What's Happening to Federally Aided Health Programs Under State Departments of Human Resources

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STATE AND LOCAL GOVERNMENTS have assumed an expanded role in the administration and delivery of human health services in recent years. Over the past 40 years, and particularly in the last decade, the Federal Government has legislated several hundred health, education, manpower, and social welfare programs, but dissatisfaction has resulted from this categorical grant system of aiding State and local governments. The proliferation of narrow categorical programs has been largely unplanned and, increasingly, it is widely recognized as an obstacle to the flexibility needed at the State and local levels to meet the comprehensive needs of individual citizens. Because of this recognition, support has increased substantially for assigning the States added authority over programs and their implementation at the Federal, State, and local levels.

The reorganization of State human services agencies into consolidated bodies called departments of human resources (DHR) in more than 30 States is a reflection of the States' initiative in the direction of assuming added responsibility. DHRs have been viewed as a way to eliminate, or at least reduce, the complex array of human services programs, each with federally imposed requirements, and to substantially increase a State's capability to plan, manage, and deliver comprehensive services.

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In 22 States, health services have become part of the new departments of human resources. This organizational change has raised major questions about the implications for health programs, and little information has been available to answer them. In the spring of 1976, the Health Resources Administration (HRA) undertook a pilot study to obtain broad background information on how health programs fared under a DHR and the impact of the programs on such departments. The study, completed in fall 1976, concentrated on four States: Arizona, Georgia, Massachusetts, and Wisconsin.

These four States represent a geographic diversity, at least 2 years each of DHR existence, and a mix of organizational structures. There is a striking difference, however, between the departments in Georgia, Wisconsin, and Massachusetts and the fourth department in Arizona. In the first three, health is combined with public assistance, social services, mental health, vocational rehabilitation, and other human services programs in one department. Changes in Georgia, Wisconsin, and Massachusetts, where health is in the DHR, are contrasted with what happened in Arizona, where health services are administered outside the DHR.

In Arizona, all public health and mental health services are combined in the department of health services, which is a health umbrella agency. The health services are administratively combined, but they function almost independently of the umbrella. Public assistance, social services, and employment services are in another, separately administered agency, the Arizona Department of Economic Security. This department is a functionally integrated structure that closely resembles a department of human resources.

The three DHRs that include health differ in the formal authority they can wield. Georgia's centralized DHR is headed by a commissioner who has authority to plan, reorganize, coordinate, and balance fundings for programs. Massachusetts has an umbrella structure, which means the programs retain most of the independence that they had before consolidation because the secretary lacks statutory authority to restructure functions or realign funding. In Wisconsin's DHR, the secretary has authority over broad program planning and program interrelationships but no authority to restructure functions or funding.

Four programs of the Health Resources Administration and three programs of the National Institute of Mental Health (NIMH) were studied in the four States. The HRA programs were comprehensive health planning, Hill-Burton program, regional medical program, and the cooperative health statistics system. The comprehensive health planning and Hill-Burton programs were consolidated with the passage of the National Health Planning and Resources Development Act of 1974. Because the regional medical program was being phased out and only a minimum of data was available, the program had to be dropped from the study. The NIMH-aided programs were the community mental health centers program, the hospital improvement program, and hospital staff development grants to State psychiatric hospitals.

In conducting the study, the research team examined existing data such as previous studies, planning and budget documents, legislative reorganization proposals, and memorandums on current management planning and programmatic aspects. We also interviewed approximately 26 persons in each State. Among those interviewed were secretaries of the departments of human resources; public health, mental health, and social services division heads; budget and planning directors; directors of the HRA- and NIMH-assisted programs; directors of county health and social services departments; members of local health and social services boards; members and staff of legislative committees; and Governors' staffs.

Because this was a pilot effort to pick up trends and changes in a limited number of health programs

and DHRs, it should not be inferred that the findings are conclusive or apply generally to health programs and to all State DHRs.

The findings relate specifically to the HRA- and NIMH-aided programs. They reveal that the impacts experienced to date have not been substantial, but they also identify changes that have a potential for future impact. The purpose of this paper is to highlight new information from the findings that sheds light on the trends affecting health programs under the DHRs and the impact of the programs on the development of these departments.

Following is a listing of the principal preliminary findings suggested by the study. I will discuss each with examples from the experiences of the States.

