

COMPREHENSIVE HEALTH PLANNING

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COMPREHENSIVE HEALTH PLANNING

THESIS

**Presented to the Graduate Council of the
North Texas State University in Partial
Fulfillment of the Requirements**

For the Degree of

MASTER OF ARTS

By

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Denton, Texas

January, 1968

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CHAPTER I

INTRODUCTION

[In March, 1966 President Lyndon B. Johnson in his Special Message to the Congress on Education and Health stated as a national goal: "Good health for every citizen to the limits of our country's capacity to provide it."¹] Secretary John W. Gardner of the Department of Health, Education, and Welfare added fuel to the fire in November of the same year when he testified before the Senate Subcommittee on Intergovernmental Relations saying, "The old system of governmental arrangements - unmanageable city government, inadequate state government, disjointed relations between federal, state and local levels, and uncoordinated federal programs - is dying."²

¹Lyndon B. Johnson, "Special Message to the Congress on Education and Health," March, 1966, cited in William H. Stewart, M.D., "Partnership for Planning," Remarks before the National Advisory Health Council, November 28, 1966; National Advisory Council on Regional Medical Programs, November 27, 1966; and the Surgeon General's Joint Conference with State and Territorial Health Authorities, Mental Health Authorities, Hospital and Medical Facilities Construction Authorities, and Mental Retardation Construction Authorities, Washington, D.C., December 6, 1966, p. 1.

²John W. Gardner, "Testimony before the Senate Subcommittee on Intergovernmental Relations," November, 1966, cited in William H. Stewart, M.D., "Partnership for Planning," p. 1.

In 1967, public health is on the threshold of change. The meanings of the two statements are clear and forceful. The people shall be served. And new ideas, new approaches, new legislation, new social instruments, new institutions and new patterns of operation shall be developed to serve them.

The concept of comprehensive health planning is a major departure from the traditional methodology in providing health care services. The purpose of this study is to conduct an examination of the concept of comprehensive health planning the type of which is mandatory if society is ever to realize comprehensive health services for the multitude of people in that society. The examination shall outline and analyze the efforts of the President of the United States, the Congress and an ambitious team of health officials in their efforts to reach the one overriding goal of this nation in the health field: Making quality medical care available to all Americans. An effort will be made to discover possible problems and prospects as the attempt is made to pull together the fragmented public health programs and to close the gaps in order to produce an effective program. It is hoped that this study will enable those in the field of public health or other related fields to gain a better understanding and a more thorough knowledge of comprehensive health planning so as to facilitate the implementation of such a program.

This study is a research project based mainly on primary sources. The sources include data from the U.S. Public Health Service, The Comprehensive Health Planning and Public Health Services Amendments of 1966, professional journals and speeches made by leading public health officials.

In view of the dramatic changes taking place and the new demands placed upon the health field causing an increase in the complexity of the health community and its programs, comprehensive health planning must be done and done now. So that the concept can become a reality, all levels of government, private organizations and individuals will have to work together toward the common goal. Today, the demands upon the health community are greater than they have ever been in the history of organized health programs. This is a great responsibility for any society to bear. But, it is one which must be borne and borne well.

Many factors have contributed to the increasing demands for professional health services and increasing health problems. In this day and time, the forces of social change are acting swiftly and strongly. And in almost every case, this change has created new demands for health care and has placed terrific pressures on the existing systems utilized to facilitate the delivery of this health care.³

³Philip R. Lee, M.D., "Health: New Directions for Partnership," The Southern Health Bulletin, III (July, 1966), 3.

[In addition, the tremendous population growth since World War II has not been paced with a comparable growth in professional manpower and facilities. The shortage is critical and becoming worse.⁴]

[Increasing urbanization in the United States has also created many new health problems. The overburdening of facilities and resources already in short supply has created problems of paramount magnitude.] The fact that populations living around the central city of the metropolitan area in many different political subdivisions has complicated the efforts of health administration and planning.⁵ [Certain cities and urban centers have grown physically more rapidly than the social consciousness of the people. As a result, the two have not experienced a parallel growth, thus creating a wider gap than before.] Consequently, there is an uneasiness and urge to close the gap very rapidly which causes anxieties because of the shortage of manpower, financial support and other resources.

[But the problems are not restricted to the population centers and the areas of increased education and income. The sparsely settled areas and the economically deprived areas without doctors and nurses and hospital facilities must also be served.⁶]

⁴Ibid.
⁵Ibid.
⁶Ibid.

To these problems must be added a few of a different kind. In recent years the leaders of the health professions have been steadily encouraged to expand their responsibility from its narrowly defined limits. Traditionally, the successes of public health and the fulfillment of the responsibility of providing service have been measured by the high quality of care given to those who actually sought the service. (Now the measurement is based on the number who need health services and those needs which go unmet. The picture is not quite so complimentary.) (Even though there is a definite shortage of trained personnel, a shortage of money and a shortage of adequate facilities, the health professions and the communities and the states and the national government are joining together in an effort to bring every person who needs care into a position to receive it.) This is the goal and adequate levels of health care will not be realized until this goal is reached.⁷

Traditionally, the recognized public health problem has been communicable disease. All public health efforts were aimed in this direction. But today, there has been an emergence of chronic disease and the conditions of aging and these problems are being recognized as major public health problems. In order to combat these "new" public health problems, a new way of doing things will have to be developed.

⁷Ibid., p. 4.

[Attention will need to be given to long term preventative and curative routines, long term care facilities, effective home care programs and a large degree of coordination.⁸ Because of the rising costs of medical care, systems must be devised to detect more adequately disease in the incipient stage prior to the onset of overt and symptomatic illness.] These new demands will necessitate a reorientation of physicians as well as patients, but this must be done.

The problems are evident and the challenge to overcome these problems has been issued by the President, the Congress and society as a whole. In 1967, the health professions, the states and the communities are becoming united in the attempt to solve these problems. The one thing that ties the many parts of the whole together is the belief that the individual has a right to good health, a right which cannot be denied simply because the times are trying and the responsibility is complex. The challenge has been issued and the health community has dedicated itself to meeting it.

[In recent times it has become universally accepted in the United States that health is a human right. It is agreed that every person should have ready access to high quality personal health services and that he should live in an environment which is safe from preventable hazard and conducive to healthful and productive living. The realization is

⁸ Ibid.

becoming apparent that these two conditions do not exist for many millions of Americans and that something should be done immediately to correct the situation.⁹]

Responsibility for the various health functions required to correct the many problems which exist is widely dispersed. A clear mandate has been issued that all government - city, state and national - has a fundamental responsibility in this area. But this does not mean that governmental agencies will or can, for that matter, do all things for all people. The mandate does not even imply that government must be the force behind the movement to accomplish the goal. In order to accomplish what the people want accomplished, many parts of the nation's total health complement will have to do their share. It will take a concerted effort of government, non-governmental institutions and systems, and individuals. Each has an obligation to assure that the public's needs are met.

What will it take? It will take a full and productive partnership. It will have to be a partnership among all health resources.¹⁰

Now, in 1967, the critical moment of truth has arrived. A clear and forceful insistence by the public for better health care and better health protection is making itself known. The expressions by the President and the Congress have reflected this insistence.

⁹Stewart, "Partnership for Planning," p. 2.

¹⁰Ibid., p. 4.

Broad national goals have been established as a result of this public mandate. The goals call for universal access to high quality care and creation of an environment that promotes healthful and productive living. The real problem is that no unified, coherent national health policy exists by which the health community can relate to these goals. No methodology exists by which the health community can determine priorities and no way in which to evaluate their progress in an effective manner.

In 1966, the State and Territorial Health Officers at their conference made a statement which recognized the problem and which urged steps toward a solution. The statement said, in part,

The State and Territorial Health Officers feel there is an urgent need, and it is timely, to establish a coherent set of long-range goals and objectives, as aims for a national policy to maintain and improve the health of every person in the community in which he lives.¹¹

The need for such a policy is apparent. Programs currently operate independently, uncoordinated and many times unplanned. The answer seems to be comprehensive health planning. Formulate a method by which planning can be done, programs can be coordinated, the efforts of all health functions can be utilized to the fullest extent possible and the needs of the people can be served. This seems to be the means by which all of the

¹¹Ibid., p. 8.

various health functions can relate to each other and through the combined efforts of all, the achievement of the total health objective can be accomplished.

In the midst of our rapidly growing knowledge in the health sciences, the general agreement has developed which supports the premise that comprehensive health planning focuses on the total health picture. It involves the combined, cooperative efforts of local, state, national, professional and voluntary resources. It involves long-range, as well as immediate and intermediate goals. Comprehensive health planning involves determining what needs to be done giving appropriate attention to the various areas which will be required to participate.¹²

The vehicle which will be utilized in order to reach the nation's goal will be Public Law 89-749, the Comprehensive Health Planning and Public Health Services Amendments of 1966.

The goal of the Act is to assure the highest level of health attainable for every person. The case for comprehensive health planning is stated very vividly in the Act's Declaration of Purpose. The Declaration summarizes very clearly and very precisely what has been stated thus far.

Section two of the Act states that

The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that

¹²U.S. Public Health Service, The Role of Health and Welfare Councils in Comprehensive Community Health Planning (Washington, 1966), p. 2.

attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshaling of all health resources - national, State, and local - to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.

To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.¹³

¹³U.S. Congress, Comprehensive Health Planning and Public Health Services Amendments of 1966, Public Law 89-749, 89th Congress, 2d Session (Washington, 1966), p. 1.

