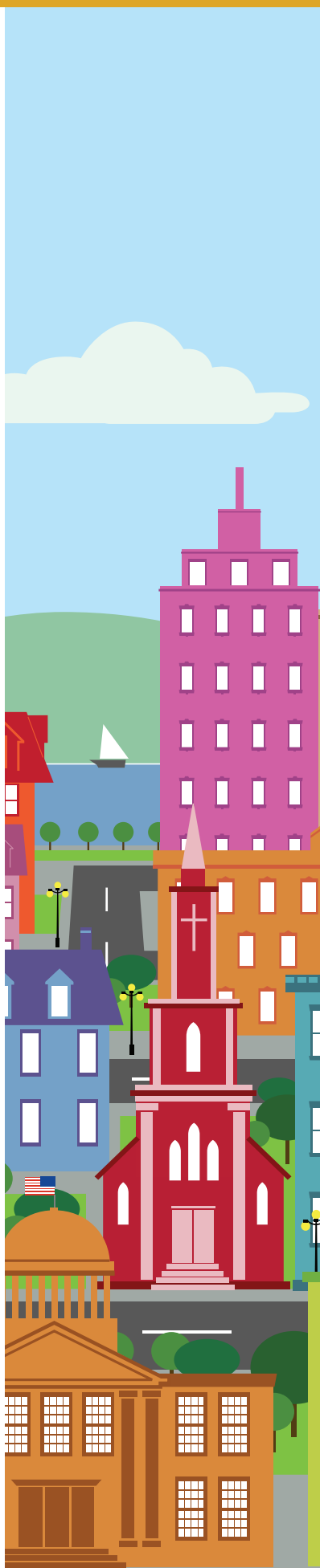
CHAPTER 2

Organizations that Help Shape Community and Public Health



Chapter Outline

Chapter Objectives

After studying this chapter, you will be able to:

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

Scenario

Mary is a hardworking senior at the local university. She is majoring in physical education and looking forward to teaching elementary physical education after graduation. Mary has always been involved in team sports and has been a lifeguard at the local swimming pool for the past 4 years. Mary has a fair complexion with honey-blonde hair and blue eyes. She has always tanned easily, so has not bothered very much with sunscreens. For the past few weeks, Mary has noticed a red, scaly, sharply outlined patch of skin on her forehead. She has put creams and ointments on it, but it will not go away and may be getting larger. Her roommate, Clare, suggests that she should make an appointment with the campus health services office. Mary lets it go another week and then decides to see the doctor.

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

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

Introduction

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

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

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

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

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

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

Governmental Health Agencies

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

International Health Agencies

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

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

Although the WHO is now the largest international health organization, it is not the oldest. Among the organizations (listed with their founding dates) that predate WHO are the following:

- International D'Hygiène Publique (1907); absorbed by the WHO
- Health Organization of the League of Nations (1919); dissolved when the WHO was created
- United Nations Relief and Rehabilitation Administration (1943); dissolved in 1946—its work is carried out today by the Office of the United Nations High Commissioner for Refugees (UNHCR) (1950)
- United Nations Children's Fund (UNICEF) (1946); formerly known as the United Nations International Children's Emergency Fund
- Pan American Health Organization (PAHO) (1902); still an independent organization but is integrated with WHO in a regional office

Because the WHO is the largest and most visible international health agency, it is discussed at greater length in the following sections.

FIGURE 2.1 China's Margaret Chan, Director General of the World Health Organization, speaks during an end-of-year press conference at the World Health Organization (WHO) headquarters in Geneva, Switzerland.

History of the World Health Organization

Planning for the WHO began when a charter of the United Nations was adopted at an international meeting in 1945. Contained in the charter was an article calling for the establishment of a health agency with wide powers. In 1946, at the International Health Conference, representatives from all of the countries in the United Nations succeeded in creating and ratifying the constitution of the WHO. However, it was not until April 7, 1948 that the constitution went into force and the organization officially began its work. In recognition of this beginning, April 7 is commemorated each year as World Health Day.[2] The sixtieth anniversary of the WHO was celebrated in 2008.

Organization of the World Health Organization

"WHO is a United Nations specialized agency concentrating exclusively on health by providing technical cooperation, carrying out programmes to control and eradicate disease and striving to improve the quality of human life."[3] Membership in the WHO is open to any nation that has ratified the WHO constitution and receives a majority vote of the World Health Assembly. At the beginning of 2016, 194 countries were members. The World Health Assembly comprises the delegates of the member nations. This assembly, which meets in general sessions annually and in special sessions when necessary, has the primary tasks of approving the WHO program and the budget for the following biennium and deciding major policy questions.[2]

The WHO is administered by a staff that includes an appointed director–general, deputy director–general, seven assistant directors–general, and six regional directors. Great care is taken to ensure political balance in staffing WHO positions, particularly at the higher levels of administration. "More than 7,000 people from more than 150 countries work for the Organization in over 150 WHO country offices, 6 regional offices, at the Global Service Centre in Malaysia and at the headquarters in Geneva, Switzerland."[2]

Purpose and Work of the World Health Organization

The primary objective of the WHO "shall be the attainment by all peoples of the highest possible level of health."[4] To achieve this objective, the WHO has 6 core functions that describe the nature of its work. They are:[5]

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
- Shaping the research agenda and stimulating the generation, translation, and dissemination of valuable knowledge
- Setting norms and standards, and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options
- Providing technical support, catalyzing change, and building sustainable institutional capacity
- Monitoring the health situation and assessing health trends

The work of the WHO is financed by its member states with assessed and voluntary contributions. Each member state is assessed according to its ability to pay; the wealthiest countries contribute the most. Voluntary contributions also come from the member states and account for more than three quarters of the budget financing.[2]

Although the WHO has sponsored and continues to sponsor many worthwhile programs, an especially noteworthy one was the work of the WHO in helping to eradicate smallpox. At one time, smallpox was the world's most feared disease until it was eradicated by a collaborative global vaccination program led by WHO.[2] The year 2015 marked the thirty-fifth anniversary of this eradication. In 1967, smallpox was active in 31 countries. During that year, 10 million to 15 million people contracted the disease, and of those, approximately 2 million died. Many millions of others were permanently disfigured or blinded. The last known natural case of smallpox was diagnosed on October 26, 1977, in Somalia.[2] In 1978, a laboratory accident in Birmingham, England resulted in one death and a limited outbreak of the acute disease. In 1979, the World Health Assembly declared the global eradication of this disease. Using the smallpox mortality figures from 1967, it can be estimated that more than 60 million lives have been saved since the eradication.

More recently, the WHO has led the efforts to contain the outbreaks of Ebola. Since July 2014 unparalleled progress has been made in establishing systems and tools that allow for rapid and effective response. Thanks to the diligence and dedication of tens of thousands of responders, scientists, researchers, developers, volunteers, and manufacturers, there are now six rapid diagnostic tools that can detect the Ebola virus in a matter of hours, 24 worldwide testing laboratories, an Ebola vaccine, registered foreign medical teams, and thousands of trained responders who can rapidly deploy to outbreaks.[6]

The work of WHO is outlined in its "general programme of work." This document, which is a requirement of the WHO constitution, "provides a vision and is used to guide the work of the organization during a pre-determined period of time."[4] At the time this book was revised the WHO was working under the *Twelfth General Programme of Work*,[5] which covers the six years from 2014 to 2019. The categories of work covered in this document include communicable diseases, noncommunicable diseases, health throughout the life cycle, health systems, preparedness, surveillance, and response; and, corporate services and enabling functions.

