The Designation of Health Service Areas

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THE LISTING of health service areas published in the Federal Register on September 2, 1975, constituted the first major step in implementing the National Health Planning and Resources Development Act of 1974 (*1*), which President Ford had signed into law on January 4, 1975. It designated a total of 202 health service areas in 47 States. (Delaware, the District of Columbia, Hawaii, Rhode Island, and Vermont had claimed exemption from designating areas under Section 1536.)

The September 2 Federal Register announcement of the health service areas, in effect, concluded a process that began on January 21, 1975, when the Governors of the 50 States and the Commonwealth of Puerto Rico and the Mayor of the District of Columbia were officially notified by a letter from the Secretary of Health, Education, and Welfare of the initiation of proceedings to establish health service areas throughout the United States in accordance with Section 1511 of the National Health Planning and Resources Development Act. This letter, which was published in the Federal Register along with the official notice, requested each Governor to submit to the appropriate DHEW Regional Office by May 3, 1975 (120 days after enactment of Public Law 93–641) an area designation plan that met the requirements of the act.

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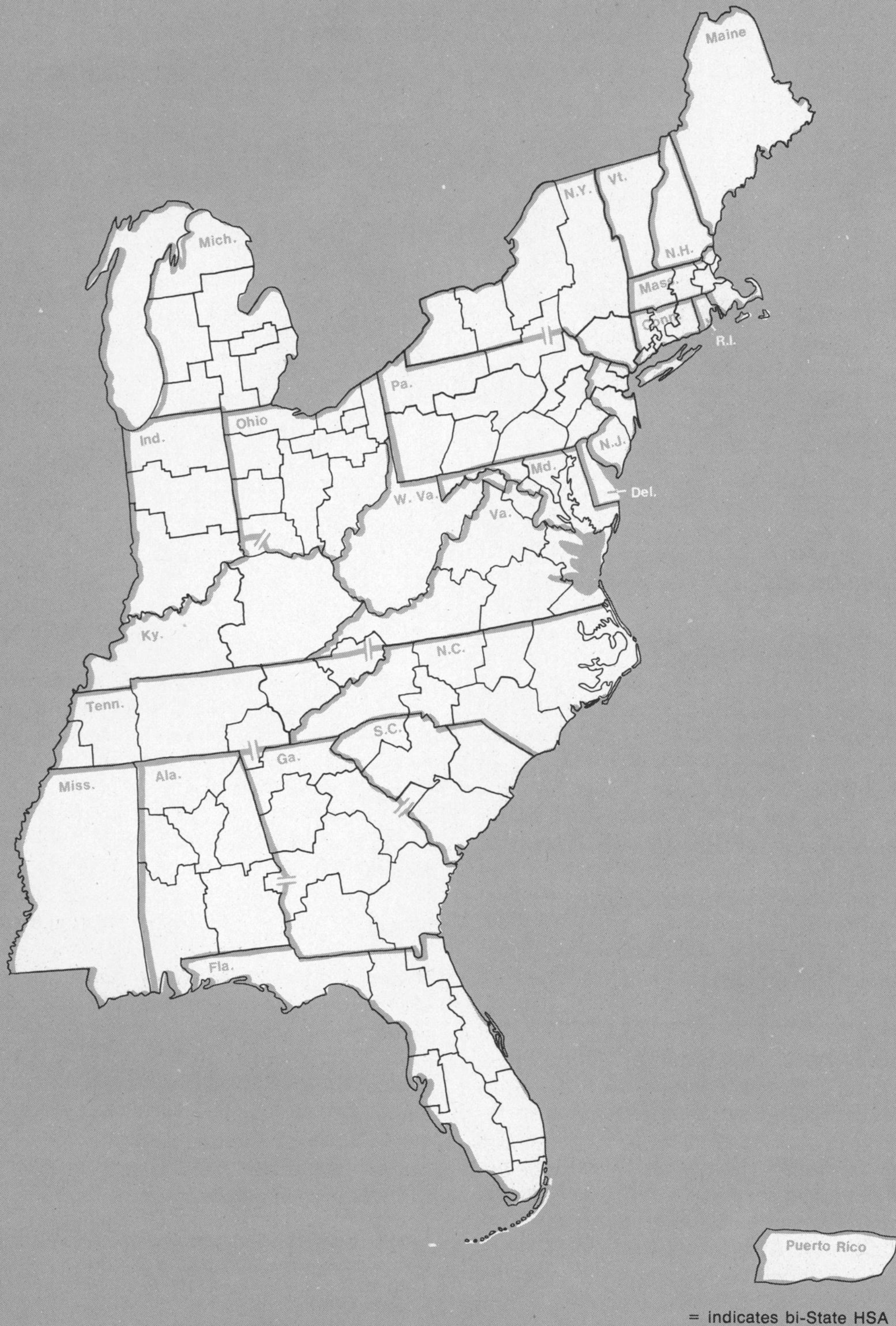
Health Service Area Requirements