CHAPTER II

THE COMMUNITY STRUCTURE AND ORGANIZATIONAL RELATIONS

The goal of good health for every person to the limits of our country's capacity to provide it through comprehensive health services which are based on comprehensive health planning must be considered in terms of existing "health service systems." In the United States today, there exists a great deal of individual and corporate responsibility and enterprise as well as a great deal of governmental responsibility and activity. Effective comprehensive health planning must recognize the many, diversified aspects of the health services system and consider all activities and accomplishments in developing plans of action.¹

For the purposes of this examination, the health service community will be categorized into six components: (1) federal health agencies, (2) state health agencies, (3) local health agencies, (4) private sector medical resources, (5) voluntary health agencies, and (6) other official public agencies.

Federal Health Agencies

The department of the federal government charged with primary responsibilities in the health field is the Department

¹U.S. Public Health Service, Organizational Relations (Washington, 1967), p. 1.

of Health, Education, and Welfare which was created by Re-organization Plan of 1953. The Department was established for the purpose of improving the administration of the various agencies of the department whose responsibilities were primarily the promotion of the general welfare in the fields of health, education and social security.² The principal agencies for the purpose of this examination are the U.S. Public Health Service and the Children's Bureau.

Public Health Service

The Public Health Service is the principal health agency of the federal government. The Public Health Service, under the direction of the Surgeon General, is the federal agency charged with the responsibilities of protecting and improving the health of the people of this nation and collaborating with governments of other countries and with international organizations in world health activities.³

The major functions of the Service are

- a. to conduct and support research and research training in the medical and related sciences including health services and the dissemination of medical knowledge,
- b. to conduct and support research, training and service programs in the area of mental health,
- c. to increase the supply and improve the qualifications of health manpower,

²United States Government Organization Manual, 1967-68 (Washington, 1967), p. 356.

³Ibid., p. 358.

- d. to provide medical and hospital services to persons authorized to receive care from the Service and to aid in the development of community health services including hospitals and related facilities, and
- e. to prevent the introduction of communicable diseases into the United States and to promote the application of new knowledge for the prevention and control of disease and the maintenance of a healthy environment.⁴

The Public Health Service provides valuable assistance to states and localities in helping them carry out their health programs through grants and professional and technical advice.

The U.S. Public Health Service has had a long and eventful history. The Congress passed the Marine Hospital Service Act in June, 1798, which authorized the President to appoint physicians in each port to furnish medical and hospital care for sick and disabled seamen.⁵ In 1902, the Marine Hospital Service was renamed the Public Health and Marine Hospital Service and given a definite form of organization under the direction of a surgeon general. In 1912, the title was changed again, this time to the U.S. Public Health Service.⁶

A tremendous growth has taken place in the Public Health Service since its inception. For example, its budget has

⁴Ibid.

⁵John J. Hanlon, Principles of Public Health Administration (St. Louis, 1960), p. 55.

⁶Ibid., p. 58.

increased from \$52 million in 1944, when the Public Health Service Act of 1944 was passed, to \$2.4 billion in FY 1967, an increase of 28 times. The staff doubled from 17,000 to 34,000 during this same period. Until 1966, this growth had taken place without any allowance for organization flexibility. Over the years, the Congress has assigned additional responsibilities to the Service which have changed its mission drastically. These dynamic changes in the PHS mission were coupled with a static organizational structure.

In 1966, President Johnson recognized the need to make the Service stronger and more efficient through reorganization. As a result, the President submitted Reorganization Plan No. 3 of 1966 to Congress, giving the Secretary of the Department of Health, Education, and Welfare the authority to change the structure of health activities within the department. During the summer of 1966, the Congress approved Reorganization Plan No. 3.⁷

Under this authority the Service has been reorganized to consist of five bureaus - Bureau of Health Services, Bureau of Health Manpower, Bureau of Disease Prevention and Environmental Control, National Institutes of Health, and a National Institute of Mental Health.⁸

⁷Willard G. Olsen, "The Federal-State Partnership in Health: Past, Present and Future," lecture presented at the Tulane University School of Public Health, New Orleans, Louisiana, November 9, 1966, p. 15.

⁸Government Organization Manual, p. 359.

The Office of the Surgeon General has also undergone changes and steps have been taken to give added strength and depth to the Office so that it can truly function as the coordinating, policy making component of the Service.⁹

The latest Public Health Service reorganization is based on a concept of the current and future role of PHS. The primary concern of the Service is the health of the American people. The Service has dedicated itself to piercing the frontiers of scientific knowledge through further research and development and to deliver the benefits of research through services to people.¹⁰ Many months of planning and hard work went into the reorganization. The Service now feels that it can "quarterback" the entire health community in meeting the health challenges of today and the years to come.

What are some of these challenges? What must the total health community with PHS leadership accomplish? The Surgeon General and others have proposed the following:

- a. Every ill or injured person should have a place to go, and should trust in it. The prevention and control of diseases and environmental hazards must take place to the fullest extent possible.
- b. Permanence and stability must continue to characterize the biomedical research effort - scientists,

⁹Olsen, "The Federal-State Partnership in Health," p. 24.

¹⁰Ibid., p. 16.

institutions and the people must know that the commitment to scientific advance has been made.

- c. Health manpower development must go forward - more educational opportunity, greater skills and orderly advancement in careers.
- d. The United States should share its knowledge and skills with nations around the world.¹¹

A tremendous task faces the health community. These are large goals, but they are goals which needed to be set and which must be reached. This accomplishment will require the talents and energy of the total community and the sustained efforts of each member of that community.

Children's Bureau

The Children's Bureau, created in 1912, investigates and reports on all matters related to child life and to increase opportunity for the full development of all children by promoting their health and social welfare.¹²

The Bureau administers, through its Division of Health Services, grants to State health agencies for extending and improving health services for mothers and children. Through a cooperative effort with national, state and local organizations and agencies, the Bureau plans for the development and extension of services for children and youth.¹³ Since

¹¹Ibid., p. 27.

¹²Government Organization Manual, p. 372.

¹³Ibid.

children, youth and mothers constitute a significant portion of our total population, the efforts of the Children's Bureau are certainly important to the health movement.

State Health Agencies

Each state has an official health authority. The State Department of Health is the only state agency whose sole function is public health. As may be expected with this assignment, the department engages in a variety of health functions.¹⁴

The powers and duties of state health departments vary greatly from state to state. Some departments have broad powers; others, very limited. In some states, such as New York and Maryland, some of their cities have virtually complete control over public health within their jurisdictions.¹⁵

State health departments usually have responsibility for providing environmental and personal health services as they relate to the detection, prevention and/or reduction of disease conditions within their jurisdictions. Particular emphasis is placed on communicable diseases. In some states, responsibility in certain areas is shared with other state agencies. For example, some states share responsibility for environmental health programs with other agencies, such as

¹⁴International City Managers' Association, Administration of Community Health Services (Chicago, 1961), p. 8.

¹⁵Ibid., p. 9.

departments of agriculture, departments of conservation, water pollution control commissions, departments of housing and/or urban renewal, and vector control commissions.¹⁶

Local Health Agencies

The degree of autonomy of local health agencies vary considerably from one state to another. For example, some states are divided into health districts administered by a state-appointed medical officer. These districts provide most of the health inspections and services. On the other hand, some excellent city and county health departments that have almost complete autonomy exist and provide practically all health services within their jurisdictions.¹⁷

Efficiently organized and adequately staffed full-time local health departments have always demonstrated an interest in community health by participating effectively in a multitude of ways. The basic functions of a local health department are control of communicable diseases, environmental sanitation, registration of births and deaths, public health laboratory facilities, protection and promotion of health of mothers and infants, public health education, and the promotion of medical care for persons unable to provide the same through their own resources.¹⁸ Communicable disease control and

¹⁶U.S. Public Health Service, Organizational Relations, p. 4.

¹⁷Ibid.

¹⁸Haven Emerson, Local Health Units for the Nation, cited in National Commission on Community Health Services, Health is a Community Affair (Cambridge, 1966). n. 225.

improvement of general sanitation rank high on the list of activities of local health departments. Since the local health departments are the nearest health unit to the people, they provide the multitude of health services directly to the people.¹⁹

Private Sector Medical Resources

Private physicians, hospitals, laboratories and nursing homes which operate on a voluntary or proprietary basis fall into this category. The non-indigent citizens in the community in need of medical care may not be able to take advantage of the services of a local health department since they are many times restricted to the indigent. These citizens procure their own physician services and medical care out of their own pockets. For the most part, the proportion of the population using free, versus "pay-as-you-go," health services will vary with the income level of the community. For example, a community, such as San Antonio, Texas, with 50 per cent of the family incomes under \$4,000 would be a heavy user of public health services. On the other hand, a city, such as Los Alamos, New Mexico, with one of the highest per capita incomes in this country would have very little need for public health programs.²⁰

¹⁹International City Managers' Association, Administration of Community Health Services, p. 27.

²⁰U.S. Public Health Service, Organizational Relations, p. 4.

Voluntary Health Agencies

In the United States voluntary health agencies, such as the American Cancer Society and the Tuberculosis Associations, play an important role in the health community. The existence of approximately 20,000 such organizations which raise funds for health purposes stems from a dynamic feature of our democracy, the right of citizens to organize for the purpose of attacking a health or health related problem.²¹ One interesting aspect of the development of these organizations is that some, such as the Tuberculosis Associations, began locally and spread upward to state and national societies, while others such as the National Foundation for Infantile Paralysis began on the national level and spread downward. Still others, such as the Mental Hygiene Associations, began on the state level and spread both upward and downward.²²

The voluntary health agencies provide financial assistance to treat patients, conduct basic research, educate the public on health problems and undertake many projects, some of which are federally assisted in terms of funds.

Voluntary health agencies are quite vocal and play an important role in the passage of local, state and national legislation.²³

²¹Ibid., p. 5.

²²Hanlon, Principles of Public Health Administration, p. 65.

²³U.S. Public Health Service, Organizational Relations, p. 5.