In addition to the program of work, much of the recent work of WHO is outlined in the United Nations Millennium Declaration, which was adopted at the Millennium Summit in 2003.[7] The declaration set out principles and values in seven areas (peace, security, and disarmament; development and poverty eradication; protecting our common environment; human rights, democracy, and good governance; protecting the vulnerable; meeting special needs of Africa; and strengthening the United Nations) that should govern international relations in the twenty-first century.[7] Following the summit, the *Road Map* was prepared, which established goals and targets to be reached by 2015 in each of the seven areas.[8] The resulting eight goals in the area of development and poverty eradication were referred to as the Millennium Development Goals (MDGs). More specifically, the MDGs were aimed at reducing poverty and hunger,

TABLE 2.1 Selected Achievements Found in the Millennium Development Goals

- "Extreme poverty has declined significantly over the last two decades. In 1990, nearly half of the population in the developing world lived on less than $1.25 a day; that proportion dropped to 14 percent in 2015."
- "The primary school net enrollment rate in the developing regions has reached 91 percent in 2015, up from 83 percent in 2000."
- "Many more girls are now in school compared to 15 years ago. The developing regions as a whole have achieved the target to eliminate gender disparity in primary, secondary, and tertiary education."
- "The global under-five mortality rate has declined by more than half, dropping from 90 to 43 deaths per 1,000 live births between 1990 and 2015."
- "Since 1990, the maternal mortality ratio has declined by 45 percent worldwide, and most of the reduction has occurred since 2000."
- "New HIV infections fell by approximately 40 percent between 2000 and 2013, from an estimated 3.5 million cases to 2.1 million."
- "Ozone-depleting substances have been virtually eliminated since 1990, and the ozone layer is expected to recover by the middle of this century."
- "Official development assistance from developed countries increased by 66 percent in real terms between 2000 and 2014, reaching $135.2 billion."

Data from: United Nations (2015). *The Millennium Development Goals Report: 2015*. New York: Author. Available at http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20%28July%201%29.pdf.

Sustainable Development Goals (SDGs) goals created by the WHO to build on the work accomplished via the Millennium Development Goals (MDGs).

tackling ill health, gender inequality, lack of education, lack of access to improved drinking water, and environmental degradation. Much success was made with the MDGs. Unified efforts have produced data that prove the MDGs have saved millions of lives and improved conditions from targeted interventions, sound strategies, and adequate resources. The momentum must continue because uneven achievements and shortfalls continue to exist; therefore, the work must continue into the new development era[9](see **Table 2.1**). As noted above, the MDGs were not exclusively aimed at health, but there were interactive processes between health and economic development that create a crucial link. That is, better health is "a prerequisite and major contributor to economic growth and social cohesion. Conversely, improvement in people's access to health technology is a good indicator of the success of other development processes."[10]

Strategies for achieving large-scale and rapid progress toward meeting the MDGs involved strong government leadership and policies and strategies that meet the needs of the poor, combined with sufficient funding and technical support from the international community.[9]

The work behind the MDGs has proven to be effective in monitoring development through measurable data to track interventions, performance, and accountability. Although much progress has been made, there is still much more work to be done. Moving forward, challenges will be addressed through a new universal and transformative post-2015 development agenda of MDGs supported by a set of 17 goals referred to as the **Sustainable Development Goals** (SDGs). SDGs were established to be interconnected and concentrated towards eradicating poverty, addressing climate change, and increasing economic growth. The goals were developed by world leaders in September 2015 to build on the MDGs and improve the lives of people through a global, unified effort.[11] SDGs are not considered legally binding; however, they do seek improved availability, quality, and timeliness of data, national level analyses, and global level outcome.[11] **Table 2.2** provides a listing of the 17 SDGs.

National Health Agencies

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

TABLE 2.2 Seventeen Sustainable Development Goals	
Goal 1	End poverty in all its forms everywhere.
Goal 2	End hunger, achieve food security and improved nutrition, and promote sustainable agriculture.
Goal 3	Ensure healthy lives and promote well-being for all at all ages.
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
Goal 5	Achieve gender equality and empower all women and girls.
Goal 6	Ensure availability and sustainable management of water and sanitation for all.
Goal 7	Ensure access to affordable, reliable, sustainable, and modern energy for all.
Goal 8	Promote sustained, inclusive, and sustainable economic growth; full and productive employment; and decent work for all.
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization, and foster innovation.
Goal 10	Reduce inequality within and among countries.
Goal 11	Make cities and human settlements inclusive, safe, resilient, and sustainable.
Goal 12	Ensure sustainable consumption and production patterns.
Goal 13	Take urgent action to combat climate change and its impacts.
Goal 14	Conserve and sustainably use the oceans, seas, and marine resources for sustainable development.
Goal 15	Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels.
Goal 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development.

Data from: United Nations (2016). *Sustainable Development Goals: 17 Goals to Transform Our World.* Available at http://www.un.org/sustainabledevelopment/

In the United States, the primary national health agency is the Department of Health and Human Services (HHS). HHS "is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves."[12] It is important to note, however, that other federal agencies also contribute to the betterment of our nation's health. For example, the Department of Agriculture inspects meat and dairy products and coordinates the Special Supplemental Nutrition Program for Women, Infants, and Children, better known as the WIC food assistance program; the Environmental Protection Agency (EPA) regulates hazardous wastes; the Department of Labor houses the Occupational Safety and Health Administration (OSHA), which is concerned with safety and health in the workplace; the Department of Commerce, which includes the Bureau of the Census, collects much of the national data that drive our nation's health programs; and the Department of Homeland Security (DHS) deals with all aspects of terrorism within the United States. A detailed description of the Department of Health and Human Services follows.

