county health district within any such county, the board of supervisors shall notify the state commissioner of health in writing of the proposed establishment of such county or part-county health district, and in such notice shall state the extent of the territory intended to be included within such district. The consent of the state commissioner of health to the establishment of any such health district shall be evidenced by a certificate, setting forth the approval of the state commissioner of health to the establishment of such health district and such certificate shall be filed with the clerk of the board of supervisors.

3. The county or part-county board of health shall consist of seven members, except that each city which becomes a part of the health district shall be entitled to one additional representative on the board of health to be appointed by the board of supervisors from a list of three persons submitted by the mayor or other administrative head of such city and which city representative so appointed shall have all the powers and duties conferred upon other members of said board and whose term of office shall be six years. The members of the board of health shall be residents of the health district, one of whom shall be a member of the board of supervisors selected by the board of supervisors, and at least three of whom shall be physicians licensed to practice in the state of New York. The county medical society of the county in which a health district is established may submit to the board of supervisors a list of physicians from which the board of supervisors may choose the medical members of the board of health. The term of office of each appointive member of said board of health shall be six years, and the term of one of the members shall expire annually. The first appointments shall be made for the respective terms of six, five, four, three, two and one years. Vacancies shall be filled by appointment for the unexpired terms.

4. The members of the board of health shall receive for attendance at meetings of the board a per diem compensation which shall be fixed by the board of supervisors and in addition thereto they shall be allowed actual and necessary traveling expenses, to be audited and paid in the same manner as other expenses of such board of health.

5. In counties having a county auditor or county comptroller, all

charges and other expenses of such district shall be audited and paid in the same manner as other charges against the county. In counties not having a county auditor or county comptroller, all accounts, charges, claims and demands of such health district shall be presented to and audited by the board of health and paid by the county treasurer upon warrants of the board of health within the limits of the appropriation made therefor.

6. Upon the establishment of a board of health as herein provided it shall exercise all the powers and perform all duties of local boards of health, and such board of health may formulate, promulgate, adopt and publish rules, regulations, orders and directions for the security of life and health in the health district which shall not be inconsistent with the state sanitary code. Every rule, regulation, order and direction adopted by a board of health shall state the date on which it takes effect and a copy thereof signed by the county commissioner of health or his deputy shall be filed as a public record in the state department of health, the county or part-county department of health and in the office of the county clerk and shall be published in such manner as the board of health may from time to time determine. Such rules, regulations, orders and directions shall be known as the sanitary code of such health district. The county commissioner of health or his deputy shall furnish certified copies of such code and its amendments for a fee of one dollar and such certified copies shall be received in evidence in all courts or other judicial proceedings in the state. The provisions of such sanitary code shall have the force and effect of law. Any violation of or non-conformance with any provision of such sanitary code or of any rule, regulation, order or special direction duly made thereunder shall constitute a misdemeanor punishable by a fine of not more than fifty dollars or by imprisonment for not more than six months or by both such fine and imprisonment.

7. Such board of health shall elect annually one of its number as president and another as vice-president. It shall also appoint a county health commissioner, who, in addition to his duties as health commissioner may be designated by the board of health to act as secretary without extra compensation. Such county health commissioner shall possess such qualifications for office as shall have been approved by the public health council. He shall serve for a term of six years and shall not be removed during the term for which he shall have been appointed, except upon written charges after a hearing and upon notice. He shall devote his whole time to the duties of his office and shall receive such compensation as the board of health shall determine within the limits of the appropriations made by the board of supervisors. He shall, within his district, possess all the powers conferred upon and perform all the duties required of local health officers. Local health officers who continue to hold office as herein provided after the establishment of a health district shall be deputies of the county health commissioner, who may require any such local health officer to perform within his local jurisdiction any such duty. The county health commissioner may, upon the authorization of

the board of health and within the limits of the appropriations therefor, appoint such additional deputies, assistant deputies and other employees as may be required to fulfill in the health district the purposes of this section. Such deputies and assistant deputies shall have the qualifications prescribed for health officers by regulation of the public health council.

The county health commissioner may designate in writing a deputy to whom shall be delegated all the powers and duties of the county health commissioner when such county health commissioner is unable to act by reason of absence or disability.

The board of health shall have the power to remove the health officer of any local health district included within such county or part-county health district or any deputy or assistant deputy of the county health commissioner for cause, upon charges, and after such health officer or deputy or assistant deputy has, with due notice, been given an opportunity to be heard. The proceedings in connection with such removal shall be subject to review by the state commissioner of health, who within thirty days of the receipt of an order of a board of health removing such local health officer, may revoke such order whereupon such order shall be void.

8. Local health districts within the area of any county or part-county health district shall continue to exist as subdivisions of such health district, and the local boards of health shall continue to exist and to retain their powers and duties subject to the rulings and regulations of the board of health, and may continue to appoint local health officers for such local health districts as provided by law.

The governing authorities of any city, village or town or the board of health of any consolidated health district may abolish such city, village, town or consolidated health district as a local health district, whereupon all the powers and duties of the local board of health of such local health district shall devolve upon the health board and all the powers and duties of the local health officer of such local health district shall devolve upon the county health commissioner. The governing authorities of a town or village, the local board of health of which has been abolished pursuant to the provisions of this section, when authorized by a proposition submitted and adopted in the manner provided by law, may employ a public health nurse or public health nurses, qualified as provided by regulation of the public health council, and make the necessary appropriation therefor. Such public health nurse, or nurses, shall work under the direction of the county health commissioner.

The governing authorities of any city which has consented to be included in a health district, may, at any time after three years shall have elapsed since such city has been included in a health district, by resolution adopted by said authorities, provide for the withdrawal of such city from a health district. Before such action is taken an opportunity shall be given for a public hearing before such governing authorities. Public notice shall be given and the health board shall be notified in writing, at least thirty

days in advance, of the time and place of such hearing. Such action by the said governing authorities shall become effective at a time to be stated in the resolution, which said time shall be not less than thirty days from the date of the adoption of said resolution. Upon the date when such resolution shall become effective, the local health district of such city shall be reinstated and it shall have all the powers of a local health district as though such city had not been included in the health district pursuant to the provisions of this act.

If a county or part-county health district as heretofore or hereafter established by a board of supervisors shall by its terms contain a portion of any village which lies partly within said county and partly within some other county, said village, without regard to population, shall continue its local health district organization in the same manner as before, in which case its health officer acting within the county or part-county health district shall be a deputy of the county health commissioner with reference to acts performed within said county or part-county health district. Provided, however, said village may, by resolution of its village board, limit its local health district to that portion of the village lying in the county outside of the county or part-county health district, in which event the compensation of the local health officer shall be based upon the number of inhabitants in the reduced village health district, and the residents of that portion of the village lying within the county or part-county health district shall not be taxed by the village for the support of such reduced local health district.

9. The health officer of each city, village, and consolidated health district included as part of any county or part-county health district, shall transmit daily all original reports of communicable disease cases, and all registrar's reports of deaths from communicable disease, to the county health commissioner. The county health commissioner shall transmit the original reports of communicable disease cases, within twenty-four hours after he receives them, to the state health department.

10. Annually the board of health shall prepare an estimate of the necessary expenses of such county or part-county health district, for the ensuing fiscal year which shall be transmitted to the board of supervisors of the county within such period of time as shall enable the board of supervisors to inquire into the necessity for the items of such estimate. The board of supervisors shall levy a tax upon the taxable property within the county or part-county health district, sufficient to provide such sums as the board of supervisors may deem necessary to meet the expenses of such health district. In preparing the items of any estimate of the expense of a county or part-county board of health, the board of supervisors may lawfully include therein and approve all items of expenses which may in any degree tend to promote the efficiency of the administration of the provisions of the public health law and other regulations adopted pursuant to the authority thereof.

11. The board of supervisors of any county in which a county health district has been established, the boundaries of which are coterminous with the county, shall have power to abolish the board

of managers of the county laboratory of such county, established and operated under the provisions of sections twenty-c to twenty-f, both inclusive, of this chapter, and to confer the powers and duties of such board of managers of such county laboratory upon the county board of health. The board of supervisors of any such county, with the approval of the state commissioner of health, may abolish the board of managers of the county tuberculosis hospital established and operated in such county under the provisions of sections forty-five to forty-nine-e, both inclusive, of the county law, and confer the powers and duties of such board of managers upon the county board of health.

12. The board of supervisors of any county in which a county or part-county health district has been or may be established, with the consent of the supervisors representing that part of a county included in the district in respect to a part-county health district, may abolish such district at any time after three years shall have elapsed following its establishment, provided, however, that before such action may be taken an opportunity shall be given for a public hearing. Public notice shall be given and the state commissioner of health shall be notified in writing, at least thirty days in advance, of the time and place of such hearing. Such action by the board of supervisors shall become effective thirty days after the adoption of the resolution to abolish such health district, and at the end of such period the terms of office of the members of the board of health and of the county health commissioner shall terminate.

§ 6. This act shall take effect immediately, except section four, which shall take effect January first, nineteen hundred forty-seven, and except that state aid reimbursement authorized by the amendments to the public health law made by this act shall be effective and accrue to the benefit of counties and cities on and after January first, nineteen hundred forty-seven.

STATE OF NEW YORK, }
Department of State. } *ss:*

I have compared the preceding with the original law on file in this office, and do hereby certify that the same is a correct transcript therefrom and of the whole of said original law.

THOMAS J. CURRAN,
Secretary of State

PUBLIC HEALTH LAW

Sections 20-c to 20-h

Section 20-c. Laboratories

The board of supervisors of any county may establish therein a laboratory or laboratories which shall serve the whole or part of the county. In the resolution of the board of supervisors establishing such laboratory they shall define the area which it is intended to serve, which area from time to time may by resolution be altered. Provided, however, that in defining such area the territory included in a town shall not be divided and provided further, that no city or any part thereof shall be included in the area so defined, unless the mayor and the common council, or the officials exercising similar powers, shall have consented thereto. The services of such laboratories shall be rendered at a moderate charge or free.

If, however, it is the intention of the board of supervisors to apply for state aid for such proposed laboratory, under the provisions of section twenty-h of this article, an application for such state aid for such proposed laboratory shall be transmitted by the board of supervisors to the state commissioner of health. On or before January first of each year the state commissioner of health shall file with the governor a statement of the aggregate amount of such applications for state aid for proposed new laboratories in addition to the aggregate amount of applications for state aid for laboratories already established.

Such sums, as revised in the discretion of the governor, shall be the estimate of state aid under this article to be used in the preparation of the executive budget.

Subsequent to enactment of the appropriation by the legislature the state commissioner of health shall revise such applications for state aid as necessary to bring the aggregate of all applications within the total appropriations available.

The board of supervisors may, in lieu of the establishment of a laboratory and with the approval of the state commissioner of health, provide for laboratory service by contracting with an established laboratory which is conveniently located and when such service shall have been provided, shall be entitled to such state aid as would be provided for under this act if the amount expended for service were expended for maintenance and operation of a laboratory established in accordance with the provisions of this act.

Upon the petition signed by two hundred or more taxpayers of the county or district to be served by such a laboratory, the governing body of that county or district at the next date for filling an elective office shall hold a referendum upon the question of establishing a laboratory the construction of which is to be financed by taxes levied for the fiscal year in which the expenditures therefore are to be made. If a majority of the votes cast are in favor of establishing such a laboratory it shall be mandatory upon the governing body of that county or district to take the

steps necessary for the establishment and maintenance of such a laboratory as provided for by this act. Nothing contained in this section shall be construed to prevent the financing of any expenditure, in whole or in part, pursuant to the local finance law.

Section 20-d. Powers of boards of supervisors in relation to laboratories.

The board of supervisors, when they shall have determined to establish such a laboratory shall have the following powers:

1. To acquire by purchase, exchange or otherwise, necessary real property, building or rooms or to erect necessary buildings.

2. To cause to be assessed, levied and collected in the same manner as other charges against the county, such sums of money as it shall deem necessary for laboratory purposes. Provided, however, that where a laboratory is intended to serve less than a whole county the expenditures made in connection therewith shall be assessed only against the area served by the laboratory.

3. To accept and hold in trust for the county any grant or device of land or any gift or bequest of money or other personal property or any donation to be applied, principal or income, or both, for the benefit of said laboratory.