Other Official Public Agencies

Numerous other public agencies administer programs related to health. The Departments of Agriculture at both the state level and the national level are good examples. Even though they do not have a responsibility for a basic sanitation program, such as milk control, they are responsible for programs relating to milk and milk production. They conduct programs on control of pesticides on crops, health of cattle, ante and postmortem examinations of animals and improvement of farm water supplies through the county agent program.

Other agencies include the food and drug agencies, departments of conservation, urban renewal and housing agencies and departments of labor. All of these agencies are performing related functions leading to a more healthy community.²⁴

Urban Versus Rural Settings

[In considering community structure it is important that attention be devoted to the urban versus rural situation. In developing a program of comprehensive health planning, this relationship must not be overlooked.]

At present, over 70 per cent of our citizens reside in Standard Metropolitan Areas. The trend has been a shift to the cities since World War II and is still continuing. The

²⁴Ibid.

inhabitants of the rural areas are migrating to the urban areas in search of job opportunities and cultural attractions and, as a result, the rural areas are steadily becoming depopulated.

[The environment of urban areas provide the following advantages in terms of health services and programs: concentrated medical and paramedical manpower, adequate and modern medical facilities, highly developed health agencies, many voluntary health agencies, short distances for which the patient must travel for medical services, good public transportation and the "user groups" reside in easily identifiable areas.²⁵]

Some of the disadvantages of the urban environment are greater air and water pollution, faster pace of living, an over-taxing of health resources due to the increase of those utilizing the services, and sub-standard housing.²⁶

The rural setting also has its advantages as well as its disadvantages, but the disadvantages far outweigh the advantages from a health programming point of view. [Some of the serious problems which have arisen in the rural environment include a lack of medical and paramedical manpower, few and scattered medical facilities which lack modern equipment and techniques, few and scattered health agencies, as in Texas,

²⁵Ibid., p. 6.

²⁶Ibid.

with only 70 organized health departments in 254 counties, practically no voluntary health agency services, tremendous distances for patients to travel for health care, inadequate public transportation, and a concentration of older people as the young have migrated to the urban areas. With a steadily declining population causing a reduction in the rural tax base, it is becoming difficult to initiate and support adequate health services.²⁷

Implications for Planning

From this analysis of the community structure and the various organizational relations, the basic justification for comprehensive health planning becomes evident. It is plain to see that the health services industry is diversified, overlapping in some areas and inadequate in others and a mixture of many kinds of individuals and agencies. One thing which ties all of these organizations, agencies and individuals together is one of their goals - the elevation of the health status of their diversified beneficiary groups.

Comprehensive health planning conducted toward an optimum health program must be based on all the resources available. Cooperation and coordination must be established to overcome the present problems caused by piecemeal planning and delivery of services.

²⁷Ibid., p. 7.

CHAPTER III

THE COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES AMENDMENTS OF 1966

The Comprehensive Health Planning and Public Health Services Amendments of 1966, Public Law 89-749, was passed during the final week's session of the 89th Congress and signed by President Lyndon Johnson on November 3, 1966.

It is the goal of the law to assure the highest level of health attainable for every person. The objectives of P.L. 89-749 are to increase the capacity for continuing, comprehensive planning for health and to redirect the focus of grant programs to revitalize state and local efforts in the delivery of services to the people.

[The law establishes a process of comprehensive health planning and improves existing programs for public health services by

- a. Authorizing formula grants to the states to assist in financing comprehensive health planning;
- b. Authorizing project grants to assist in comprehensive regional, metropolitan area and local area planning;
- c. Authorizing project grants for training, studies and demonstrations in comprehensive health planning;

- d. Consolidating the existing formula grants now awarded to the states by health categories for combating specific diseases and public health problems into a flexible single grant to be awarded on a matching basis to assist in meeting the public health needs identified through the comprehensive health planning; and
- e. Continuing and extending the existing program of project grants to public and nonprofit organizations and agencies for providing services to meet health needs of limited geographic scope or of special significance, stimulating and initially supporting new health service programs, undertaking studies, demonstrations or training designed to develop new or improved methods of providing health services, and providing for the interchange of federal and state and local workers.^{1]}

It is the intent of P.L. 89-749 to establish a planning process to achieve comprehensive health planning on a state-wide basis. The planning process shall identify health problems within the state, set health objectives directed toward improving the availability of health services, identify existing resources and resource needs and relate the activities of other planning programs to the meeting of the health

¹U.S. Congress, Comprehensive Health Planning and Public Health Services Amendments of 1966, pp. 1-10.

objectives. Public Law 89-749 provides financial assistance to state and local officials, to private voluntary health organizations and institutions in order to achieve the most effective allocation of resources in accomplishing the objectives.²

In order to better understand the legislative instrument provided for the attainment of these purposes, it will be necessary to divide the law into three distinct categories.

The first part of the Comprehensive Health Planning and Public Health Services Act provides an attempt to focus on a planning entity. While it is true that a great deal of planning is going on in connection with all of the health programs, nowhere is there an entity that relates these plans to each other and decides on relative priorities. No data exist whereby one can base decisions between alternatives. No one has either the knowledge or the authority to decide to give priority to one public health program as opposed to another. It is believed that this decision-making, planning entity should be at the state level.

To qualify for a grant for comprehensive state health planning, the governor must designate or create a single state planning agency with the responsibility for administering or supervising the state's health functions in the development of a comprehensive plan. The governor has some flexibility

²U.S. Public Health Service, Fact Sheet: The Complementary Relationships Between the Comprehensive Health Planning and Public Health Services Amendments of 1966 and the Heart Disease, Cancer, and Stroke Amendments of 1965 (Washington, 1967), p. 4.

in that the state agency can be a new agency, an existing agency, or an interdepartmental entity. It will be the basic function of the agency to examine the needs of the state and recommend priorities for meeting those needs with the resources available. The importance of this body cannot be overemphasized.

In addition, a state health planning council must be established to advise and assist the agency in its planning function. The council must be broadly representative of public and private health agencies and organizations in the state with a majority of its members representing consumers of health services. This state health planning council, if wisely selected and utilized, can be an important new social instrument for relating health planning and services between those providing the services and those receiving the services.³

It is not the intent of P.L. 89-749 to supplant existing planning mechanisms in specialized programs, such as hospital construction programs, mental retardation programs or construction of community mental health centers. Rather, it is designed to bring into order the now existing spotty and fragmented planning process. It would provide, for the first time, resources to measure and evaluate the special health needs and make possible the establishment of priorities for meeting

³William H. Stewart, M.D., "Partnership for Planning," Public Health Reports, LXXXII (May, 1967), 396.

those needs.⁴ The Congress recognized the relationship of comprehensive health planning to other planning activities when, in the Report of the Senate Committee on Labor and Public Welfare, it stated:

The comprehensive planning of the state health planning agency with the advice of the council would complement and build on such specialized planning as that of the regional medical program and the Hill-Burton program, but would not replace them...

The state health planning agency provides the mechanism through which individual specialized planning efforts can be coordinated and related to each other. The agency will also serve as the focal point within the state for relating comprehensive health plans to planning in areas outside the field of health, such as urban redevelopment, public housing and so forth.⁵

As a supportive measure in this attempt to achieve comprehensive health planning, P.L. 89-749 provides a project grant program for areawide health planning. It requires a relationship between these project grants, made on a regional or local basis, and the comprehensive health program just mentioned. This relationship is of paramount importance. It links statewide planning with the planning efforts in the metropolitan areas where so many people and problems are concentrated.⁶

The second major aspect of P.L. 89-749 deals with service-providing functions - the U.S. Public Health Service and the

⁴Olsen, "The Federal-State Partnership in Health," p. 95.

⁵Report of the Senate Committee on Labor and Public Welfare (Washington, 1966) as cited in U.S. Public Health Service, Fact Sheet, p. 3.

⁶Stewart, "Partnership for Planning," Public Health Reports, p. 397.

state health department programs for health services. Prior to P.L. 89-749, these services were categorized into nine categories. Priorities for service were determined at the national level within the bounds of the nine categories. This method severely limited the states. For example, if a state health department determined that it was more important to concentrate on a specific health need which it believed to be important, rather than on a priority set nationally, it had no flexibility to fit the funds into the state's priorities. This aspect of the law will be discussed more fully in Chapter IV.

[It goes without saying that the needs vary from one part of the country to another, from one state to another, and within a single state. The second important aspect of the new law is flexibility. The new law provides flexibility in the use of new formula grant funds. In the future, the state will be able to fight the problems that are most prominent in the state. The granting of funds will depend upon a state plan which shows what the state intends to do. This plan, in turn, must be related to the comprehensive plan. The important thing to remember is that the new law provides for a range of choice within the structure of formula grants for health services.⁷]

The third important aspect of P.L. 89-749 relates to project grant authorities. Over the years the U.S. Public

⁷Ibid.

Health Service has provided grants to public and nonprofit private organizations. Most of them were for specific disease control problems or for developing new ways of delivering services. Each of these authorities was very limited and restrictive. For example, the community health services and facilities project grants were limited to out-of-hospital services and limited in favor of the chronically ill and aged.

In the new law, an attempt has been made to pool these project grant funds and to broaden the use of the grants to include innovation, demonstration or a specific target, such as tuberculosis. None of these possibilities represent a national need, but each is of critical importance in certain areas.⁸

These three aspects are the important contributions of P.L. 89-749 to the health community and to society. Its intent is clear. It intends to give more initiative, more flexibility and more responsibility to the states, the cities and the counties. It also intends to permit the use of federal funds for meeting the special requirements of different areas.

*In summary, it is felt that through the Comprehensive Health Planning and Public Health Services Amendments of 1966 the health community will be able to do the following:

⁸Ibid.