1. Health programs generally have neither constrained nor effected the establishment of the DHRs.
2. Mental health programs have been an important stimulus to the development of DHRs.
3. Health planning and statistical programs have contributed to the DHR's efforts to strengthen policy management and program coordination.
4. Objections of some health professionals to the integration of services have complicated but not prevented the development of DHRs.
5. DHRs have had limited impact on health programs.
6. Health programs can contribute effectively to the integration of services.
7. DHRs have effectively recruited health professionals and are hiring nonmedical professionals in increasing numbers.

Background

Three major concerns have prompted the States to organize DHRs: (*a*) how to divide powers among Federal, State, and local governments, (*b*) how to manage and coordinate federally mandated programs, and (*c*) how to deliver services more effectively to clients.

The 1973 "Policy Statement on Human Resources" of the National Governors' Conference (*1*) asked for these major changes:

1. A restructuring of the Federal-State-local partnership and a redistribution to the State and local levels of responsibilities for policy and program management of human services.
2. Increased flexibility for State and local governments to foster a multiservice concept, to balance funding among programs, to relate disparate agencies within one category of services, and to coordinate related programs.
3. Support for reorganization of services to deal with the client as a "whole person" and to correct the fragmentation and lack of continuity and accessibility that has characterized services delivery.

Some of the changes suggested by the Governors' Conference had already been initiated in the mid-60s, when the trend to DHRs began. At the Federal level there was some sharing with States and cities of the decisions for approval and funding of Federal programs (*2, 3*). Examples of these are revenue sharing, A–95 review, block grants such as the Comprehensive Employment and Training Act, the Housing and Community Development Act (*4, 5*), and Title XX of the Social Security Act. Title XX, particularly important to the DHRs, requires the Governor to produce a comprehensive annual services plan coordinated with related human services and covering the social services formerly funded under separate programs. Block grants in health and education programs had also been proposed.

In addition, recent Secretaries of the Department of Health, Education, and Welfare encouraged integration by providing funding to stimulate and experiment with projects in cross-program planning in the Services Integration Target of Opportunity (SITO) projects and the DHEW Partnership Grants Program. The purpose was to increase coordination between State and local governments in human services planning and delivery (*6*). Each of these efforts, although separate, was an attempt to bring about program and organizational coordination at the point where program responsibility shifted to State and local officials (*7, 8*).

During the 1960s the States were also trying to build a better framework for policy development, program coordination, and administration of State functions. They reorganized and modernized the machinery of government extensively.

Reorganizing a State's executive structure for administrative convenience and efficiency was not new. Illinois did it in 1917. Since the 1960s, however, it has been a far more difficult and complex task (*9*). The average number of programs and services administered by the States has increased fourfold. Yet what was innovative in these recent moves was the organization of a comprehensive agency with an inherent bias toward integrating program services (*7*). Old-line autonomous departments of health and social service agencies were broken up and consolidated under a DHR umbrella with some or all of the following: mental health, public assistance, youth

services, corrections, vocational rehabilitation, housing, aging, medical care, and veterans programs.

An immediate and obvious advantage of the umbrella agencies was the Governors' new ability to maximize Federal dollars, especially in health and mental health; immediate changes, some in the direction of services integration, were effected. Services integration was a major objective in some DHRs and of less importance in others. In most DHRs, it was and is highly controversial and difficult to implement (*10*).

The experience of Georgia and Arizona indicates that consolidation at the top level can encourage coordination across program lines but does not overcome formidable barriers at the delivery level (*10*). The National Academy of Public Administration, in a recent evaluation, called Florida's integration of services the most advanced in the nation. However, although considerable progress had been made, local officials, some health professionals, and supporters of the National Rehabilitation Association have presented forceful opposition. The mounting pressure from constituents may pull health programs out of the Florida DHR (*11, 12*). In New Mexico, the opposition has succeeded in dismantling the combined health and social services departments (*13*).

Yet, whatever the degree of commitment to services integration, setting up a department of human resources has involved significant changes, and those changes can involve health programs. Changes primarily affect:

1. Lines of authority to and from the secretary
2. How programs are structured and operated
3. Relationships between and among programs
4. How programs are perceived as supportive of reorganization objectives

Within these broad areas of potential change we sought information through this pilot study on what was happening to health programs under the DHRs.