Department of Health and Human Services

The HHS is headed by the Secretary of Health and Human Services, who is appointed by the president and is a member of his or her cabinet. The Department of Health and Human Services was formed in 1980 (during the administration of President Jimmy Carter), when the Department of Health, Education, and Welfare (HEW) was divided into two new departments, HHS and the Department of Education. HHS is the department most involved with the nation's human concerns. In one way or another it touches the lives of more Americans than any other federal agency. It is literally a department of people serving people, from newborn infants to persons requiring health services to our most elderly citizens. With an annual budget in excess of approximately $1.150 trillion (representing about 25% of the federal budget), HHS is the largest department in the federal government.[12,13]

The fiscal year 2010 overview document of the United States government budget indicated that the approved HHS budget established a reserve fund of more than $630 billion, over a 10-year period, to fund health care system reform. According to the HHS budget document, "the reserve is funded half by new revenue and half by savings proposals that promote efficiency and accountability, align incentives toward quality, and encourage shared responsibility. In addition, the Budget calls for an effort beyond this down payment, to put the Nation on a path to health insurance coverage for all Americans."[14] To date, some significant legislation has been passed that works toward fundamental health care reform, such as the American Recovery and Reinvestment Act (ARRA) of 2009, which includes $22 billion for health information technology, subsidies for those who are recently unemployed to maintain health insurance, and $1 billion for continued effectiveness research in health.[13] Moreover, in March 2010, a sweeping bill to overhaul the American medical system, put forth by President Barack Obama, was passed by a historic vote of 219 votes to 212. The new health care reform law provided a series of duties and responsibilities for the HHS. Among these were (1) the implementation of new provisions to assist families and small business owners in getting information to make the best choices for insurance coverage, in a new transparent, competitive insurance marketplace; (2) working with states and additional partners to strengthen public programs, such as the Children's Health Insurance Program (CHIP), Medicare, and Medicaid; (3) coordinating efforts with other departments to design and implement "a prevention and health promotion strategy" to promote prevention, wellness, and public health; (4) taking action to strengthen and support the primary care workforce; (5) taking on the new and improved authority to establish a transparent health care system to oversee that every dollar authorized to be spent in the act is done so in a wise and transparent manner; (6) the implementation of new provisions to decrease the costs of medications; (7) taking on authority to establish the Community Living Assistance Services and Supports Act (CLASS Act), which is a voluntary, self-funded long-term care insurance option; and (8) the implementation of the Indian Health Care Improvement Act (IHCIA), which was reauthorized in the new health care law and provides modernized and improved health care services to Alaska Natives and American Indians.[14] This revolutionary commitment has advanced access, quality, and affordability in the nation's health care system to historic levels by providing more than 90% of American with health care coverage through the Affordable Care Act.[14]

Since its formation, HHS has undergone several reorganizations. Some of the more recent changes have been the addition of the Center for Faith-Based and Community Initiatives and an Assistant Secretary for Public Health Emergency Preparedness. Currently, the HHS is organized into 11 operating agencies (see **Figure 2.2**) whose heads report directly to the Secretary. In addition, the HHS has 10 regional offices (see **Table 2.3**). These offices serve as representatives of the Secretary of HHS in direct, official dealings with the state and local governmental organizations. Eight of the 11 operating divisions of HHS (AHRQ, ATSDR, CDC, FDA, HRSA, IHS, NIH, and SAMSHA—see their descriptions below), along with Office of Global Affairs (OGA), the Office of Public Health and Science (OPHS), and the Office of the Assistant Secretary for Preparedness and Response (ASPR), now constitute the Public Health Service (PHS). Another three operating divisions (CMS, ACF, and ACL) comprise the human services operating divisions.

Administration for Community Living (ACL)

The ACL, which was established in 2012, is the division of the HHS that integrates efforts of the Administration on Aging (AoA), the Administration on Disabilities (AoD), the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), the Center for Integrated Programs (CIP), the Center for Management and Budget (CMB), and the Center for Policy and Evaluation (CPE).[15] The ACL serves as the federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

Administration for Children and Families (ACF)

The ACF is composed of a number of smaller agencies and is responsible for providing direction and leadership for all federal programs to ensure children and families are resilient and

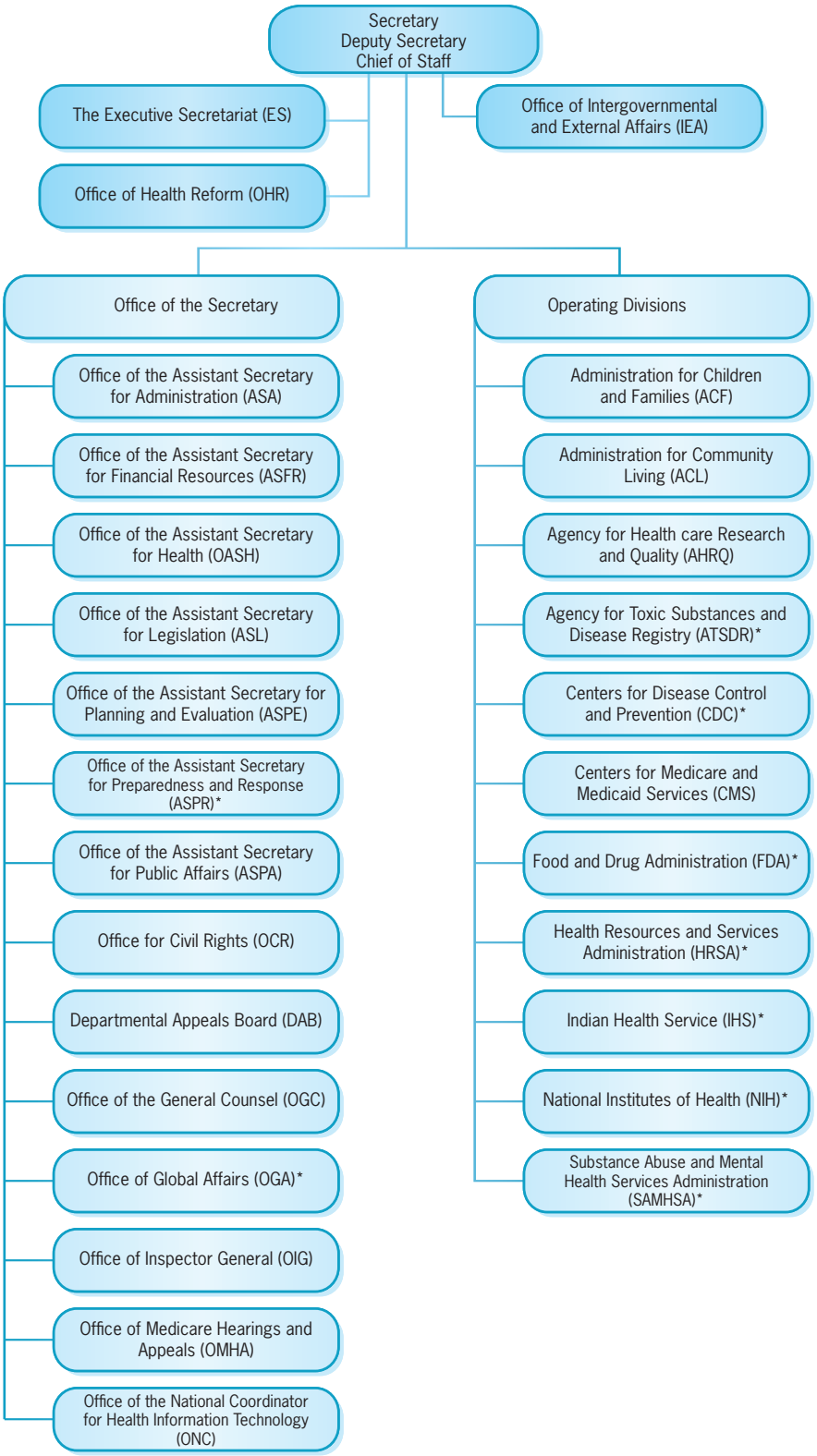


FIGURE 2.2 Organizational chart for the U.S. Department of Health and Human Services (HHS).