- a. Establish state and areawide health goals;
- b. Define the total health needs of all people and communities within the area served;
- c. Inventory and identify relationships among varied local, state, national governmental and voluntary programs so that these programs can be assisted in making more effective impact with their resources;
- d. Provide information, analyses and recommendations which can serve as the basis for the governor, various programs and communities in making more effective allocations of resources in meeting health goals;
- e. Provide a focus for interrelating health planning with planning for education, welfare and community development;
- f. Strengthen planning, evaluation and service capacities of all participants in the health endeavor; and
- g. Provide support for the initiation and integration of development and pilot projects for better delivery of health services and develop plans for targeting flexible formula and project grants at problems and gaps identified by the planning process.⁹

Comprehensive health planning is intended to strengthen Creative Federalism. It calls for more productive mechanisms

⁹U.S. Public Health Service, Fact Sheet, p. 5.

for partnership and cooperation between the national, state and local levels of government; the public and voluntary private health activities; and the academic and health services environments. The ultimate goal has been set by society - it will take the untiring efforts of all concerned to accomplish the goal.

CHAPTER IV

PARTNERSHIP FOR HEALTH

GRANTS-IN-AID

In view of the tremendous importance placed upon the grant-in-aid as it affects the partnership for health and the radical change in grants management which became effective on July 1, 1967, it is deemed appropriate to devote some attention to this very vital area.

For many years, grants-in-aid have played a very significant role in the relationship of the federal government to state and local governments. In regard to public health services, the types of federal assistance needed by the states and communities have been widely debated for many years. It is felt that the partnership for health, which is an entirely different approach to federal health grants management, will settle some of the major issues in this area.

A committee of the Council of State Governments defined grants-in-aid as "...payments made by the national government to state and local governments, subject to certain conditions, for the support of activities by the states and their political subdivisions."¹ The grant-in-aid is a payment of funds by the

¹Francis J. Manno, "Grants-in-Aid: The Best Alternative," Nation's Cities, III (March, 1965), 37.

federal government to a state or local government for a specified purpose - to build highways, to eliminate slums, to improve health services. The funds are generally awarded on a matching basis and used in accordance with federal standards and regulations.

In order to better understand the impact that grants-in-aid have had on today's public health programs, it would be appropriate to review briefly the history of federal-state relations, examine some of the major federal programs in health during the past ten years and look at the current situation.

The first important grants were the land grants. Grants-in-aid can be traced to 1785, when the United States operated under the Articles of Confederation. At that time, Congress decided that a certain amount of land in the Northwest Territory would be reserved for public schools. Since then, several landmark acts have been passed bearing witness to the growing importance of grants-in-aid.

The following list illustrates the expanding federal role as well as the early beginning of many of our present programs:

- a. The Morrill Act of 1862 assisted the states in establishing and maintaining the land grant colleges;
- b. The Smith-Lever Act of 1914 assisted in establishing agricultural extension services in states;
- c. The Smith-Hughes Act of 1917 established grants for vocational education;

- d. The Chamberlain-Kahn Act of 1918 provided grants to control venereal disease and marked the beginning of grants for public health services;²
- e. The Vocational Rehabilitation Program, one of the oldest grants-in-aid programs for providing services to individuals, had its start in 1920;
- f. The Social Security Act of 1935 provided for federal grants-in-aid to states for public assistance, employment security, public health services, maternal and child health services and crippled children's services;
- g. The National Cancer Act was passed in 1937 creating the National Cancer Institute and authorizing research grants and research fellowship grants;
- h. The Public Health Act was passed in 1944, consolidating much pre-existing authority, broadening authority in research and training and authorizing grants for tuberculosis control;
- i. The Hill-Burton Program or the National Hospital Survey and Construction Act for hospital construction was authorized in 1946;
- j. The Water Pollution Control Act was passed in 1948; and
- k. Federal grants for the construction of sewage treatment facilities were first made available in 1956.

²Ibid., p. 39.

In the past ten or so years, federal grant-in-aid programs have expanded tremendously to include mental health, mental retardation, accident prevention, air pollution, health services for migratory workers, maternal and infant care, comprehensive medical care services for preschool and school-aged children and a number of other areas.³

The historical trend of grants-in-aid has been clearly in the direction of more categorized aid for the stimulation and support of state-local health services. As may be seen from the following statistics, the tremendous expansion of federal assistance can be attributed to the rapid expansion in special purpose grants, which rose from \$51.8 million in 1960 to \$263.0 million in 1966.⁴

APPROPRIATIONS FOR HEALTH SERVICE GRANTS

Fiscal Years - Millions of Dollars

KIND OF GRANT	1940	1950	1960	1966
Grants administered by the Public Health Service	\$13.8	\$43.1	\$33.3	\$138.0
General Health - Formula	9.5	14.2	15.0	10.0
Venereal Disease - Formula	4.3	7.8	0	0
Project	0	5.3	2.4	6.2
Tuberculosis Control - Formula	0	6.8	4.0	3.0
Project	0	0	0	9.7

³Lee, "Health: New Directions for Partnership," p. 5.

⁴Berdj Kenadjian, "Appropriate Types of Federal Grants for State and Community Health Services," Public Health Reports, LXXXI (September, 1966), 815.

KIND OF GRANT	1940	1950	1960	1966
Grants administered by the Public Health Service - Continued				
Cancer Control - Formula	\$0	\$3.5	\$2.2	\$3.5
Project	0	0	1.5	13.9
Mental Health - Formula	0	3.6	5.0	6.8
Heart Disease - Formula	0	2.0	3.1	9.5
Chronic Illness and Aged - Formula	0	0	0	12.3
Home Health Services - Formula	0	0	0	9.0
Radiological Health - Formula	0	0	0	2.5
Dental Health - Formula	0	0	0	1.0
Neurological and Sensory Diseases - Formula	0	0	0	7.2
Community Health - Project	0	0	0	10.0
Vaccination Assistance - Project	0	0	0	8.0
Migrant Health - Project	0	0	0	3.0
Staffing Mental Health Facilities - Project	0	0	0	19.5
Implementation of Mental Retardation Planning - Project	0	0	0	2.8
Grants administered by the Children's Bureau				
Maternal and Child Health - Formula	6.6	18.5	33.5	135.0
Project	3.8	9.5	14.6	35.8
	0	1.5	2.9	9.2

KIND OF GRANT	1940	1950	1960	1966
Grants administered by the Children's Bureau - Continued				
Gripped Children's Services - Formula	\$2.8	\$5.6	\$14.0	\$36.6
Project	0	1.9	2.0	8.4
Maternal and Infant Care - Project	0	0	0	30.0
Health of School and Pre- School Children - Project	0	0	0	15.0
Total Federal Grants	20.4	61.6	66.8	273.0
Categorical Formula and Project	10.9	47.4	51.8	263.0 ⁵
General Health - Formula	9.5	14.2	15.0	10.0 ⁵

It should be noted further that the ratio of grants for special purposes to general health grants peaked at 26 to 1, compared with ratios of less than 3.5 to 1 in 1960 and in 1950. In 1940, this ratio was about 1 to 1.⁶

Public Law 89-749 authorizes formula grants to state health and mental health authorities for comprehensive public health care. The Act consolidates the group of previously compartmented or categorical Public Health Service grants. Previously, the nine PHS formula grant categories were

- a. Cancer Control
- b. Chronically Ill and Aged
- c. Dental Health
- d. General Health

⁵Ibid., p. 817.

⁶Ibid., p. 815.

- e. Heart Disease Control
- f. Home Health Services
- g. Mental Health
- h. Radiological Health
- i. Tuberculosis Control⁷

What is now a "block" grant under P.L. 89-749 was formerly awarded to the states in the nine categories corresponding to the nine "national health problems" identified by the Congress. Such categorical funds could not be transferred between categories regardless of the need for such action. Consequently, the units seeking help were handicapped.⁸

The lack of flexibility and planning capacity have become a matter of increasing concern to states, counties and cities due to the expanded public health responsibilities and scope of activities. The change from categorical grants to block grants is one step which will help to alleviate the growing problem of inflexibility at the local level where the services are being provided.

⁷U.S. Public Health Service, Previous PHS Grants and Federal-State Administrative System (Washington, 1967), p. 7.

⁸Ibid.

CHAPTER V

THE PLANNING AGENCY AND THE ADVISORY COUNCIL

The establishment of a state health planning agency advised by the state health planning council will provide a means for considering state health needs and for developing appropriate courses of action to meet those needs. The utilization of this type of program provides a new kind of concentration of strength in the health field.

The Comprehensive Health Planning and Public Health Services Amendments of 1966 provide for a state program, a state agency and a state council. The success or failure of this country's attempt to provide adequate health services to all of the people will depend, in large part, upon the adequacy or inadequacy of these three elements. The state program refers to the state plan for comprehensive health planning which contains the information, proposals and the assurances submitted by the state agency. The state agency means the single state agency designated in the state program for administering or supervising the administration of the state's health planning functions under the state program. The state council means the body which will advise

the state agency in carrying out its function under the approved state program.¹

The Planning Agency

As was pointed out in Chapter III, the planning agency must be designated or created by the governor. He has some flexibility as to the organizational arrangement in that the state agency may be in an existing state operating department, as a new unit in the governor's office or as a new interdepartmental entity. Each arrangement has its good points as well as its bad. Each must be evaluated in terms of the special requirements of the particular state.

Operating Department

If the state planning agency were placed in an existing department, in all likelihood, that department would be the State Department of Health. This arrangement would have certain advantages and certain disadvantages.

Advantages

- a. The State Department of Health would very likely already have a related planning competency.
- b. It would have the health leadership necessary for such planning.
- c. It would, by law and tradition, have the necessary commitment to the amelioration of health problems.

¹"Title 42 - Public Health," Federal Register, XXXII (Washington, July 22, 1967), 10792.