Section 1511 of Public Law 93–641 required that health service areas be established throughout the United States. It specified that each such area should meet the following requirements.

- The area shall be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.
- The area, upon its establishment, shall have a population of

Health service areas in the eastern United States



not less than five hundred thousand or more than three million; except that—

(A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

(B) The population of an area may—

(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

(ii) be less than—

(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary),

(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary),

if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

- Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that if the Governor of each State in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other requirements of this subsection a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.
- To the extent practicable, the area shall include at least one center for the provision of highly specialized health services.
- To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1152 of the Social Security Act for Professional Standards Review Organizations, existing regional planning areas, and State planning and administrative areas.
- The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas.

These legislatively mandated requirements reflected both the desired outcomes and certain concerns of the substantive congressional committees (House Interstate and Foreign Committee and its Subcommittee on Health and Environment and Senate Labor and Public Welfare Committee and its Subcommittee on Health) with respect to such areas and their establishment.

The act was designed to assure that health service areas would be established "throughout the United States." Federally supported local or areawide health planning agencies established under the predecessor Comprehensive Health Planning (CHP) program served only about 80 percent of the total population of the United States.

The overarching general requirement that the health service areas be geographic regions "appropriate for the effective planning and development of health services" was given more specific and sharper definition by the other requirements.

The specific minimum-maximum population requirement was adopted by the conferees from the House bill (H.R. 16204). As the House committee report (*3*) stated, "The 500,000 people minimum reflects the experience that effective health planning can be conducted only with an adequate base of population and health resources to sustain a planning process." Conversely, the limitation that the population of a health service area not exceed 3 million (unless it includes a Standard Metropolitan Statistical Area (SMSA) which has a population of more than 3 million) suggests a concern that too large areas might materially compromise local or community involvement and inputs to the Health Systems Agency (HSA) established to serve and plan for that area.

The House committee noted in its report that although health service areas should generally be larger than Standard Metropolitan Statistical Areas, SMSAs are a useful delineation of our major metropolitan areas, and the committee felt rather strongly that health service areas should not divide them. In a real sense, SMSAs were viewed as constituting a surrogate or proxy measure of medical trade areas. Since SMSAs sometimes cross State boundaries, as medical trade areas do also, the committee intended that when a major metropolitan area straddled a State boundary, its health service area would also cross the State boundary.

The House committee report (*2*) noted that the requirement as to highly specialized health service "reflects the desire that the health service areas provide a self-contained, comprehensive and complete range of health services such that an individual residing in the area would rarely if ever have to leave it in order to obtain needed medical care." It also seemed to suggest that these areas should encompass a health resource base (for example, facilities, manpower) sufficiently large and varied to permit effective health planning.

In its report, the House committee recognized that since "the boundaries of areas defined for different purposes cannot all be identical, the criteria for designation of health service areas do not require that the boundaries be identical with those for PSRO areas, regional planning areas, or State planning and administrative areas." To insure close coordination, however, between the HSAs being established by this act and other State, regional, and local health and health-related planning and administrative areas and agencies, the health service areas needed to be congruent insofar as possible with one or several State planning and development districts as defined for purposes of the Office of Management and Budget Circular A–95. Insofar as practicable, the health service areas were either to encompass one or more PSRO (Professional Standards Review Organization) areas in their entirety,

or several health service areas were to be encompassed totally within a single PSRO area. Generally the health service areas were not to divide locally established areas of functioning and recognized regional planning bodies.