4. To appoint a board of managers for the laboratory which shall consist of at least five members, two of whom shall be physicians duly licensed to practice in the state of New York. The county medical society may present to the board of supervisors a list of physicians residing in the county from which the board may choose the medical members of the board of managers. The board of managers shall hold a meeting at least four times in each year, and at such other times as it may deem necessary and each member attending meetings shall receive his actual and necessary expenses incident thereto, to be audited and paid in the same manner as other expenses of the laboratory. In counties having a county board of health and a county health officer, the president of the county board of health and the county health officer shall be members of the board of managers ex-officio. The members of such board, with the exception of the members ex-officio, shall first be appointed so that the term of one member shall expire within one year from the first day of January of the year in which he shall have been appointed, the term of another member shall expire within two years of the first day of January of the year in which he shall have been appointed, the term of another member shall expire within three years of the first day of January of the year in which he shall have been appointed, the term of another member shall expire within four years of the first day of January of the year in which he shall have been appointed, and the term of another member shall expire within five years of the first day of January of the year in which he shall have been appointed. Thereafter the terms of membership shall be made for five years from the first day of January of the year in which the appointment is made. Nothing in this act shall be construed to repeal or amend any provision of law not inconsistent herewith relating to laboratories in counties or to abrogate any powers of boards of supervisors relating thereto.

Section 20-e. Powers of boards of managers of laboratories.

The board of managers of each laboratory shall have the following powers and duties:

1. To elect a chairman, vice-chairman and a secretary.

2. To appoint a director or a bacteriologist in charge of the laboratory. Any person appointed as such director shall comply with such qualifications as may be prescribed by the public health council.

3. To fix the salaries of the director of the laboratory and all other employees within the limits of the appropriation made therefor by the board of supervisors.

4. To exercise general management and control of said laboratory, of the grounds, buildings, rooms, employees and of all matters relating to the government, discipline, contracts and fiscal concerns thereof.

5. To make such rules and regulations as may be necessary in relation to the administration of the laboratory and the fees to be charged for laboratory service, not inconsistent with the provisions of this act.

6. Notwithstanding any other general or special law, to erect all additional buildings found necessary after the laboratory has been placed in operation and make all necessary improvements and repairs within the limits of the appropriations made therefor.

7. To make to the board of supervisors annually at such time as said supervisors shall direct a detailed report of the operation of the laboratory during the calendar year, the number and kind of specimens examined and the results of such examinations, together with suitable recommendations and such other matters as may be required of them and full and detailed estimates of the appropriations required during the ensuing year for all purposes including maintenance, erection of buildings, repairs, renewals, extensions, improvements, betterments or other necessary purposes.

8. To establish branch laboratories if the area to be served by the laboratory is so large, if its topography is such as to make access to the laboratory difficult, or for any other reason such action seems reasonable or desirable.

Section 20-f. Powers of the director of a laboratory.

The director or the bacteriologist in charge of such laboratory, subject to the board of managers, shall:

1. Equip the laboratory with all necessary furniture, appliances, fixtures and other needed facilities for the conduct of laboratory work and purchase all necessary supplies within the appropriations made therefor.

2. Have general supervision and control of the internal affairs and work of the laboratory. He may make and enforce such rules, regulations and orders as he may deem necessary, not inconsistent with law or with the rules and regulations of the board of managers.

3. Appoint employees of the laboratory within the limits of his appropriations, and remove them.

4. Cause to be kept proper accounts and records of the business and operation of the laboratory, including such records relating to specimens

examined and render such reports as may be required by law or by the regulations of the state commissioner of health; certify all bills and accounts including salaries and wages, and transmit them to the board of supervisors which shall provide for their payment in the same manner as other charges against the county. The board of supervisors of a county not having a purchasing agent may make an appropriation for the maintenance of such laboratory and direct the county treasurer to pay all bills, accounts, salaries and wages which are approved by the director of the laboratory within the amount of such appropriation, subject to such regulations as to the payment and audit thereof as the board of supervisors may deem proper.

Section 20-g. Laboratories in cities.

Nothing contained in section twenty-e to twenty-f hereof inclusive, shall be construed to repeal or amend any provision of law under which any health function or activity may be carried on in any city, or to transfer or affect any authority in relation to health activities now being exercised in any city by any public board or officers. Provided, however, that any public board or officers of a city now exercising health functions may, with the approval of the mayor, contract with the board of managers of any laboratory for the purpose of cooperation and to join and share facilities. If a city desires to avail itself of the state aid provided for in section twenty-h of this act, the common council or any body exercising similar powers in any city with the approval of the board of estimate, if such exists, shall have the power to establish a laboratory in such city. Upon the establishment of such laboratory by such city, all the powers and duties of the board of supervisors, in relation to laboratories hereinbefore provided for, shall devolve upon the common council or other body exercising similar powers, except that the mayor shall appoint the board of managers of such laboratory and that the salaries of the director and other employees of the laboratory, and contracts to be made for, by, or on behalf of the laboratory and appropriations for the acquisition of sites and buildings and for maintenance, shall all be under the control of the same officials as now have control of similar items and shall be governed by the same provisions of law. In cities when more than one laboratory is established, but one board of managers shall be appointed, which shall have jurisdiction over all the laboratories established or operating under this act in said city. In cities of the second and third class the president of the local board of health, if such office exists, and the local commissioner of health or health officers shall be ex-officio members of the board of managers of the laboratory.

Section 20-h. State aid.

Where a laboratory as hereinbefore provided for shall have been established, the state, through the legislature, shall provide the following aid: a grant of an amount not to exceed one-half of the actual cost of maintenance of the laboratory or laboratories not in excess of seven thousand five hundred dollars per annum for each laboratory and of twenty-five hundred dollars toward the initial installation and equipment of such laboratory.

The salaries and traveling expenses of employees of the state department of health engaged in supervision or inspecting laboratories unless otherwise provided for and other expenses necessarily incurred by the state department of health in the execution and enforcement of this act shall be paid from the sum appropriated toward maintenance and operation of laboratories as hereinbefore specified.

The board of supervisors of any county or the common council or other body exercising similar powers of any city which has heretofore established and is maintaining a laboratory or which is already providing laboratory service by contract with another laboratory may apply for state aid in maintaining and operating such laboratory or in otherwise providing such laboratory service and upon complying with the provisions and requirements of this act, shall be entitled to such state aid, provided however, that in the event that the total amount appropriated for state aid is not sufficient to pay in full the state aid and other expenses hereinbefore provided for, counties or cities establishing laboratories or providing laboratory service under this act shall be given precedence and any balance remaining of moneys appropriated under this act, after the payment of full state aid to such counties or cities, shall be allotted to such counties or cities as have heretofore established and are now maintaining laboratories or are providing laboratory service by contract and have applied for state aid.

The work of all laboratories, except in the city of New York, established or receiving aid in accordance with the provisions of this act shall be inspected and standardized by the state department of health, and no state aid shall be given to any laboratory under the provisions unless the area of the district, site, design and construction of the buildings, equipment, work and conduct of such laboratory shall be first approved in writing, after inspection, by the state commissioner of health or his representative.

The comptroller after receiving the written approval of the state commissioner of health, hereinbefore provided for, shall determine the amount due in any one year to the various laboratories in the state under this act, and shall draw his warrant upon the state treasury in favor of the county treasurer of each county or the city treasurer of each city for the total amount to be paid to each laboratory in such county or city or in consideration of laboratory service contracted for in such county or city as shall be determined by him and shall indicate the amount to be paid to each laboratory or to each county or city in consideration of laboratory service contracted for. The county or city treasurer shall pay out such amount in the same manner and upon the same vouchers and proof as all other moneys devoted to such laboratory.

The board of managers of a laboratory may appeal from any decision of the comptroller or of the state commissioner of health or any refusal to furnish the written approval herein provided for to the governor, and the action of the governor shall be final and conclusive and his approval, if granted, shall be accepted by the comptroller in lieu of the certificate of the commissioner of health herein provided for.

Laboratories established or receiving aid under this section, except in the city of New York, shall be under the supervision of the commissioner.

GENERAL MUNICIPAL LAW

SECTIONS 126 to 133

Section 126. Establishment of public general hospitals.

The governing board of any county, town, city or village may by resolution determine that there shall be in said county, town, city or village a public general hospital for the care and treatment of the sick and in any county not having a tuberculosis hospital established under sections forty-five to forty-nine-e, both inclusive, of the county law, said public general hospital may include a pavilion or other provision for the care of tuberculosis patients. In any city in which a board of estimate and apportionment or other board is required to approve appropriations for public purposes, the resolution of the governing board to establish a public general hospital shall be effective only after the necessary appropriation for lands and buildings for such public general hospital shall have been approved by said board of estimate and apportionment or other board, in the same manner and by the same vote by which it is required by law to approve other appropriations for public purposes. When the governing board of any county, town, city or village shall have voted to establish a public general hospital, such governing board shall have the following powers:

1. To purchase and lease real property therefor, or acquire such real property and easements therein by condemnation proceedings in the manner prescribed in the condemnation law, in any locality within the jurisdiction of such governing board.

2. To cause to be assessed, levied and collected such sums of money as shall have been approved as hereinabove provided for suitable lands and buildings, and as it shall deem necessary for equipment and improvements for said hospital, and for the maintenance thereof, and for all other necessary expenditures therefor; or such governing board may finance expenditures for the erection of such hospital and for the purchase of a site therefor pursuant to the provisions of the local finance law, and may transfer such moneys so appropriated to the treasurer of such hospital, subject to such regulations as to audit thereof by such governing board as it may deem proper when such board of managers have appointed a treasurer as hereinafter provided for.

3. To accept and hold in trust for the county, town, city or village of which it is the governing board, any grant or devise of land, or any gift or bequest of money or other personal property, or any donation to be applied, principal or income, or both, for the benefit of said hospital, and apply the same in accordance with the terms of the gift.

4. Such governing board may also adopt a resolution authorizing the board of managers of such hospital to elect a treasurer, who shall be bonded, and who shall establish an account in a bank or banks in the name of such hospital and deposit in such account all money received or collected by such hospital and pay therefrom all bills, accounts, and salaries and wages, when approved by the board of managers of such hospital, within the

budget limits, by resolution subject to such regulations as the governing board may deem proper, provided, however, that the proceeds, inclusive of premiums, from the sale of bonds, bond anticipation notes, capital notes or budget notes shall be deposited in a special account in a bank or trust company located and authorized to do business in this state, shall not be commingled with other funds, and shall be expended only for the object or purpose for which such obligations were issued.

Section 126-a. Joint hospitals for cities, towns or villages.

Two cities in the same county or adjoining counties, or a city and one or more villages located within the same county or adjoining counties or two or more villages located within the same county or adjoining counties or two or more towns in the same county or adjoining counties or a city and one or more towns located within the same county or adjoining counties or one or more towns and one or more villages (including a village or villages within one or more of such towns) located within the same county or adjoining counties, subject to approval at a general county, town, city or village election in each of said counties, towns, cities or villages, by a majority of the voters qualified to vote and voting upon the proposition therefor, may jointly acquire real property by purchase, lease or condemnation for the purpose of this article and establish, construct, equip, maintain and operate for such municipalities jointly in accordance with the provisions of this article, a public general hospital for the care and treatment of the sick, and by appropriate resolution and subject to like approval by the voters as provided in this section, any two cities, towns or villages as above specified, may be appropriate action of the governing board, create a joint hospital for such cities, towns or villages as above specified of any existing hospital, established, constructed, equipped and operating by one of such cities, towns or villages and enlarge or add thereto.

The ordinance or resolution providing for such joint action, either in the establishment of a new joint hospital or the creation of a joint hospital or addition thereto, of one already existing by one of such cities, towns, and villages, shall be adopted by the local governing board of a city, town or village of each municipality and the board of trustees as specified in section one hundred twenty-seven hereof shall be composed of members appointed by the supervisor of the town, the mayor of the city, or the president of board of trustees of the village of each of said cities, towns or villages in proportion to the ratio of the assessed value of each of the cities, towns, or villages to the other. The ordinance or resolution may specify matters as to which the action of the board of trustees shall require the joint approval of such governing bodies or boards. The ordinance or resolution also shall prescribe the proportions of the cost of such project to be borne by the municipalities respectively, based upon the ratio of the assessed value of each city, town or village to the whole. In a town, wholly or partly containing a village or villages joining with it for the purposes of this section, the proportion of the cost of such project to be borne by such town may, however, be based upon the ratio that the assessed valuation of such town outside such village or villages bears to the whole. The moneys to be paid shall be provided in the same manner as hereinbefore prescribed in this article. The ordinance or resolution of the governing board may be amended from time to time with the concurrence of each of such governing board of each of said cities, towns or villages. A joint hospital established under this article, shall be within the county in which the city, town or village, or one of them is located.

