

# A HISTORY OF HEALTH AND SOCIAL SERVICES IN ALASKA



An Alaskan field nurse and patient review a manual titled "Home Care of Tuberculosis: A Guide for the Family," ca. 1940s–1960s.  
(Courtesy Alaska State Library, Alaska Department of Health & Social Services Photograph Collection)

*Dedicated to the 1993 centennial of public health nursing in Alaska*

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## **DEDICATION**

For over 100 years, nurses have been a dominant force in protecting and promoting the health of Alaskans. The first professional nurse arrived in Bethel in 1893, three years before the first doctor arrived and 23 years before the first hospital was built in that area. Over the next ten years, nurses began working in Sitka, Skagway, Circle City and Nome.

For many, the traveling nurse was the only source of health care. Carrying kits equipped with basic remedies, vaccines, sutures, forceps, and other paraphernalia, nurses traveled from one community to the next. Barrow to Ketchikan, the Aleutians to Canada and across the Interior on foot, by dog sled, river boats, steamship, and later by train, plane, and military vessel, itinerant nurses covered thousands of miles and provided health care to as many people as possible.

Nurses incorporated health education and disease prevention into their primary health care practices: They taught good nutrition, cleanliness, dental hygiene, and family care. They held classes on prenatal development and child behavior, immunized children and adults against infectious diseases, administered hearing and vision tests, and delivered babies.

Today the [State of Alaska] Department of Health and Social Services Section of Nursing has 106 public health nurses. They serve 275 communities through 21 health centers and 33 itinerant nurses.

This publication is dedicated to the pioneering spirit of Alaska's public health nurses and their counterparts of yesteryear.

## **ACKNOWLEDGEMENTS**

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Dr. Theodore A. Mala, Commissioner of the Alaska Department of Health and Social Services, had the vision of documenting the Department's history. The publication was researched and written by Lisa M. Short and edited by Dr. Brian Saylor.

May, 1993

Dear Employees and Friends:

For many years health and human service professionals have urged the compilation of a department history within the context of evolving health and human services. This publication was prepared in response to those requests and is proudly dedicated to the 100th Anniversary of Public Health Nursing in Alaska and each employee, past, present and future for their contribution to this department.

From the traditional healing practices of the Alaska Natives and the gold rush pioneering days through the twentieth century, Alaska's health and welfare programs have been continually challenged to keep pace with the changing times and progressing technology. A History of Health and Social Services in Alaska is an overview of those factors which have influenced the development of health and human services in Alaska.

A History of Health and Social Services in Alaska reviews broad issues and events, highlighting their contribution to health and social services in our state. We hope that skilled historians, providers, and interested Alaskans will continue to fill in historical gaps, clarify the relationship between events, and update this publication as new developments warrant. We thank everyone who has contributed to the development of this department.

We are happy to have made this publication a reality and hope that it will create a better understanding of the evolution of health and human services in Alaska.

Sincerely,

//s// Walter J. Hickel, Governor

//s// Theodore A. Mala, MD, MPH, Commissioner

## *Health and Welfare prior to 1912*

### ***Introduction***

The history of health and welfare in Alaska begins with its indigenous people.

The Eskimo lived on the tundra north of the Alaska Peninsula, west of the Alaska Range and north of the Brooks Range. Aleuts occupied hundreds of islands on the Aleutian Chain. The Athabascans inhabited Southcentral and Interior Alaska, while the Tlingit and Haida established communities on the inlet shores of Southeastern Alaska.

The Natives occupied a land of extremes. The people of Kaktovik on the Beaufort Sea lived in a frozen world. The Aleuts scattered along the windswept Aleutian Islands and weathered the constant storms of the Bering Sea. The Indians of Southcentral followed game over the semi-arid regions of the Interior and the Indians of the Alexander Archipelago lived amongst immense stands of spruce, cedar and hemlock.

Travel throughout much of Alaska was limited by the sheer size of the wilderness, towering mountains, glaciers and rivers. Some Native communities were isolated by natural barriers. Others traded extensively along established trade routes. Travel, when it did occur, was by small boat and by foot over the trails along the coast and into the Interior.

### *Endemic Health Problems*

The health problems faced by Natives and later, the early Euroamericans were similar to those of other northern countries around the world. For centuries people struggled to survive the harsh living conditions. Opportunities for hunting, fishing, and gathering plants largely determined where people lived and what they ate. Challenging conditions made the people vulnerable to the weather, seasons, and migration patterns of the animals. Men, women and children foraging food were challenged by their surroundings every day. The subsistence lifestyle made the Natives susceptible to starvation and drowning, loss of limb and loss of life.

Most communities were small, transient, and almost everywhere extended families lived together. The environment impacted the inhabitant's health. Injuries were the major cause of disability and death. There were a number of illnesses caused by unsanitary conditions. Inadequate nutrition was widespread. Many Natives suffered from severe pulmonary disorders. Malnutrition, chronic eye, ear and dental diseases were prevalent. Although malnutrition is not a disease, it contributed heavily to the onset of sickness.

### *Indigenous Health Care*

The material for this section draws heavily upon the work of Dr. Robert Fortuine.

Medicine, shamanism and surgical techniques have been practiced throughout Alaska's history. Alaskan Natives used a number of plants for health care remedies.

There was a short and limited growing season for plants in the north and a longer growing season for plant life in the south. Plant remedies were more abundant for people in Southeastern Alaska than in the far north. Natural medicines (those organically extracted from plants or animals) were the only prescriptions. Traditional healers developed their own treatments and use of medicinal herbs. Some healers trained helpers in their work, while others kept their knowledge a secret; many traditional healing practices were subsequently lost.

Although the applications varied, plant remedies were routinely prescribed in almost every Native community. Sore throats, cuts, wounds, external bleeding, upper and lower respiratory illnesses were commonly treated by plants and their extracts. Flowers and fruits including buds, stems, seeds, and leaves as well as pitch, sap, bark and other natural ingredients were boiled into a "tea" and taken internally. Sometimes poultices were applied to the skin. Plants were cooked, chewed, or placed raw upon affected areas.

Early medicine also included the use of animal products, minerals, heat, cold, and steam. Broken arms and legs were set with slabs of bark or pieces of bone. Wounds were sewn with sinewy thread made from animal or plant fibers. Hot mineral springs saturated with iron and sulphur were used to treat various skin diseases. Heated rocks warmed a chill, cold water lowered a fever, and sweat houses cleansed the pores.

The Russians were the first to record the customs of Alaska's Native people. Mariners exploring regions of Alaska kept detailed accounts of the geography, vegetation, marine life, and the people they encountered. Detailed notes describe not only traditional healing methods but also surgical techniques practiced at that time. Blood letting, acupuncture, piercing, tattooing, and surgery were performed in some communities.

The shaman was the major medical practitioner in traditional Alaskan health care. Shamanism was a religious medical practice based on a belief of good and evil spirits. By incantation, song, trance, prophesying, and sorcery a shaman interceded with the spirit world to rid the sick of evil spirits. The shaman was not effective when it came to smallpox though and the Russians' vaccine eroded the power of the shaman among his people.