Health Programs and Establishing the DHRs

In the four States studied, HRA-assisted programs played little part in the creation of the DHRs. Because of their categorical nature, the relatively low level of State funding, and the lack of direct services, the programs presented no critical issues and did not contribute to the major changes anticipated by consolidating health and human services. They were neither very helpful nor harmful.

In Georgia, Wisconsin, and Massachusetts, key issues in establishing the DHR were (*a*) reducing the number of State agencies, (*b*) putting health in the DHR, (*c*) rationalizing the process of allocating resources, (*d*) increasing the State's capacity to plan, manage, and coordinate across program lines, and (*e*) improving and coordinating services delivery at the local level. The Governors' staff, legislators, and administrators whom we interviewed reported that there were few pressing reasons to consider HRA-funded programs' impact on DHR-related decisions. For example, the Georgia DHR Commissioner noted that he could reallocate or "balance" funds according to DHR priorities without considering HRA-funded programs because they did not involve "significant amounts of State funding." The Wisconsin and Massachusetts DHR Secretariat staffs pointed out that the HRA-funded programs neither required substantial increases in State funding nor presented major obstacles (such as Federal plan requirements) to the establishment of the DHR. The Arizona Department of Health Services also reported no significant changes in State funding for HRA-aided programs. The consolidated budget process proposed for Georgia's DHR and new directives and budget cycles established in the Wisconsin and Massachusetts DHRs were not seriously affected by HRA-assisted programs.

The pattern of Federal funding of HRA-assisted programs seems to leave little opportunity to influence the development of the DHR, although there were exceptions. Officials in the Wisconsin Secretary's office were concerned that the Federal guidelines allowing tracking of fiscal and programmatic accountability of HRA programs would weaken the DHR's strategy to achieve functional consolidation. At the time of the interviews, it was too early to tell whether this was actually happening.

In Massachusetts, however, an HRA-aided program had a direct impact on the DHR. The cooperative health statistics system provided the DHR with Federal funds to develop the capability to collect and use health statistics, which it had previously lacked. DHR management used health statistics as a tool in health regulation and program coordination. The program became so valuable to the DHR that State funding increased substantially, the only significant increase in State funding for HRA-aided programs identified in the study.

Aside from these two exceptions, however, it appears that within or without a DHR, Federal funding for HRA-assisted programs is allocated largely directly to the programs. Since State funds are not great or increasing substantially, there is little reason for serious impact on the organization and development of the DHR.

Mental Health Programs Stimulate DHRs

Mental health programs and DHRs have been natural allies. In Georgia, Massachusetts, and Wisconsin they achieved new status, visibility, and support from the creation and operation of the DHR. In return, mental health programs have strengthened the DHRs' capacity to capture Federal dollars and have led in unifying and coordinating the planning, budgeting, and delivery of mental health and social services programs.

In Georgia, the improvement, expansion, and "liberation" of mental health programs from public health was a primary goal of the newly created DHR. In 1972 Governor and Mrs. Jimmy Carter personally committed themselves to bringing Georgia's mental health programs out of the "snake pit" era into modern community-based facilities. The DHR was to be the mechanism to achieve this end. The commitment to mental health programs was a key factor in securing support for the Governor's reorganization plan.

In addition, mental health program heads and professionals worked with the Governor's staff and legislature in Georgia to capture Federal mental health dollars and Title XX funds so that the DHR could implement the Governor's commitment. A similar cooperative effort also occurred in Wisconsin and Massachusetts. In all three States, the ability to capture Federal dollars enabled the DHRs to enlarge and improve social services programs and also to support cross-program working arrangements between mental health and social services. The new departments have the staff to initiate joint planning and to use Title XX to fund community mental health centers to deliver day care, foster care, aging, alcoholism and drug abuse treatment, and other services. The DHRs take much credit for the improvements.

The federally aided mental health programs have also helped Georgia's DHR to integrate State psychiatric institutions and community mental health centers into a single system of regional care, an accomplishment that contrasts sharply with the failure of Georgia's local public health departments to support the DHR's goal of a single system of care in counties.

In Massachusetts the reorganization of local services called "areazation" is a prime objective of the DHR and generally supported by mental health programs. In pyramid fashion (from the area to the region to the central office in the DHR), all mental health planning, budgeting, and programmatic functions are beginning to be coordinated and integrated.