Whenever two or more cities, towns or villages shall establish a joint hospital as herein provided, all other provisions of this article respecting hospital, if applicable, shall apply to such joint hospital.

Two or more cities, towns or villages as hereinbefore specified, may under the provisions of this article by appropriate resolution of the respective boards of said city, town, or village, and subject to like approval by the voters as provided in this section, provide for the joint operation and management only of an already existing hospital in one of such cities, towns or villages.

Section 127. Appointment and terms of office of managers.

1. Except as provided in subdivision two, when a governing board of a county, town, city or village shall have determined to establish a public general hospital for the care and treatment of the sick, the board of supervisors of the county, the supervisor of the town, the mayor of the city or the president of the board of trustees of the village shall appoint not less than five and not more than fifteen citizens of the county, town, city or village, respectively, who shall constitute a board of managers of the said hospital. The term of office of each member of said board shall be five years, and the term of one of such managers shall expire annually; the first appointments, however, being made for the respective terms of five, four, three, two and one years. Appointments of successors shall be for the full term of five years, except that the appointment of a person to fill a vacancy occurring by death, resignation or cause other than the expiration of a term shall be made for the unexpired term.

2. When the board of supervisors of any county having a population of more than six hundred thousand but less than one million shall have determined to establish a public general hospital for the care and treatment of the sick, the board of supervisors of such county shall appoint seven citizens of the county who shall constitute a board of managers of such hospital. The members of such board first appointed shall be appointed for terms of office as follows: one for a term of one year, two for terms of two years each, one for a term of three years, two for terms of four years each, and one for a term of five years. Their successors shall be appointed for terms of five years each. Vacancies occurring by death, resignation or cause other than the expiration of a term shall be made for the remainder of the unexpired term.

3. Failure of any manager to attend three consecutive meetings of the board shall cause a vacancy in his office, unless said absence is excused by formal action of the board of managers. The managers shall receive no compensation for their services, but shall be allowed their actual and necessary traveling and other expenses, to be audited by the governing board, and paid in the same manner as the other expenses of the hospital. Any manager may be removed from office at any time by the appointing authority after having received notice in writing of the cause of the proposed removal and after an opportunity to be heard thereon. Unless a treasurer for the hospital is appointed as herein provided the treasurer of the county, town, city or village by which the hospital is maintained shall be treasurer of the hospital.

Section 128. General powers and duties of managers.

The board of managers shall:

1. Elect from among its members annually a president, a vice-president, and a secretary. It shall appoint a superintendent of the hospital, who shall not be a member of the board of managers, and who shall hold office at the pleasure of said board.

2. Erect all necessary buildings; make all necessary improvements and repairs and alter any existing buildings, for the use of said hospital, provided that all expenditures for new buildings or alterations, other than ordinary repairs, shall first be authorized by the governing board of the county, town, city or village and the plans therefor approved by the state board of charities.

3. Fix the salary of the superintendent and the number and salaries of all other employees, within the limits of the appropriation made therefor by the governing board, and such salaries, together with maintenance when provided, shall be compensation in full for all services rendered. The board of managers may determine the amount of time required to be spent at the hospital by said superintendent in the discharge of his duties, and may also determine in what cases maintenance shall be provided for nurses and other employees of the hospital.

4. Provide for the medical care and treatment of all persons admitted to the hospital; and shall appoint and may at pleasure remove resident, visiting and consulting physicians and surgeons; and shall establish rules and regulations governing the service thereof.

5. Have the general superintendence, management and control of the said hospital and of the grounds, buildings, officers, employees and inmates thereof; and of all matters relating to the government, discipline, contracts and fiscal concerns thereof; and make such rules and regulations as may seem to them necessary for carrying into effect the purposes of such hospital; and may designate the purchasing agent of any municipality as the purchasing agent of said board for the purchasing of all necessary furniture, appliances, fixtures and other needed facilities for the care and treatment of patients and for the use of officers and employees thereof, and all necessary supplies, and said purchasing agent shall render a monthly report of his activities to said board.

6. Maintain an effective inspection of said hospital, and keep itself informed of the affairs and management thereof; shall meet at the hospital at least once in every month, and at such other times as may be prescribed in the by-laws; and shall hold its annual meeting at least three weeks prior to the meeting of the governing board at which appropriations for the ensuing year are to be considered.

7. Keep in a book provided for that purpose a proper record of its proceedings, which shall be open at all times to the inspection of its members, of the members of the governing board and of duly authorized representatives of the state board of charities.

8. Certify all bills and accounts, including salaries and wages, and transmit them to the governing board, who shall provide for their

payment in the same manner as other charges against the county, town, city or village. The board of supervisors of a county not having a purchasing agent or auditing commission may make an appropriation for the maintenance of such hospital and direct the county treasurer to pay all bills, accounts, salaries and wages, which are approved by the board of managers, within the amount of such appropriation, subject to such regulations as to the payment and audit thereof as the board of supervisors may deem proper. When authorized by resolution of the governing board the board of managers may appoint a treasurer in the manner provided in subdivision four of section one hundred twenty-six. The treasurer shall pay the bills and accounts, including salaries and wages, approved by resolution of the board of managers and at least once each month shall transmit to the governing board an itemized statement thereof.

9. Make to the governing board of the county, town, city or village by which the hospital is maintained, at such times as said board shall direct, a detailed annual report of the operations of the hospital, the number of patients received, the methods and results of their treatment, and such other matters as may be required of them. Such reports shall include full and detailed estimates of the appropriations required during the ensuing year for all purposes, including maintenance, erection of buildings, repairs, improvements and other necessary purposes.

Section 129. General powers and duties of superintendent.

The superintendent shall be the chief executive officer of the hospital and, subject to the by-laws, rules and regulations thereof, and to the general control of the board of managers, shall:

1. Equip the hospital with all necessary furniture, appliances, fixtures and other needed facilities for the care and treatment of patients and for the use of officers and employees thereof, and purchase all necessary supplies, unless the board of managers shall designate the purchasing agent of a municipality as the purchasing agent of said board as provided in subdivision five of section one hundred twenty-eight.

2. Have general supervision and control of the records, accounts, and buildings of the hospital and all internal affairs, and maintain discipline therein, and enforce compliance with, and obedience to, all rules, by-laws, and regulations adopted by the board of managers for the government, discipline and management of said hospital, and the employees and inmates thereof. He shall make and enforce such further rules, regulations and orders as he may deem necessary, not inconsistent with law, or with the rules, regulations and directions of the board of managers.

3. Appoint such employees as he may think proper and necessary for the efficient performance of the business of the hospital, and prescribe their duties; and for cause stated in writing, after an opportunity to be heard, discharge any such employee at his discretion.

4. Cause proper accounts and records of the business and operations of the hospital to be kept regularly from day to day, in books and on forms provided for that purpose; and see that such accounts and records are correctly made up for the annual report to the governing board, as required by subdivision seven of section one hundred and twenty-eight of

this chapter, and present the same to the board of managers, who shall incorporate them in their annual report to the said governing board.

5. Receive into the hospital, under the rules established by the board of managers, any person in the county, town, city or village who is sick or mained or injured and who is in need of hospital care, irrespective of whether such person is able to pay for his care or not; and may also receive persons from without the county, town, city or village, provided there is a vacancy in the hospital, and provided the reception of such person does not interfere with the proper care and treatment of persons received from the county, town, city, or village.

6. Cause to be kept proper records of the admission of all patients, their name, age, sex, color, marital condition, residence, occupation, place of last employment and the names and addresses of their nearest relatives or friends. He shall also cause a careful examination to be made of the physical condition of all persons admitted to the hospital; and shall cause a record to be kept of the condition of each patient when admitted, and from time to time thereafter.

7. Discharge from said hospital any patient who is found to have recovered from his illness sufficiently to be no longer in need of hospital care, or who shall wilfully or habitually violate the rules thereof, or who for any other reason is no longer a suitable patient for treatment therein; and shall make a full report thereof at the next meeting of the board of managers.

8. Collect and receive all money due the hospital, keep an accurate account of the same, report the same at the ensuing monthly meeting of the board of managers, and transmit the same within ten days after such meeting to the treasurer of the county, town, city or village by which the hospital is maintained. When a treasurer has been appointed as herein provided, all moneys collected and received by the superintendent shall be transmitted to the treasurer who shall deposit the same in a bank or banks in the name of the hospital and he shall also at least once in each month transmit to the governing board an itemized statement thereof.

8-a. Establish and maintain, out of any moneys received by him, a fund, not to exceed two hundred dollars at any time, as a revolving petty cash fund for the payment of small emergency debts and to account to the board of managers at each monthly meeting for all expenditures made during the preceding month from such fund.

9. Give a bond before entering upon the discharge of his duties, in such sum as the board of managers may determine, to secure the faithful performance of such duties.

10. To accept and hold in trust for the county, town, city or village of which it is the governing board, any grant or devise of land, or any gift or bequest of money or other personal property, and to apply the principal or income, or both, for the benefit of said hospital, in accordance with the terms of the gift.

Section 130. Admission and maintenance of patients.

Whenever a patient shall have been admitted to such hospital, the superintendent shall cause to be made such inquiry as he may deem necessary, relative to the ability of such patient, or of the relatives of

such patient legally liable for his support, to pay for his care and treatment. If he finds that such patient, or said relatives, are able to pay for his care and treatment in whole or in part, an order shall be made by the superintendent directing such patient, or said relatives, to pay to the treasurer of such hospital for the support of such patient a specified sum per week, in proportion to their financial ability, but such sum shall not exceed the actual cost of maintenance. The superintendent shall have the same power and authority to collect such sums from the patient, or his relatives legally liable for his support, as is possessed by an overseer of the poor in like circumstances. If the superintendent finds that such patient, or his said relatives, are not able to pay, either in whole or in part, for his care and treatment in such hospital, the unpaid cost of his maintenance shall become a charge upon the county, town, city or village by which the hospital is maintained; provided, however, that in case such patient is not a resident of said county, town, city or village, the cost of his maintenance shall be a charge upon the civil division of the state upon which he would be a charge as a poor person. No employee of such hospital shall accept from any patient thereof any fee, payment or gratuity whatsoever for his service.

Section 131. Training school for nurses.

Subject to the provisions of the education law the board of managers of any hospital under this article may establish and maintain in connection therewith and as a part of the public hospital a school of nursing. The board may, in its discretion, appoint an advisory board for such training school and define the functions of such advisory board.

Section 132. Room for detention and examination of persons who are suspected of being insane.

The board of managers may provide a suitable room for the temporary detention, observation and care of persons who are suspected of being insane and shall do so upon the direction of the governing board or of the department of mental hygiene; provided, however, that such department before making such direction shall give to both the board of managers and the governing board due notice and opportunity to be heard thereon.

Section 133. Visitation and inspection.

Members of the board of managers shall be admitted to every part of the hospital and premises, and shall have access to all books, papers, accounts and records pertaining to the hospital and shall be furnished with copies, abstracts and reports whenever required by them. All hospitals established or maintained under the provisions of sections one hundred and twenty-six, one hundred and twenty-seven, one hundred twenty-eight, one hundred and twenty-nine, one hundred and thirty, one hundred and thirty-one, one hundred and thirty-two, one hundred and thirty-three, and one hundred and thirty-four of this act shall be subject to inspection by any duly authorized representative of the state board of charities, of the state department of health, of the state charities aid association, and of the governing board of the county, town, city or village by which the hospital is maintained; and the resident officer in charge shall admit such representatives into every part of the hospital and premises, and give them access on demand to all records, reports, books, papers and accounts pertaining to the hospital.

SOCIAL WELFARE LAW

Section 21. Visitation, inspection and supervision.

The board (Social Welfare) . . .

3. shall establish and may alter and amend rules concerning records, buildings, and equipment and standards of care which shall apply in the care of destitute, delinquent, abandoned, neglected or dependent children; in the operation of any hospital, infirmary, dispensary, clinic, or home, or institution for convalescent, invalid, aged or indigent persons, or lying-in asylum where women may be received, cared for or treated during pregnancy or during or after delivery, and in the placing-out or boarding-out of children.

Section 22. Information to be sought on visits or inspections.

Upon visitation or inspection of any institution under this article, inquiry may be made to ascertain:

1. Whether the objects of the institution are being accomplished.

2. Whether the laws and the rules of the board and regulations of the department, applicable to it, are fully complied with.