The requirement that the differing needs of "metropolitan and nonmetropolitan areas" be recognized in establishing health service area boundaries reflected congressional concern that nonmetropolitan or rural areas be insured fair and equitable treatment in the designation of areas. It has the effect of moderating the requirements relative to the population of nonmetropolitan areas and the range of health services and facilities in them. The floor debate in the House in this connection was particularly relevant. For example, Representative Alexander (Arkansas), who introduced the amendment, noted that health service areas in nonmetropolitan regions with "a limited range of tertiary services could properly be established with one of their health resource development objectives being increasing the range of tertiary services offered . . ." And Representative Roy (Kansas) observed: "While the committee is serious about the use of 500,000 as the minimum population for health service areas, it is well within reason that the exception provided for in [the act] . . . be applied when necessary to overcome travel time, geographic and/or economic barriers to receipt of health services in nonmetropolitan areas."

Waivers. Two of these requirements could be waived upon the request of Governors with the approval of the Secretary: the minimum 500,000 population requirement and the requirement that a health service area not divide an SMSA.

It should be noted, however, that no provision was made for granting a waiver (or variance) of the 3 million maximum population requirement. The act only permitted an area to have a population exceeding that if it included an SMSA (or a major portion thereof) with a population of more than 3 million, in which case it constituted an allowance exception rather than requiring a waiver.

In the case of interstate SMSAs, the waiver provision with respect to splitting SMSAs required that all Governors concerned request such waivers. It precluded the Secretary from granting a waiver to split an interstate SMSA upon request of only one of the Governors concerned; the Department in effect was required to consider and act upon the request of the Governor who had proposed an area encompassing the entire SMSA.

Process Followed In Designating Areas

Public Law 93–641 placed the major responsibility for designating areas on the Governors of the individual States. The role of the Department was essentially limited to ensuring that the health service areas proposed by Governors did in fact meet the requirements and determining whether or not requested waivers were justified and thus should be granted.

As noted before, Governors were formally requested by a letter from the Secretary on January 21, 1975, to undertake the designation of health service areas in their States. This request was reiterated in an official notice published in the Federal Register on January 28, 1975.

In January 1975, four regional conferences were held to provide representatives of existing State and local health planning agencies, Regional Medical Programs (RMPs), and others with information about the new health planning and resource development program created by Public Law 93–641. These conferences were held in Atlanta (January 13–14), Baltimore (January 16–17), San Francisco (January 23–24), and St. Louis (January 28–29). The process requirements and timetable to be followed in designating areas was a major item of discussion at those conferences.

Department representatives also attended a National Governors Conference in Chicago February 6–7, 1975, to similarly brief State officials and Governors' representatives about the new act and the designation of health service areas under it.

Implementation by States. One of the first actions taken by most Governors in initiating the area designation process was to appoint an individual to serve as their designee for area designation purposes. In all but three instances, the persons named were either members of the Governor's immediate staff or office or another State official. Fourteen of the designees were in the immediate office of the Governor; (most of these 14 were from the offices of Governors who had just been elected the previous November). Thirteen designees were from State departments of health (often the director of the department); 12 were from State departments of human resources or health and welfare (again, usually the director); 6 were from State Comprehensive Health Planning (CHP) agencies; and 4 were from State offices of planning and budget.

In addition to the substantive requirements that the areas had to meet, the act also prescribed one relating to process, namely:

> Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 314(a), each entity within the State which has developed a comprehensive regional, metropolitan or other local area plan or plans referred to in section 314(b), and each regional medical program established in the State under title IX.