The Wisconsin DHR, with the cooperation of mental health programs' staff, has been able to go even further at the local level, because of traditional cooperative relationships between mental health and social services programs. Mental health, mental retardation, health, welfare services, and aging programs all have some working arrangements, implemented through their staffs' membership on community service boards.

Mental health programs, therefore, have been heavily supportive of the development of DHRs. Without them the DHRs' capacity to attain Federal funding for a wider base of services and to foster the deinstitutionalization of mental patients would have been substantially weaker. Both sides have benefited from the alliance.

Contributions of Planning and Statistics

Mechanisms to strengthen the DHRs' management and regulation of health issues and health care costs have been critical to their development. In two DHRs, health planning and health statistics programs are providing tools for the DHR to use in making and implementing health policy through comprehensive and coordinated planning. Planning and statistics have brought together major health components of other human services to work on issues relating to health facilities construction, health manpower, health education, and rate setting for services, physicians, and hospitals.

In Wisconsin, for example, the well-developed health planning program, formerly in the Office of the Governor, has been returned to the DHR. This action eliminated a major adversary to the consolidation of health and social services and, in effect, returned policy and planning functions to the DHR at a time when cost containment was urgent. The health planning program provided the DHR with a State plan for implementing Public Law 93–641, responsibility for health facilities planning, enactment of a State certificate of need law, and the capability to conduct the required HSA (health systems agency) review of health needs. The DHR was designated the SHPDA (State health planning and development agency), and the health statistics program works "hand in glove" with the health planning program, as the DHR Secretary put it, to support that function.

Stimulated by Public Law 93–641, the health planning and health statistics programs have provided the comprehensive approach that has enhanced the Wisconsin DHR's capability to initiate and manage some planning, regulation, and budgeting across program lines. Health statistics staff have initiated working arrangements to exchange data, personnel, and certain training activities with programs such as vocational rehabilitation, mental health, and aging.

Health planners participated in developing annual plans with human services components relating to health manpower, facilities construction, and other issues.

Both programs together, then, provide the linkages for coordination, a role that DHR secretaries have indicated is essential to DHR policy management and a function that they intend to expand. The following examples of health planning activities in Wisconsin illustrate these linkages:

- Implementation of the comprehensive health plan through the budgets of the health and mental health programs
- Coordination with mental health staff in reviewing the phaseout of mental health facilities
- Joint planning among health planning, vocational rehabilitation, and Hill-Burton program staff for construction of vocational rehabilitation facilities

In Massachusetts, the health planning and health statistics programs have strengthened DHR policy management. The health planners' most critical role, however, is that of staff arm to the Health Policy Group (HPG), an administrative body that makes policy and conducts planning across program lines. The HPG members represent the health components of all the human services under the DHR umbrella—that is, public health, mental health, vocational rehabilitation, youth services, and the elder affairs program, (which is not administered under the umbrella); the members also serve on the State Health Coordinating Committee. Staffing the HPG puts the health planning and health statistics programs in a strong position in the Massachusetts DHR because the HPG views these programs as tools to effect policy across program lines. The issue papers and agenda items that the health planning program staff prepare concern the most critical issues in Massachusetts health policy: the quality and cost of care; hospital charges; physicians' fees; Medicaid costs; the building, remodeling, and merger of facilities; and the distribution of physicians, nurses, and allied health professionals. The health planning staff also review proposed health legislation for the DHR before the bills go to the Governor.

Health Professionals' Objections

Some health professionals have been outspoken in objecting to the development of DHRs. Most objections were based on two fears: (*a*) the DHR will decrease the impact of special health interest groups, and a decrease in revenue and resource-building capacities for health programs will result and (*b*) the DHR will separate service delivery authority and functions from planning and programmatic functions administered by health professionals, placing them under an administrator who is not a health professional.

A striking example of health professionals' opposition based on these fears was the reaction among Georgia State and county health officers and members of the State medical association. They fought hard against putting health in the DHR, dividing health and mental health into two offices, and appointing a former head of the department of welfare as the second DHR commissioner. Their opposition fueled the legislative controversy surrounding the establishment of the DHR and held up the appointment of the DHR commissioner for many months. The legislature finally overruled the health professionals on both issues.