3. Its methods of and equipment for industrial and scholastic education and for moral training, and whether the same are best adapted to the needs of its inmates or beneficiaries.

4. Its methods of government and discipline of its inmates or beneficiaries.

5. The qualification and general conduct of its officers and employees.

6. The condition of its grounds, buildings and other property.

7. The sources of public moneys received by any institution in receipt of public funds and the management and condition of its finances generally.

8. Any other matter connected with or pertaining to its usefulness and good management or to the interests of its inmates or beneficiaries.

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Effective Local Units for Health Service in New York State

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The problem of providing local health services in the United States has received much attention from time to time and has recently been emphasized anew by the appearance in 1945 of the Commonwealth Fund publication LOCAL HEALTH UNITS FOR THE NATION, prepared by Dr. Haven Emerson as Chairman of the Sub-committee tee on Administrative Practice of the on Local Health Units of the Commit- American Public Health Association.

Public health workers in Massachusetts have not overlooked the need of extending adequate health services of high standard so that all areas and all persons are reached. But such a program is not put into operation quickly without preliminary organization, planning, and state-wide education.

Accordingly, the MASSACHUSETTS HEALTH JOURNAL has published articles which would interest its readers in the subject of local health services. This address, given by Dr. Van Volkenburgh at the Annual Conference of Health Officers and Public Health Nurses of New York on June 25, 1946, describes the problems encountered in providing local health services in New York State and urges the establishment of county health departments with state financial assistance as the only alternative to the assumption by the state of additional responsibility for and control of local health services.

DURING the past years, much has been said and a great deal written as to what constitutes an efficient, economical unit of government to provide basic local public health services. A brief review of the past indicates that this subject has been a part of and frequently emphasized at the Annual Conferences of Health Officers and Public Health Nurses of New York State in addresses by New York State Governors, State Health Commissioners, Presidents of the State Medical Society, and outstanding public health leaders.

Health publications are replete with articles in which local health services are discussed, and of special interest is the volume *Public Health in New York State* published in 1932, representing the report of a Special Health Commission charged with the duty of making a comprehensive survey of the entire subject of public health as a governmental function both state and local.

In reviewing these many sources one is impressed with the almost complete unanimity of professional opinion endorsing the county as the most practical, efficient, and economical unit of government to provide basic local public health services.

In view of this weight of informed and impersonal opinion, it might well be asked what is the need to discuss the subject further. The question is, of course, rhetorical since we all are aware that only six* of New York State's fifty-seven counties† are organized as county departments of health. For this and other reasons it would seem worth while to explore briefly the situation as it exists today.

Perhaps by examining the problem together it may be possible to bring to light some of the factors which have caused New York State to run counter to trends in other states as well as to the collective opinion of national and state medical societies and of specialists in public administration. As a result of our probing, perhaps it may be possible to venture a fair opinion, after having examined the facts and made up one's mind, as to whether basic local health services should continue to be provided under existing conditions in which the State has progressively taken over more and more the responsibility for direct local health services, or whether these obligations should be cared for by a suitable local unit of government in which the personnel are adequate in number, have no conflicting obligations, and possess the knowledge and ability to do the work adequately.

Analysis of Existing Facilities

To analyze the problem, certain fundamental facts are necessary. The answers to the following questions should provide most of them; namely, what does the job consist of; what personnel are now available to do the job; what type of local health organization is provided; how well is the work being done.

What Constitutes Present Health Services?

Let us first consider the job. In New York State, public health activities of a primary nature comprise at present: (1) the discovery, investigation, and control of communicable diseases, including tu-

*Dr. Van Volkenburgh has held many important positions. He was Special Staff Member of the International Health Division of the Rockefeller Foundation; Epidemiologist for the John J. Abel Fund for Research on Upper Respiratory Diseases; Assistant Physician at the Johns Hopkins Hospital; Research Associate and Associate at Johns Hopkins University; and District Health Officer, New York State Department of Health.

*Since giving this address, four additional counties have established county health departments.

†The five counties comprising greater New York City are excluded.

berculosis and syphilis; (2) the hygiene of maternity and infancy and the promotion of the health of children of preschool age; (3) the discovery of physically handicapped children and alleviation of their condition; and (4) the discovery and control of cancer.

Activities which are mainly supportive, but equally important, include health education of the general public; pre-service and in-service training of public health personnel; public health laboratory services; the compilation, interpretation, and use of vital statistics data; environmental sanitation including milk, milk products, public eating places and summer camps and hotels; instruction in nutrition; dental hygiene and dental corrective services; various diagnostic and immunization clinics; research; local and state tuberculosis sanatorium care; state-aided county general hospital services, and state cancer and orthopedic hospital care. More recent arrivals receiving public health attention include accident prevention, blood bank services, and mental hygiene clinics undertaken in cooperation with the Department of Mental Hygiene. Looming on the horizon are rheumatic heart disease, cerebral palsy, and the degenerative diseases.

This is a formidable list, yet it is not complete. It represents most of the activities in effect today provided through state and local public health units, although their provision is not uniform throughout the State. It represents activities which reflect the application of the ever-increasing newer discoveries in the field of preventive medicine. It represents services expected by the public. It is, in short, an attempt to apply to the business of being born, of growing up, and of growing old the best health services which human wisdom now makes possible.

When we ask ourselves, therefore, what unit of local organization is best adapted to present-day needs, it is essential that we consider the health service not as an organization concerned with the control of the ordinary communicable diseases and rudimentary sanitation problems, but as an organization whose prime concern is to bring to the people of the State the latest and best available methods of health conservation.

V. A. VAN VOLKENBURGH, M.D.

Present Staff Inadequate

The staff now employed at state and/or local levels to service the foregoing public health program represent numerous specialties. To mention a few: There are health officers, both full time and part time; sanitary engineers; sanitary inspectors; milk sanitarians; public health nurses; dental hygienists; dentists; health educators; bacteriologists; pathologists; nutritionists; tuberculosis specialists; radiologists; orthopedists; physical therapeutists; syphilologists; pediatricians, etc. The employment of the various types of personnel is dependent on the need of the particular health projects provided. They should be supplied in an amount no greater than is necessary to meet adequately the local need.

As a matter of fact, health conservation services reach but a fraction of the public since the staff now employed at the various governmental levels is insufficient to meet known needs. For example, the minimum number of public health nurses necessary for basic public health services is at least one per 5,000 population. Using this standard, there should be employed in the State, exclusive of New York City, at least 1,250 such nurses. As of recent date, the total number of these positions for which appropriation had been made by city, county, township, village, and consolidated health districts totaled 734. Obviously, in this most important and basic service position, considerable is lacking.

Services at Various Governmental Levels—

At this point it would seem advisable to examine the administrative facilities limiting our consideration to counties not having a county health department and excluding cities of 50,000 population or more. Just how are these multiple services and the various types of service personnel both official and unofficial coordinated? Where does leadership originate, who determines public health needs, provides technical and administrative direction, assesses quality and quantity of the work, provides stimulation, guidance and disciplinary control? In short, what makes this public service taken as a whole "click?"

—(1) By Local Boards of Health

Perhaps if we examine a specimen county, it may be possible to visualize the situation. In such a county there is a sizable number of part-time local health officers employed by the local boards of health of the individual townships, villages, consolidated health districts, and small cities. A public

health nurse may similarly be employed by the more populous local health districts. All do their best to discharge their duties but of necessity act independently of each other because their authority and, therefore, their interest is limited by the boundaries of their specific health jurisdiction.

Although the part-time health officer has had rudimentary training in civilian public health practice, it cannot be expected nor should it be necessary that he have the qualifications or provide the services of the specialists in public health practice. It would be impossible for him independently to place in effect the broad plan of a general public health program limited as he is, in all but a few instances, by the small population served and consequently by the funds available. Moreover, since only a small fraction of specialized services is necessary for these small population health jurisdictions, it would be impractical if not impossible to make them available on an independent basis.

Considered collectively, these part-time health officers, sometimes referred to as the general practitioners of public health, serve a very useful purpose. They are close to the people in their jurisdiction, frequently sense needs and discover health hazards, enforce control measures for the ordinary communicable diseases, and place in effect rudimentary environmental sanitation measures. Some perform duties far in excess of that which the community could reasonably require of them for the small compensation they receive. There are others, however, whose work is negligible.

—(2) Other Local Services

In addition to these health officers and nurses serving multiple units of small population, we find a number of school medical inspectors and school nurses employed by individual school boards on a school district basis. They are not concerned with other health problems in the home nor is there much effective coordination between them and other public health agencies.

There also exist small municipal water plants and pasteurizing plants serving limited areas.

Public Health Nurse
Demonstrates Baby's Bath

—(3) Official Services at County Level

Pyramiding these independent "grass-root" services, we find employed by the county board of supervisors a variable but usually insufficient number of public health nurses. County funds are also made available for a limited amount of clinic services, mainly for venereal disease, child health, and dental hygiene. Local supervision is provided by a county public health committee meeting for a few hours once every two months. It can hardly be expected that such a committee could alone provide the necessary technical and administrative direction or coordination required for the day-to-day functioning of a service of this type.

Existing independently of other local health services is a county public health laboratory under the direction of a board of managers appointed by the board of supervisors. Similarly, there may be a county tuberculosis sanatorium with its own separate board of managers, a few employing a tuberculosis visiting nurse. Other health agencies having some official status are the County Nutrition Committee, the County Health Preparedness Committee, etc.

—(4) County Voluntary Agencies

The unofficial county health organizations are also active, have separate committees, and some employ full-time workers. Such agencies are the Tuberculosis and Public Health Committee, the Red Cross, the Foundation for Infantile Paralysis, and the Women's Field Army. Many local organizations of a broad nature include health conservation among their primary aims. Examples are the 4-H Club, Home Bureau, Rural Policy Committee, Community Council, various service clubs, the Federation of Women's Clubs, etc.

Coordination Lacking Where County Health Department Is Lacking

To summarize the situation existing in a typical New York State county lacking a county health department, it is apparent that local health services are provided through a multiplicity of agencies of limited capacity with an overlapping of effort, each acting independently and at times in conflict with one another. Administratively, there is no systematic plan of development of the work in the county as a whole. There is no local director to head up such a program and, therefore, no provision for unity of direction or proper coordination of activities, and no adequate machinery for efficient utilization of the services already existing or the development of needed services.

State Department Has Helped—

That complete chaos does not exist in such counties is largely due to services provided by State Department of Health personnel, its district health officers, sanitary engineers, milk sanitarians, supervising nurses and orthopedic nurses, as well as its central office staff of consultants in specialty fields. In order to knit together the unorganized local health facilities and to provide direct services which are beyond the limitation of local personnel in the expanding field of public health practice, it has been necessary for the State to take over responsibilities which cannot be cared for locally.

—(1) Guidance and Technical Advice

I refer to the guidance and technical advice, on a voluntary basis, given by State personnel to county public health committees and the various other official and unofficial agencies. The purpose has been to assist in determining the health needs of the county; in laying plans to meet those needs, including coordination of all health agencies; in obtaining local funds or State services to secure the necessary specialized personnel and equipment to service the program, and in organizing the work to obtain the best degree of efficiency.

—(2) Assumption of Some Local Responsibility

I refer to the State's assumption of local responsibility for tuberculosis, venereal disease, and cancer control work, including the following up of cases and contacts, because of lack of proper local organization. I refer to the inspection and permitting of farm labor camps, children's camps, summer camps and hotels, and pasteurizing plants.

—(3) Other Work

I refer to the personal epidemiological investigation of communicable disease outbreaks by State personnel, to the immediate supervision of public health nurses lacking local supervisory facilities, and to the many supportive actions provided part-time local health officers. These are all duties which a full-time, capable county health department staff should handle. The State representatives should not be expected to function in this fashion.

The Road Ahead

Counties Have Not Organized Health Departments

The reluctance of New York State counties to employ a full-time health officer trained in the specialty of public health and to develop their own adequate modern health conservation service is said to be somewhat of a puzzle to professors of public health administration. Since 1921 when legislation was first enacted to permit formation of county health districts, only six counties have elected to do so, the last being Nassau County in 1938.* Despite concerted but admittedly sporadic drives to influence counties to accept their own responsibilities, the result has been obviously negligible.

What are some of the reasons for this negative response? Do they exist now? It was at the suggestion of Governor Dewey that thought was given recently toward removing any legislative handicaps that might exist and providing additional financial inducements to counties to establish county health departments.