This requirement, like the others, was reflected in the guidelines (*3*) issued by the Department to assist Governors and their designees in preparing their State area designation plans. The purpose of the guidelines was to provide (*a*) an elaboration of the area designa-

Health service areas in the midwestern United States
N. Dak.
Minn.
Wis.
Mich.
S. Dak.
Iowa
Nebr.
Ill.
Mo.
Kans.
Okla.
Tex.
Ark.
La.
= indicates bi-State HSA

tion requirements set forth in the act, (*b*) instructions and the format to be followed in developing and submitting health service area designations, and (*c*) a brief description of the Federal review and approval process with respect to area designations.

As to the consultative requirement included in the act itself, the guidelines, for example, urged that in designating areas, Governors or their designees consult with other agencies, groups, and organizations in their States, including:

- Agencies funded by the Appalachian Regional Commission and other local planning agencies presently performing 314(b) functions, but not directly funded under that authority.
- Any experimental health services delivery systems (EHSDS) within the State.
- Professional Standards Review Organizations.
- Various State health and related agencies such as health and mental health departments, Hill-Burton agencies, and vocational rehabilitation agencies.
- Major health provider groups such as State medical societies and hospital associations.
- Voluntary health organizations such as State heart associations and mental retardation chapters.
- Appropriate consumer or public interest groups.

The manner in which Governors and their designees approached the designation of health service areas varied considerably. To develop proposed areas, including possible alternatives, a large number of the Governors or their designees established task forces or committees that included representatives of many agencies, groups, and organizations within the State. The required consultation with local elected officials, State and areawide CHP agencies, and RMPs (Regional Medical Programs) also was satisfied in differing ways. In some instances, views and comments were formally solicited in writing. In many other States, meetings were held with groups or State associations representing those interests and agencies. In some States, public hearings also were held in an attempt to obtain inputs and reactions from a broader spectrum of interests and individuals at the local or community level.

An observer of the process followed by the States, including the consultative aspects of that process, was left with two distinct impressions. For the most part, the process was a rather "open" one in which conflicting viewpoints could be, and frequently were, advanced. As a result, in some cases certain groups, institutions, and individuals, especially at the local level, were displeased with the areas finally proposed by their Governors.

Many Governors personally played an active role in the designation process. A number in effect laid down additional requirements that areas in their States would have to meet. For example, sub-State planning districts were not to be divided by the health service areas designated. The areas, however, might encompass several of the districts but only in their entirety. Other Governors insisted that the areas proposed not entail any waiver requests whatsoever.

In some States, Governors had alternate plans or area proposals presented to them for their final decision or determination rather than having a single one recommended to them for approval or concurrence.

Federal review and approval. At the Federal level, a two-tiered, two-stage review process was followed. HEW's Regional Offices had the principal responsibility for reviewing proposed health service area designations submitted by Governors and making recommendations with respect to the areas proposed. Any regional office recommendation of nonapproval of a proposed area that obtensibly met the minimum population and SMSA requirements, however, was subject to review and to concurrence or override by an Ad Hoc Area Designation Review Panel consisting of program officials from the Department's central and regional offices. Similarly, all requested waivers of the minimum population or SMSA requirement were subject to review by this panel to insure national consistency in application of the waiver criteria against which those requests were assessed.

Each regional office review group included the Regional Director or his designee, the Regional Health Administrator or his or her deputy, and the Regional PSRO representative. Most groups had other members as well, although other members were not required. Regional representatives of various programs such as the community mental health centers, EMS, or HMOs (Health Maintenance Organizations), and other organizational constituents of the Department such as Social and Rehabilitation Services and the Social Security Administration also provided input to these review groups.

Provision was made so that in the event any Governor failed to designate areas, or the area designation plan submitted was only a partial one, the Regional Office would be responsible for developing recommended area designations for that State in accordance with the requirements of the act. This provision was not needed, however, since all States submitted plans or, in a few instances, formal claims of exemption from designating health service areas under Section 1536.

The initial area designation plans submitted were reviewed by the regional offices in late May. An ad hoc review panel appointed by Dr. Kenneth M. Endicott, Administrator of the Health Resources Administration, met on June 5 and 6, 1975, to consider all requests to waive the minimum population and SMSA requirements of Public Law 93–641. (In all, 56 minimum population waivers were requested, and it was proposed that 12 interstate and 26 intrastate SMSAs be split.)