*Designates a component of the U.S. Public Health Service

Data from: U.S. Department of Health and Human Services (2016). U.S. Department of Health and Human Services Organizational Chart. Available at http://www.hhs.gov/about/agencies/orgchart/index.html.

TABLE 2.3 Regional Offices of the U.S. Department of Health and Human Services

Region/Areas Served	Office Address	Telephone Number
Region 1: CT, MA, ME, NH, RI, VT	John F. Kennedy Bldg. Government Center Boston, MA 02203	(617) 565-1500
Region 2: NJ, NY, Puerto Rico, Virgin Islands	Jacob K. Javits Federal Bldg. 26 Federal Plaza, Suite 3835 New York, NY 10278	(212) 264-4600
Region 3: DE, MD, PA, VA, WV, DC	Public Ledger Building 150 S. Independence Mall West Suite 436 Philadelphia, PA 19106	(215) 861-4633
Region 4: AL, FL, GA, KY, MS, NC, SC, TN	Atlanta Federal Center 61 Forsyth Street, SW Atlanta, GA 30303	(404) 562-7888
Region 5: IL, IN, MI, MN, OH, WI	233 N. Michigan Avenue, Suite 1300 Chicago, IL 60601	(312) 353-5160
Region 6: AR, LA, NM, OK, TX	1301 Young Street, Suite 1124 Dallas, TX 75202	(214) 767-3301
Region 7: IA, KS, MO, NE	Bolling Federal Building 601 East 12th Street, Room S1801 Kansas City, MO 64106	(816) 426-2821
Region 8: CO, MT, ND, SD, UT, WY	Bryon G. Rogers Federal Office Building 999 18th Street, Suite 400 Denver, CO 80202	(303) 844-3372
Region 9: AZ, CA, HI, NV, American Samoa, Guam, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, Republic of Palau	Federal Office Building 50 United Nations Plaza 90 Seventh Street, Suite 5-100 San Francisco, CA 94103	(415) 437-8500
Region 10: AK, ID, OR, WA	701 Fifth Avenue, Suite 1600 MS-01 Seattle, WA 98121	(206) 615-2010

Data from: U.S. Department of Health and Human Services. *HHS Region Map.* Available at http://www.hhs.gov/about/agencies/iea/regional-offices/index.html.

economically secure. One of the better-known programs originating from this division is Head Start, which serves nearly one million preschool children. Other programs are aimed at family assistance, refugee resettlement, and child support enforcement. In 2015, Head Start celebrated 50 years of service in school readiness of young children from low-income families.

Agency for Health Care Research and Quality (AHRQ)

Prior to 1999, this division of the HHS was called the Agency for Health Care Policy and Research, but its name was changed as part of the Health Care Research and Quality Act of 1999. AHRQ is "the Nation's lead federal agency for research on health care quality, costs, outcomes, and patient safety."[16] AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use, and access. The information helps health

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

care decision makers—patients and clinicians, health system leaders, and policy makers—make more informed decisions and improve the quality of health care services.

Agency for Toxic Substances and Disease Registry (ATSDR)

This agency was created by the **Superfund legislation** (Comprehensive Environmental Response, Compensation, and Liability Act) in 1980. This legislation was enacted to deal with the cleanup of hazardous substances in the environment. ATSDR's mission is to "serve the public through responsive public health actions to promote healthy and safe environments and prevent harmful exposures."[17]

To carry out its mission and to serve the needs of the American public, ATSDR evaluates information on hazardous substances released into the environment in order to assess the impact on public health; conducts and sponsors studies and other research related to hazardous substances and adverse human health effects; establishes and maintains registries of human exposure (for long-term follow-up) and complete listings of areas closed to the public or otherwise restricted in use due to contamination; summarizes and makes data available on the effects of hazardous substances; and provides consultations and training to ensure adequate response to public health emergencies. Although ATSDR has been responding to chemical emergencies in local communities across the country for the last 35 + years, like many of the other federal health agencies its work has taken on new meaning since 9/11. For example, some of the projects the agency's staff worked on or continue to work on include sampling dust in New York City residences after 9/11; working with New York health agencies to create a registry of people who lived or worked near the World Trade Center (WTC) on 9/11 to collect health information on those most heavily exposed to smoke, dust, and debris from the collapse of the WTC; conducting environmental sampling at anthrax-contaminated buildings; and disseminating critical information to agencies and organizations with a role in terrorism preparedness and response.[18]

Centers for Disease Control and Prevention (CDC)

The CDC, located in Atlanta, Georgia (see **Figure 2.3**), "is the nation's leading health agency, dedicated to saving lives and protecting the health of Americans."[19] "The CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States."[20] Once known solely for its work to control communicable diseases, the CDC now also maintains records, analyzes disease trends, and publishes epidemiological reports on all types of diseases, including those that result from lifestyle, occupational, and environmental causes. Beyond its own specific responsibilities, the CDC also supports state and local health departments and cooperates with similar national health agencies from other WHO member nations.

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

Courtesy of James Gathany/CDC.

Currently, the CDC uses the tagline of "CDC 24/7" as a summary statement for its current role, which includes:

- "Detecting and responding to new and emerging health threats
- Tackling the biggest health problems causing death and disability for Americans
- Putting science and advanced technology into action to prevent disease
- Promoting healthy and safe behaviors, communities, and environment
- Developing leaders and training the public health workforce, including disease detectives
- Taking the health pulse of our nation."[21]

To carry out its work the CDC is organized into Centers, Institutes, and Offices (CIOs). The CIOs "allow the agency to be more responsive and effective when dealing with public health concerns. Each group implements the CDC's response in their areas of expertise, while also providing intra-agency support and resource-sharing for cross-cutting issues and specific health threats."[22] **Figure 2.4** shows how the CIOs are organized in the CDC.

Like other public health agencies, the CDC's most important achievements are the outbreaks that do not happen, the communicable diseases that are stopped before spreading, and the lives saved from preventable chronic diseases and injuries.[23] Some of the most recent visible work of the CDC has included the Ebola outbreak in 2014 and the Zika outbreak in 2015–16. When West Africa experienced the largest Ebola outbreak in history, the CDC was there to help. "In response to the outbreak, CDC activated its Emergency Operations Center to coordinate technical assistance and control activities with other U.S. government agencies, the World Health Organization, and other domestic and international partners. CDC also deployed teams of public health experts to West Africa".[24]

While the Ebola outbreak was half a world away, the Zika virus was much closer in South America with the potential to move northward into the United States. In an effort to assist in controlling the outbreak, personnel from the CDC and the Pan American Health Organization worked with public health experts in Brazil and other affected countries to investigate the link between the Zika virus infection and Group B streptococcus (GBS), microcephaly, and other pregnancy outcomes. The CDC also worked with officials in the Puerto Rico Department of Health to learn more about the spectrum of birth outcomes and developmental concerns among infants and children born to women with Zika virus during pregnancy. Back home, the CDC's work included the development of a registry to learn more about pregnant women in the United States with confirmed Zika virus infection and their infants.[25]

Food and Drug Administration (FDA)

The FDA touches the lives of virtually every American every day. It "is charged with protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; ensuring the safety of foods, cosmetics, and radiation-emitting products; and regulating tobacco products.

