PARTNERSHIP FOR PLANNING

By SURGEON GENERAL WILLIAM H. STEWART

Discussions by James H. Cavanaugh, Ph.D., Robert L. Smith, M.D., Stephen J. Ackerman, Kenneth Z. Baum, and Jerry Osterweil, Ph.D.

THE COMPREHENSIVE Health Planning and Public Health Services Amendments of 1966, known as Public Law 89–749, were enacted on November 3, 1966. The act's Declaration of Purpose states:

> 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 attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations. . . .

The Congress then declares that Federal financial assistance must be directed to support the marshaling of all health resources and "finds that comprehensive planning for health services, health manpower and health facilities is essential at every level of government. . . ." It calls for strengthening of State health agencies and for broadening and increasing the flexibility of support for health services in the community.

This is the stated purpose. Unstated but implicit is the attempt to break down unnecessary restrictive barriers among categories, to provide for priority determination and decision at a level closer to the needs of the people, and thus to use this instrument as a means of reorienting Federal-State relations—and by extension, all relationships—within the health field.

Before we look in detail at the legislative instrument provided for the attainment of these purposes, let me sketch for you briefly a breakdown of the kinds of Federal funds now flowing into any given State. From 40 to 100 different programs are involved in this flow, and they stem from many Federal agencies. Despite their diversity, I think they can be generally categorized into three types.

First there are the funds that create resources. This category includes the money that helps

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to build medical schools, nursing schools, hospitals, and other facilities; the research grants and other funds intended to create new knowledge; and the training programs aimed at manpower development. These funds have many sources—Public Health Service, Vocational Rehabilitation Administration, Children's Bureau, and others. In the given State, the money is received and used by a variety of agencies. Some are governmental, some are private.

The second category includes those programs which provide services. For the most part these are vendor payment programs on behalf of the individual who purchases services from various sources. Here again there are numerous sources—medical assistance under title 19 of the Medicare act, the OEO programs, VRA, and so forth—and there are numerous separate channels of flow at the State level.

The third category is made up of programs aimed at specific targets, designed to encourage innovation, to demonstrate new methods, to find and apply better ways of doing things. These consist for the most part of what we have called "categorical" programs.

Obviously all of these types of funds and the programs they support are interrelated in fact. They are also interwoven at the point of delivery with State and local funds and—largest of all—with private dollars.

The importance of these interrelationships is obvious. Resource development cannot be logically separated from the resource consumption that takes place in the providing of services. Setting of standards of service cannot logically be divorced from innovative programs designed to upgrade standards, to do things better.

Meanwhile a great deal of planning is going on in connection with each of these programs, considered separately. Some planning is statewide. Some is based on a locality or a metropolitan area. This multiplicity of planning efforts at the State level operates under the same multiplicity of agencies and authorities—some governmental, some nongovernmental, some a mixture of both.

But nowhere is there an entity that relates these plans to each other and decides on relative priorities. There are no data on which to base decisions between alternatives. No one is equipped to say, for example, that unless money is poured into five new nursing schools in our State next year we cannot extend the benefits of title 19 to more people. No one has either the knowledge or the authority to decide to give priority to building nursing homes in a particular area of the State instead of spending those dollars for something else.

State Health Planning

The first part of the Comprehensive Health Planning and Public Health Services Act is an attempt to provide a focus for this kind of decision at the State level. To qualify for a grant for comprehensive State health planning, the Governor must designate or create a single State agency with the responsibility for administering or supervising the State's health planning functions in the development of a comprehensive plan. This can be a new agency, an existing agency, or an interdepartmental entity. Its basic job is to examine the needs of the State and recommend priorities for meeting those needs with the resources available.

This State health planning agency will have to possess a base in official governmental authority which permits it to obtain plans and data from all agencies charged with health responsibilities and relate these into a total health planning effort. It will need authority to receive and spend funds, to employ a full-time executive and qualified planning staff. It will require the competency to provide staff support for comprehensive health planning, as a basis for decision-making by the Governor and legislature and by the many other official and nonofficial participants in the planning process.

The act does not endow this agency with direct authority. But if the agency does its job well, it will certainly be influential in the fundamental decision on where the State health dollar should go, and on where a great many Federal dollars would go as well.