Local Boards of Health May Continue

One of the handicaps has been the requirement for abolishing local health districts of towns and villages of less than 3,000 population when the county establishes a county health department. This requirement has been stricken out in the new law, effective January 1, 1947. The matter is left to the discretion of *all* local governing authorities as to whether or not the boards of health shall continue to exist and employ a local health officer. If continued, his salary and expenses under the law would be met by the municipality, not the county.

It has already been shown that most part-time local health officers serve a useful purpose. It is believed they should be of material, although necessarily limited, assistance to a county health officer. Retention should also serve to maintain local interests. The continuance of local boards of health would similarly strengthen such interests since the boards may continue to enact local health regulations not inconsistent with the county and state sanitary codes. Home rule is further preserved by legal requirements as to the membership of the county board of health. *All* cities are entitled to a representative on such a board. Towns and villages may be represented through the physician and supervisor appointees.

Large Cities Need Not Be In County Health Department

In some instances failure to form a county health department has been due to the unwillingness of the supervisors of a dominant city to support such a measure even though it did not include the city and did not affect its taxes. A provision in the new law relating to part-county districts authorizes petitioning the county board of supervisors by the supervisors of the area lying *outside* of cities of 50,000 or more to form a part-county unit. If not granted by the board of supervisors acting as a whole within a reasonable time, State aid for such cities may be jeopardized.

*There are now ten counties.

Conversely, opposition has come from supervisors outside of such large cities who were opposed to an organization which included the city. Some cities provide in their health budgets for services for which the remainder of the county might have little use and it was felt the latter should not be expected to share the expense. In the amended law, the area outside of the cities of 50,000 or more now can vote to exclude cities from the county health district, if this is their determination.

It is recommended, however, that, where expedient, cities of 50,000 population or more be a part of the county health district. Administratively, this is sound, will provide a unified service, and avoid conflicts and overlapping of functions. Moreover, population statistics show that, with few exceptions, from 50 to 80 per cent of the population living outside of cities having a population of 50,000 or more reside within ten miles of such a city. In Schenectady County the percentage is 95.5. Although residing outside of the city, most of these people shop, work, and obtain much of their recreation within the city. They are as much a part of the city population as those dwelling within the city boundary.

State Aid Increased

Some counties of a mercenary turn of mind and failing to see that conservation of health would save the county money expended for care of the indigent may have felt that State aid provisions were niggardly. The amended law increases the amount of State aid for county and part-county health departments to 75 per cent on the first $100,000 expended for general public health work. Expenditures above $100,000 are reimbursable on a 50 per cent basis. Considering each of the fifty-six counties as a whole, inclusive of all cities, calculations show that the cost* of establishing and operating a very efficient county health department for general public health services would be less than $100,000 in thirty-three counties. In seven, it would range from a little over $100,000 to $125,000. In six it would range from over $125,000 to $200,000, and would amount to over $200,000 in the remaining ten, seven of which are counties containing a city or cities of more than 50,000 population. The cost on a per capita basis, using the average of the cost of all 56** counties, is only $1.52 per annum. In a county expending $100,000, the *local* per capita tax cost under state aid would amount to 38c per annum. *There would seem to be no question of the ability of counties to afford such a health service under the new state aid provisions.*

State Forced to Assume Some Local Services

Another deterrent to county health department formation is said to be a fear of State domination. In this connection it should be remembered that by law the State Commissioner of Health is charged with the enforcement of the public health law and the sanitary code, is responsible for the security of life or health and the preservation and improvement of public health in the State, and must exercise general supervision over the work of all local health authorities.

I have already shown that failure on the part of counties to provide adequately for a modern health

*Excludes public health laboratory service, tuberculosis hospitalization and medical rehabilitation hospital, clinic and appliance costs for which separate state aid provision is made. Also: industrial hygiene services, mental hygiene clinics and hospitalization, and school health service in all but a few small population counties wherein it might seem desirable for the school board to contract with the health department for such services; these services are the responsibility of other governmental agencies in New York State.

**Hamilton County because of its small population (3,433) has been omitted from the calculations.

Immunization Clinics discussed by health officer and public health nurse.

conservation program has forced the State to take over many of the local health services which should be provided by an adequate county health department service. Because of this fact, it was necessary over the years for the State department to augment its field staff and to increase the number of State health districts to twenty until each such district comprises no more than two to four counties each. In effect, there exists today in the State twenty multiple-county health departments in which State personnel hold the key positions and are directed in their work by the State.

To me this represents State control of local health services. It has come about because counties have failed to organize an efficient, adequate, up-to-date health conservation program under the direction of a qualified full-time staff. If State domination is not desired, then the alternative is establishment of a local county health department.

Adequate Service Should Be Provided Locally

As stated previously, it is not the policy of the present State administration to provide basic local health services through a state agency. Such State services would be contrary to the concept of home rule and is the reason behind recent amendments to the public health law. To conform with this policy, adequate health services should be provided locally, utilizing the county or large city as a base, each having been accepted by public health administrators as efficient and economical units of government to provide basic local health services.

State Ready to Assist

The State is ready to do its part. Qualifications for public health personnel already exist and minimum standards have been issued to guide the district state health officers in helping local authorities prepare statements of required personnel, scope of work, and costs for each of the counties. It is hoped that suitable counties, mainly those of limited population, may consider establishing a state-aided county general hospital which will also house the county health department and county laboratory. Plans have also been made to divide the State into six supervisory state health regions and, as county health departments are established, the existing smaller state health districts would correspondingly be decreased in number. The duties of the staff of the regional state offices, as stated by Dr. E. S. Godfrey, Jr., State Commissioner of Health, "will be advisory and observational; to assist in local planning; to note deficiencies and exceptional accomplishments; to visit the central office frequently and keep it in touch with conditions in the field, and keep the field in close touch with the State health department's objectives." The multiple direct health services now provided most counties through the district state offices would be discontinued and become the function of the county health department.

Conclusion

It would seem apparent that a fork in the road had been reached. If the branch road is taken, local communities would assume their responsibility for providing adequate and modern health conservation services through establishment of a county health department with state financial assistance. If the present road is followed, the State would be required to absorb additional local responsibility, increase its staff, and more than double the number of its present district offices to provide equivalent local health services. The choice of the road should be of immediate concern to the affected localities. The decision cannot be delayed much longer if the people of the State are to receive the type of health conservation services they have every right to expect.

Appendix C-1

Form Adm. 22

NEW YORK STATE DEPARTMENT OF HEALTH
ALBANY, N. Y.

Edward S. Godfrey, Jr., M. D.
Commissioner

Official Notice to Boards of Supervisors

Applications for State Aid for Public Health Purposes

Notice is hereby given that pursuant to the provisions of Article 2-B of the Public Health Law, I will consider applications for grants of state aid for the year 19 for the following purposes:

1. COUNTY HEALTH DEPARTMENTS *

Seventy-five per centum of the first one hundred thousand dollars and fifty per centum of amounts in excess of one hundred thousand dollars of the cost of establishing and operating county departments of health.

2. COUNTIES NOT ORGANIZED AS COUNTY HEALTH DEPARTMENTS

Fifty per centum of the salaries and expenses of public health nurses, dentists, dental hygienists, physicians, milk inspectors and sanitary inspectors.

Fifty per centum of the cost of establishing and operating clinics for maternity and child hygiene, venereal diseases, dental hygiene, tuberculosis, preventive inoculations, etc.

3. MENTAL HYGIENE CLINICS

Subject to the joint approval of the commissioner of mental hygiene, reimbursement in accordance with Item 1 above for the cost of establishing and operating mental hygiene clinics as a part of the budget of a county health department.

4. COUNTY GENERAL HOSPITALS **

(a) Fifty per centum of the cost of construction, and/or fifty per centum of the operating deficit for maintaining and operating county general hospitals, subject to the following conditions:

1. The county shall have had a population of less than fifty thousand at the last federal census.

2. The county shall have a demonstrable need for additional or improved hospital services.

3. The county shall have established a county health department which shall include the total area of the county.

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* Effective January 1, 1947.

Fifty per centum reimbursement allowable during 1946 inclusive of the cost of operating expenses of county tuberculosis sanatoria receiving state aid for this purpose during the county fiscal year 1945-1946.

** Copies of Rules established by the State Health Commissioner governing State-aided County General Hospitals may be obtained from the State Department of Health.

(OVER)

4. The plans for a county general hospital to be constructed, established or maintained shall be approved by the state commissioner of health and shall provide suitable quarters and facilities within the hospital for the county health department staff and for the efficient performance of its services.

5. Provision shall be made for the proper coordination of the services of the hospital and the county health department.

(b) Fifty per centum of the operating deficit for maintaining and operating county general hospital facilities for which state aid was paid during the county fiscal year 1945-1946.

5. ADULT POLIOMYELITIS: Remedial Care

Fifty per centum of the cost of remedial care and treatment (including hospitalization, surgery, and appliances) of poliomyelitis or its aftereffects in persons twenty-one years of age and over for whom such care cannot otherwise be provided. Such care must be authorized by the local health officer and approved by an authorized representative of the State Department of Health. Individual applications must be submitted for each case.

6. OTHER COUNTY PUBLIC HEALTH PROGRAMS

Other county public health programs may be submitted for consideration, the decision as to approval depending on the merits of the individual proposal.

Where services are rendered by health agencies to children of school age, such services must be made available to all children irrespective of the schools they attend.

It will be necessary in making applications for state aid to supply a detailed budget of proposed expenditures, indicating not only titles for personnel but the subdivisions of the department to which they are attached. The initial application must be accompanied by a narrative statement of the functions of the various subdivisions of the department. The narrative statement in subsequent years should explain all major proposed changes in the budget but so far as functions of the department are concerned, it need indicate only changes from the original descriptive statement which accompanied the initial application.

The applications for state aid for 19 must be received at the office of the State Department of Health on or before the first day of December 19 .

Dated:

Edward S. Godfrey, Jr.

Commissioner

NEW YORK STATE
RULES FOR STATE-AIDED COUNTY GENERAL HOSPITALS
(in effect as of July 1, 1946)

Pursuant to the provisions of Article II-B of the Public Health Law, the following rules are promulgated for the operation of county general hospitals established under Article 6 of the General Municipal Law when such hospitals are receiving State aid:

1. The hospital shall be operated and maintained in accordance with the provisions of law (the important provisions of law which are applicable to county general hospitals are listed in the attached sheet).

2. The professional standards in the hospital shall meet the minimum requirements established by the American College of Surgeons for an approved hospital. (Copy of these rules is appended.)

3. There shall be a medical staff to which all registered physicians residing in the county shall be eligible for membership.

4. Under regulations of the board of managers approved by the state commissioner of health the medical staff from their own number shall nominate for election by the board of managers a medical board of not less than five members.

5. The medical board, subject to the approval of the board of managers and the state commissioner of health shall:

   a) prepare rules and regulations for the conduct of the professional work of the hospital,

   b) formulate whatever by-laws it deems necessary for the efficient conduct of the business of the staff and the medical board.,

   c) recommend appointment for the surgical, medical, special and nursing services of the hospital,

   d) supervise and control all of the professional service of the hospital.

STANDARDS FOR APPROVAL BY THE AMERICAN COLLEGE OF SURGEONS

Minimum Standard for Hospitals

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite medical staff. Such organization has nothing to do with the question as to whether the hospital is open or closed, nor need it affect the various existing types of medical staff organization. The word staff is here defined as the group of doctors who practice in the hospital inclusive of all groups, such as the active medical staff, the associate medical staff, and the courtesy medical staff.

2. That membership upon the medical staff be restricted to physicians and surgeons who are a) graduates of medicine of approved medical schools, with the degree of Doctor of Medicine, in good standing, and legally licensed to practice in their respective states or provinces; b) competent in their respective fields; and c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatsoever, be prohibited.

3. That the medical staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations , and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide a) that medical staff meetings be held at least once each month; b) that the medical staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and the other specialties; the medical records of patients, free and pay, to be the basis for such review and analysis.

4. That accurate and complete medical records be written for all patients and filed in an accessible manner in the hospital, a complete medical record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, x-ray, and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and miscroscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up; and, in case of death, autopsy findings.

5. That diagnostic and therapeutic facilities under competent medical supervision be available for the study, diagnosis, and treatment of patients, these to include at least a) a clinical laboratory providing chemical, bacteriological, serological, and pathological services; b) an x-ray department providing radiographic and fluoroscopic services.

Fundamental Principles

1. A modern physical plant, free from hazards and properly equipped for the comfort and scientific care of the patient.

2. Clearly stated constitution, by-laws, rules and regulations setting forth organization, duties, responsibilities, and relations.