But the Georgia county health boards successfully blocked the DHR's efforts to control and coordinate local service delivery through the area network system and the assigned district coordinators. Opponents did not appear to reject the concept that health and social services need to be coordinated nor that health providers should cooperate with social services providers. Rather, their objection was primarily to the DHR's attempts to reorganize the administration of services delivery by placing it under a "generalist" regional director. In their view, skilled health professionals, not generalists, should have complete authority for all stages of a program. The DHR system, they argued, confused the lines of authority, placed excessive paperwork demands on them and, rather than enhancing coordination, interfered by upsetting informal arrangements among service providers. With support from other groups, county health professionals persuaded the Georgia legislature to dismantle the DHR's regional system for services delivery and thereby halted implementation of a regional, integrated structure. The DHR commissioner, however, appears confident that the agency will slowly work out acceptable modes for the delivery of integrated services.

In Wisconsin local public health officials also posed serious opposition to the inclusion of health in the DHR. They feared a setback in health program priorities and a loss of administrative control. The immediate transfer of some environmental programs out of the health department reinforced the second fear. The Wisconsin State medical society opposed the DHR, fearing loss of its influence on health matters in contrast to the increasing influence of social service and public assistance interests. The so-

ciety's opposition delayed the establishment of the DHR. Since the DHR came into being, local health professionals, the medical society, and hospital and nursing groups have successfully blocked the enactment of State certificate of need legislation and opposed certain other health initiatives.

Working out alternatives when facing health professionals' opposition was necessary in Massachusetts. The DHR came into direct conflict with county health directors, hospital and medical associations, and especially mental health professionals, when it proposed putting mental health and public health services in one division and combining all health regulatory functions with health planning in another division. By combining health and mental health services, the DHR sought to strengthen its own control over the budgets, planning, personnel, and programmatic aspects of the operating programs. These actions were opposed by certain mental health professionals who felt the changes would submerge mental health interests. Massachusetts health professionals also opposed the DHR's approach to regulating health care costs and coordinating health planning with human services by the establishment of the single regulatory office. (The office was to be responsible for public health regulations, Medicaid, licensing of mental health facilities, health insurance regulation, rate setting, health manpower, and comprehensive health planning.) The opponents perceived the office as a "health czar," and the proposal was defeated in the legislature.

In 1975, however, when the Massachusetts Medicaid deficit created a crisis in cost containment, the DHR devised an alternate approach to the health regulatory office. The DHR Secretary established the Health Policy Group discussed previously. Though the group has no official place in the DHR structure, its bimonthly meetings bring together key people to consider and resolve major interagency issues relating to cost containment, regulation, and coordination.

DHRs' Limited Impact on Health Programs

In the four States, the DHRs caused few changes in the structure, funding, organizational placement, staffing, or functions of the health programs that we studied. The agencies' limited impact appears largely attributable to the categorical nature of the health programs, their small size, and the lack of a direct delivery component. Unless particular Federal grant programs are perceived by DHR and other officials as being directly related to their own human services or health agenda (such as mental health in Georgia and health planning and health statistics in Massachusetts and Wisconsin) the programs operate largely under Federal rules interpreted by health professionals.

Frequently this attitude means that the State Government and the DHR do not scrutinize these programs closely. In Massachusetts and Arizona, for example, personnel funded with Federal money are not required to meet Civil Service hiring ceilings. This exception is permitted because funds are not being sought from the State legislature. Thus budgets and personnel of federally aided health programs are frequently free of State legislative control and often of DHR management.

This outsider image of Federal programs was typified by the regional medical programs because they were outside State Governments, frequently in universities. The comprehensive health planning program (predecessor to the SHPDA in Georgia), although technically in the DHR, was also considered an outsider. It was located several miles from Atlanta and was functionally separate from other health, planning, and DHR offices. The health planning function, an important one to the DHR, was performed by the DHR commissioner's planning office, not by the health planning program.

Despite the absence of DHR effects on health programs, some noteworthy exceptions were found when the DHR perceived the programs to be directly related to the agency's objectives. In Georgia, the Hill-Burton program was used to support State certificate of need activities. All three DHR States—Georgia, Wisconsin, and Massachusetts—used Federal mental health and Title XX dollars to expand and link mental and social services programs. This has not occurred in Arizona. The DHRs also accelerated the deinstitutionalization of mental patients from hospitals to community-based mental health facilities and regionalized planning and budgeting for mental health programs.