- d. It would possess much of the requisite professional and technical health knowledge.
- e. It would have an organized staff experienced in dealing with health problems and data.
- f. It would have the inbeing authority to implement recommendations affecting its own public health activities.

Disadvantages

- a. An operating department would tend to be preoccupied with its own programs and might lack motivation for developing a proper understanding of other health activities.
- b. It might not be objective about evaluating its own programs, as opposed to other programs.
- c. It would have only limited authority over health programs administered by other departments - such as employee safety and mental health.
- d. It would be unlikely to have much authority to implement recommendations outside its own health programs.²

Governor's Office

The second alternative would be a planning unit within the governor's office. Like the alternative of the operating

²U.S. Public Health Service, Planning Agency (Washington, 1967), p. 2.

department, this one has definite advantages as well as some disadvantages.

Advantages

- a. Such an arrangement would foster interdepartmental cooperation.
- b. It would be in a good position to coordinate with other statewide planning units or staffs.
- c. It would be in a good position for dealing with the private sector.
- d. Being close to the governor, it could more easily arouse public interest and support.
- e. It could strengthen overall state planning competence.

Disadvantages

- a. Some states have weak and poorly managed executive offices.
- b. Requisite planning expertise may be lacking.
- c. There would be an absence of health knowledge.³

Interdepartmental Agency

The third alternative would be to form an interdepartmental agency composed of representation from both the operating department and the executive branch. The agency should be comprised of department heads or their representatives from the health department and other departments with health

³Ibid.

related responsibilities and with some representation from the governor's office.

Advantages

- a. It would have the planning competence of the health department at its disposal.
- b. It would have the commitment to eliminate both health and related problems.
- c. It would have leadership from health and related fields.
- d. It would have, or have access to, the necessary health knowledge.
- e. It would have the power to implement its recommendations within the represented departments.
- f. It would encourage interdepartmental cooperation in health and related matters.

Disadvantages

- a. It would be a new component of state governments and as a result would have neither the health department's prestige and working relationships with the state's health industry nor the prestige and authority of the governor's office.
- b. The presence of representatives from several departments might produce more competition than objective planning.⁴

⁴Ibid., p. 3.

The type of arrangement for the planning agency and the programs and projects undertaken by that agency will depend largely upon many factors and conditions existing within the state. For example, if the governor has only a two year term and/or cannot succeed himself, it is likely that the agency should not be placed in his office. It might lose some of its permanency and continued accountability. It would be equally undesirable to place the agency in the State Health Department if that department was weak and the city and county health departments within the state were strong. The best solution will be the one which can best assist in the reduction of state health problems.⁵

It will be the objective of the planning agency to establish and maintain a continuing planning process for developing and adopting recommendations to guide the organization as related to the financing and the provision of health services, facilities and manpower. The agency should be primarily concerned with problem identification, goal establishment and priority determination. All of these aspects will formulate the basis of the comprehensive state health plan.

The state agency will perform a variety of functions. They will include development and periodic revision of the comprehensive state health plan, provide information and consultation and promote coordination of health and other programs.

⁵Ibid., p. 4.

The first function, and possibly the primary function, will be the development and periodic revision of the comprehensive state health plan. This function should include the following:

- a. Select and apply measures for evaluating the health of the population and assess the impact on health status of environmental, social, economic and other related factors.
- b. Undertake studies to define the scope, nature and location of health problems and identify and assess the resources available and necessary to solve them.
- c. Select goals and priorities for solving identified health problems through the use of available resources or through the development of new resources.
- d. Develop both current and long-range policy and action recommendations for meeting the health needs of the people of the state through public, voluntary and private efforts.
- e. Develop criteria for evaluating health programs and their contribution to attaining the goals established through comprehensive health planning.⁶

The second function of the agency shall provide for information gathering and dissemination and consultation. In order to fulfill its responsibility in this area, the agency should do the following:

⁶U.S. Public Health Service, Information and Policies on Grants to States for Comprehensive Health Planning under Section 314(a), Public Health Service Act as Amended (Washington, April 11, 1967)

- a. Provide information that will serve as a basis for responsible public decision-making in the development of new or additional health resources to serve health needs.
- b. Undertake, either directly or by arrangements with other agencies, special studies and continued gathering and analysis of data on health problems and resources.
- c. Promote the development of areawide health planning organizations and assist them in their work.
- d. Provide information to, consult with and generally assist specialized health planning agencies and public and voluntary operating health organizations in the development of their plans and programs.⁷

The third functional area of the agency should provide for the promotion of coordination of health and other programs. Much of the success or failure of the overall effort depends on what happens in this area. The agency should accomplish the following:

- a. Provide channels of communication among public, voluntary and private agencies and groups with health and related concerns.
- b. Recommend measures for the assignment and coordination of health functions in the state which promote maximum

⁷Ibid., p. 4.

efficiency and minimize overlap and duplication of functions and resources.

- c. Recommend measures for more effective coordination of health activities with related activities in such areas as welfare, education and vocational rehabilitation.
- d. Work with counterpart agencies in other states to identify and suggest possible approaches for handling health problems that cross state boundaries.⁸

It is apparent that such a planning body is needed. In order to be effective in reducing the health problems of an area, the agency must possess certain characteristics.

First, the agency should possess a broad outlook on health problems and their relation to the entire area. The agency must be able to relate the many health organizations, health occupation groups, beneficiary or consumer groups, and providers of financial support to each other and to the total environment. It must be objective in its efforts and lay prejudices aside. In addition to dealing with the traditional, health oriented agencies, the planning agency must be equipped to work effectively with such organizations and agencies not usually associated with health as highway departments, urban renewal programs, public works departments,

⁸ Ibid.

school systems, welfare activities and even fish and game commissions. In short, the agency must have a broad viewpoint.⁹

Another trait or characteristic which the planning agency must possess is prestige or respect. Most of the agencies and organizations with which the planning agency will work will be under little, if any, control of the agency. Therefore, to win support, the agency will have to "sell" itself. It can only accomplish this if it conveys an impression of integrity and competence. It must employ people who are known to be competent and who attract respect and then it must perform in such a way as to deserve and keep that respect and trust. The agency must begin on a high level and then remain there.¹⁰

A third trait is authority. The agency must have authority. Its effectiveness will depend to a considerable degree on the amount of authority it possesses. At a minimum, the agency should have ready access to needed information and be permitted to make recommendations affecting all health activities. It should also have the authority to enforce certain of its recommendations, such as those pertaining to the nature and location of proposed new facilities. Authority is necessary to overcome bottlenecks and conflict.¹¹

⁹U.S. Public Health Service, Comprehensive Health Needs (Washington, 1967), p. 3.

¹⁰Ibid., p. 4.

¹¹Ibid., p. 5.

Fourth, the agency must be dynamic. It must recognize the need for changes and be an innovator and initiator of changes. It must provide leadership in creative, rational, vigorous attacks on the multitude of health problems.¹²

Fifth, the planning agency must be able to relate closely with other planning agencies and planners. It is not the intent of the planning agency to replace the specialized planning functions. It is the intent, rather, to strengthen that which is specialized. The agency must have a sound working relationship with the specialized entities so that the transfer of information can be carried on effectively as all concerned work toward the common goal.¹³

A sixth trait is permanency. In order to give continuity and responsibility, the agency must have a certain degree of permanency. Short term plans and short terms of tenure by planning staff could result in indifference and a shirking of responsibility. It is imperative that those who make the plans be around to defend and support their plans. Plans can only be of value if they are supported and put into action at the appropriate time.¹⁴

The seventh and last trait which a planning agency must possess is flexibility. It must be able to adjust to variable

¹²Ibid.

¹³Ibid.

¹⁴Ibid., p. 6.

political, social and economic conditions. As conditions dictate, the agency must be willing to adopt new procedures and points of view. Its foremost concern should always be better health for the population within its jurisdiction and should be flexible enough to fulfill this responsibility.¹⁵

These traits are all essential to a viable planning agency. The planning agency must be one with a broad outlook, prestige, authority, a dynamic approach, good working relations with planners and planning bodies, permanency, flexibility and able to relate the planning process to the public.

The Advisory Council

In order to assist the state planning agency in the performance of its assigned duties under the state program, a health planning council must be established. Because it is necessary for the council to facilitate a broad outlook on health problems and reflect a wide range of views, it is desirable for the council to be composed of competent, respected persons, representatives of many walks of life, in its membership.

In order to accomplish these ends, the council should include the following:

- a. The major state agencies concerned with physical, mental and environmental health aspects of the

¹⁵Ibid.

overall problem should be represented. They may be selected from among such agencies as the health, mental health and welfare departments, those concerned with vocational rehabilitation, services for crippled children, administration of Hill Burton programs, mental retardation, water pollution, air pollution and education.

- b. Representatives of non-governmental health organizations and groups should also be selected. These may be selected from among such organizations or groups as medical schools and other research and training institutions, hospitals, health insurance or prepayment organizations, voluntary health agencies, regional medical programs, medical and other professional societies, and areawide planning organizations.
- c. The local agency should, by all means, have representation. These may be selected from among such agencies as local health, welfare and education departments, mental health agencies, local governments, associations of local governments, regional planning or economic development commissions, and regional councils of government.
- d. Consumer representatives must constitute a majority of the council membership. Although state or local

public officials may be considered consumers, most consumer representatives should be private citizens. No person whose major occupation involves the administration of health activities or performance of health services is qualified for membership in this category.¹⁶

It is suggested that the membership of the council not exceed twenty-five persons. Members of the council should be appointed for staggered terms, to ensure continuity.¹⁷ It is desirable for the governor to appoint the membership. The selection should be made only after consultations have been conducted with leaders of prominent health, consumer and other appropriate organizations, societies and associations in the state. The criteria for selection should be prestige, interest in health problems, ability and availability. The council member should be well known and respected, have an interest in and concern about the health problems of his area and state, have proven abilities and have the time and freedom to participate in the council's functions. All political affiliations should be represented, where practicable.¹⁸

It goes without saying that the success or failure of comprehensive health planning is laid squarely on the shoulders

¹⁶U.S. Public Health Service, Advisory Councils (Washington, 1967), pp. 1-2

¹⁷Ibid., p. 3.