### *The Introduction to Western Disease*

As European and American exploration of Alaska continued, smallpox, tuberculosis, and influenza were introduced to Alaskan Natives. Russians began exploring the North Pacific in 1741, Spain in 1774, England in 1778, France in 1786, and Americans in the 1790's. By the turn of the century, disease traveled along the various trade routes.

Gold was discovered on the Stikine River in 1861, at Juneau in 1880, the Kenai Peninsula in 1890's, and the Klondike in 1896. Voices crying "Gold in Alaska!" rang out in the Lower 48 and thousands swarmed aboard northbound steamships. Cities grew out of trading post sites and mining towns sprang up overnight.

More than gold was discovered. Copper was found in the Wrangell Mountains and oil and gas were pumped at Katalla. The early miners, traders, whalers, fishermen, farmers and prospectors traveled north to Juneau, Dawson, Nome, Fairbanks, and beyond. Foot traffic increased in the Interior and sternwheelers operated along the Tanana, Kuskokwim, and Yukon rivers. Steamships called at Southeastern ports regularly and tourists strolled the streets of the small towns.

As the pioneers traveled north, whooping cough, measles, mumps, chicken pox, small pox, diphtheria, scarlet fever, and influenza traveled with them. Epidemics of poliomyelitis, meningococcus meningitis, typhoid fever, dysentery, venereal disease, and salmonella hit the North. The Natives were particularly vulnerable to the communicable diseases that were new to them and epidemics swept through villages. It was too common to see children with birth defects resulting from disease, deformed hips and hunchbacks, faces scarred by smallpox and limbs crippled by polio.

The deadliest epidemics left village after village deserted. Corpses were left unburied as people fled. Tuberculosis, the scourge of Alaska, crippled old and young alike and those who were not infected knew someone who was. Armed with whatever medical knowledge was available to them, the Russian Orthodox, Roman Catholic, and Protestant missionaries gave their time, skills and resources to minister to the ill and dying and comfort to the orphaned and widowed.

In addition to the epidemics, venereal disease and a host of other illnesses, scurvy, frostbite, and starvation plagued the people. Settlements were miles apart and inaccessible during most of the year. There were no roads. People were isolated. Most communities had no medical or health services of any kind. Health care in many places depended on what one could do for one's self.

### *(1867 — 1912)*

In 1867, "ownership" of Alaska was transferred from Russia to the United States. When the Army arrived in Sitka to defend America's newest acquisition, it took over one of the Russians' four established hospitals, a 15-bed hospital that had been operated by the Russian American Company. The Army operated the hospital for the next 10 years, with one or more doctors and several male nurses.

In the late 1800's, missionaries and teachers across Alaska cared for the residents in their districts. Medical officers, including physicians and male nurses, assigned to revenue cutters, offered their skills at the coastal communities. The few private practitioners in Alaska traveled hundreds of miles through the wilderness to tend to the sick. At best, medical visits were sporadic and often in response to an emergency situation. The land was too remote and the population spread too thin to attract many doctors.

When the United States purchased Alaska from Russia in 1867, the U.S. Bureau of Education was the first federal agency charged to provide for the health and education of Alaska Natives. Most of the schools in Alaska were run by missionaries. Medical facilities, such as they were,

were hundreds of miles apart. Gradually, the Bureau of Education began to build and run its own schools and hospitals. The Bureau of Education placed physicians and dentists on revenue cutters patrolling Alaskan waters and sent nurses to the field. Teachers in Native schools were instructed to place considerable emphasis on health education. Each school was provided with a medicine chest and, if possible, the teacher had taken a training course in first aid.

### *The First Health Care Providers*

Prior to 1884, health care in Alaska was unregulated. The passage of the First Organic Act on May 17, 1884 formed the District of Alaska and established civilian government. From 1867 to 1906, Alaska had no representation in Congress and each year the Governor of the District requested funds in his annual report for health and welfare with little success.

In 1885, three Catholic nuns, all nurses, arrived in Juneau and established a hospital. Early in 1888, the Presbyterian Mission at Sitka built a hospital which employed a doctor and a nurse. Philippine King, a Moravian missionary nurse headed north in 1893. In the 1890's the St. John's Maternity Hospital in the Tlingit village at Sitka was built but the Tlingit women refused to use it.

After graduating from medical school in Philadelphia and completing some post-graduate work in surgery, Moravian missionary Joseph Herman Romig arrived in Bethel in 1896. Dr. Romig traveled by dog team throughout southwestern Alaska to care for the sick and injured. His "clinics" were wherever he found shelter; sod houses, missions, and trading posts.

In 1897, Miss Ann Dickey, an Episcopal missionary, served as matron of the hospital in Skagway, gateway to the Yukon gold fields. Her hospital was a crude log cabin in Alaska's largest city. Episcopal Deaconess, Elizabeth Dean, chose to serve at Circle City, another gold rush boom town. In 1902, four Catholic Sisters of Charity of Providence arrived in Nome.

Harry Carlos DeVighne, assigned by the Bureau of Education in the early 1900's, inspected the region from Alaska's southern most boundary to the furthestmost Aleutian Island. His transportation included anything available from steamship and revenue cutter to Native canoe. Dr. DeVighne visited over 100 villages and examined over 5,000 Natives.

Lulu Herron traveled to Akiak in 1916, when the first hospital in that area was built. Herron became the traveling nurse stationed in Bethel from 1924 until the first hospital built there in 1940.



## *Territorial Health*

### **1912 – 1940**

With passage of the Second Organic Act on August 24, 1912, signed by President Taft, Alaska's status changed from District to Territory. The Organic Act of 1912 remained in effect until statehood was approved in 1958.

Alaska's Governor, charged to gather statistics on communicable diseases and implementation of quarantine laws, served as Commissioner of Health. Chapter 42, SLA 1913 directed every school district outside of incorporated towns to become a health district. Each district's board of health was composed of the president of the school board and two citizens of the district, and provided that wherever practicable, one member shall be a licensed physician.

In 1919, the Territorial Legislature passed a series of laws which were the initial authority for public health activities in Alaska. The Territorial Legislature created the office of Commissioner of Health and the first physician to be appointed took office on a part-time basis. Unfortunately, funds for a commissioner's salary were not provided until 1923.

## *Community Health Care*

### **(1919 — 1935)**

From 1919 to 1935, incorporated communities appointed local physicians as town health officers on a part-time basis. The distribution of public health services focused first on the urban areas. In the cities, where schools and businesses were established, doctors and nurses met the needs of the greatest number of people. The people living nearby made their way into town when they were ill or injured if they could. Health care in general was a problem accentuated by great distance, severe climate, poor transportation, limited communications and small populations.

Professional nursing organizations joined the missionaries and became active in the Territory. In the fall of 1922, Stella Fuller, the first American Red Cross Nurse to Alaska reached Seward, Alaska. Stella covered her territory on the *Starr*, a staunch little mail ship that served west coast communities. In the years that followed, the U.S. Public Health Service sent public health nurses to augment the number of doctors practicing in the territory and the growing population.