Specifically, FDA is responsible for advancing the public health by:

- Helping to speed innovations that make medicines and foods safer and more effective
- Providing the public with the accurate, science-based information they need to use medicines and foods to improve their health
- Regulating the manufacture, marketing, and distribution of tobacco products to protect the public and reduce tobacco use by minors
- Addressing the nation's counterterrorism capability and ensuring the security of the supply of foods and medical products."[26]

Much of this work revolves around regulatory activities and the setting of health and safety standards as spelled out in the Federal Food, Drug, and Cosmetic Act and other related laws. However, because of the complex nature of its standards and the agency's limited resources, enforcement of many FDA regulations is left to other federal agencies and to state and local agencies. For example, the Department of Agriculture is responsible for the inspection of many foods, such as meat and dairy products. Restaurants, supermarkets, and other food outlets are inspected by state and local public health agencies.

Centers for Medicare and Medicaid Services (CMS)

Established as the Health Care Financing Administration (HCFA) in 1977, the CMS is responsible for overseeing the Medicare program (health care for the elderly and the disabled), the federal portion of the Medicaid program (health care for low-income individuals), and the related quality assurance activities. Both Medicare and Medicaid were created in 1965 to ensure that the special groups covered by these programs would not be deprived of health care because of cost. Currently, about 124 million Americans are covered by these programs.[27] In 1997, the State

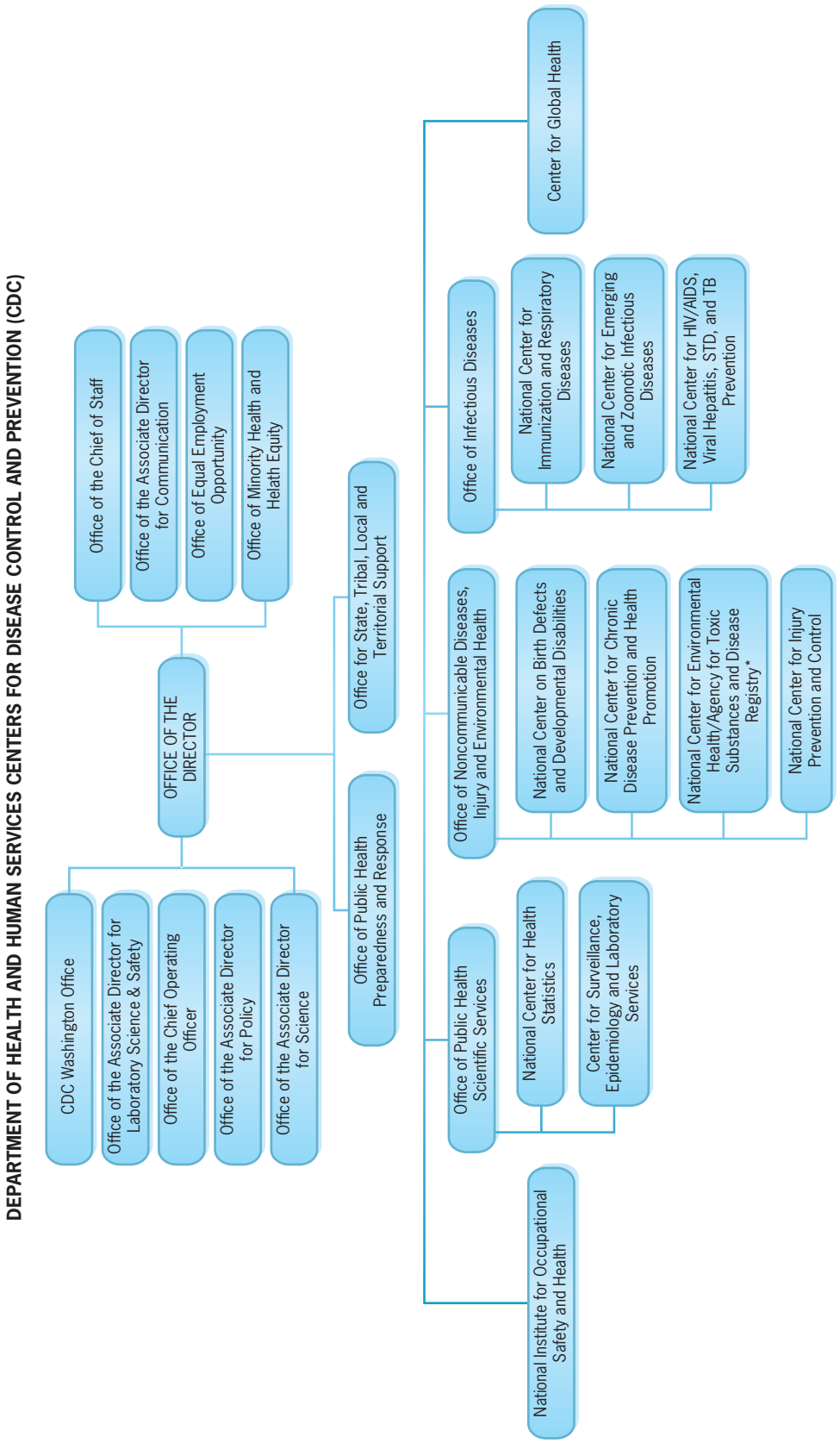


FIGURE 2.4 Organizational chart of the Centers for Disease Control and Prevention.

Data from: Centers for Disease Control and Prevention (2015). Management Analysis and Services Office. Available at http://www.cdc.gov/maso/mab_Charts.htm.

Children's Health Insurance Program (SCHIP), now known as the Children's Health Insurance Program (CHIP), also became the responsibility of the CMS. Medicare, Medicaid, and CHIP are discussed in greater detail elsewhere in the text.

Health Resources and Services Administration (HRSA)

The HRSA is the principal primary health care service agency of the federal government that provides access to essential health care services for people who are low income, uninsured, or who live in rural areas or urban neighborhoods where health care is scarce.[12] It "is the primary federal agency for improving access to health care services for people who are underinsured, isolated, or medically vulnerable."[28] The cited mission of HRSA is "to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs."[28] HRSA "maintains the National Health Service Corps and helps build the health care workforce through training and education programs."[12] The agency "administers a variety of programs to improve the health of mothers and children and serves people living with HIV/AIDS through the Ryan White CARE Act programs."[12] HRSA is also responsible for overseeing the nation's organ transplantation system.[12]

Indian Health Service (IHS)

The IHS "is responsible for providing federal health services to American Indians and Alaska Natives."[29] Currently, it "provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 35 states."[29] "The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people."[29] The mission of the IHS is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level,"[29] while its goal is "to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people."[29]

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

National Institutes of Health (NIH)

Begun as a one-room Laboratory of Hygiene in 1887, the NIH today is one of the world's foremost medical research centers, and the federal focal point for medical research in the United States.[30] The mission of the NIH "is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability."[30] Although a significant amount of research is carried out by NIH scientists at NIH laboratories in Bethesda and elsewhere, a much larger portion of this research is conducted by scientists at public and private universities and other research institutions. These scientists receive NIH funding for their research proposals through a competitive, peer-review grant application process. Through this process of proposal review by qualified scientists, NIH seeks to ensure that federal research monies are spent on the best-conceived research projects. **Table 2.4** presents a listing of all the institutes and centers located in NIH.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The SAMHSA was established in 1992 as the primary federal agency responsible for ensuring that up-to-date information and state-of-the-art practice are effectively used for the prevention and treatment of addictive and mental disorders. "SAMHSA's mission is to reduce the impact of substance abuse and mental illness on American's communities."[31] Within SAMHSA, there are four centers—the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS), and the Center for Behavioral Health Statistics and Quality (CBHSQ), formerly known as the Office of Applied Studies.[31] Each of these centers has its own mission that contributes to the overall mission of SAMHSA.