¹⁸Ibid.

of the states. If the state programs, the state agencies and the state councils are successful, comprehensive health planning will be successful. It's as simple as that. If they are not, comprehensive health planning will have been nothing more than a noble try.

CHAPTER VI

THE MINNESOTA EXPERIENCE

The story of health planning in Minnesota began a year before the passage of the Comprehensive Health Planning and Public Health Services Amendments of 1966. As a pioneer in the area of comprehensive health planning, Minnesotans have been involved in a search for answers. They have attempted to learn how to initiate planning, how to accomplish broad involvement, how to catch and hold a governor's interest, how to mold that interest into leadership of the planning effort, how to overcome the narrowness of bureaucracy, and how to implement a program. They have dealt with problems of organizing, defining the task, locating the funds and proceeding to establish a planning capability. A review of the successes and defeats in Minnesota may be useful for planners who are now seeking answers in their own states.

In view of the problems of disorganization, inadequate supervision and unevenness of quality in publicly supported health and rehabilitation programs which he saw, a trusted friend and adviser of the governor who was a psychiatrist and chief of the Department of Physical Medicine at the University of Minnesota Medical School wrote to the governor late in 1965 proposing a Governor's Advisory Committee on Health. He

recommended the appointment of this committee to deal with the problems in the area of health.¹

During the time that the proposal was under consideration, the President called the White House Conference on Health in Washington, D.C., on November 3-4, 1965. The governor and a small group of Minnesotans with an interest in health matters attended the conference. During the conference the Governor's Advisory Committee was a primary subject. At the end of the conference, there was a consensus of opinion that such a committee was needed.

Late in November, 1965 the governor named a small Ad Hoc Committee to consider the feasibility of such an advisory committee. The Ad Hoc Committee's feasibility report to the governor recommended the appointment of a Governor's Commission on Health Care and that the commission be asked to consider the following five major areas:

- a. The overall quality of the health of the citizens of the state of Minnesota, which would include a broad summary of the health and illness statistics available in various state and federal bureaus, with appropriate regional breakdown as available.
- b. A review of the existing health manpower, including an analysis of the distribution of health manpower, the number of persons in the various medical and paramedical professions, and the resources for

¹ American Rehabilitation Foundation, One State's Story in Health Planning (Minneapolis, 1967), p. 1.

educating health personnel.

- c. The organization of publicly-financed and operated health care programs, including an analysis of the state-federal relationship and a review of the quality of publicly-supported health care.
- d. A review of the existing and proposed health facilities, including the numbers of facilities, the geographic distribution of facilities, the various sources of funds for the construction of these facilities and the variety and organization of the various health facilities planning agencies.
- e. An analysis of the economics of health care which would include a study of the extent and quality of private and public health care insurance coverage and an examination of the variations by region in the cost and supply of health care, with a view to developing optimum utilization of health care services.²

The governor endorsed the initial proposal and the Ad Hoc Committee proceeded to study the subject in more depth. During the following four months, the Ad Hoc Committee studied the four aspects of funding, placement of the health planning agency, membership of the commission and the scope of the endeavor.

²Ibid., p. 2.

Attention was given to several possible sources of funding. An attempt was made to acquire funds from the Vocational Rehabilitation Amendments, P.L. 89-333, which authorized grants for the purpose of planning for the development of a comprehensive program for vocational rehabilitation, but this failed. Several single-purpose health-related planning projects were underway within the state. The Ad Hoc Committee made several attempts to get a portion of these funds, but this also failed. In Minnesota more than \$80 million annually is spent for health and rehabilitation. The Committee tried to acquire part of this large amount for planning, but again failure was theirs. Private foundations were also approached for funding. This approach was also unsuccessful. The problem of money was temporarily resolved by the Public Health Service and the Office of Vocational Rehabilitation. An attempt was also being made to get money by seeking legislative appropriations during the 1967 session.³

The Ad Hoc Committee considered a number of alternatives in making a decision concerning the placement of the comprehensive health planning authority. The alternatives included the University of Minnesota, a nongovernmental research institution, a new nongovernmental agency, an operating department of the state government, an interdepartmental governmental agency and the State Planning Agency. It was the decision of

³Ibid., p. 4.

the Ad Hoc Committee to place the health planning function in the State Planning Agency which had been established in 1965. The idea was met with considerable opposition from the Commissioner of Administration, who was charged with the administering of the new state planning law. The health planning was seen as a logical "functional" assignment for the health department, with appropriate interagency relationships as needed.

In winning the decision to place the health planning function in the State Planning Agency, the Ad Hoc Committee cited the following advantages:

- a. Close linkage with the office of the chief executive, thus facilitating implementation,
- b. Strengthened authority to accomplish interdepartmental cooperation,
- c. Interface with overall planning,
- d. Involvement of the private sector,
- e. Enhancing the state's planning competence, and
- f. Greater public visibility.⁴

In determining the membership of the commission, careful attention was given to preserving a nonpartisan character and to assure full recognition of the various key interest groups which would be most directly concerned with and affected by the work of the health planning agency. The commission was made as representative as possible. Of the thirty-two persons

⁴Ibid., pp. 5-8

asked to become a member in a letter from the governor dated April 15, 1966, thirty-one accepted promptly and enthusiastically. The governor selected as chairman the executive director of the American Rehabilitation Foundation, a voluntary rehabilitation, planning, education and research agency.⁵

The scope of the comprehensive health planning endeavor had been fairly well defined in the earliest considerations of the idea of a Governor's Commission. As the idea moved toward reality, the scope and goals were naturally refined. The governor's letter of invitation contained a new emphasis on the changing relationships between the public and private sectors of health services, and called for the exercise of care "to protect the continuing effectiveness of the good working partnership which has been developed."⁶

The first meeting of the Governor's Commission on Health and Rehabilitation was held on July 12, 1966. During the first few months of its existence, the Commission organized its membership into four task forces - Planning, Rehabilitation, Resources and Economics.

The areas of consideration assigned to the Planning Task Force included current planning efforts in Minnesota, development of mechanisms for continued planning, and some specific

⁵Ibid., p. 8.

⁶Ibid., p. 9.

health care areas for which planning was deemed necessary, such as facilities planning.

The assigned areas of consideration of the Rehabilitation Task Force included preparation of a roster of the disabled, an evaluation of programs, an identification of barriers hampering the provision of services, and the development of ways for improving, extending and coordinating needed programs.

The primary area assigned to the Resources Task Force was to consider the recommendations of the Hill Foundation's Medical Manpower Study, an analysis of medical and dental manpower in Minnesota and surrounding states. The other areas of consideration assigned to this task force included problems relating to residency programs, para-medical personnel shortages and an evaluation of the need for registration as a means of assessing the distribution of personnel in the state.

The assigned areas of consideration for the Economics Task Force included the quality of the health and the health protection of the citizens of the state, the effectiveness of governmental health programs, mechanisms for assuring quality and an examination of health insurance programs.⁷

A key development occurred in the Minnesota health planning effort with the passage of P.L. 89-749 on November 3, 1966. The possibility of enactment of this federal

⁷ Ibid., pp. 10-13.

comprehensive health planning legislation was the force behind Minnesota's initial interest. Minnesota's interest in and promotion of the legislation was an important factor in the ultimate passage of S.3008. When the bill did become law, Minnesota had a running start. This fact elicited further financial support from the Public Health Service, which was now more interested in finding out about the real life problems and perils of health planning as experienced on the front line.⁸

On March 27, 1967 the governor notified HFW Secretary Gardner that the State Planning Agency would serve as the comprehensive health planning authority for the state of Minnesota. No action has yet been taken as far as making the Governor's Commission the advisory council.

Numerous planning actions have taken place in Minnesota since August, 1965. It is not easy to evaluate what has been done. The outcome may not be known for several years.

Looking first at what seems to have been done right, three principles which were followed and have proven to be sound principles for any planning effort deserve comment. These principles were a broad approach to health planning, an open-mindedness and readiness to adjust to conditions and a recognition of the key role of the governor of the state.

And there were problems. The problems were the type which any state entering into the comprehensive health

⁸Ibid., p. 14.

planning field can look forward to in one way or another. The problem areas included the absence of statutory recognition for the health planning program, lack of a legislative appropriation of state funds to couple with federal grants, traditional understaffing of the governor's office, and the absence of the essential tools of management, to name a few. These problems were political as well as economic, and these types of problems are difficult to solve.⁹

The business of getting started in health planning is still going on in Minnesota. Much has been learned and done, but the goal is still far in the distance. Those who have watched the progress up to now have concluded that some important guidelines have been formulated and some useful facts have been disclosed. The proving ground for comprehensive health planning lies just ahead. Now that the legislation has passed at the federal level and interest has become prominent at the state and local levels, those interested in learning can surely do so from the Minnesota experience.

⁹Ibid., pp. 17-18.

CHAPTER VII

COMPREHENSIVE HEALTH PLANNING AT THE LOCAL LEVEL

Since the passage of P.L. 89-749, most of the discussion about comprehensive health planning has been directed toward the federal and state roles. Very little attention has been given to the part the local government will play in this new "Partnership for Health." This fact is somewhat disturbing since the local governments will, or at least should, play a significant role in this new arrangement.

While it is true that the role the local government will play will depend, in large part, on the attitude of the state as well as the initiative of the local community, it is deemed appropriate at this time to analyze a typical, local health effort in a metropolitan area and see how it fits in to the comprehensive health planning puzzle.