From Barrow to Ketchikan, the Aleutians to Canada by foot, steamship, train, and plane, the public health nurses traveled hundreds of miles and saw thousands of patients. They carried sleeping bags and slept in school houses, village homes, and tents. Nurses inoculated entire communities, pulled teeth, sutured wounds, set broken bones, and delivered babies. They taught mothers and Native midwives about hygiene, nutrition and basic first aid.

The Alaska Territorial Health Department and the U.S. Public Health Service frequently worked together. In a joint effort in 1926, every passenger sailing for Alaska was vaccinated against smallpox. As a result, *only* four cases of smallpox appeared in the territory the following year.

Both agencies shared the responsibility of examining and vaccinating all cannery employees. In addition, they distributed smallpox vaccine throughout Alaska and more than 8,000 people were vaccinated in 1927.

Despite the interaction between the Health Department and the Public Health Service, other health care services throughout the Territory continued to be fragmented. The Territorial Commissioner of Education provided health education programs in the public schools. The Department of the Interior continued to provide funding and services for Alaska's insane — transporting mental health patients to Morningside Hospital in Portland, Oregon.

### *1931 — The Bureau of Indian Affairs*

On March 16, 1931, the Bureau of Education transferred its responsibilities for Alaska Native education and health to the Bureau of Indian Affairs (BIA). The Bureau of Indian Affairs, Department of the Interior, became responsible for the education, health care, welfare and relief of 36,000 Natives in the territory.

### *1935 — The Matanuska Colony*

During the depression years health officials became active in the colonization project of the Matanuska Valley. The colony began as a tent city in 1935 when the Federal government brought two hundred pioneers and their families to the Valley. Crowded living conditions and inadequate water and sewer supplies created serious health problems. Measles, chicken pox and scarlet fever epidemics broke out.

Dr. Joseph Romig, now the Chief Surgeon for the Railroad residing in Anchorage, urged Dr. Conrad Earl Albrecht to consider a position at the Matanuska Colony. Dr. Albrecht and three nurses from Anchorage were assigned to the Valley. They implemented quarantine measures, promoted hygiene and health education and operated an efficient medical facility. Dr. Albrecht would later become one of the commissioners of Alaska's Department of Health.

### *Progress Shapes the Health Care System*

Several developments in the 1900's shaped Alaska's health and welfare. Fishing, mining and farming continued to lure pioneers north. Communities continued to grow as military bases were established in the 1940's. Transportation and communications were improved throughout the territory. The U.S. Geological Survey mapped much of Alaska. Mt. McKinley National Park and the Chugach and Tongass National Forests were created. The railroad between Fairbanks and Seward created the city of Anchorage. A public education system was established, including a state university at Fairbanks. Legislation gave women and then Natives the right to vote.

These developments opened up Alaska, provided employment and attracted people to the Territory. As the population grew, the Department of Health was faced with providing a public health program specifically designed to fit Alaskans. Tuberculosis control, crippled children services, and environmental sanitation needed attention. The concentration of medical personnel and facilities in a few towns left many people in remote areas of Alaska without access to medical services.

### *Social Security Act Funds Health & Welfare (1936)*

In February of 1936, federal funds under the Social Security Act were extended to all states and the Territory of Alaska. The Act allowed public health services to expand. Health programs for communicable diseases, maternal and child health care were started. The Division of Maternal and Child Health Care in Alaska was organized in 1936 for the development of a territorial-wide program concerned with the health of mothers and children.

The department's Division of Maternal and Child Health Care administered the Public Health Nursing Program from 1936 to 1942. Eunice Anderson and Alice Moran were the first two public health nurses hired and for the first year their tuberculin testing and community assessment services were limited to Southeast Alaska.

Sanitation remained a serious problem in Alaska. Public health sanitarians and engineers monitored barber shops, restaurants, hotels and public lavatories. They studied milk sanitation and the possibility of developing a supplementary milk source outside the territory.

Salmon canneries and shellfish packers throughout the state were inspected annually and ships in Alaskan waters were continually watched for rat infestations. Water and sewer supplies were monitored, but the engineers had limited travel funds and many of the remote communities were not studied. Although improvements were made to public water supplies and sewage disposal systems, most small towns still lacked safe water and the proper disposal of sewage.

In 1937, the Territorial Legislature directed the Commissioner of Health to establish a department to care for crippled children. The Department of Maternal and Child Health Care added Crippled Children's Services that year.

While the health and welfare of Alaskans was slowly improving, many programs needed further development. Church sponsored homes cared for hundreds of children. But neither they nor the territory provided specialized care for handicapped children. There were no special services available to the mentally impaired. Children and adults requiring custodial care were placed in institutions outside of Alaska where they were far removed from their families and communities. The Territory provided no means of caring for juveniles.

Private groups helped support the inadequately funded and staffed Territorial health and welfare programs. The combined efforts of the Bureau of Indian Affairs, the Red Cross, the churches, Salvation Army, fraternal orders, service clubs and many individuals gave time and money to

needy Alaskans from Ketchikan to Kotzebue. Their donations and volunteered services helped meet some of the critical needs of the people that could not be borne by the department alone.

By 1938, the Department of Health had two physicians, eleven public health nurses, one public health engineer, a sanitarian, two laboratory technicians, and a clerical staff of five. The Commissioner and his three deputies were part-time employees as were the four Orthopedic Surgeons in Seattle and a part-time vital statistics clerk.

### *Public Welfare Agency Established*

Health and Welfare were administered separately for many years. Alaska's first public welfare programs were created with the Federal Social Security Act of 1935. The Department of Public Welfare and the Board of Public Welfare were established by legislation in 1937, eighteen years after the Department of Public Health was established. The welfare programs provided financial assistance and services to needy people, to dependent and neglected children, and to children in need of protection. Old Age Assistance, the Temporary Relief Program, and Child Welfare Services, lightened the financial burden formerly borne by the Territory.

The Temporary Relief Program provided food, housing, clothes, fuel, utilities, hospitalization, and medical care to needy people. Alaska's General Relief Program still exists today, although many of its functions have been absorbed by the newer Medicaid program.

Through a federal grant the Territory of Alaska established services for children. The Child Welfare Services provided protection and care for homeless, dependent and neglected children, and children in danger of becoming delinquent. This agency was the predecessor of today's family and youth services program

### *World War II (1941-1945)*

World War II's impact on the territory was enormous. The Western Defense Command was activated December 11, 1941, to prevent the Japanese from destroying American bases and occupying islands in the outer Aleutians. The military brought people, invested money, and built bases and airstrips, changes that impacted the physical and mental health of the Alaskan people. Between 1941 and 1945, over a billion federal dollars were fed into the Alaskan economy.

In the process of preparing Alaskan defenses, the military developed communications and modern infrastructure linking rural communities with cities and the continental United States. Eleven thousand soldiers constructed 1,420 miles of road bridging the gap between Alaska and the Lower 48 with the Alcan Highway. Communication networks were established and Alaska became a military stronghold in the west.