In Wisconsin and Massachusetts, the functions of both health planning and health statistics programs have been expanded to help the DHR coordinate policy and provide linkages for planning comprehensive human services. These expansions are still in their initial stages. By contrast, under the autonomous Arizona Department of Health Services, health planning and health statistics functions have not substantially changed. Table 1 highlights the major changes that have occurred in health programs under a DHR.

Table 1. Changes identified in federally assisted health programs under State departments of human resources (DHR)

Massachusetts	*Wisconsin*	*Arizona*	*Georgia*
Health Planning Program			
Functional change—policy tool to coordinate health policy, regulatory activities, and human services planning Linkage mechanism—to other health and human services programs, wide exchange of health plans	Functional change—tool for policy management, health planning, and health regulation across program lines	Linkage mechanism—wide exchange of health plans	
Mental Health Programs			
	Budgetary and functional changes—combined mental health and social service plans and budgets mandated at the county level		Budgetary change -- combined mental health, mental retardation, State psychiatric institutions' budgets at regional level Funding change—significant increases in funding use of Title XX funds
Health Statistics Program			
Funding change—State share substantially increased; program identified as separate entity in DHR budget. Staff increase Functional change—Initiated interrelationships in health and human services programs, close relationship to health planning	Functional changes—linkage mechanism to other health and human services, close relationship to health planning, health resources data and health programs linked		
Hill-Burton Program			
Functional change—made part of certificate of need program			

Health Programs and Services Integration

If the DHR actively pursues integration of services or the coordination of health and human services programs, the evidence suggests that health programs, particularly since the passage of Public Law 93-641, can contribute significantly. In two of the DHR States studied, for example, the health planning program staff exchange program plans and help to develop joint plans with mental health, aging, and vocational rehabilitation programs on issues such as facilities construction, health manpower, health regulations, and cost containment. Health statistics program staff contribute by providing and exchanging support data and sometimes training in data processing activities.

In Massachusetts the linkage takes place formally, in the Health Policy Group, in which the health components of all the human services are represented and agendas are prepared by the health planning staff, as well as informally, when health planning

and human services people meet to mesh program plans and comprehensive health plans.

In Wisconsin, the linkage has been emphasized by the placement of staff of health planning and health statistics programs on interagency task forces. Health planning and health statistics personnel have central roles on the Medicaid and cost containment task forces, two areas where coordination is critical.

The evidence also suggests that mental health programs work with other social services programs to coordinate services. A new partnership among community mental health and mental retardation programs and State psychiatric institutions in Georgia is a prime example. The partnership grew out of a DHR process that coordinates the budgeting and planning of community mental health centers' programs with that of State psychiatric institutions; the goal is to integrate their programs into a single system of care delivered out of regional multiservice centers. The Georgia DHR staff consider the coordination of mental health programs and the multiservice centers their most successful effort in integration of services.

Mental health programs in Georgia, Massachusetts, and Wisconsin have also supported and encouraged the DHR to make coordinative arrangements between health and social services funded under Title XX of the Social Security Act. The DHR facilitates the contractual arrangements for community mental health centers to provide day care, alcohol abuse, drug addiction, and mental retardation services. Planning for these services has brought the community mental health center directors and local social service agencies together for joint discussions and program development.

The participation of mental health staff on local human services boards in Wisconsin also contributes to services integration. The long-standing, good working relationship between mental health and social services programs has been important in the successful coordination taking place in these unified boards and in three pilot projects to integrate services at the county level directed by the Wisconsin DHR. Table 2 summarizes the contribution of health programs to the DHRs' services integration efforts.

DHRs' Recruitment of Health Professionals

Taken as a whole, absolute numbers of health professional personnel have not decreased in the DHR States, and the turnover rate has not increased (except in Massachusetts, as noted subsequently) despite

Table 2. Contributions of health programs to integration of services in departments of human resources (DHR)