The City Health Department of Dallas, Texas, had its origin in 1873 with the appointment of Dr. Matt Cornelius as the city's first health officer.¹ Since that time, the Dallas City Health Department has grown to include approximately 300 employees and an operating budget of almost \$2.5 million

¹Dallas City Health Department, Annual Report, Ninety Years of Public Health (Dallas, 1963), p. a.

dollars.² From the mere size of the organization and the amount of the annual expenditure, it is not difficult to envision the scope of services and the contribution made by the department to the community and to the health field, in general.

In addition to the Dallas City Health Department, there are some forty health agencies, public and private, in the city of Dallas. As a result, there has been duplication of some services, lack of others and frequent confusion on the part of the citizen seeking service and the health professional or social worker seeking to give him help. This situation has been of growing concern to Dallas leaders, health and otherwise. In recent years there has been considerable effort to alleviate these problems.

In 1966 the Goals for Dallas included a statement that health care and services should be on a comprehensive basis, involving health information, preventive medicine, in-hospital and out-of-hospital care for physical and mental health problems of all economic classes of citizens. The Goals for Dallas reflected the attitude of Dallas. The Goals even went so far as to recommend that enabling legislation be developed and introduced to provide the legal authority and status of health planning bodies.³ In a revised

²City of Dallas, Texas, General Budget for Fiscal Year 1967-1968, 1967, pp. 85-108.

³Goals for Dallas (Dallas, 1966), p. 78.

presentation in 1967, the Goals for Dallas included a recommendation for the formation of an Area Health Planning Council composed of representatives from, among others, medical schools, hospital districts, hospitals, city and county health departments, medical and health associations and laymen to help coordinate efforts to solve long-range and growing problems.⁴

By now it should be quite clear that the local government performs a vital function in conjunction with a multitude of other service-providing organizations in the health field and that there is a growing concern about some of the problems confronting the community.

Comprehensive health planning as envisioned in the Comprehensive Health Planning and Public Health Services Amendments of 1966 can open the door for many local governments if the states will give them a vote of confidence. In Dallas, the City Health Department has an excellent working relationship with the U.S. Public Health Service and the Children's Bureau, the two federal agencies most closely related to the health activity. One reason for this is that the regional offices of these two agencies are located in Dallas. The relationship with the Texas State Health Department is good, but could be better. This factor could be a problem as the two try to work toward a comprehensive health effort. Since Texas has not progressed to the state of having

⁴Goals for Dallas, 2nd edition (Dallas, 1967), p. 9.

a state health planning agency and a health planning council, it is difficult to tell what the ultimate atmosphere will be.

While the state of Texas has not established any guidelines under which the local entities will make their contributions, it would seem appropriate that the local effort include a program for the gathering, analysis and evaluation of data. Since the local health units are closest to the people and the problems, it would seem advisable to strengthen the local health unit's information gathering and evaluation capabilities and concentrate some of the planning effort in these units. By utilizing biostatisticians and other key staff people, the local health unit could strengthen its own program and provide information to the state planning agency and council for their use. The Dallas City Health Department does not have a biostatistician or a planning staff. The only planning that is done is conducted by the director and his immediate staff who are overburdened with routine line and service duties and as a result the planning function gets very little attention.

One of the problems which plague the local health unit, as well as all others in the community concerned with health and related matters, is the inadequate arrangement for information dissemination. No one in the community has a complete picture of the community's health situation. Before comprehensive health planning can be successful, this problem will

need to be solved. There exists a very grave communication breakdown. This not only includes communication between the public and private organizations, but also between the three levels of government.

Section 314(b) of the Comprehensive Health Planning and Public Health Services Amendments of 1966 states that any public or nonprofit private agency or organization can be the recipient of a project grant for developing and from time to time revising comprehensive regional, metropolitan area or other local area plans for coordination of existing and planned health services.⁵ Public and private organizations in the community have failed, for one reason or another, to perform the planning function satisfactorily. The planning that has been done has been fragmented and piecemeal, for the most part. This legislation would provide an excellent opportunity for the local health community to pursue this avenue toward comprehensive health planning. The section in the legislation further states that if the project grant is applied for prior to July 1, 1968, approval of the state agency shall be required only if such state agency is in operation at the time of the grant.⁶ Even if the state is dragging its feet, the door to comprehensive health planning is still open to the local health organizations. It would seem appropriate for the Dallas City Health Department, the Community Council of Greater Dallas or some other appropriate

⁵U.S. Congress, Comprehensive Health Planning and Public Health Services Amendments of 1966, p. 3.

agency to instigate a movement in this direction.

While P.L. 89-749 helps the local unit, it also presents some problems. One such problem is related to Section 314(e). This section provides for grants to any public or nonprofit private agency, institution or organization for special projects. The legislation, however, does not provide for channeling the grants through the local health department. This means that any public or nonprofit private agency, institution or organization, at the state level or at the local level, may apply for and receive a grant for a health project without the local health department knowing of the addition to the total health effort in that community. It is very important that the local health officials be aware of all activities regarding health and health related matters being conducted in the community. Under the present requirements of the legislation, health projects may be initiated without the knowledge of the local health agency. This factor alone complicates the planning effort considerably.

It is too early to tell what the actual impact of the legislation will have on the local health effort. Many of these questions will be answered after the states make their commitment. The local health effort is an important one to say the least. Local health agencies are located in areas of high population concentration with large numbers of people in the low socioeconomic bracket. These are the people who receive the majority of public health benefits. So, it is

not difficult to determine the importance of the local health contribution to the health endeavor. The local health agency and other related organizations in the community must play a major role in the comprehensive health planning effort. If they do not, the entire endeavor will be in rather serious trouble.

CHAPTER VIII

PROBLEMS AND PROSPECTS

With the passage of the Comprehensive Health Planning and Public Health Services Amendments of 1966, the health community witnessed an event of revolutionary magnitude. In order to fulfill the requirements of the public mandate which states that comprehensive health services shall be readily available to all who need them, and that every person shall live in an environment which contributes to healthful individual and family living, many dramatic changes have taken place.

New emphasis has been placed on planning of a comprehensive nature, the U.S. Public Health Service has been completely reorganized, placing new responsibilities on the regional offices, the states have slowly begun to take action to fulfill their new obligations, and the grants-in-aid programs in the health field have been completely revised, to name a few changes. While activities have been in progress for a little longer than a year, tremendous progress has been made. But the job has only started.

Since the passage of the legislation on November 3, 1966, many problems have arisen which have impeded the achievement of a comprehensive health planning effort.

A problem of paramount significance is that there is no how-to-do-it manual for comprehensive health planning - either

prepared or capable of preparation. There is no recipe to follow. There is no magic button to push. No one knows just how to cope with the task which lies ahead. Public Law 89-749 is an expression of faith in the process of planning. The legislation has placed the burden on the states and the communities. The legislation is an invitation to initiative which the states and the communities must provide if success is to be forthcoming. To offer this invitation and then prescribe a formula which must be followed would be to deny the entire purpose. The states and the communities will have to rely solely on their experience and the principles of good planning in order to accomplish this task and not on some ready-made formula because none exists.¹

Since the states and the communities will have to rely on the principles of good planning as a vehicle to success, it seems appropriate at this time to discuss some of the problems which are inherent in planning. These problems arise out of the three characteristics of planning; namely, planning is rational, dynamic and has political implications.²

Planning is rational. Plans which are based on known relationships and reason reach goals more often than random actions. Planning implies that a rational approach and not a random approach be taken. Plans will never materialize

¹William H. Stewart, M.D., "Comprehensive Health Planning," speech presented at the National Health Forum of the National Health Council, Chicago, Illinois, March 21, 1967, pp. 10-11.

²U.S. Public Health Service, Concepts in Planning (Washington, 1967), p. 1.

if the basic assumptions are wrong. The quality of the reasoning and assumptions is the major factor in determining the quality of a plan.³

Deficiencies in rationality can be categorized under three headings - knowing where one is, knowing where one wants to go and knowing how best to get there. Ideas on where one is are commonplace. The smaller the organization, the better the hunches. However, when the problems and programs are large, the hunches are generally inadequate. Sound information systems must exist for rational planning. The first problem is that one seldom really knows the present situation because of insufficient information.

Another problem presents itself when one attempts to determine where he wants to go. The process of selecting goals is not an easy task. The goals which are selected are largely tempered by the ability to reach them. Thus, one should formulate long term goals and short term goals. Long term goals are those relatively free of constraints of current practice and knowledge. Short term goals or objectives are those which are considerably tempered by the constraints of present practice and knowledge. Goals must be stated in operational terms, that is, in terms which can be related to a world of action and can be measured in that world. For example, a goal to eliminate air pollution might also eliminate most human activity. A goal to reduce air

³Ibid.

pollution so that it is not dangerous to health or is aesthetically displeasing will provide a basis for determining how much control should be used once the danger to health is defined in terms of air pollution. One must continually evaluate where he wants to go. In planning, goals must be set toward which efforts are directed. Too often, these goals are not realistic. As a result, failure.

Finally, problems exist which are associated with knowing how to reach the predetermined goals. This aspect is very important because only limited resources exist and cannot afford to be wasted. The efficient use of resources must be made. A resource is used efficiently if the benefit obtained from its use is greater than that which would have been obtained if the same resource had been used for something else. This idea is simple, but applying it requires a great deal of knowledge about the world and how things work in it.