## *WWII's Impact on Health*

As a result of rapid growth, health care and sanitation issues became an even greater priority for Alaska's health department. The major program areas addressed by the Department of Health during the war and postwar years were environmental sanitation, hospital facilities, preventive medical services related to chronic disease and aging, cancer, polio, tuberculosis and venereal disease. Military personnel and their dependents soon accounted for nearly half of Alaska's population. To meet their own demand, military bases established on-site hospitals and clinics supported by well-trained physicians and nurses. Military nurses delivered care to the families of military personnel and initiated a massive blood typing campaign during the war.

Besides servicing the hospitals and base clinics in remote areas such as Bethel and Nome, medical officers assisted in the inpatient and out-patient care of local facilities. In emergency situations, military personnel traveled to the villages in an effort to stop diphtheria or other life threatening epidemics.

Military personnel touched the lives of people in isolated communities too. Critically ill patients in remote areas were transferred to hospitals through the military operations of rescue and evacuation. Alaskans' health care and delivery system improved with the cooperation of the military's medical staff.

## *New Health Care Programs Emerge*

There were other agencies distributing health care services and programs to Alaskans during the War years. Revenue Cutters offered medical and dental care at remote coastal communities. The Alaska Railroad provided medical and hospital care for their employees through a hospital and clinic at Anchorage and emergency services at Seward and Fairbanks.

Voluntary agencies provided a number of vital but limited health programs including the Alaska Crippled Children's Association, the American Cancer Society and the Alaska Tuberculosis Association. Health care in Alaska was a combined effort by a number of different agencies working with the Department of Health.

## *The Post War Era (1945-1958)*

### ***The Alaska Department of Health***

After World War II, physician Governor Ernest Gruening initiated a major program to improve health care in the territory. Gruening called a special session of the legislature to address tuberculosis, reorganized the Department of Health and initiated an aggressive program to improve health conditions.

Many state and national agencies with a mutual interest and concern for Alaska's public health joined the Governor in a cooperative effort. The Anchorage Hospital, the United States Public

Health Services, The National and Alaska Tuberculosis Associations, the Center for Poison Control in Washington, D.C., the Center for Communicable Disease, Johns Hopkins University, the University of Washington Medical School and St. Vincent's Hospital in Portland helped initiate Alaska's health care reform.

In 1945, the territorial legislature passed an act giving the Health Department legal status and establishing a full-time Commissioner of Health. Dr. C. Earl Albrecht, the same physician invited to Alaska by Doctor Romig, became the first full-time commissioner.

In addition to the Nursing Program, Public Health Engineering under Communicable Disease Control, Crippled Children's Services, the Division of Public Health Laboratories, the Venereal Disease and the Maternal and Child Health programs strengthened the department.

When Alaska reverted to an inactive status after the War, the Army Nurses Corps returned to the Lower 48. The majority of nurses remaining were located in fourteen cities extending from Ketchikan to Nome under the direction of Dorothy Whitney. The Nursing Program received financial support from the territorial Department of Health, the Bureau of Indian Affairs and local communities for whom the public health nurses were a desired service.

Alaska's major health issues included: environmental sanitation, hospital facilities, cancer, polio, tuberculosis, and venereal disease, additional problems created by the mushroom-like growth of certain areas during the Postwar boom.

## *Tuberculosis*

### ***Narrative by Dr. Frank Pauls***

“For many years tuberculosis was the leading cause of death in Alaska. Tuberculosis is caused by a very small germ called the tubercle bacillus. An unguarded cough, sneeze, or even loud talking by a person with contagious tuberculosis could project these germs into the air in droplets of moisture where they could be breathed in by an unsuspecting healthy person.

“Any personal articles of an infected person could carry the germ, dishes, drinking glasses, bed linen, or anything else that touched the person's lips. Protected by a wax coating, the germ could remain active for long periods of time preserved against drying or freezing. Consequently, contaminated dust blown by currents of air also carried the disease.

“In 1946, 43% of all death certificates for Indians, Eskimos, and Aleuts listed tuberculosis as the cause of death. There were 130,000 people in Alaska and 5,600 were listed on the tuberculosis register of the Department of Health as having actual or suspected cases.”

The territory had thousands more people suffering from TB than there were hospital beds. Patients for whom there were no beds stayed at home exposing family and friends to the disease until they died.

In 1946, the Alaska Territorial Legislature unanimously passed the Alaska Tuberculosis Control Act. A quartet of a million dollars, one tenth of the entire annual government budget, was appropriated to fight the disease. Commissioner Albrecht supported the department's purchase of military hospitals and equipment in Seward, Skagway and Mt Edgecumbe.

In 1948, armed with a stack of X-rays confirming active tuberculosis, Commissioner Albrecht traveled to Washington, D.C., to address Congress. Given the floor, Albrecht informed Congress of the great sanitation and health problems facing Alaska.

During the next legislative session, the appropriations were almost triple for health and sanitation purposes. In June, Congress awarded \$1,115,000 for "Disease and Sanitation Investigations and Control" for the Territory of Alaska. Through this appropriation, special funds were made available to implement new programs under the territorial Department of Health and to permit expansion of existing services.

Money alone could not stop tuberculosis. Alaskan agencies and independent institutions worked together in an effort to control the disease. Commissioner Albrecht coordinated the efforts of the Department of Health, Fish and Wildlife Service, Alaska Railroad, U.S. Public Health Service, Children's Bureau, Veterans Administration, voluntary health agencies and the Indian Health Service in the fight against the disease.

The Alaska Tuberculosis Association promoted health education programs, chest X-ray surveys and brought vocational rehabilitation personnel to work in the sanatoria. The Alaska Crippled Children's Association donated active assistance in the development of health programs and contributed funds for the transportation and hospitalization of crippled children in Alaska. The Alaska Chapter of the American Cancer Society strengthened its educational program. The American Red Cross, at the end of the war, turned over a considerable quantity of its surplus supplies to the Commissioner of Health.

Alaska opened an orthopedic hospital in Sitka in 1947, housing more cases of bone tuberculosis under one roof than in any other spot on the North American Continent. The Bureau of Indian Affairs hired the nurses but the Department of Health hired the orthopedic surgeon as well as the physical therapist. The department's aggressive assault against tuberculosis turned the tide and in 1951, tuberculosis dropped from first place to third place as the leading cause of death in Alaska.

By 1952, the Bureau of Indian Affairs had a 400-bed TB hospital under construction, and a major breakthrough was made for tuberculosis patients when an effective arsenal of tuberculosis drugs became available and were distributed by the department. The hospital, opened in 1955 as a tuberculosis hospital, has gradually changed its role. Today it is a general medical and surgical hospital serving over 85,000 Alaskan Natives living statewide and providing clinical backup and specialty consultation to other service unit hospitals located throughout the state.

### *The Parran Report Impacts Alaskan Native Health Care (1953)*

The structure of the Alaska Area Native Health Service is largely a result of a detailed report on the health status of Alaska, called the Parran Report. The BIA administered health services to Alaskan Natives prior to the adoption of the report's recommendations.