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

TABLE 2.4 Units within the National Institutes of Health (NIH)

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

Data from: National Institutes of Health (2016). *Institutes, Centers, and Offices.* Available at http://www.nih.gov/institutes-nih/list-nih-institutes-centers-offices.

FIGURE 2.5 Each of the 50 states has its own health department.

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State Health Agencies

All 50 states have their own state health departments (see **Figure 2.5**). Although the names of these departments may vary from state to state (e.g., Ohio Department of Health, Indiana State Department of Health), their purposes remain the same: to promote, protect, and maintain the health and welfare of their citizens. These purposes are represented in the **core functions of public health**, which include assessment of information on the health of the community, comprehensive public health policy development, and assurance that public health services are provided to the community.[32] These core functions have been defined further with the following 10 essential public health services.[33]

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.

7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Ensure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems (see **Figure 2.6**).

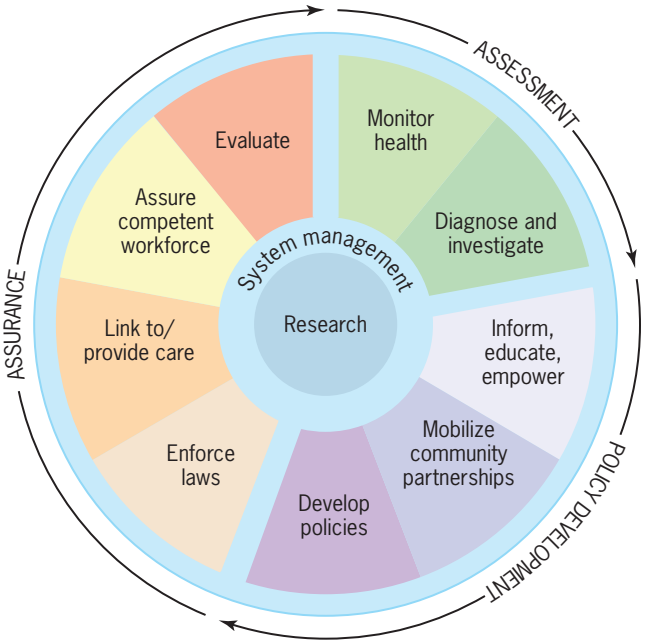

FIGURE 2.6 Core functions of public health and the 10 essential services.

Reproduced from: Centers for Disease Control and Prevention (2014). *The Public Health System and the 10 Essential Public Health Services.* Available at http://www.cdc.gov/nphpsp/essentialservices.html.

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

Most state health departments are organized into divisions or bureaus that provide certain standard services. Typical divisions include Administration, Communicable Disease Prevention and Control, Chronic Disease Prevention and Control, Vital and Health Statistics, Environmental Health, Health Education or Promotion, Health Services, Maternal and Child Health, Mental Health, Occupational and Industrial Health, Dental Health, Laboratory Services, Public Health Nursing, Veterinary Public Health, and most recently, a division of Public Health Preparedness to deal with bioterrorism issues.

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

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

Local Health Departments

Local-level governmental health organizations, referred to as local health departments (LHDs), are usually the responsibility of the city or county governments. In large metropolitan areas, community health needs are usually best served by a city health department. In smaller cities with populations of up to 50,000, people often come under the jurisdiction of a county health department. There are most of the population is concentrated in a single city, a LHD may have jurisdiction over both city and county residents. In sparsely populated rural areas, it is not uncommon to find more than one county served by a single health department. There are approximately 2,800 agencies or units that met the Profile definition of an LHD. However, for the 2013 Profile Study 2,532 LHDs were included in the study population; of that number, 61% were located in nonmetropolitan areas and 49% were in metropolitan areas.[34]

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

Organization of Local Health Departments

Each LHD is headed by a health officer/administrator/commissioner (see **Figure 2.7**). In most states, there are laws that prescribe who can hold such a position. Those often noted are physicians, dentists, veterinarians, or individuals with a master's or doctoral degree in public health. If the health officer is not a physician, then a physician is usually hired on a consulting basis to advise as needed. Usually, this health officer is appointed by a board of health, the members of which are themselves appointed by officials in the city or county government or, in some situations, elected by the general public. The health officer and administrative assistants may recommend which programs will be offered by the LHDs. However, they may need final approval from a board of health. Although it is desirable that those serving on the local board of health have some knowledge of community health programs, most states have no such requirement. Often, politics plays a role in deciding the makeup of the local board of health.

The local health officer, like the state health commissioner, has far-reaching powers, including the power to arrest someone who refuses to undergo treatment for a communicable disease (tuberculosis, for example) and who thereby continues to spread disease in the community. The local health officer has the power to close a restaurant on the spot if it has serious health law violations or to impound a shipment of food if it is contaminated. Because many local health

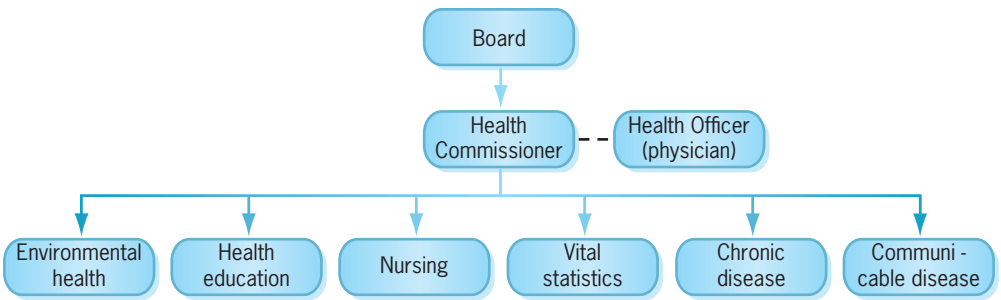

FIGURE 2.7 Organizational chart of a local public health department.

departments cannot afford to employ a full-time physician, the health officer is usually hired on a part-time basis. In such cases, the day-to-day activities of the LHD are carried out by an administrator trained in public health. The administrator is also hired by the board of health based upon qualifications and the recommendation of the health officer.