Planning must be rational because the quality of thought and knowledge will be reflected in the quality of the plans. One can readily see that part of the problem in planning is in its rationality. One does not always know where he is, one does not always know where he is going and often one does not know how to get there - let alone the best way.⁴

Planning is dynamic. Plans must change as conditions change. The process of formulating a plan must also be

⁴Ibid., pp. 7-11.

dynamic. Plans must be effective and in order to be effective they must be based on goals and objectives which are obtainable. The success of the plan is dependent on changes involved in all the factors related to the plan. If no provision has been made to incorporate the unpredicted in the planning process, the plan will be far less than desirable.⁵

Many problems are caused by planning's dynamic nature. The world does not stand still and assumptions upon which plans are built are continually changing. This factor must always be taken into consideration. Planning must recognize that the world does not stand still and must allow for this if it is to be truly effective. Too many plans and planning bodies do not make these allowances. The result is plans which do not work well or are abandoned as "unrealistic." Plans cannot set on shelves; they must consider the dynamics of our time.⁶

Planning has political implications. The determining of a society's values and goals are political decisions. Vested interests want different goals and different ways of attaining them. One of the basic steps in the planning process is the selection of goals. This step can easily evolve into a major political struggle.

In making plans for reaching certain goals, planners will chose between alternatives. Different alternatives

⁵Ibid., p. 2.

⁶Ibid., p. 12.

favor different groups. Planners must be aware of the value and thus the political consequences of their proposals, for a proposal which is not acceptable will delay attainment of a goal.⁷

Political goals are likely to change, and as they do, so do the programs to achieve these goals. It is very difficult to adjust to changing goals. Planning must recognize the political ramifications. When it does not, plans may be unacceptable and never used. Often planning has not been able to incorporate the political nature of its purpose and thus has been ineffective. Planning must always consider the political aspects of a plan, whether this is an ideal situation or not.⁸

In addition to the problems already mentioned, there are other problems which make good planning difficult. First, there is the inertia which resists change in the comfort of the status quo. The only way to overcome this problem is by the stimulation of exciting programs and ideas, and in some cases by administrative disciplining.

Another problem in planning is attitude and a conflict which may arise in the beliefs and mores of persons involved. Planning may encourage new programs and the elimination of old ones. Some people may passively object, while others

⁷Ibid., p. 3.

⁸Ibid., p. 13.

may take an active role. Plans should recognize this possibility, allow for resistance and make an effort to win the support of all concerned.

Finally, there is a somewhat justified resistance to planning based on past experience. Too often in the past plans have not worked well or have not worked at all. Planning will have to erase this image if it is to be successful.⁹

Another problem of considerable significance in the comprehensive health planning effort is the reluctance of some members of the health community to move actively into the area of comprehensive health planning as an integral part of the total health movement. Many of the members of the health community have operated so long as a separate entity that they are now reluctant to participate in a situation which might endanger their traditional position. They desire to maintain their autonomy and their feeling is that participation in the total health effort may alter that autonomy.

Difficulty in recognizing planning as a shared responsibility of government and the voluntary sectors and of citizens and professionals alike to achieve a workable system of health services has also presented some problems. Where there has been a recognition of this responsibility, honest but real differences among planning agencies, health and medical professionals, and citizens regarding appropriate goals have developed.

⁹Ibid., pp. 13-15.

One of the greatest problems existing today which has a very definite relation to comprehensive health planning is that of an acute shortage of manpower in the health and social work fields. Plans will never be made if there is insufficient manpower to make these plans. And, the plans will never be implemented if there is not sufficient manpower for that purpose. The manpower situation is very grave and must be corrected.

To date, there has only been limited communication between the various components of the health community in regard to comprehensive health services through comprehensive health planning. It is imperative that information flow freely if the ultimate goal is ever to be realized. There are many people and groups involved in this effort and they must communicate and pass information to each other.¹⁰

While considerable attention has been devoted to the problems which have been or will be encountered, the intention is not to paint a black picture. The picture, on the contrary, is quite bright and promising. The first step in the problem solving process is to recognize the problem. The promising aspect of this entire effort is that the problem has been recognized and that untiring efforts are being devoted toward its solution. The primary problem is that adequate health capabilities do not exist whereby all the people can obtain

¹⁰U.S. Public Health Service, The Role of Health and Welfare Councils, p. 14.

the highest level of health attainable. All of these other problems mentioned are secondary, but nonetheless, an integral part.

Society has set the goal. The health community must accept the challenge. From all indications thus far, they will.

CHAPTER IX

SUMMARY AND CONCLUSIONS

The Comprehensive Health Planning and Public Health Services Amendments of 1966 has made a very real and a very dynamic contribution toward developing the setting for the delivery of comprehensive health services. Up until the passage of the legislation, it was doubtful if all the people of this country - rich, middle class and poor - would realize total health services. The legislation recognized the strengths and weaknesses of the existing health system. The provision of comprehensive health services is beyond the scope of responsibility of any one particular group in the health community. Its achievement depends upon a partnership, involving close intergovernmental collaboration, official and voluntary efforts and the active participation of individuals and organizations.

Public Law 89-749 was developed based on five assumptions. The first guiding assumption was that while some health problems may be national in scope, their urgency and the best approach for meeting them differs from place to place - hence, the strong state emphasis.

A second guiding assumption was that further progress in improving the availability and quality of comprehensive

health services requires planning - hence, the emphasis on planning.

A third assumption was that planning can best be done at the level most closely related to the individuals requiring services, while at the same time covering a broad geographical base to insure effective handling of problems - hence, state and areawide planning and the tie-in between the two.

Another assumption was that effective planning must involve those people providing the health services as well as those receiving - hence, the composition of the planning council.

And the fifth and last assumption was that planning in the abstract can easily become a meaningless exercise unless there is a built-in capability to carry out the planning - hence, the backup provided by formula and project grants.¹

Comprehensive health planning will be difficult and its progress can only be measured over a long period of time. The legislation developed a base for a vital step forward, not an end in itself. It is not a new and different program, but a dynamic process and means for identifying and delineating courses of action. In contrast to many previous health planning efforts, the planning effort as outlined in P.L. 89-749 is not limited in time, or to a collection of programs or to

¹James H. Cavanaugh, "Comprehensive Health Services," Public Health Reports, LXXXII (May, 1967), p. 400.

a segment of the health system. The process and the agencies involved will provide the mechanism through which

- a. All health planning can be linked and strengthened, and clarity of purpose secured;
- b. Health status can be measured, goals and objectives defined, priorities set and actions planned for;
- c. Interrelationships can be explicitly described and made more effective;
- d. Service, manpower and facility needs can be identified and interrelated and program accomplishments assessed;
- e. Channels of communication and methods of cooperation can be strengthened between agencies and groups with mutual concerns; and
- f. The people of a state, through their governor and legislature - and the Surgeon General, and the state and national health effort - can have the benefit of the best recommendations for action.²

From his experience in gathering the material for this study and from his experience in working in a local health department in a large metropolitan city, it is the opinion of the writer that the Comprehensive Health Planning and Public Health Services Amendments of 1966 represents the greatest advancement in the health community to date. The

²Ibid., p. 401.

legislation has set some very exciting and challenging goals and delegated additional responsibility for action to the states and the communities. It has provided for a means of coping with people and their problems rather than just diseases. It has provided for funds in order to implement the planning and for follow through on the plans after they have been made.

But, this legislation only represents one step. Many more, just as important, must follow. Will the states and the communities assume the responsibility? Are they able even if they have the desire? Are all governors interested in the health problem or will some only pay lip service to the commitment and not make a notable contribution? Will the state health planning agencies, once they are established, be staffed with people who are perceptive or those who are full of traditionalism? Will they truly do some planning or will they merely go through some motions which resemble planning? All of these are questions which must be asked. Because problems are going to present themselves in each of these areas.

In examining the legislation and the other research for this study, it is the opinion of the writer that there are three important conclusions which must be given attention.

First of all, if this country is ever to realize comprehensive health services of the magnitude envisioned by

this legislation, the states and the communities will have to reorganize in the same manner as the U.S. Public Health Service did on July 1, 1967. Under present conditions the states and the communities cannot fulfill the obligations and responsibilities laid at their feet. The local effort will have to be strengthened considerably in the areas of data gathering, data analysis and program evaluation. It is imperative that this be done because the local unit, be it city or county, plays a key role in this endeavor. The local units are located in the areas of high population concentrations in the low socioeconomic strata who benefit greatly from social programs. As a result, local units spend billions of dollars providing services. These local units are in the best position to gather, analyze and evaluate what is happening on the front lines. But they cannot fulfill this function if they are hamstrung under current operating procedures. It should be these units who gather most of the data which is furnished to the state health planning bodies.

The second conclusion is that the health community will have to undergo a tremendous educational program. This program will be necessary in order to educate and "sell" the community on the concept of the health planning legislation. The federal government must initiate this effort, since the legislation evolved out of Washington. The states must

be encouraged to participate wholeheartedly and they, in turn, must encourage the local units and all others, however remote their concern, to participate.

The third conclusion is related to the critical manpower shortage in the health field. Young people will have to be encouraged to seek careers in the health field early in their academic pursuits. The responsibility in this area lies with the institutions of higher learning and with the professional societies and organizations. Young people will need to be recruited early in life, so that they can prepare adequately for a health career. This not only includes careers as physicians and nurses, but also careers in the hundreds of other job opportunities in the health and related fields.

There has been much accomplished during the past year or so in the health field. But what has happened has only placed a dent in the thick armor of traditionalism. Today, the demands are contemporary. Consequently, the methods utilized to answer these new demands must be contemporary. They must be new; they must be exciting. Only time will tell whether what has been done was what should have been done. Many problems have already arisen as the result of trying a new approach. Some of these problems have been solved; others have not.

Never before has the health community been faced with such challenging opportunities to better the health of the

citizens of our country. The U.S. Public Health Service is confident that the new approach will succeed. They have worked diligently toward this end. The success or failure now lies with the states and the communities. Will they follow through? Will comprehensive health planning be the next step?

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