Early in 1953, prompted by the desire to improve the effectiveness of existing health programs serving the Territory, Commissioner Albrecht, the Legislature, and Governor Gruening urged the Department of the Interior to make a formal survey of the health conditions, resources and programs serving Alaska. Participating in the two-year survey were members of the University of Pittsburgh School of Public Health, the Bureau of Indian Affairs, and the Departments of Health, Education, and Welfare.

The investigation covered all aspects of health in Alaska including federal, territorial, voluntary, and private health programs. The Legislature and the Governor requested that particular attention be paid to the health problems of Alaska Natives.

The survey team arrived in Juneau on July 21, 1953. Their inquiries led the group over 6,000 miles throughout the Territory. During their review, the team studied individual hospitals, their internal operations, financing and relationship with other health agencies and institutions. They evaluated existing data and research and studied the organization, programs and facilities of the Alaska Territorial Department of Health.

When the survey was complete, the Parran Report verified the results of the Department of Health's X-ray surveys conducted in 1946 and 1947. The report ascertained the extent of tuberculosis and highlighted the inadequacy of the health care delivery system to the Native population. The committee made several recommendations which dramatically influenced health care in Alaska. The Alaska Native Service Anchorage Hospital should be staffed opened and operated immediately, environmental sanitation should be improved, health education, nutrition and preventive medical services in all of the Native villages should be provided, remote field hospitals should be established, further training programs should be developed for Alaskan Natives, and the commitment of Alaska's insane should be addressed. The recommendations of the committee rested on the premise that every Alaskan was entitled to the same assurance of life and health which was the right of every American citizen.

The Parran Report had more far reaching consequences than previous surveys. The Nation recognized the Territory's concern for improved health care for every citizen. The responsibility for the health of Alaskan Natives was transferred from the Bureau of Indian Affairs to the Division of Indian Health, U.S. Public Health Service on July 1, 1955.

The distribution of health care services to Alaskan Natives became significantly improved under the Division of Indian Health. Federal funds were made available for repairing old facilities and constructing new hospitals. Trained administrators were placed in charge, medical personnel were assigned to staff and efficient patient care programs evolved. Although most of the



recommendations involved the Alaska Native Health Service, the impact on the Department of Health was tremendous.

### *The Arctic Health Research Center's Impact on Alaskan Health Care*

Arctic research in Alaska was enhanced during the post War years. In 1946, Secretary of the Interior, Julius Krug asked the American Medical Association (AMA) to investigate health conditions in Alaska. One of the AMA recommendations was that an Arctic Institute of Health be established for the study of the Arctic and its bearing on health, sanitation, nutrition, engineering, construction, food, clothing.

Congress asked the U.S. Public Health Service to establish a research center in Alaska. The \$1,115,000 appropriation Alaska received in 1948 helped launch the center. The Arctic Health Research Center provided research, administered special health grants and provided technical assistance to Alaska.

The Arctic Health Research Center investigated the major health concerns of both the Department of Health and the Alaska Native Health Service. As a result, the Center's research work benefitted every Alaskan. Scientists at the center collected, studied and analyzed and then shared their research data with the department's staff, including the dietary patterns of the Eskimo and Indian; the prevalence of coronary disease in Natives; iron deficiency anemia; the adaptation of animal and man to the Arctic environment; rural sanitation and special designs for water distribution.

A program for the home treatment of tuberculosis was started by the Center using Isoniazid and PAS medication. The Alaska Native Health Service and the Alaska Department of Health were also involved in the tuberculosis drug therapy program. The Arctic Health Research Center clearly helped provide enhanced health care services to Alaskans.

### *The Mobile Health Units*

Thanks to the War Assets Administration, the Territory was able to obtain demobilized military medical facilities in Skagway, Seward, and Sitka, the M/V Hygiene, and a small arms repair truck for a mobile health unit. Through the cooperation of the department, U.S. Children's Bureau, the Bureau of Indian Affairs, and the Alaska Native Health Service, a plan was developed to take the public health services to the people who were scattered over great areas along the coast and major rivers. The M/V Hygiene started operating in March 1945 but quickly proved too small. It was replaced with the M/B [sic] Hygiene. The mobile health units provided a way for physicians, nurses and technicians to carry their work with them. The units were a creative solution to the inaccessibility of a number of rural communities.

### *Floating Health Centers*

In March of 1946, the M/V Hygiene, dubbed the "Shot Ship" by children, sailed from Southeast Alaska's Hyder near Ketchikan, up Cook Inlet and Prince William Sound, west past Dutch Harbor to Akutan and Nikolski and up through the Bering Sea serving most of the coastal villages west and south of Nome. The floating health center provided public health care, medical, nursing, bacteriological and X-ray services to the people living along the inlets and bays. The vessel housed a seven-man crew and contained a doctor's office, nurse's office, clinic room, X-ray equipment and a secretary's office. The professional staff consisted of a field physician, public health nurse, bacteriologist, dentist, dental assistant and a secretary.

The unit recorded case findings in the fields of crippling and handicapped conditions in children, vision and auditory defects, tuberculosis and venereal diseases. Prenatal examinations, physical examinations and immunizations of preschool and school children were the primary services offered developing into a family centered service. After the M/V Hygiene exploratory travels, it shared the coastline services with other units.

### *Health Centers Roads and Rivers*

The original Highway Mobile Unit, an Army surplus truck, was staffed by a field physician, a public health nurse, and a technical assistant. The unit started its services to communities with limited health service along the Glennallen, Richardson, Tok and Alaskan Highways in September of 1946. In addition to the "clinic on wheels" and the M/V Hygiene, the Railroad Unit and barge units traveled along the railbelts and water routes of the interior.

The M/V Yukon Health was a shallow draft river barge. In 1949 it began carrying public health programs to areas along the Yukon and Kuskokwim Rivers. The staff of the Yukon Health transferred to the railroad unit during the fall and winter months.

Together these units administered vision and hearing tests, diagnostic examinations, dental services, immunizations, made routine sanitary inspections, and provided programs for prenatal and preschool care. In the process many villages experienced their first contact with medical services provided by visiting teams. The units returned with statistics which could be translated into hospital beds, medical programs and healthier Alaskans.

By 1951 there were twenty-three public health centers located throughout Alaska. Public Health Nurses served an average of 2,000 Alaskans each year. Areas served by some of the doctors and nurses extended over thousands of square miles. The delivery of health care service by the mobile units was needed, not only to beat tuberculosis but to address the territory's other health care issues.

Gradually the major health care issues were brought under control. Modern hospitals and health facilities had been built with millions of federal dollars poured into the Alaskan economy during the war. Highways, railroads and the development of commercial transportation made health care

throughout the territory more accessible. Emergency evacuations, sophisticated medical equipment, telegraph, telephone and two-way radios began replacing the demand for the mobile units. Eventually the public health funding for the units could be utilized more effectively in other programs and the era of the mobile health unit came to an end.