The recommendations of the regional offices and of the panel were then submitted to the Secretary for his

concurrence. Following his decision, the Governors were advised of the Department's tentative actions. Those 20-odd States which had one or more requests tentatively denied were asked to resubmit revised plans or to provide additional justification.

Revised or resubmitted plans were then reviewed by the regional offices and on July 25, 1975, by the ad hoc review panel. The panel consisted of one regional director, four regional health administrators, and four central office members. The central office members included the Deputy Assistant Secretary for Planning and Evaluation (Health), the Director of the Office of Policy Development and Planning (a principal staff arm of the Assistant Secretary for Health), the Associate Administrator of HRA's Office of Planning Evaluation and Legislation, and the Director of the Bureau of Community Health Services. The Acting Director of the Bureau of Health Planning and Resources Development served as the panel's nonvoting chairman; staff support was provided by the area designation work group that had been established within that Bureau early in the year.

Recommendations once again were forwarded to the Secretary. Because of a change during August 1975 in Secretaries, the designation of health service areas was delayed until August 21, 1975. Immediately thereafter and before the Federal Register announcement on September 2, 1975, Governors were formally notified in writing of the final, official health service area designations.

Results

The total number of health service areas recently designated, 202 in 47 States, closely approximates congressional expectations, for the House report (2) had stated: "It is anticipated by the Committee that these [area designation] requirements will lead to the designation by Governors of approximately 200 health service areas throughout the United States. . . ."

The areas designated, moreover, overwhelmingly reflect what the Governors had proposed. In only 8 of the 47 States did the health service areas officially established by the Department differ from those the Governors had proposed either initially or in the case of Colorado, New Mexico, and Tennessee, in their revised submissions.

Three States—Illinois, Nebraska, and Wisconsin—had one or more of their requests for waiver of the 500,000 minimum population requirement denied. Five States—Alabama, Illinois, Kentucky, South Carolina, and Virginia—had waiver requests to divide an interstate SMSA denied and thus had a bi-State area encompassing the entire SMSA designated by the Department. In every one of those instances, however, the Governor of an adjoining State had not agreed to division of the SMSA in question; rather he had proposed a bi-State health service area. Under those circumstances, the Department had no alternative, since in the case of interstate SMSAs, the act explicitly required that each Governor agree to and request a waiver in order for the Secretary to grant it.

Illinois also had requested that six separate areas be established in the nine-county metropolitan Chicago region, but the Department designated only four. In Pennsylvania, the area proposed by the Governor for the metropolitan Pittsburgh region was not approved since its population exceeded 3 million.

Population and size of areas. The population breakdown of the 202 areas designated was as follows:

Number of areas	*Population*
3	Under 200,000
44	200,000–499,999
85	500,000–999,999
49	1,000,000–1,999,999
16	2,000,000–2,999,999
5	3,000,000 and over