3. A carefully selected governing board having complete and supreme authority for the management of the institution.

4. A competent, well trained executive officer or administrator with authority and responsibility to carry out the policies of the institution as authorized by the governing board.

5. An adequate number of efficient personnel, properly organized and under competent supervision.

6. An organized medical staff of ethical, competent physicians for the efficient care of the patients and for carrying out the professional policies of the hospital, subject to the approval of the governing board.

7. Adequate diagnostic and therapeutic facilities with efficient technical service under competent medical supervision.

8. Accurate and complete medical records, promptly written and filed in an accessible manner so as to be available for study, reference, follow-up, and research.

9. Group conferences of the administrative staff and of the medical staff to review regularly and thoroughly their respective activities in order to keep the service and the scientific work on the highest plane of efficiency.

10. A humanitarian spirit in which the best care of the patient is always the primary consideration.

REFERENCES ON HOSPITAL AND HEALTH CENTER PLANNING AND CONSTRUCTION

"Planning Suggestions and Demonstration Plans for Acute General Hospitals", by Neil F. MacDonald and Marshall Shaffer (Material prepared by the Hospital Facilities Section of the U. S. Public Health Service) published in Hospitals, July 1943.

"Planning for Integrated Service: The District Hospital", by the Hospital Facilities Section of the U. S. Public Health Service, published in Hospitals, September, 1945.

"Planning for Integrated Service: A 50-bed Rural Hospital and Health Center", by the Hospital Facilities Section of the U. S. Public Health Service, published in Hospitals, July 1945.

"Public Health Centers, Architectural Building Types Study No. 67", published in Architectural Record, July 1942.

"Hospitals, Architectural Record's Building Types Study No. 104", by the Hospital Facilities Section of the U. S. Public Health Service, published in Architectural Record, August 1945.

"Planning for Integrated Service: A Health Center Unit", by the Hospital Facilities Section of the U. S. Public Health Service, published in Hospitals, May 1945.

ABSTRACT

Public Law 725 79th Congress

FEDERAL HOSPITAL SURVEY AND CONSTRUCTION ACT
(Hill-Burton Bill S 191)

This Act is title 6 of the Public Health Service Act, Part A.

"Part A - DECLARATION OF PURPOSE

Purpose is to assist the several states --

(a) To inventory their existing hospitals.
(b) To survey the need for construction of hospitals.
(c) To develop programs for construction of such public and other non-profit hospitals.
(d) To construct public and other non-profit hospitals.

"Part B -

(1) $3,000,000, authorized to be appropriated to assist the States in carrying out PART A, and to remain available until expended.

"STATE APPLICATIONS

(a) to be approved a State application for funds for carrying out the purposes of Survey and Planning.

"(1) designate a single State agency as the sole agency for carrying out such purposes;

"(2) provide for the designation of a State advisory council;

"(3) provide for making an inventory and survey and for developing a state hospital program;

"(4) provide for submission of such reports as are required by the Surgeon General of the United States Public Health Service.

"ALLOTMENTS TO STATES

Allotment to the States for survey and planning shall be such proportion of the Federal appropriation as the States population bears to the population of the United States. Each State shall be entitled to receive 33-1/3 per cent of its expenditures subject to the limitation of the State allotment. Any funds paid to the State under this Section and not expended for the purpose for which paid shall be re-paid to the Treasury of the United States.

"Part C - CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

"AUTHORIZATION OF APPROPRIATIONS

In order to assist the States in carrying out the purpose of Hospital construction there has been authorized to be appropriated for the fiscal year ending June 30, 1947 and for each of the four succeeding fiscal years the sum of $75,000,000, for the construction of public and non-profit hospitals.

NOTE: While the Act authorized the appropriation, no actual appropriation has been made for the present fiscal year; nor can one be made until the Congress convenes.

The sums appropriated shall be used for making payments to the States which have submitted and had approved by the Surgeon General State plans for carrying out the purposes of construction and for making payments to the political subdivisions and public or other non-profit agencies in such States.

NOTE: Chapter 666 of the Laws of 1946 for New York State provides that the State of New York can accept such funds and that they shall be administered by the New York State Postwar Public Works Planning Commission or any other agency so designated by the Governor; in order to meet the Constitutional restrictions on the allocation of lump sums to non-profit agencies, the above State Law provides for the setting up of a special fund by the State Department of Taxation and Finance. This Act makes it unnecessary for the Federal Government to make payments direct to local agencies in New York State.

GENERAL REGULATIONS

Within six months after the enactment, the Surgeon General with the approval of the Federal Hospital Council and the Social Security Administration shall, by general regulation prescribe:

(a) the number of general hospital beds required to provide adequate hospital services to the people residing in the State and the general method or methods by which such beds shall be distributed among base areas, intermediate areas and rural areas.

Provided, that the total of such beds for any State shall not exceed 4.5 beds per one thousand population except in those States sparsely populated. In any areas (as defined in the regulations) within the State there are more beds than required by the standards prescribed by the Surgeon General. The excess over such standards may be eliminated in calculating this maximum allowance.

(b) The number of beds required to provide adequate hospital services for tuberculosis patients, mental patients and chronic disease patients in a State and the general method or methods by which such beds shall be distributed throughout the State.

Provided, that the total number of beds for tuberculosis patients shall not exceed 2-1/2 times the average annual deaths from tuberculosis in the State over the five year period from 1940 to 1944 inclusive, the total number of beds for mental patients shall not exceed 5. per thousand population and the total number of beds for chronic disease patients shall not exceed 2. per thousand population.

(c) The number of public health centers and general method of distribution of such centers throughout the State which for the purpose of this title shall not exceed one per thirty thousand population except in the more sparsely populated states.

(d) The general manner in which the State agency shall determine the priority of projects based on the relative need of different sections of the population and of different areas lacking adequate hospital facilities, giving special consideration to the hospitals serving rural communities and areas with relative small financial resources.

(e) General standards of construction and equipment for hospitals of different classes and in different types of location.

(f) That the State plan shall provide for adequate hospital facilities for the people residing in a State without discrimination on account of class, creed or color, and shall provide for adequate hospital facilities for persons unable to pay therefore.

(g) General methods of administration of the plan by the designated State agency, subject to limitations set forth in the next section (a) (6) and (8).

"STATE PLANS

(A) After such regulations have been issued, any State desiring to take advantage of this part may submit a State plan for carrying out the purposes of construction. Such State plan must --

(1) designate a single State agency as the sole agency for supervising and/or the administration of the plan.

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan in conformity with this part;

(3) provide for the designation of a State advisory council.

(4) set forth a hospital construction program.

(a) which is based on a statewide inventory of existing hospitals and survey of need.

(b) which conforms with the regulations as prescribed by the Surgeon General (a) (b) and (c).

(c) which in the case of a State which has developed a program of construction, conforms to the program so developed, except for any modification required in order to comply with regulations (a) (b) and (c), and except for any modification designated pursuant to paragraph (1) of this section and approved by the Surgeon General.

(d) which meets the requirements of the Surgeon General's regulations under (f) above. i.e., race, color, creed and medical indigency.

(5) Set forth the relative need in accordance with the regulations prescribed under section (d) for the several projects included in such programs and provide for the construction, in-so-far as financial resources available, therefore and for maintenance and operation make possible, in order of such relative need.

(6) Provide such methods of the administration of the State plan including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods) as the Surgeon General prescribes under paragraph (g) and (h).

(7) Provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of hospitals which receive Federal aid under this part;

(8) Provide for affording to every applicant for a construction project an opportunity for hearing before the State agency;

(9) Provide that the State agency will make such reports as the Surgeon General may from time to time reasonably require, and give the Surgeon General, upon demand, access to the records upon which such information is based;

(10) Provide that the State agency will from time to time review its hospital construction program and submit to the Surgeon General any modifications which it considers necessary.

(B) The Surgeon General shall approve any State plan or any modification thereof which complies with the sub-section (A) above.

If any such plan or modification is disproved by the Surgeon General, the Federal hospital council shall upon request of the State agency afford it an opportunity for hearing.

If the council determines that the plan or modification complies with the provisions of sub-section (a), the Surgeon General shall thereupon approve such plan or modification.

(c) No changes in the State plan shall be required within two years after initial approval thereof, or within two years after any change thereafter required by reason or any change in the regulations of the Surgeon General, except with the consent of the State.

(d) If any State, prior to July 1, 1948, has not enacted legislation providing compliance with minimum standards of maintenance and operation shall be required in the case of hospitals which shall have received Federal aid under this title, such State shall not be entitled to any further allotments for construction.

"ALLOTMENTS TO STATES

Each State for which a State plan has been approved prior to or during a fiscal year shall be entitled for such year to an allotment of a sum bearing the same ratio to the sums authorized to be appropriated for construction for such year as the product of (a) the population of such State and (b) the square of its allotment percentage (as defined in section 631, paragraph (a)) bears to the sum of the corresponding products for all of the States. The amount of the allotment to a State shall be available for payment of 33-1/3 per cent of the cost of approved projects within such States. Sums alloted to a State for a fiscal year for construction and remaining unencumbered at the end of such year shall remain available to such State for such purposes for the next fiscal year (and for such year only), in addition to the sums alloted for such State for the next fiscal year.

"APPROVAL OF PROJECTS AND PAYMENTS FOR CONSTRUCTION

(a) For each project for construction pursuant to a State plan, approved under this part, there shall be submitted to the Surgeon General through the State agency an application by the State or a political subdivision thereof or by public or other nonprofit agency. Such application shall set forth:

(1) a description of the site for such project.

(2) plans and specifications therefor in accordance with the regulations prescribed by the Surgeon General under paragraph (e).

(3) reasonable assurance that title to such site is or will be vested solely in the applicant.

(4) reasonable assurance that adequate financial support will be available for the construction of the project and for its' maintenance and operation when completed.

(5) reasonable assurance that the rates of pay for laborers and mechanics engaged in the construction of the project will be not less than the prevailing local wage rates.

The Surgeon General shall approve such application if sufficient funds to pay 33-1/3 per cent of the cost of construction of such projects are available from the allotment to the State and if the Surgeon General finds:

(A) that the application contains such reasonable assurance as to title, financial support and payment of prevailing rates of wages,

(B) that the plans and specifications are in accord with the Surgeon General's regulations,

(C) that the application is in conformity with the approved State plan and contains an assurance that the applicant will conform to the applicable requirements of the State plan and to the Surgeon General's regulations.

(D) that it has been approved and recommended by the State agency and is entitled to priority within the State in accordance with the Surgeon General's regulations. No application shall be disapproved until the Surgeon General has afforded the State agency an opportunity for hearing.

"(b) Upon approving an application under this section, the Surgeon General shall certify to the Secretary of the Treasury an amount equal to 33-1/3 percent of the estimated cost of the project and designate the appropriation from which it is paid. Such certification shall provide for payment to the State except that if the State is not authorized by law to make payments to the applicant the certification shall provide for payment direct to the applicant.

NOTE: The latter is not necessary in this State.

Upon certification by the State agency based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, the Surgeon General shall certify such installment for payment by the Secretary of the Treasury. If the Surgeon General has ground to believe that a fault has occurred, he may, upon giving notice of hearing, withhold certification.

(c) Amendment of any approved application shall be subject to approval in the same manner as an original application.

(d) Funds paid under this section shall be used solely for carrying out projects as so approved.

(e) If any hospital for which funds have been paid under this section shall be sold or transferred to any person, agency, or organization which is not qualified for benefits under this Act or if it cease to be a non-profit hospital, the United States shall be entitled to recover 33-1/3 per cent of the current value of such hospital.

"Part D - MISCELLANEOUS

"DEFINITIONS - For the purposes of this title --

(a) the allotment percentage for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States (excluding Alaska), except that:

1. the allotment percentage shall in no case be more than 75 per cent or less than 33-1/3 per cent.

2. the allotment percentage for Alaska and Hawaii shall be 50 per cent each and the allotment percentage for Puerto Rico shall be 75 per cent.

"(b) allotment percentages shall be promulgated by the Surgeon General between July 1 and August 31 of each evennumbered year,

"(c) population of the several States shall be determined on the basis of the latest figures certified by the Department of Commerce,

"(d) the term 'State' includes Alaska, Hawaii, Puerto Rico, and the District of Columbia,

"(e) the term 'hospital' includes public health centers and general, tuberculosis, mental, chronic diseases and other types of hospitals and related facilities such as laboratories, out-patient departments, nurses' home and training facilities and central service facilities operated in connection with hospitals and does not include any hospital furnishing primarily domiciliary care,

"(f) the term 'public health center' means a publicly owned facility for the provision of public health services including related facilities such as laboratories, clinics and administrative offices operated in connection with public health centers.