*WE'RE IN!*

*Statehood (1959)*

### ***Health and Welfare Combine***

On January 3, 1959, local newspapers claimed "WE'RE IN" and Alaska became the 49th state. Charged with the responsibility of providing for the public's health and welfare, the first state legislature combined the Departments of Health and Welfare and Juvenile Institutions under a new Department of Health and Welfare. The new department combined the responsibilities of the programs that dealt directly with the state's most important resources — its people. Section 12, Chapter 64, SLA 1959, denotes the duties, powers and responsibilities of the department:

“The Department of Health and Welfare is hereby vested with the duties, powers and responsibilities involved in the administration of the state programs of public health and welfare, including, but not limited to, maternal and child health services; preventive medical services; public health nursing services; sanitation and engineering services; nutrition services; health education; laboratories; mental health treatment and diagnosis; management of state institutions; medical facilities; old age assistance; aid to dependent children; aid to the blind; child welfare services; general relief, licensing and supervision of child care facilities; and probation and parole supervision.”

Alaska in the 1960's was still a frontier in transition. Health and welfare problems required continual change, settlement, and development of early programs. Alaska Natives were moving from a subsistence culture to a more modern lifestyle. A transient military population continued merging with established settlers. Newcomers and seasonal workers created additional demands for new and expanded public health and welfare services.

Disease prevention and control were central to the Alaska public health mission. Oral polio vaccine (1961) and measles vaccine (1966) were supplied through over twenty centers and four laboratories which constituted the department's front line. The Department's staff included nurses, medical social workers, laboratory personnel, sanitary engineers, sanitarians, health educators, statisticians, and administrators. The Division of Public Welfare rendered Adult Public Assistance, Aid to Families with Dependent Children, General Relief, Child Welfare, and Foster Homes.

The capacity and resilience of these new public health and welfare programs was successively challenged by the Good Friday Earthquake of 1964, the Fairbanks floods in 1967, North Slope oil discovery, increases in public welfare programs and recipients, and dramatic increases in

alcoholism and drug abuse. The changes brought program enhancements and increased commitment.

During the early 1970's, the Department of Health and Welfare, now called the Department of Health and Social Services (DHSS), grew slowly and struggled to respond to the health and welfare problems resulting from economic change. Alaska's Native people united their efforts to settle the Native land claims issue once and for all. In 1971, Congress passed the Alaska Native Claims Settlement Act (ANCSA). The ANCSA legislation granted the Eskimo, Aleut and Indians of Alaska title to over 40 million acres of land. In addition, they were awarded almost one billion dollars. The Act not only designated Native land ownership in Alaska, it also addressed Native health, education and welfare.

Federal legislation funneled funding through twelve regional corporations and allowed their nonprofit subsidiaries to direct health and social service related programs previously administered by federal agencies. As a result, the first Alaska Native consumer controlled health organizations were implemented: The Yukon Kuskokwim Health Corporation headquartered in Bethel and The Norton Sound Health Corporation headquartered in Nome.

On January 4, 1975, the Indian Self-Determination and Education Assistance Act was passed. This federal legislation strengthened the Native communities' ability to determine and provide management and development for Native health care resources. The Act permitted an orderly transition from the Federal implementation of programs to regional-programs administered through the Native regions. At the close of 1975, all of the Native regions had established health entities.

Today, Native regional health corporations are the focal point of health care delivery in most of rural Alaska. The corporations administer state and federal health and social service programs, run hospitals and nursing homes and provide some social services.

The downsizing of the major military in Alaska severely strained the department's resources as troops withdrew and a number of bases and sites were closed. As a result, the strength of health care distribution was temporarily reduced until public and private, city and state health officials could fill the gap. The TransAlaska Pipeline was completed in 1977. Hundreds of people were unemployed. Public assistance and public health bore the burden of the unemployed and the uninsured. Driven by a depressed economy, the statistics of alcohol and drug abuse began rising. The number of people applying for public assistance benefits rose too.

### *Mental Health*

Prior to statehood, Alaska's territorial status prevented the Department of Public Health from exercising mental health authority. Treatment and custodial services for the mentally ill, mentally retarded and senile Alaskans was provided by Morningside Hospital, a private psychiatric facility in Portland, Oregon. This meant that people needing these services were required to leave

Alaska and travel to a facility far away from familiar surroundings. With the advent of statehood, the first state-operated mental health clinic was opened in Anchorage.

The Alaska Psychiatric Institute in Anchorage was built in 1962 with \$6,000,000 allocated by the Federal government for the construction of a psychiatric facility and a comprehensive statewide mental health program. When it opened in October, its completion ended 58 years of transporting the mentally ill to Morningside. An unused housing complex in Valdez was converted into the Harborview Nursing Home in 1961. The Division of Mental Health began gradual relocation of mental health patients to these two Alaskan hospitals.

Destroyed by the earthquake on March 27, 1964, Harborview was rebuilt in 1967 to house severely mentally retarded adults. Simultaneously with the development of state mental health services, private and federal programs were established throughout the state. In 1974, the passage of the Mental Health Center Act ushered in a new era of community based mental health services which still remain the standard of appropriate care for the mentally ill and developmentally disabled.

### *Public Assistance*

The Department of Public Welfare, established in 1937, administered Alaskans welfare programs. These included social services, economic support and medical care for the poor. Welfare payments were provided to families with children under the federal Aid to Families with Dependent Children program and to the blind, disabled, and elderly under Adult Public Assistance. General Relief Medical provided medical care for the poor. This department was merged with the Department of Health after statehood.

The Food Stamp Program was created in 1961. The program was created to improve the level of nutrition among low income households. Under the program food coupons, commonly referred to as food stamps, supplemented the food buying power of eligible low-income households. The Food Stamp Act of 1964 permanently established the Food Stamp Program and authorized expansion to all states.

Until 1974, Alaska's Public Assistance program was administered by social workers. Eligibility information provided by potential recipients was generally accepted without independent verification. Program administrators viewed public assistance benefits as a means of stabilizing a family's situation so that a social services plan could be designed to move the family off public assistance. Accuracy of benefits took a back seat to mobilizing adequate financial, medical and food assistance to assist Alaskan families. This remained the agency's philosophy until 1975.

Pre-pipeline impact began to be felt in Alaska as a large influx of job seekers reached the state. However, court battles ensued and pipeline construction did not start up immediately. The negative impacts of the population increase began to take their toll on the public assistance system in Alaska and caseloads climbed dramatically.

In addition, a federal mandate called for separation of social services from Public Assistance in anticipation of creating a more accountable system to achieve a higher quality benefit delivery system by ensuring that eligibility decisions were made by skilled financial technicians.

In 1972, Congress repealed the Adult Public Assistance programs for the aged, blind and disabled replacing them with the federal Supplemental Security (SSI) program. Cash, food and medical assistance were combined into a new state agency in 1975 — the Division of Public Assistance. During the next four years, caseloads continued to swell as pipeline-related activities impacted public assistance programs. The demands for Public Assistance benefits have not tapered off since those early days.