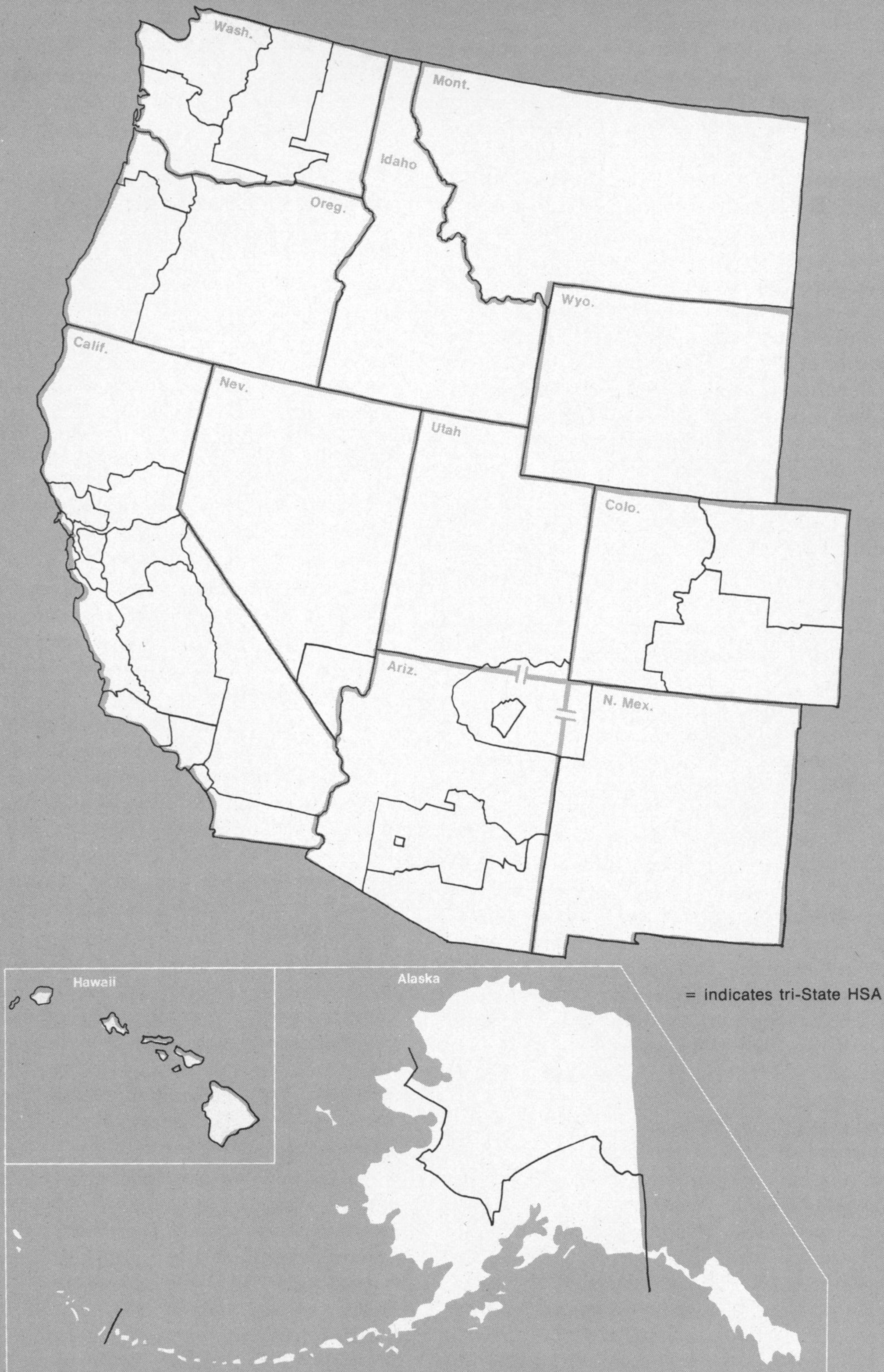
The population figures in the preceding table, like all others in the paper, are based upon U.S. Bureau of the Census provisional estimates for 1973 (*4*). These provisional figures were the most recent population figures by county available when the health service areas were being designated.

As the table shows, the distribution of the areas in terms of their population is essentially bimodal. The single largest cluster is around a population of 750,000; there is a second and somewhat smaller cluster at 1.5 million population.

Area 1 in Alaska, which encompasses the so-called Panhandle portion of that State, has the smallest population, 47,000. Only two other areas have populations of less than 200,000. One is in Alaska; the other encompasses the Navajo reservation in Arizona, New Mexico, and Utah. (The majority of the other 47 health service areas with populations of under 500,000 also are in the relatively more sparsely populated States in the West.)

Area 7 in New York, whose boundaries are identical to those of New York City, has the largest population, approximately 7.7 million. The other four areas with populations of more than 3 million are Los Angeles County (California area 11), City of Chicago (Illinois area 6), the metropolitan Detroit region (Michigan area 1) and the metropolitan Philadelphia region (Pennsylvania area 1).