"(g) the term 'non-profit hospital' means any hospital owned and operated by a corporation or association, no part of the net earnings of which inures, or may inure lawfully, to the benefit of any shareholder or individual,

"(h) the term 'construction' includes construction of new buildings, expansion, remodeling, and alteration of existing buildings and initial equipment of such buildings including architects fees and excluding the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land;

"(i) the term 'cost of construction' means the amount found by the Surgeon General to be necessary for the construction of a project.

"WITHHOLDING OF CERTIFICATION

Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the State agency, finds that the State is not complying substantially with the intent and regulations of the Act, he may withhold further certifications. If the Surgeon General refuses to approve any application, the State agency through which the application was submitted, or if any State is dissatisfied with the Surgeon General's action, such State may appeal to the appropriate United States Court of Appeals. The findings of fact by the Surgeon General, unless substantially contrary to the weight of the evidence, shall be conslusive, but the court, for good cause shown, may remand the case to the Surgeon General to take further evidence. The court shall have jurisdiction to affirm the action of the Surgeon General or set it aside in whole or in part. The judgment of the Court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in sections 239 and 240 of the Judicial Code, as amended.

"FEDERAL HOSPITAL COUNCIL

"(a) The Surgeon General is authorized to make such administration regulations and perform such other functions as he finds necessary to carry out the provisions of this title. Any such regulations shall be subject to the approval of the Social Security Administrator.

"(b) In administering this title, the Surgeon General shall consult with a Federal Hospital Council consisting of the Surgeon General, who shall serve as Chairman ex-officio, and eight members appointed by the administrator. Four of the eight appointed members shall be persons who are outstanding in fields pertaining to hospital and health activities, three of whom shall be authorities in matters relating to the operation of hospitals and the other four members shall be appointed to represent the consumers of hospital service and shall be persons familiar with the need for hospital services in urban and rural areas. Appointees shall hold office for a term of four years subject to the usual regulations of new appointees and appointees for vacancies. The Council shall meet as frequently the Surgeon General deems necessary but not less than once each year. Upon the request of three or more members, the Surgeon General shall call a meeting of the Council.

"CONFERENCES OF STATE AGENCIES

The Surgeon General shall call conferences of the agencies designated by the States to carry out this Act as needed but at least once annually. Upon application of five or more State agencies, the Surgeon General shall call a conference of representatives of all State Agencies.

"STATE CONTROL OF OPERATIONS

Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any hospital with respect to which any funds have been or may be expended under this title.

Abstracted by:

Joint Hospital Board
Postwar Public Works Planning
Commission

Commissioner Robert T. Lansdale,
Chairman

John J. Bourke, M. D.
Survey Director

NEW YORK STATE PLAN FOR SURVEY OF HOSPITAL FACILITIES

AND

PROGRAM FOR REGIONAL HOSPITAL PLANNING

FOR

POSTWAR HOSPITAL CONSTRUCTION

NEW YORK STATE POSTWAR PUBLIC WORKS PLANNING COMMISSION

JOINT HOSPITAL BOARD

Robert T. Lansdale, Chairman
John J. Bourke, M.D.
Survey Director
State Office Building
Albany, New York

PLAN FOR SURVEY OF HOSPITAL FACILITIES AND REGIONAL PLANNING FOR POSTWAR HOSPITAL CONSTRUCTION

In order to meet the requirements of the proposed Hill-Burton Bill, S-191, and to more efficiently plan for postwar hospital construction, the Postwar Public Works Planning Commission, through its Joint Hospital Board, is inaugurating an intensive survey of existing facilities and an appraisal of needed hospital construction.

To secure the assistance and advice available through individuals and groups responsible for the construction, operation and use of hospitals, the work is to be approached on a regional basis.

For the purpose of facilitating the completion of the survey and for postwar hospital construction planning, the State will be provisionally divided into hospital regions and primary and secondary service districts within each region.

Representatives from each of the primary and secondary hospital service districts will be chosen at regional meetings to which will be invited all hospital administrators and others with interest and responsibility for hospital care. With the hospital service district representatives as a nucleus of the membership, Regional Hospital Planning Councils will be established in each of the regions.

This joint local and state action should result in an orderly and intelligent solution to the problem of meeting the needs for additional hospital and related facilities for the care of the sick.

The following is a resume of the plan adopted by the Joint Hospital Board:

I PURPOSE OF THE JOINT HOSPITAL BOARD OF THE NEW YORK STATE POSTWAR PUBLIC WORKS PLANNING COMMISSION

(1) To inventory the existing hospitals of every character.

(2) To survey the need for the construction of hospitals.

(3) To develop programs for the construction of such public and non-profit hospitals as will afford, in conjunction with existing facilities, the necessary physical facilities for furnishing adequate hospital clinic and similar service to all of the people.

II STATE ORGANIZATION

(1) The Governor has designated the New York State Postwar Public Works Planning Commission to act as the sole state agency. The Joint Hospital Board, consisting of the Commissioners of Health, Mental Hygiene and Social Welfare, is to assist and cooperate.

(2) A State Advisory Council to the Postwar Public Works Planning Commission is being appointed and will be under the chairmanship of Assemblyman Lee B. Mailler, who has been designated by the Governor as advisor to the Joint Hospital Board.

III REGIONAL HOSPITAL PLAN FOR THE STATE

(A) PURPOSE

1. To provide a decentralized method of completing the survey of hospitals.

2. To make available the results of the Survey to the local individuals and groups with responsibilities for hospital care.

3. To provide, through Regional Hospital Planning Councils, appraisals of existing facilities for hospital care.

4. To secure regional recommendations regarding the need for additional facilities.

5. To assist hospitals in their plans for expansion by co-ordinated regional hospital planning and to enhance working relationships between individual hospitals and services.

6. To take advantage of the position of the four up-state medical teaching institutions for improving facilities for undergraduate and postgraduate medical, public health and nursing education and for the provision of an adequate distribution of medical services requiring specialty training.

7. Through the work of the Regional Hospital Planning Councils, to assist the Joint Hospital Board and the New York State Postwar Public Works Planning Commission in meeting its responsibilities.

(B) ORGANIZATION

1. The provisional division of the state, (exclusive of New York City) into 4 major hospital regions and 2 smaller regions for the extra metropolitan area.

2. The provisional division of each region into primary and secondary hospital service districts. (See map attached)

3. The Hospital Council of Greater New York, with its Postwar Hospital Planning Committee, and with the co-operation of the Greater New York Hospital Association, will act as the clearing house for New York City.

4. Establishment of Regional Hospital Planning Councils in each of the up-state regions. Regional Hospital Planning Councils should be composed of the hospital administrators, acting as representatives of the primary and secondary hospital districts, representatives of the New York State Hospital Association and its local hospital councils, boards of trustees of hospitals, representatives of the medical and nursing professions, the medical school and representatives of Public Health, Public Welfare, Agriculture, Labor and Industry.

5. The appointment of a competent hospital administrator, on a full or part time basis, for a temporary period, for each of the Regional Planning Councils to act as secretary to Regional Planning Councils and to assist in completing the hospital inventory schedules. State funds will be available to cover this service and travel expenses.

6. One local hospital administrator from each of the hospital districts will be asked to volunteer as the representative of his hospital service district and to assist the local hospitals in completing the inventory schedules. This will mean that no one volunteer would be responsible for more than 10 or 12 institutions. These district representatives will receive instruction concerning the interpretation of the inventory schedules from the secretaries of the Regional Hospital Planning Councils and the Joint Hospital Board.

(C) OPERATION OF THE PLAN

1. The 22 page inventory schedule will be sent directly to each of the hospitals of more than 25 bed-capacity.

   Hospitals of less than 25 beds will receive a Short 9 page inventory schedule in duplicate.

   Two copies of the schedule are to be completed, the hospital will retain one for its own use, the second copy will be turned over to the representative of the hospital service district, who will review it with the hospital superintendent, if necessary.

   The secretaries to the Regional Planning Councils will meet with the hospital service district representative, check the schedules for the several hospitals within the district, and forward them to the Joint Hospital Board at Albany.

   The Hospital Council of Greater New York will distribute the inventory schedules and complete the contacts with hospitals in New York City. Inventory schedules for maternity homes, nursing homes and related institutions will be completed with the assistance of the several state departments concerned.

2. The completed inventory schedules will be forwarded to Chicago, where the Commission on Hospital Care has volunteered to perform the coding, preparation of punch cards and preliminary tabulations.

   The statistical tabulations and completed inventory schedules and punch cards will then be returned for appraisal and planning uses in New York State.

3. Shortly after the inventory schedules have been mailed to the hospitals, organizational meetings will be held in each of the regions. To these meetings will be invited representatives of the New York State Hospital Association and its local Councils, trustees and superintendents of hospitals in the regions, representatives of the medical and nursing professions, the Deans of the medical schools and representatives of public health and social welfare, agriculture, labor and industry.

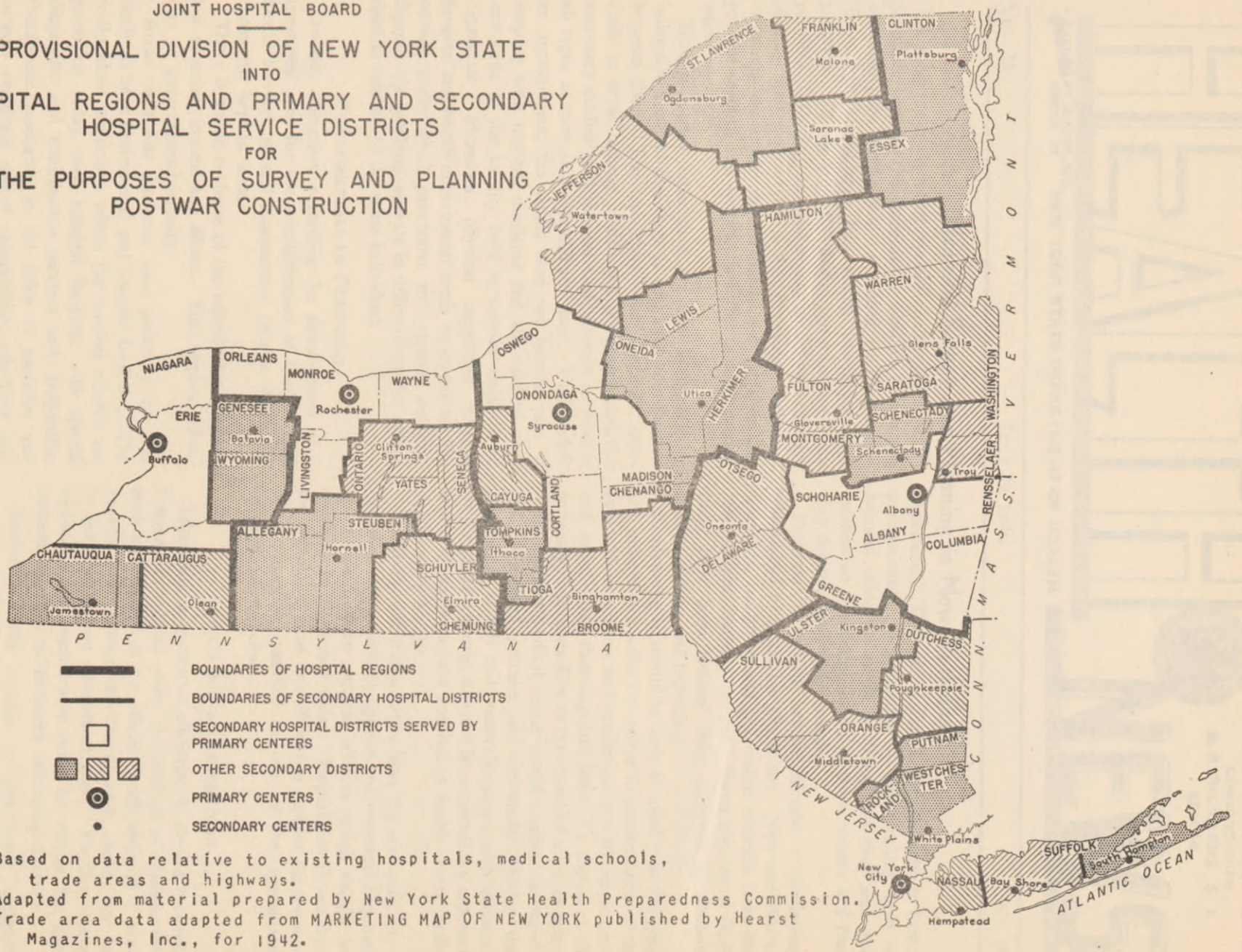
At the regional organization meetings, the Regional Hospital Planning Councils are to be established, a secretary appointed and the survey inaugurated. Each Regional Hospital Planning Council should be composed of the hospital service district representatives and representatives of the groups enumerated above.