P.L. 89–749 requires that this designated State agency be advised by a State health planning council, representing State and local agencies and groups concerned with health but 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 to the needs felt by the public we seek to serve.

Thus P.L. 89–749 supports the creation of a State health planning agency. It also has other provisions supportive of health planning. One of these is a project grant program for areawide health planning similar to the existing program except that the new law requires a relationship between these project grants, made on a regional or local basis, and the comprehensive planning program I have just outlined. This relationship is of vital importance. It links statewide planning with the plans and actions undertaken in the metropolitan areas where so many people and problems are concentrated. Another aspect of support for planning is provided through funds for training people in planning skills—a field of critical manpower shortage.

Health Services Programs

The second major aspect of P.L. 89–749 deals with service-providing functions—the Public Health Service-State health department programs for health services. These have been compartmentalized stringently in the past into eight or nine categories. For example, before P.L. 89–749, if a State health department decided in a given year that it was more important to concentrate on a specific health need which it believed to be important and soluble, rather than on a nationally determined disease control priority, it had no flexibility to fit these funds into the State's priorities.

Obviously, needs vary from one part of the country to another, from one State to another, and within a single State. Variations are especially dramatic in urban settings. Therefore, the second principal thrust of the new law is to provide flexibility in the use of these formula grant funds. Now, a State will be able to plan its use of health services money—to strike hard at the eradication of syphilis, for instance, because it appears that this is an area in which important success can be attained. Obviously, the granting of these 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 is that there is now a range of choice within the structure of formula grants for health services.

The third important aspect of P.L. 89–749 relates to the series of project grant authorities which have proliferated over a period of years. These were grants from the Public Health Service to public or nonprofit private organizations in the cities and counties. Most of them were for specific disease control purposes or for developing new ways of delivering a variety of services. Each of these authorities was quite strictly limited—even the community health services and facilities project grants, for example, were limited to out-of-hospital services and weighted toward the chronically ill and aged.

What has been done in this instance is to pool these project grant funds and to broaden the possibilities of using these grants for innovation, demonstration, or a specific target. One such target might be tuberculosis. Another might be narcotics addiction. A third might be putting services into a local area with a critical shortage of health manpower. None of these three examples represents a uniformly distributed national need, but each is of critical importance in certain places.

This is the act we have constructed. Its intent is clear—to give to the States, cities, and counties more initiative, more flexibility and—just as important—the attendant responsibility. It is designed to permit Federal funds to meet the special requirements of different areas.

Administration of the Act

In looking at this revolutionary new approach to the Federal-State relationship, many people have been skeptical. They have pointed out that States will vary widely in their initial capability to handle this big new delegation of responsibility. They have predicted dire conflict and skirmishing among vested interests at the State level. Some have also cocked a quizzical eyebrow at *us*—we are calling for the creation of a genuine policy-creating and priority-setting mechanism at the State level while no such mechanism yet exists in the Federal Government. As I have already pointed out, we feel this lack of coherent policy direction and are taking beginning steps to remedy it.

Within the Public Health Service, our planning for the administration of the act has been

a strenuous and sometimes painful process. Essentially, we have decided to change our way of doing business, in a rather radical way.

In the past, the bureaus, divisions, and programs of the Service have carried full operating responsibility. This responsibility has prevailed not only in Washington but through our nine regional offices to the actual level where the program is being carried out. The Office of the Surgeon General has primarily performed a coordinative and policy-setting function, and the nine regional offices have served principally as "hotels" for the program operators whose first line of responsibility traces back to the bureau and division chief in Washington. This structure was a reflection of the extreme fragmentation of programs.

But the new program simply would not fit this mold. Every bureau is deeply involved: the Bureaus of Health Services and Manpower almost by definition, the Bureau of Disease Prevention and Environmental Control through its targeted programs, the National Institutes of Health through the regional medical programs, the National Institute of Mental Health through its deep roots in State and community planning and activity.

Thus we decided to put the budget for this program in an organizational entity responsible directly to the Surgeon General and related closely to all the bureaus. It will be administered as a Public Health Service enterprise. And its operations will stem from the regional offices.

Stating it a little differently, the development of policy and tools for implementation will be the responsibility of my immediate office, with strong and continuing input from all five bureaus. A special responsibility for assisting the regional health directors in the operating phase of the program is assigned to the Bureau of Health Services. The regional offices will be where the action is.