In terms of area or size, the largest health service area is area 3 in Alaska, which encompasses the northern two-thirds of the State and about 320,000 square miles. Four other areas cover more than 100,000 square miles, and another eight exceed 50,000 square miles (or are roughly the size of Arkansas). The smallest area in terms of size is area 3 in New Jersey—Hudson County—which covers only 46 square miles. There are 14 health service areas of less than 1,000 square miles (or somewhat smaller than Rhode Island).


Health service areas in the western United States
Wash.
Mont.
Idaho
Oreg.
Wyo.
Calif.
Nev.
Utah
Colo.
Ariz.
N. Mex.
Hawaii
Alaska
= indicates tri-State HSA

Other characteristics. The Governors of 10 States designated single, statewide areas. They were Idaho, Maine, Mississippi, Montana, New Hampshire, Oklahoma, Puerto Rico, South Dakota, West Virginia, and Wyoming.

California has the largest number of areas, 14. The only other States with 10 or more health service areas are Texas with 12, Illinois with 11 (of which 2 are interstate in character), and Ohio with 10 (of which one is interstate).

Number of States	*Number of areas*
10	1
3	2
8	3
5	4
5	5
4	6
4	7
2	8
2	9
4	10 or more

Fifteen of the 202 health service areas are interstate; 14 of these 15 are bi-State and one, covering the Navajo reservation, is tri-State. All but two of the 15 interstate areas encompass SMSAs that cross State lines. (Twenty-five of the 38 interstate SMSAs are divided by 2 or more health service areas.)

The overwhelming majority of the 270-odd SMSAs in the United States, both intrastate and interstate, are wholly contained within a single health service area. Several of the larger SMSAs, however, are split among several health service areas. These larger SMSAs include Boston, Chicago, Memphis, Minneapolis-St. Paul, New York, Philadelphia, San Francisco-Oakland, and Washington.

This division of SMSAs, all of which required the approval of waiver requests by the Department, suggests or reflects several things. SMSAs frequently are only an approximate and imprecise surrogate or proxy measure of medical service areas. Many of the waiver requests included rather persuasive evidence and supporting information indicating that there was a significant flow from an SMSA, particularly at the periphery, to hospitals and other health facilities in adjoining areas. The evidence also suggests that in the case of interstate SMSAs State boundaries and the maintenance of their "integrity" continue to exert considerable political, emotional, and other kinds of influence.

Approximately 15 percent of the health service areas, or 30-odd of the total, are exclusively nonmetropolitan (or rural) in character; that is, they do not include any SMSA, however small, in whole or in part, within their boundaries. A slightly larger number and percentage of the areas designated are entirely metropolitan (or urban); that is, the entire area consists of one or more SMSAs, again in whole or in part. Roughly two-thirds of the 202 designated health service areas are of a "mixed" character and include both metropolitan and nonmetropolitan, urban and rural areas.

Relationship to other areas. The designation of areas for health and other planning purposes is not a new concept. Public Law 93–641 recognized this in the requirement that the boundaries of the health service areas designated under it should, to the maximum feasible, be appropriately coordinated with those of existing sub-State planning and development districts and PSRO areas.

The Intergovernmental Cooperation Act of 1968 (Public Law 90–577 mandated each Governor to designate sub-State planning and development districts within his State. That act, in effect, established a network of "clearinghouses" to permit all levels of government to participate in the planning, review, and coordination of Federal development programs.

Although no thoroughgoing analysis has as yet been made of the relationship between the recently established health service areas and these sub-State planning and development districts, the basis for appropriate coordination appears to have been laid. Probably the great majority of the new health service areas are congruent with sub-State planning and development districts; that is, the health service areas encompass one or several of such districts in their entirety. As noted before, some Governors made such congruence a specific and additional requirement in designating areas for their States.

Unlike the recently designated health service areas, none of the 203 PSRO areas designated so far under provisions of the Social Security Amendments of 1973 (Public Law 92–603) cross State lines. A preliminary analysis of the health service areas and these PSRO areas indicates that roughly one-third of the PSRO areas split health service areas. The two sets of areas are identical in a few instances; identical boundaries for both sets of areas are particularly likely in States with both statewide health service areas and statewide PSRO areas. For the most part, the two sets of areas are congruent, in that a single health service area encompasses several PSRO areas in their entirety, or vice versa.

