

4. Rural Health Departments. The weakest link in our health chain. The reasons for this are the nature of our rural social and political organization; the size of the allotment to health; and the administrative difficulties.

a. Survey of Field. Virtually all the rural health work now being done is the result of the co-operative efforts of local and state departments of health with the U.S. Public Health Service and the International Health Board (Rockefeller Foundation)

Only 19% in 1928 of rural population had local health service under the direction of a full time health officer.

b. Rural Sanitation Service of U.S. Public Health Service. Created by Acts of 1893 and 1912.

(1) Objectives

- (a) Improvement in sanitary devices
- (b) Co-operation with local health departments financially and functionally.

(2) Methods

- (a) Small subsidies
- (b) Demonstrations (Cape Cod District)

(3) Extent. 109 counties in 17 States. Such service needed for 60% of population. At present it is available for only 19%.

(4) Cost (1928)

Federal funds	\$77,628.01
State and local funds	948,838.24
Private organizations	<u>91,489.53</u>
Total	\$1,117,955.78

References: Public Health Reports - Nov. 30, 1928  
(Document Room and Magazine Room)  
Contains excellent accounts of work of San Joaquin Health District.

c. International Health Board is one of the subsidiaries of the Rockefeller Foundation. One of the important activities has been their co-operation with federal and local health officials in promoting rural public health.

(1) Method. Through a co-operative agreement with State and Local government the I.H. Board gives financial support to local health projects until they have proven their worth and are taken over by the people.

d. North Carolina County Health Work. Dr. Watson Rankin, State Health Officer of North Carolina, has been one of the outstanding leaders in the rural health field.

(Reference: North Carolina Health Bulletin, Jan. 1920)