4. Subsequent meetings of the Regional Planning Councils are to be arranged through its chairman, as necessary and by request of the Joint Hospital Board.

The Joint Hospital Board will make available to each of the Regional Hospital Planning Councils, information secured through the survey and data pertaining to the social and economic factors in hospital planning.

POSTWAR PUBLIC WORKS PLANNING COMMISSION
JOINT HOSPITAL BOARD

PROVISIONAL DIVISION OF NEW YORK STATE INTO HOSPITAL REGIONS AND PRIMARY AND SECONDARY HOSPITAL SERVICE DISTRICTS FOR THE PURPOSES OF SURVEY AND PLANNING POSTWAR CONSTRUCTION



BOUNDARIES OF HOSPITAL REGIONS

BOUNDARIES OF SECONDARY HOSPITAL DISTRICTS

SECONDARY HOSPITAL DISTRICTS SERVED BY PRIMARY CENTERS

OTHER SECONDARY DISTRICTS

PRIMARY CENTERS

SECONDARY CENTERS

Based on data relative to existing hospitals, medical schools, trade areas and highways.
Adapted from material prepared by New York State Health Preparedness Commission.
Trade area data adapted from MARKETING MAP OF NEW YORK published by Hearst Magazines, Inc., for 1942.

PROVISIONAL DIVISION OF NEW YORK STATE
INTO
HOSPITAL REGIONS AND PRIMARY AND SECONDARY
HOSPITAL SERVICE DISTRICTS
FOR
THE PURPOSES OF SURVEY AND PLANNING
POSTWAR CONSTRUCTION
POSTWAR PUBLIC WORKS PLANNING COMMISSION
JOINT HOSPITAL BOARD

HEALTH NEWS

EDWARD S. GODFREY, JR., M. D.
COMMISSIONER
B. R. RICKARDS, S. B.
EDITOR

ISSUED AT ALBANY, N.Y. WEEKLY BY NEW YORK STATE DEPARTMENT OF HEALTH

VOL. 23 JULY 29, 1946 No. 30

Hospital Survey and Planning in New York State*

Among the many controversies concerning a health program, perhaps the foremost is whether or not any adequate plan for medical care need be compulsory. Too often compulsion has stifled inspiration and progress. To my mind this is not the most important problem: The first essential of any sound and effective plan for extended service is that it provide individual initiative, encourage improvement, and advance and provide medical and hospital facilities of high quality where needed.

Hospitals once established are apt to operate as isolated institutions and there is very little coordination between them. Too frequently small hospitals, especially in areas lacking wealth and population and the necessary medical and surgical staff, attempt to furnish all types of care as a self-sufficient unit. Under such an arrangement, the public does not receive care in keeping with modern medicine and the medical care standards of the locality tend to remain static or to depreciate. Moreover, physical separation between hospital and health departments tends to perpetuate the custom under which preventive and curative services, figuratively speaking, operate in different worlds rather than in relation to the same individual.

Fundamentals in Planning

In any discussion regarding the development of a functional plan for the administration of hospital and health services, several fundamental criteria should be constantly kept in mind.

There is ample evidence of the relationship between low economic income and illness. This implies voluntary or governmental subsidy.

Areas on a low economic level generally are less likely to have professional and hospital facilities. The well-trained physicians whom the medical schools are providing today need hospital facilities with special diagnostic and consultation services and, frequently, therapeutic assistance in the fields of medicine and surgery requiring special postgraduate education and experience. The tendency of recent graduates to locate predominantly in proximity to the teaching type of hospital center is ample evidence that they seek the intellectual stimulation found in these centers and that they desire a progressive career.

Progress in medical science dictates a continuing educational program for physicians. New methods of diagnosis, treatment and prevention emanate from the research and teaching centers. Rural physicians especially have been isolated from advances in modern medical science and technology.

In planning it should be kept in mind that the general practitioner is the key person in community medical care. New patterns and procedures should supplement and assist rather than supplant him. To transport all seriously ill patients fifty or one hundred miles or more to the nearest medical center would weaken the standard of medical practice and eventually deprive the community of full and comprehensive health services. At the other extreme, it would be economically unsound and inadvisable to have hospital or health center facilities in every hamlet.

Relatively few communities have the economic, professional, and medical equipment and resources required to provide modern medical services which should be available to all people today. Experience shows that the population must be sufficient to support the services of a physician qualified in one of the specialized branches of medicine.

Affiliation a Prerequisite

Obviously, a system of affiliation is needed between hospitals of various sizes, the medical profession, the medical schools and the official health agencies if preventive and curative services of high quality are to be provided on an economical basis. Further, these affiliations are necessary in order to narrow the gap between scientific achievement and actual practice.

Analysis of the location of physicians, qualified specialists, and teaching centers, especially in New York State, leads to the belief that regional and district hospital planning offers much hope in meeting the aims

* Abstract of paper presented by John J. Bourke, M.D., survey director, Joint Hospital Board, New York State Postwar Public Works Planning Commission, at the Annual Conference of Health Officers and Public Health Nurses, Saratoga Springs, New York, June 25, 1946.

for better service. This is not a new idea; it involves an unselfish approach in the development of inflow and outflow services between the teaching center and the institutions which might be referred to as satellite hospitals.

The Regional Concept of Hospital Service

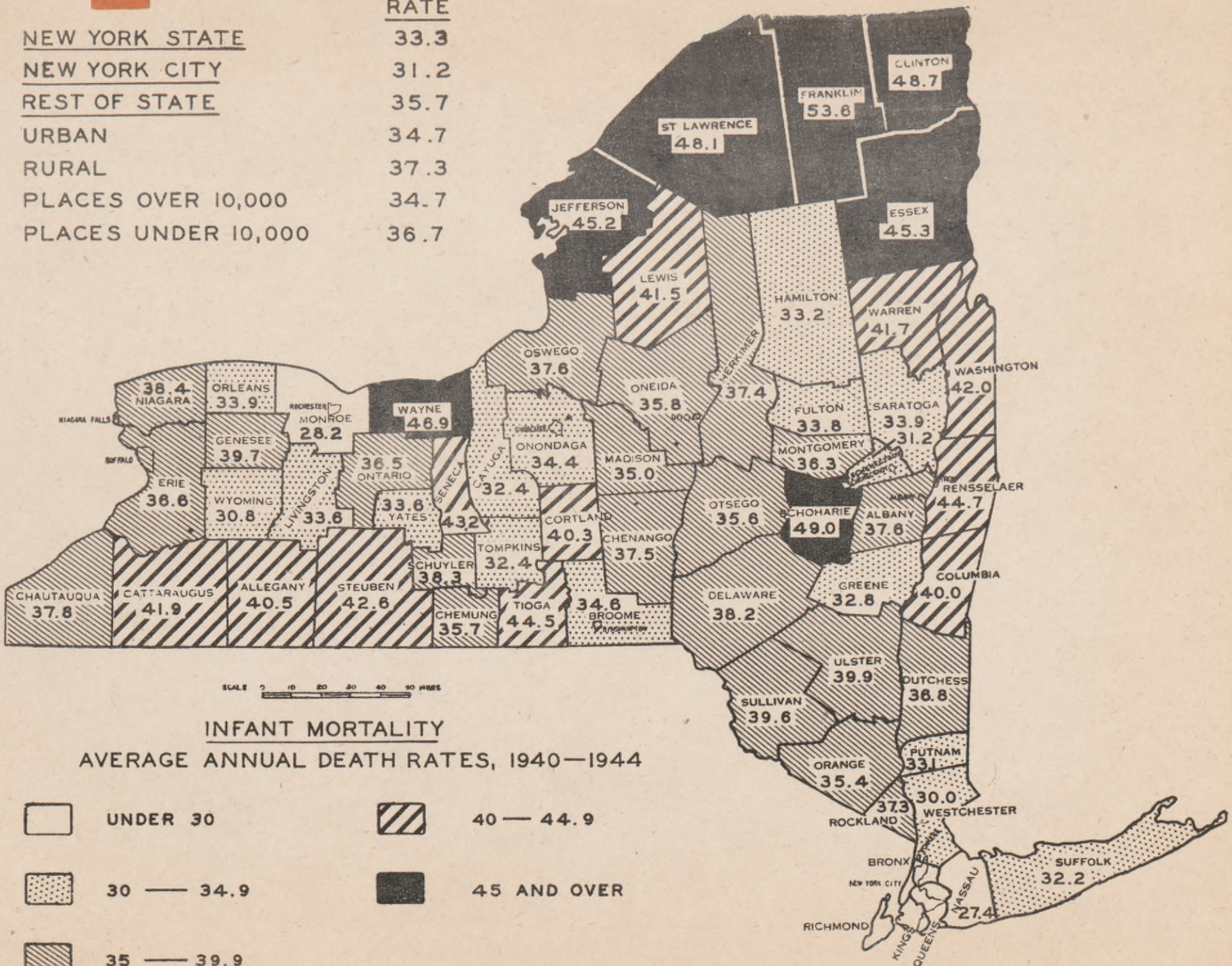
The regional concept of hospital service has much to merit its widespread adoption. I believe that the medical schools and larger hospitals of high quality wish to extend their influence and assistance in raising the standards of hospital care. Further, hospitals in rural and small urban areas appear eager to have the assistance which these teaching centers offer. The medical and nursing professions should receive much benefit. The larger institutions will have to assure the smaller hospitals and the medical profession that affiliation is not a competitive program designed to deprive the rural hospitals and physicians of patients but rather a method of improving medical care and medical education. This should make it possible ultimately for more patients to obtain care at their community hospital. On the other hand, the local hospital and the local practicing physician will have to subject themselves to a critical analysis of the scope of their abilities for the best interests of the patient.

It is with the previously mentioned points in mind that the Joint Hospital Board, under the chairmanship of State Commissioner of Social Welfare, Mr. Robert T. Lansdale, and comprising the State Commissioners of Health and Mental Hygiene, Dr. Edward S. Godfrey, Jr., and Dr. Frederick MacCurdy, has attempted to meet its responsibility for state hospital survey and planning. Assemblyman Lee B. Mailler has been appointed by the Governor as advisor to the Joint Hospital Board and is chairman of the State Advisory Council on Hospital Survey and Planning. The responsibilities of the Board are to "inventory the existing hospitals of every character in the State of New York, and to survey the need for construction of such public and other nonprofit hospitals, as will afford in conjunction with existing facilities, the necessary facilities for furnishing adequate hospital clinic and similar services to all the people."

For the purpose of survey and planning, the State has been provisionally divided into five regions. Each region has a primary hospital service center associated with a medical school and several secondary hospital centers where there are hospitals of 100-bed capacity or more. The nuclei of regional planning councils have already been completed. The councils are active in the completion of the hospital survey and include competent hospital administrators from each of the primary and secondary centers. The Joint Hospital Board plans to assist the local councils in expanding their membership to include representatives of the medical and nursing professions, of official public health and public welfare departments, boards of supervisors, mayors of cities, and deans of medical schools within the region and other interested persons with responsibility for the establishment, operation, support and use of the hospitals.

About the first of September, these councils will be supplied with the results of the hospital survey and with other pertinent data of social, economic and health nature which are currently being assembled. It is believed that with this information, the regional councils can formulate basic recommendations of great importance to the State and localities as to needs for new construction and expansion of existing facilities and the desirability of certain amalgamations and affiliations between hospitals of various types and sizes and health centers.

	RATE
NEW YORK STATE	33.3
NEW YORK CITY	31.2
REST OF STATE	35.7
URBAN	34.7
RURAL	37.3
PLACES OVER 10,000	34.7
PLACES UNDER 10,000	36.7



INFANT MORTALITY

AVERAGE ANNUAL DEATH RATES, 1940—1944

- UNDER 30
- 30 — 34.9
- 35 — 39.9
- 40 — 44.9
- 45 AND OVER

APPENDIX E