Congress amended the Social Security Act to create the Work Incentive (WIN) program, an employment and training program for welfare recipients. This major new initiative severely taxed the capacity of the Division. In response, the Division of Public Welfare split in 1975, becoming the Division of Public Assistance and the Division of Social Services.

From 1975 to 1979, caseloads continued to swell in all programs and offices were so inadequately staffed that lines formed in major urban areas, even in the middle of Alaska's extreme winters. This caused considerable public pressure to deal with the demand for Public Assistance benefits.

Again, the pressures focused on timely delivery of benefits rather than containment of issuance error rates or increased surveillance of client information. During this period, payment error rates were consistently over 20 to 30 percent in all Public Assistance programs and staff were overwhelmed with the size of the caseloads. Even in a self-declaration or "honor system" environment, the agency's data processing systems were in serious trouble. In fact, the data processing systems supporting medical payments for Medicaid recipients were experiencing such credibility problems that increasing hostility arose between the Department and the medical community over long payment time frames and lost billings. Similar symptoms were evident in the eligibility data systems which generated cash payments to recipients. The state was heading for a very serious failure of both its medical payment and its eligibility data systems.

Surprisingly, there was no federal pressure to make significant management improvements. Other states had begun to place greater accountability on Public Assistance funds and improve the eligibility process as early 1970. Alaska was years behind in initiating an effort to improve Public Assistance administration and sinking fast. Top level commitment and adequate resources were-needed to protect the state and federal distribution of funds.

In January 1979, backed by a commitment from the Commissioner and the Governor to deal with the agency's critical problems, the seriousness of the Public Assistance environment was finally perceived by the Alaska Legislature. The Medicaid claims processing system as well as the eligibility data processing systems were both replaced at a cost of nearly \$5 million dollars over the three-year period. The field staff was doubled over the three-year period. This reduced the

caseload per eligibility technician and permitted movement from the honor system to the very tightly controlled verification-oriented eligibility system which is maintained today.

Home visits and quality assurance were introduced to verify residence, household membership, and income. Performance standards were developed. Fee Agents were trained to be the link between the Division of Public Assistance and rural Alaska residents. The implementation of these services signaled a commitment to improve the quality of the decision-making occurring within the agency and to reduce the number of inappropriately spent dollars in the Public Assistance programs to better serve Alaskans needing help.

The Department secured funding for the Energy Assistance program and the new Division of Public Assistance began operating this 100-percent federally funded program in 1977, providing cash assistance to help low-income households pay home energy bills. November 4, 1980, was a victory for the unique needs of Alaskans when special regulations were adopted to accommodate the distinct characteristics of rural Alaska. Regulations included the unique fee agent system developed to provide rural Alaskan households an easier way to apply for food stamps and use of food stamps for subsistence hunting and fishing equipment purchases.

The Family Support Act of 1988, the most massive national reform effort in recent history, opened the doors for welfare reform in Alaska. There were major philosophical changes in the way welfare was perceived. Alaskan welfare recipients were enrolled in programs designed to help them achieve education, skill enhancement, and self-sufficiency. The JOBS (Job Opportunities & Basic Skills) program provided supportive services, job training, and child care to assist clients from welfare to work. The change in welfare philosophy meant new hope for Alaska's welfare recipients.

Today, Public Assistance conducts the eligibility determination functions for the Medicaid and General Relief-Medical programs.

### *Family and Youth Services*

Social services for families and children have been considered essential in Alaska since the Jesse Lee Home was built in Seward in territorial days. Within the department, they were originally provided in conjunction with financial assistance programs as part of the Division of Public Welfare.

Prior to 1967, the Division of Public Welfare was responsible for Adult Public Assistance, Aid to Families with Dependent Children, General Relief, Child Welfare, and the regulation of foster homes and institutions. Youth and Adult Authority was responsible for probation and parole and for the operations of prisons, services and facilities for both juveniles and adults. In 1967, the Youth and Adult Authority became the Division of Corrections. McLaughlin Youth Center opened in 1969. Although the state provided services for youthful offenders, prevention of child abuse and neglect which often led to delinquency was not fully realized until 1971. That year,

child protection laws were added to Title 47 of Alaska Statutes and in the following year the Division of Public Welfare, as it was called, hired their first "Child Protection" worker.

A major piece of legislation passed in 1974 when Congress passed the Juvenile Justice and Delinquency Prevention Act. In August, 1977, Alaska's Children's Code took effect. The new law required separation and eventual removal of children from adults in adult jails and lockups. This eventually led to the separation of adult corrections into a free-standing department in 1983. The Division, renamed "Family and Youth Services" in 1980, was responsible for youth corrections and child protection responsibilities. Juvenile correction programs (probation, short-term detention, long-term secure and nonsecure treatment, and aftercare services) were added to the Division of Family and Youth Services in 1980.

Child Protective Services (CPS) and Adult Protective Services (APS) are a relatively recent outgrowth of the increased understanding of the problems of child abuse and abuse of the elderly. CPS includes investigations of child abuse and neglect and legal intervention, services to children in their own homes, custodial care, treatment services to reunify families, and adoption services.

Continual conflicts between the state's child protection responsibilities and the social and cultural integrity of Alaskan Natives were addressed through the Indian Child Welfare Act of 1978. The Act permitted tribal intervention in child protection cases and required a preference for placement of American Indian and Alaska Native children in homes of their own heritage.

### *Medical Care Financing for the Poor*

The Division of Medical Assistance was established in 1972 to develop and supervise Alaska's Medicaid Program. Alaska was one of the last states to join the Medicaid Program under which Alaska and the Federal government shared the costs of medical care for low-income Alaskans.

The Division of Public Assistance functions were originally part of the Division of Family and Children Services. Medical services were directed to the Division of Medical Assistance in 1972, recombined with Public Assistance and split out again in the 1980's. However, there was an extensive medical program for the poor prior to Medicaid. General Relief Medical was huge and growing prior to Medicaid. This totally funded state program has declined as Medicaid has grown over the years and today pays medical bills for a limited number of clients.

The Alaska Legislature was concerned that the Medical program would have an unlimited drain on state revenues. Commissioner Fred McGinnis drafted legislation to protect state revenues by putting into legislation a minimum benefit package. With the knowledge of the extent of the state's obligation and with the understanding that only the Legislature could add or delete additional Medicaid-funded services, the Legislature approved Alaska's participation in the Medicaid program.



Congress and the Alaska Legislature initially established Medicaid as a funding source for a limited array of traditional medical services to individuals who received cash assistance. Since then, the program has been expanded to offer a much broader array of services to over 70,000 Alaskans, many of whom qualify for no other assistance program. Preventive care for pregnant women and children has become a major focus, and new services which emphasize home and community-based care as an alternative to institutionalized have been included.

### *Public Health*

On March 1, 1977, the Department scored a major public health victory when "NO SHOTS, NO SCHOOL" made the headlines of Alaskan newspapers. The prevention of communicable disease and the promotion of individual health remained at the top of the public health agenda.