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

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

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

Whole School, Whole Community, Whole Child (WSCC) Model

Few people think of public schools as governmental health agencies. Consider, however, that schools are funded by tax dollars, are under the supervision of an elected school board, and include as a part of their mission the improvement of the health of those in the school community. Because school attendance is required throughout the United States, the potential for school health programs to make a significant contribution to community and public health is enormous, especially when it comes to "promoting the health and safety of young people and helping them establish lifelong healthy behavior patterns."[35] In fact, it has been stated that schools "could do more perhaps than any other single agency in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives."[36]

Current thinking is that schools, along with government agencies, community organizations, and other community members, can be a part of a collaborative and comprehensive approach to have a positive impact on the health outcomes of young people.[35] To create such a program the CDC and the ASCD (previously known as the Association for Supervision and Curriculum Develop) developed the Whole School, Whole Community, Whole Child (WSCC) model. "The focus of the WSCC model is an ecological approach that is directed at the whole school, with the school in turn drawing its resources and influences from the whole community and serving to address the needs of the whole child."[37] The WSCC model expands on the eight elements of CDC's coordinated school health (CSH) approach and is combined with the tenets of the whole child approach.[34] The eight elements of CSH include: health education (i.e., a carefully planned health curriculum); nutritional environment and services; employee wellness; health services; counseling, psychological, and social services; physical education; healthy and safe school environment; and family/community involvement. The expansion of these eight elements to form the WSCC model takes place with the last two elements into four distinct components—social and emotional climate, physical environment, community involvement, and family engagement. This expansion "meets the need for greater emphasis on both the psychosocial and physical environment as well as the ever-increasing and growing roles that community agencies and families must play. This new model also addresses the need to engage students as active participants in their learning and health."[35] If communities were willing to work with the public health and education sectors, the contribution of Whole School, Whole Community, Whole Child model programs to community and public health could be almost unlimited.

Quasi-Governmental Health Organizations

The **quasi-governmental health organizations**—organizations that have some official health responsibilities but operate, in part, like voluntary health organizations—make important contributions to community health. Although they derive some of their funding and

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

legitimacy from governments, and carry out tasks that may be normally thought of as government work, they operate independently of government supervision. In some cases, they also receive financial support from private sources. Examples of quasi-governmental agencies are the American Red Cross (ARC), the National Science Foundation, and the National Academy of Sciences.

The American Red Cross

The ARC, founded in 1881 by Clara Barton[38] (see **Figure 2.8**), is a prime example of an organization that has quasi-governmental status. Although it has certain "official" responsibilities placed on it by the federal government, it is funded by voluntary contributions. "Official" duties of the ARC include (1) providing relief to victims of natural disasters such as floods, tornadoes, hurricanes, and fires (Disaster Services) and (2) serving as the liaison between members of the active armed forces and their families during emergencies (Services to the Armed Forces and Veterans). In this latter capacity, the ARC can assist active-duty members of the armed services in contacting their families in case of an emergency, or vice versa.

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

The ARC was granted a charter by Congress in 1900, and the ARC and the federal government have had a special relationship ever since. The president of the United States is the honorary chairman of the ARC.[38] The U.S. Attorney General and Secretary of the Treasury are honorary counselor and treasurer, respectively.

The Red Cross idea was not begun in the United States. It was begun in 1863 by five Swiss men in Geneva, Switzerland, who were concerned with the treatment provided to the wounded during times of war.[39] The group, which was called the International Committee for the Relief to the Wounded, was led by Henry Dunant (1828–1910 C.E.).[39] With the assistance of the Swiss government, the International Committee brought together delegates from 16 nations in 1864 to the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field (now known as the first Geneva Convention) to sign the Geneva Treaty.[39]

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

The efforts of Henry Dunant and the rest of the International Committee led to the eventual establishment of the International Committee of the Red Cross (ICRC). The ICRC, which is still headquartered in Geneva and governed by the Swiss, continues to work today during times of disaster and international conflict. It is the organization that visits prisoners of war to ensure they are being treated humanely.[39]

Today, the international movement of the Red Cross comprises the Geneva-based ICRC, the International Federation of Red Cross and Red Crescent Societies (the red crescent emblem is used in Moslem countries), and the over 190 National Red Cross and Red Crescent Societies.[39] There are a number of other countries that believe in the principles of the Red Cross Movement but have not officially joined because the emblems used by the movement are offensive. Thus, the ICRC created a third emblem that meets all the criteria for use as a protective device and at the same time is free of any national, political, or religious connotations. The design is composed of a red frame in the shape of a square on the edge of a white background. The name chosen for this distinctive emblem was "red crystal," to signify purity[40] (see **Figure 2.9**).

Other Quasi-Governmental Organizations

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

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

Nongovernmental Health Agencies

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

Voluntary Health Agencies

Voluntary health agencies are an American creation. Each of these agencies was created by one or more concerned citizens who thought that a specific health need was not being met by existing governmental agencies. In a sense, these new voluntary agencies arose by themselves, in much the same way as a "volunteer" tomato plant arises in a vegetable garden. New voluntary agencies continue to be born each year. Examples of recent additions to the perhaps 100,000 agencies already in existence are the Alzheimer's Association and the First Candle (formerly SIDS Alliance). A discussion of the commonalities of voluntary health agencies follows.

Organization of Voluntary Health Agencies

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

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

The state-level offices of voluntary agencies are analogous to the state departments of health in the way that they link the national headquarters with local offices. The primary work at this level is to coordinate local efforts and to ensure that policies developed at the national headquarters are carried out. The state-level office may also provide training services for employees and volunteers of local-level offices and are usually available as consultants and problem solvers.

In recent years, some voluntary agencies have been merging several state offices into one to help reduce overhead expenses.

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

Purpose of Voluntary Health Agencies

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

Fundraising is a primary activity of many voluntary agencies. Whereas in the past this was accomplished primarily by door-to-door solicitations, today mass-mailing, emailing, and telephone solicitation are more common. In addition, most agencies sponsor special events such as golf outings, dances, or dinners. One type of special event that is very popular today is the "a-thon" (see **Figure 2.10**). The term "a-thon" is derived from the name of the ancient Greek city Marathon and usually signified some kind of "endurance" event. Examples include bike-a-thons, rock-a-thons, telethons, skate-a-thons, and dance-a-thons. These money-making "a-thons" seem to be limited in scope only by the creativity of those planning them. In addition, some of these agencies have become United Way agencies and receive some funds derived from the annual United Way campaign, which conducts fundraising efforts at worksites. The three largest voluntary agencies in the United States today (in terms of dollars raised) are the American Cancer Society (see **Box 2.1**), the American Heart Association, and the American Lung Association.

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

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

Professional Health Organizations/Associations

Professional health organizations and associations are made up of health professionals who have completed specialized education and training programs and have met the standards of registration, certification, and/or licensure for their respective fields. Their mission is to promote high standards of professional practice for their specific profession, thereby improving the health of society by improving the people in the profession. Professional organizations are funded primarily by membership

BOX 2.1 A Closer Look at One Voluntary Health Agency: The American Cancer Society

The American Cancer Society (ACS) was founded in 1913 by 10 physicians and 5 laymen.[41] At that time, it was known as the American Society for the Control of Cancer. Today, with offices throughout the country and approximately 2.5 million volunteers, ACS is the largest voluntary health organization.[42] Despite success, its mission has remained constant since its founding. It is "dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy and service."[43]

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

The American Cancer Society's educational programs are targeted at two different groups—the general public and the health professionals who treat cancer patients. The public education program promotes the following skills and concepts to people of all ages: (1) taking the necessary steps to prevent cancer, (2) knowing the seven warning signals, (3) understanding the value of regular checkups, and (4) coping with cancer. The society accomplishes this by offering free public education programs, supported by up-to-date literature and audiovisual materials, whenever and wherever they may be requested. These programs may be presented in homes, worksites, churches, clubs, organizations, and schools. A few of their better-known programs include Circle of Life, I Can Cope, and Reach to Recovery.[44] From time to time, the ACS also prepares public service messages for broadcasting or televising.