Public Law 92–603 created a national end-stage renal disease (ESRD) network to facilitate the treatment of ESRD patients. Twenty-nine ESRD networks (or areas) have been proposed. Information about them was published in the Federal Register of July 1, 1975. These proposed networks will be considerably larger than health service areas; a number will cover all or parts of several States. From all indications, these networks as finally established and the health service areas recently designated will with a very few exceptions be congruent; that is, they will encompass several health service areas in their entirety. Final designation of the ESRD networks is expected some time early in 1976.

Forty-three, or roughly one-fourth, of the 202 health service areas designated in September 1975 are identical to ones presently served by areawide CHP agencies. On the other hand, only 7 of the new health service areas are identical to those presently served by RMPs, and in all but one instance those are single Statewide areas.

Special problems. The so-called Pell amendment, which expanded upon Section 1536 of the act, exempted certain States as well as specified territories (American Samoa, Guam, the Trust Territory of the Pacific Islands, and the Virgin Islands) from designating health service areas. Delaware, the District of Columbia, Hawaii, Rhode Island, and Vermont all claimed exemption under this section. As of November 30, 1975, the Secretary had determined that the District of Columbia and Rhode Island were exempt, whereas Delaware and Vermont were not. Hawaii's claim was still pending.

As noted before, one proposed area exceeded the 3 million maximum population and did not include an SMSA with a population greater than that figure. It could not be approved and designated by the Department since section 1511 of the act does not allow waiver of the maximum population requirement. (If an area has an SMSA within it with a population of more than 3 million, a waiver is not required.) In that specific instance, the 12-county area that was proposed for southwestern Pennsylvania (the metropolitan Pittsburgh region) by the Governor of that State in all probability was more appropriate than the 10-county area which the Department in effect was forced to designate by virtue of the statutory language of the act.

In a few instances, local public officials, provider groups, and others have expressed considerable dissatisfaction with the health service areas designated by Governors and approved by the Department.

The health service areas as officially designated are not, of course, necessarily fixed for all time. Indeed, the act explicitly provides for the redesignation of areas and mandates that the "Secretary shall review on a continuing basis and that the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas" as initially designated.

It is clear though, from both the statutory language itself and the legislative history, that Congress intended that there be a period of operational experience with the health service areas designated or that there be a material change in certain relevant characteristics of the area, such as population, before any area as initially established would be reexamined and its boundaries possibly changed.

Thus, from a practical and substantive standpoint, it is unlikely that unless the characteristics of an area so change as to make it ineligible to continue to be a health service area, the Department would be prepared to support any proposed area changes or redesignations within the next 6 to 12 months, much less initiate them based upon its own "review on a continuing basis." Even then the circumstances would have to be unusual; for example, rather persuasive evidence would be needed showing that the inability to develop a health systems agency designated for a given area was in any significant measure attributable to the nature of the health service area itself.

Conclusion

The first major step in implementing the National Health Planning and Resources Development Act, the designation of health service areas, has been completed. That it was done in a satisfactory and timely fashion is due in large measure to the responsiveness of the nation's Governors and the earnestness with which they approached this important task.

It also owes a great deal to the hard work and dedication of literally thousands of people—State and local officials, the directors and advisory board members of existing CHP agencies and RMPs, representatives of hospital associations, medical societies, and other provider groups, and many other citizens with an interest and commitment to making their communities a better place to live and work—who served on the various task forces and committees set up to assist Governors, provided staff support to those efforts, and expressed their views and concerns in public hearings and other forums.

The results clearly reflect differing approaches. Some States, for example, by designating a greater number of smaller health service areas, sought to maximize the potential for community and grassroot inputs to the HSAs and local health planning efforts to be established. Other States gave greater weight to the desirability of including a more comprehensive range of health resources and services within their areas and thus designated fewer but larger areas. Regardless of the particular approach and the other considerations taken into account by different States in varying ways, the results from a national perspective appear good in terms of the areas being "appropriate for the effective planning and development of health services." However, the proof of the pudding is in the eating.

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