Successful immunization campaigns against Hepatitis B and influenza also attest to our success in this mission. However, with the late 1970's and 1980's came a growing awareness that the health problems of modern Alaska were changing. Some problems reflected the resource-based Alaskan economy, others were related to the individual lifestyle and closely mirrored the health problems of the Lower 48.

In response to these new threats to the health of Alaskans, public health mounted major initiatives in injury prevention, chronic disease, indoor air pollution, AIDS and education regarding healthy lifestyles. Public health became increasingly involved with occupational safety and environmental risks previously under the jurisdiction of the Department of Labor.

The department established an Emergency Medical Services program and air ambulance services provided faster longer-range search and rescue or medivac missions to rural Alaskans. The Division of Public Health began working closely with the Occupational Safety and Health Branch (OSHA) of the Alaska Department of Labor, the National Institute for Occupational Safety (NIOSH), and the departments of Natural Resources and Environmental Conservation.

Public health nursing services continue to be the largest direct operation with approximately 100 public health nurses in 22 locations throughout the state. They provide a comprehensive public health nursing program and serve as field agents for the majority of the other public health programs, such as the handicapped children's program, maternal and child health programs, environmentally and sexually transmitted diseases, and immunizations. Nurses work closely with programs of the Alaska Area Native Health Service and Native Regional Health Corporations, visiting isolated communities without a health care facility or Community Health Aide. Their role has changed from general practice to a specialized provider of preventive health care services.

A new type of health worker spells relief for itinerant nursing in some of the rural communities. The Community Health Aides provide primary care in the village. They report to physicians by radio, keep the village drug and medical supplies and monitor the health status of the people in their community.

## *Alcoholism and Drug Abuse*

Prior to 1972, alcoholism and public intoxication were considered criminal justice problems. With treatment services largely unavailable, chronic hard-drinking Alaskans were whisked off downtown streets of Alaskan cities and towns and "dried out" in jails or given community service. Anchorage's potato farm at Point Woronzof and greenhouses at Russian Jack Park are notable examples of such community service.

In 1972, the Legislature created the State Office of Alcoholism and a separate Office of Drug Abuse by enacting AS 47.37 and AS 44.29. This legislation, modeled after the federal Uniform Alcoholism and Intoxication Treatment Act of 1970, recognized alcoholism and drug abuse as a public health problem rather than a criminal justice problem. Similar legislation was adopted by thirty-seven states during the 1970's. Since its passage, substance abuse prevention and treatment services sponsored by non-profit community agencies have been developed and funded in most communities in Alaska.

In 1977, the Office of Drug Abuse and the Office of Alcoholism were merged by budgetary action into the Office of Alcoholism and Drug Abuse (SOADA) and a statute merging the offices was passed in 1980. After the merger, the agency continued to receive statewide citizen input and policy advice from two separate advisory bodies, the Review Board on Alcoholism and the Advisory Board on Drug Abuse. The two advisory boards were merged in 1988 through an Executive Order.

In 1990, the Division of Alcoholism and Drug Abuse (ADA) was established by Executive Order replacing the State Office of Alcoholism and Drug Abuse. This action recognized the importance of the mission of the Division in combating alcohol and drug abuse, Alaska's number one health problem.

## *Circumpolar Health Emerges*

Since the 1980's, there has been a growing recognition of the similarity of health and human service problems among the people of the north. People living in the polar regions shared the common bond of a frigid environment hosting permafrost, cold weather and a limited food source. Northern people experienced common health problems as well: injuries, malnutrition, famine, parasites, frostbite, and hypothermia. Moreover, they shared common problems relating to alcoholism, Fetal Alcohol Syndrome, Fetal Alcohol Effect, psychiatric problems, viral and invasive disease.

This recognition led medical professionals in the Northern Hemisphere to create an organization to collaborate in the study of human health in the unique conditions of living and working in the arctic and sub-arctic. In 1968 the Circumpolar Health Conference was organized with a \$65,000 grant from the U.S. Public Health Service. With the help of Dr. Albrecht, Alaska Territorial

Commissioner of Public Health, the first Circumpolar Health Conference was convened. Canada, Denmark, Greenland, Finland, Norway, Sweden, Russia, and the United States were represented.

In 1988, Alaska Senators John Binkley and Jay Kerttula introduced legislation creating a focus for circumpolar health research and professional exchange. The initiative built on the foundation of the University of Alaska's Alaska-Siberia Medical Research Program. Through this legislation, the Institute for Circumpolar Health Studies was established within the University of Alaska as a major new step towards finding solution to health problems of Alaskans and inhabitants of other circumpolar regions.

The newly-created Institute was envisioned as a world headquarters for circumpolar health studies, providing information, coordination, research and training for the international medical and health sciences community. Working with the Alaska Department of Health and Social Services, the Institute was to set up a medical data base on research done in Alaska as well as in other countries, and begin the task of bringing other circumpolar scholars to Alaska to jointly explore common solutions. Alaska emerged as a world leader in promoting international relations among the Circumpolar nations.

The Department of Health and Social Services continues to compare data and establish joint research ventures with scientists from northern nations in the search for answers to the unique problems of our arctic region. The effects of weather on the psychology of the body, alcohol and drug abuse, dietary intake, the effects of toxic waste, environmental sanitation, cold weather clothing, and prototypes for buildings are examined.

The Department of Health and Social Services has also initiated a number of agreements to cooperate in emergency medical and disaster situations between the State of Alaska and regions of the Russian Far East. Several dental, trauma, nursing, orthopedic and emergency medical exchanges have transpired. Meanwhile, the study of circumpolar health related topics continues. The national and global application of health sciences continues to improve the quality of life for all northern residents in the fragile environment we call the arctic.

### *Summary*

The department continues to work closely with its counterparts; municipal governments, state and federal agencies, profit and nonprofit organizations and private individuals to obtain its goal: assuring the availability, accessibility, quality and integration of health and human services essential to protect and promote the health and welfare of the people of this state.

## DHSS commissioners 1945–2012

Dr. C. Earl Albrecht	1945–1956
Dr. Charles R. Hayman	1956–1957
Harry V. Gibson	1957–1960
Paul Winsor	1960–1963
Dr. Levi M. Browning	1963–1967
Dr. John Chapman	1967–1968
J. Scott McDonald	1968–1969
Joseph Betit	1969–1970
Robert A. Hall	1970–1971
Dr. Frederick McGinnis	1971–1975
Dr. Francis Williamson	1975–1978
Dr. Helen D. Bierne	1978–1983
Robert London Smith	1983–1984
John Robert Pugh	1984–1986
Myra Munson	1986–1990
Dr. Theodore A. Mala	1990–1993
Margaret Lowe	1993–1994
Karen Perdue	1994–2001
Jay Livey	2001–2002
Joel Gilbertson	2002–2005
Karleen Jackson	2005–2008
William Hogan	2008–2010
William J. Streur	2010–



Walter J. Hickel, Governor

State of Alaska

Theodore A. Mala, MD, MPH, Commissioner

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