Contribution	Health planning program	Health statistics program	Mental health programs	Hill-Burton Program
Capacity of DHR to plan comprehensively	Massachusetts Wisconsin	Massachusetts Wisconsin	Georgia Massachusetts Wisconsin	Georgia Massachusetts Wisconsin
Planning health programs in relation to other human services programs	Georgia Massachusetts Wisconsin	Georgia Massachusetts Wisconsin	Georgia Massachusetts Wisconsin	
Linkage for joint planning	Massachusetts Wisconsin	Massachusetts Wisconsin	Georgia Massachusetts Wisconsin	Wisconsin Massachusetts
Linkage for joint budgeting	Massachusetts Wisconsin	Massachusetts Wisconsin	Georgia Massachusetts Wisconsin	
Shared products of program	Massachusetts Wisconsin	Massachusetts Georgia	Georgia Massachusetts Wisconsin	Massachusetts Wisconsin
Interest in interacting with other human services	Massachusetts Wisconsin	Massachusetts Wisconsin	Georgia Massachusetts Wisconsin	Georgia Massachusetts Wisconsin
Impact on coordination of health and human services delivery			Georgia Massachusetts Wisconsin	

the high turnover of DHR secretariats. Georgia's DHR has been able to recruit better qualified professionals because of a higher salary scale. In Massachusetts, the number of health professionals has increased as additional personnel were hired to administer the State's certificate of need legislation, a tool to control health costs. The control of health care costs is also the motive behind the Wisconsin DHR secretary's intent to hire more health professionals.

Massachusetts' high turnover of health professionals is related to the controversies over DHR reorganization plans, especially consolidation of health and mental health programs into a single system of regional care. The result has been the resignation of the assistant secretary, the commissioner of health and, in rapid succession, five commissioners of mental health.

The most noticeable change in staffing of the DHRs, however, has been a decrease in the proportion of health professionals to generalist personnel. According to the DHR secretaries and major division chiefs, ineffective recruitment of health professionals is not the reason. DHRs' current policies emphasize recruiting persons with managerial and administrative training and experience and placing them in positions that traditionally have been filled by medical professionals. The rationale is that management-oriented people will be more effective in cost containment and in implementing regulations, two major DHR objectives.

In Georgia, the proportion of nonmedical personnel in health programs has increased, especially in the mental health programs. Management-oriented superintendents and deputy superintendents have replaced physicians in several mental health institutions and some physical health facilities. The Wisconsin DHR's intention to replace a physician with a health economist also reflects the new emphasis on management orientation. A decrease in medical personnel at State psychiatric institutions, however, seems less attributable to the new emphasis and more to a shifting of services to community-based mental health clinics. Although Wisconsin had no noticeable increase in numbers of generalist personnel, as did Georgia and Massachusetts, the new emphasis on management skills seems to suggest that the trend may appear there in the near future.

A second noticeable change in DHR recruitment is the trend to hiring younger and more activist health professionals. The motivation seems to be to improve the quality of programs and to eliminate the hiring of staff who would oppose DHR objectives. "We want to hire people who possess the imagination necessary to develop the dynamic, integrated, and coordinated programs under the new DHR structure," was the way the Georgia DHR commissioner put it.

Implicit in this trend is the hiring of fewer retired county public health personnel and former military physicians, professionals who are considered to be more traditionally inclined and less favorable to integrating health and social services programs.

Conclusion

While one must be careful not to draw conclusions from an exploratory study of such small dimensions, this study suggests that a DHR (from umbrella to integrated types) can make a difference in federally aided health programs and that federally aided health programs can affect the way a DHR operates given the following conditions:

1. The health program is a priority of the DHR.
2. The health program's goals are consistent with DHR objectives.
3. The health program brings substantial Federal funding and requires substantial State matching funds.
4. The program is not set in a rigid categorical mode (that is, the DHR can use it to strengthen policy management and coordination.)

In Georgia, for example, improving and expanding community-based mental health centers was a major priority of the DHR. Federal funding was plentiful, at least in the DHR's early years, and this program was flexible enough to allow the DHR to make some major management decisions. As a result, mental health programs were taken out of the health department and elevated to division status in the DHR. The DHR then developed its centerpiece—a decentralized, zero-based budgeting and program planning process for all mental health programs. The DHR also helped mental health programs to enter into arrangements with Title XX programs, co-located under the DHR, to deliver social services in community-based mental health facilities. Because Title XX was specifically designed to be coordinated with the plan of the State and other programs to provide social services, it was a natural vehicle for the DHR to use. The arrangements enlarged the State's social services programs and maximized use of existing service centers. The result was a DHR success in coordination with direct payoff at the delivery level.