The Society's professional education program is aimed at the professionals who work with oncology patients. The objective of this program is to motivate physicians and other health care professionals to maintain and improve their knowledge of cancer prevention, detection, diagnosis, treatment, and palliative care. Such education is provided through professional publications, up-to-date audiovisual materials, conferences, and grants that fund specialized education experiences.

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

The ACS is the largest source of private, not-for-profit cancer research funds in the United States, second only to the federal government in total dollars spent. Since 1946, when the ACS first started awarding grants, it has invested about $4.0 billion in cancer research. The research program consists of three components: extramural grants, intramural epidemiology and surveillance research, and the intramural behavioral research center.[45] The most recent addition to the work of the ACS is in the area of advocacy. Specifically, the ACS works to (1) support cancer research and programs to prevent, detect, and treat cancer; (2) expand access to quality cancer care, prevention, and awareness; (3) reduce cancer disparities in minority and medically underserved populations; and (4) reduce and prevent suffering from tobacco-related illnesses.

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

dues. Examples of such organizations are the American Medical Association, the American Dental Association, the American Nursing Association, the American Public Health Association, and the Society for Public Health Education, Inc.

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

Like voluntary health agencies, another important activity of some professional organizations is advocating on issues important to their membership. The American Medical Association, for example, has a powerful lobby nationally and in some state legislatures. Their purpose is to affect legislation in such a way as to benefit their membership and their profession. Many professional health organizations provide the opportunity for benefits, including group

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

insurance and discount travel rates. There are hundreds of professional health organizations in the United States, and it would be difficult to describe them all here.

Philanthropic Foundations

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

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

Some of the larger foundations, in addition to the Bill and Melinda Gates Foundation, that have made significant commitments to community health are the Commonwealth Fund, which has contributed to community health in rural communities, improved hospital facilities, and tried to strengthen mental health services; the Ford Foundation, which has contributed greatly to family-planning and youth sexuality efforts throughout the world; the Robert Wood Johnson Foundation, which has worked to improve the culture of health and policies dealing with health-related systems; the Henry J. Kaiser Family Foundation, which has supported the health care reform and community health promotion; the W. K. Kellogg Foundation, which has funded many diverse health programs that address human issues and provide a practical solution; and the Milbank Memorial Fund, which has primarily funded projects dealing with the integration of people with disabilities into all aspects of life.

Service, Social, and Religious Organizations

Service, social, and religious organizations have also played a part in community and public health over the years (see **Figure 2.11**). Examples of service and social groups involved in community health are the Jaycees, Kiwanis Club, Fraternal Order of Police, Rotary Club, Elks, Lions, Moose, Shriners, American Legion, and Veterans of Foreign Wars. Members of these groups enjoy social interactions with people of similar interests in addition to fulfilling the groups' primary reason for existence—service to others in their communities. Although health may not be the specific focus of their mission, several of these groups make important contributions in that direction by raising money and funding health-related programs. Sometimes, their contributions are substantial. Examples of such programs include the Shriners' children's hospitals and burn centers; the Lions' contributions to pilot (lead) dog programs and other services for those who are visually impaired, such as the provision of eyeglasses for school-aged children unable to afford them; and the Lions' contributions to social and emotional learning of PreK–12 children via the educational program named "Lions Quest."[46]

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

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The contributions of religious groups to community and public health have also been substantial. Such groups also have been effective avenues for promoting health programs because (1) they have had a history of volunteerism and preexisting reinforcement contingencies for volunteerism, (2) they can influence entire families, and (3) they have accessible meeting room facilities.[47] One way in which these groups contribute is through donations of money for missions for the less fortunate. Examples of religious organizations that solicit donations from their members include the Protestants' One Great Hour of Sharing, the Catholics' Relief Fund, and the United Jewish Appeal. Other types of involvement in community health by religious groups include (1) the donation of space for voluntary health programs such as blood donations, Alcoholics Anonymous, and other support groups; (2) the sponsorship of food banks and shelters for the hungry, poor, and homeless; (3) the sharing of the doctrine of good personal health behavior; and (4) allowing community and public health professionals to deliver their programs through the congregations. This latter contribution has been especially useful in black American communities because of the importance of churches in the culture of this group of people.

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

Corporate Involvement in Community and Public Health

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

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

Chapter Summary

- Contemporary society is too complex to respond effectively to community and public health problems on either an emergency or a long-term basis. This fact necessitates organizations and planning for health in our communities.
- The different types of organizations that contribute to the promotion, protection, and maintenance of health in a community can be classified into three groups according to their sources of funding and organizational structure—governmental, quasi-governmental, and nongovernmental.

- Governmental health agencies exist at the local, state, federal, and international levels and are funded primarily by tax dollars.
- WHO is the largest and most visible governmental health agency on the international level.
- The Department of Health and Human Services (HHS) is the U.S. government's principal agency for the protection of the health of all Americans and for providing essential human services, especially for those who are least able to help themselves.
- The Whole School, Whole Community, Whole Child (WSCC) model expands on the coordinated school health model and incorporates an ecological approach directed at the whole school, with the school drawing its resources and influences from the whole community to address the needs of the whole child.
- The core functions of public health include the assessment of information on the health of the community, comprehensive public health policy development, and assurance that public health services are provided to the community. Ten essential services are used to meet these core functions.
- Quasi-governmental agencies, such as the American Red Cross, share attributes with both governmental and nongovernmental agencies.
- Nongovernmental organizations include voluntary and professional associations, philanthropic foundations, and service, social, and religious groups.
- Corporate America has also become more involved in community and public health, both at the worksite and within the community.

Scenario: Analysis and Response

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

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

Review Questions

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

Activities

1. Using the Internet, identify 15 health-related organizations that service your community. Divide your list by the three major types of health organizations noted in this chapter.
2. Make an appointment to interview someone at one of the organizations identified in Activity 1. During your visit, find answers to the following questions:
   a. How did the organization begin?
   b. What is its mission?
   c. How is it funded?
   d. How many people (employees and volunteers) work for the organization, and what type of education/training do they have?
   e. What types of programs/services does the organization provide?
3. Obtain organizational charts from the U.S. Department of Health and Human Services (see Figure 2.2), your state department of health, and your local health department. Compare and contrast these charts, and describe their similarities and differences.
4. Call a local voluntary health organization in your community and ask if you could volunteer to work 10 to 15 hours during this academic term. Then, volunteer those hours and keep a journal of your experience.

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