Specifically, the management of the new grants programs will be located in the regional offices. The regional health directors will receive applications, arrange for and supervise review of applications both technically and in terms of conformance with comprehensive plans, award the grants, and carry out necessary followup procedures. One obvious advantage appears immediately—instead of some 15 places to which applications were directed for these grant programs, there will now be a central focus and a single point of application.

Obviously, it will not be possible to have all the necessary technical skills in every regional office. Our intention is that the regional health director will be able to get his technical advice from a wide variety of sources—a university, a local health department, a program in the Public Health Service—wherever the competence exists to meet his need.

In this connection too, we hope to create in each region an outside advisory council which would be a strong source of guidance to the regional health director in managing this program. These councils would include competencies from industry and the universities, from medical practitioners, from experts in public affairs, and the like. This council system, in addition to serving a vital purpose in support of the regional health director, would have the further advantage of bringing additional talented and competent people into the review of Federal-State-local programs.

As I have indicated, this involves almost a 180-degree turn in the operation of our regional offices. Heretofore each has had a very small "house" staff plus a large number of program representatives from the various bureaus, all owing their basic allegiance to their home program and frequently engaged in a kind of competitive scramble for grants business. This was a perfectly natural outgrowth of a system which measured accomplishment in terms of "sales."

We anticipate that the changed procedure will bring about a changed climate in this regard. The programs will now be charged with defining objectives, assisting States in setting goals, measuring program effectiveness, and similar activity.

Federal-State Partnership

Above and beyond these practical benefits, we believe that there will be an intangible but important strengthening of the Federal-State partnership through the geographic decentralization of substantial authority. We are truly joining together—not in a contest over rights

and powers but in a common cause. We are striving to meet needs as they exist, where they exist.

We have a great deal to do together. Our ultimate goal has been set for us by society—the best level of health for all people up to the limits of our national potential. Toward this end we need to achieve access to high-quality health care for all and create an environment that fosters rather than impedes human fulfillment.

It is manifest that the Federal Government cannot do this job alone, that it cannot do the job in sole partnership with State government, nor in dual partnership with State and local government. Total health achievement requires total commitment of health resources. More than that, it requires deployment of health resources in organizational patterns that cause the whole to be greater than the sum of the parts.

I am not talking about a monolithic system at the Federal, the State, or any other level. Rather, I am talking about a fusion of public and private endeavor for the ultimate good of the people we serve. If we create the right kind of partnership, every partner will be strengthened in his capability to do his job supremely well.

I am convinced that this year we are taking an important step toward solving a number of the problems with which all of us are deeply concerned. I believe that, by entering freely and fully into partnership, we can eliminate many of the difficulties that have resulted from fragmentation of effort, in Washington and across the nation. More importantly, by so doing, I believe we can generate the social action necessary to deliver the nation's full potential for advancing the health of the American people.

DISCUSSIONS

Comprehensive Health Services

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We now have a national commitment to the goal of the highest level of health attainable for every citizen. To translate the fruits of resources, knowledge, and technology into human benefits is now our challenge, and this challenge is to be met through the development of comprehensive health services and through comprehensive health planning.

The term comprehensive health services is a fairly abstract phrase which describes a full range of activities and techniques directed toward health maintenance, toward prevention, diagnosis, and treatment, and toward rehabilitation from the effects of disease.

To the patient, comprehensive health services means such things as clean water, learning and practicing good health habits, and overcoming the crippling effects of stroke. To health personnel, comprehensive health services means the opportunity to see the patient and the community as a whole, to call upon colleagues, and to use resources as needed. In order to provide those comprehensive health services, we must effectively marshal a wide array of health resources, including physicians, nurses, and skilled technicians to provide personal health services; hospitals, extended care facilities, and other related facilities and equipment to provide the setting for the delivery of comprehensive personal health services; and engineers and sanitarians to protect the environment.

When looked at from this standpoint, the elements required to insure comprehensive health services are clearly seen to lie beyond the ability of any individual practitioner to provide, any single mechanism to finance, or any single group or agency to plan or organize.

P.L. 89–749 makes a very real and dynamic contribution toward developing the setting for the delivery of comprehensive health services. The legislation recognizes the strengths of our existing health systems and therefore insists that there be no interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.