Both the Wisconsin and Massachusetts DHRs also paired Title XX money with delivery of social serv-

ices through community mental health centers. The DHRs' most significant impact in those States, however, was on health planning and health statistics. The Massachusetts DHR reshaped the health planning and health statistics programs to use as policy tools in implementing its health priorities (health care cost containment, rate regulation) and coordinated the priorities with the health components of the other human services. Data exchange between health statistics and other human services has backed up joint planning efforts and has been a linking mechanism. In the opinion of the Massachusetts DHR secretary (echoed by the NAPA report in Florida), Public Law 93–641 has further enhanced opportunities for DHRs to manage and coordinate health policy. By mandating the development of the State health plan with other human services plans, Public Law 93–641 is a major departure from the categorical grants mold. At the local level, the HSA planning process also has the potential to support integrated planning and delivery of services. Both health planning and health statistics programs represent potential policy tools in management and coordination for other DHR States. These tools also represent a possible model for future change in Federal categorical health programs that may further enhance State and local ability to coordinate across program lines.

The potential effects of a DHR on mental health programs, health planning, and health statistics can be positive. Negative effects of the DHR, the study suggests, are also possible, especially in regard to the response of health professionals to reorganization. In each of the three DHR States studied, opposition from State medical societies, county health departments, and health personnel seriously aggravated the already complex and difficult tasks of consolidation. When integrated delivery of services was attempted in Georgia (and similarly in Florida) health professionals' opposition became powerful enough to disrupt the system and threatened to tear apart the DHR. Health professionals demanded a return to a separate department of health, with one of their own in charge. These experiences are likely to have an important impact on whether other States try to consolidate health with human services.

In summary, the experiment of combining health and social services into umbrella-type structures is active and alive. The interest of DHR administrators, service professionals, and Federal, State, and local officials in this study and others indicates a need for information that will spotlight the changes that can occur and their positive and negative effects. The information can also be a stimulus to the Federal Government to modify categorical programs to help State and local governments assume a greater share of the responsibility for improving the planning and delivery of health and human services. The possibilities here are endless.

Because of the constant flux in personnel, administrative procedures, and placement of programs that are characteristic of post-reorganization, further research in a larger sample is needed to ascertain if the changes noted by this study are permanent and widespread and how they impact on improving health services delivery to clients. It does seem clear, however, that if the Federal Government intends to strongly support DHRs' efforts at coordination, action is needed to develop and implement strategies to modify the categorical grant system and to be more responsive to State initiatives and reforms.

References

1. Proceedings of the National Governors' Conference, June 1973. The National Governors' Conference, Lexington, Ky., 1973, pp. 222–235.
2. Executive summary of volume II of the Study Committee on Policy Management Assistance reports, "Strengthening public management in the intergovernmetal system." Public Administration Rev 35: 700–705, December 1975.
3. Agranoff, R.: Services integration. *In* Managing human services, edited by W. F. Anderson, B. J. Frieden, and M. J. Murphy. International City Management Association, Washington, D.C., 1977, pp. 527–561.
4. Macaluso, A. C.: Background and history of the Study Committee on Human Management. Public Administration Rev 35: 695–700, December 1975.
5. Olson, K. C.: The States, governors, and policy management: changing the equilibrium of the Federal system. Public Administration Rev 35: 764–770, December 1975.
6. Lucas, W. A., Heald, K., and Vogel, M.: The 1975 census of local services integration: a working note prepared for the Department of Health, Education, and Welfare. Rand Corp., Santa Monica, Calif., 1975, pp. 2–3.
7. Gans, S. P., and Horton, G. T.: Integration of human services: the State and municipal levels. Praeger Publishers, New York, 1975, p. 36.
8. A study of the roles for cities under the allied services approach of the Department of Health, Education, and Welfare. National League of Cities—U.S. Conference of Mayors, Washington, D.C., 1974, p. 96.
9. Book of the States 1976. Council of State Governments, Lexington, Ky., 1976.
10. Human services integration: State functions in implementation. Council of State Governments, Lexington, Ky., 1974.
11. Lynn, L. E., Jr.: Organizing human services in Florida. Evaluation 3: 58–78 (1976).
12. Reorganization in Florida. National Academy of Public Administration, Washington, D.C., 1977.
13. Howard R.: Address at the Conference of Western States Human Resources Directors. Olympia, Wash., July 27, 1977.