Two Opposing Views—Replies to Dr. Ingraham

By SEWALL MILLIKEN, M.P.H., *executive director, Public Health Federation, Cincinnati, Ohio.*

DR. INGRAHAM'S PAPER is extremely valuable for public health workers, inasmuch as grantsmanship in public health needs greater and more thoughtful focus and effective use in meeting the potential for program development. Public health professionals must give more careful consideration to the role and importance of grants in the total public health field at all levels and in all professional areas including research, training, and service.

The basic accuracy and validity of Dr. Ingraham's paper is substantially correct in terms of the State of New York, and, as he states, the New York State Health Department has moved ahead realistically and forcefully in initiating new programs through the proper use of Federal grant aid. However, in many other States there is not only a considerable or complete default but also a lack of interest and concern for State responsibility in this area. Further, as a result of daily involvement in a metropolitan health planning program which includes three States, it is my concern that interstate cooperative responsibility be developed. In the "Ohio River Valley Sanitation Compact" (Indiana, West Virginia, Ohio, New York, Kentucky, Pennsylvania, and Virginia, June 30, 1948), it was necessary to have direct Federal and State legislative action as well as Federal funds to meet the tremendous pollution problem on a coordinated and cooperative basis with a common method of attack.

I mention these factors because it is important to use Federal grants in the best possible way for solving problems and developing programs for total public health.

It is also important to eliminate the hazard of singling out one level of activity to the detriment of others. I am more and more concerned that Federal grants remain flexible and of broad scope so they can continue to motivate and initiate new procedures of program development at various governmental levels as well as official, voluntary, professional, and university levels. Manpower is one of the greatest problems in public health development. The Federal training grant programs which work directly with universities, schools of public health, and medical, nursing, and engineering training facilities, as well as State and local health departments, have produced effective results which directly benefit local, State, and Federal programs.

Although I find no basic disagreement with Dr. Ingraham's statement that "the State is ultimately responsible for the direction of public health within its borders," I am concerned that in many States, such as Ohio, the State Health Code itself directs that certain powers and responsibilities rest with the local community and, while the local community must maintain certain standards set by the State, it may go beyond these standards, if the community and its health officials deem it necessary.

To this end, the local community must often work with other State government departments, such as mental hygiene, education, or others, and consequently it must meet grant-in-aid requirements of both State agencies in order to have a whole and coordinated facility or program. Mental health and mental retardation projects are current examples of flexible State, local, and Federal projects combining research, training, and service components. Environmental health is another example.

In the rehabilitation field, community health-related construction and program funds from other sources are also involved. It is therefore desirable, in many States, that this ultimate responsibility be shared with other State

agencies and with local metropolitan communities, with flexible use of funds from many sources.

Another difficulty for many States is a rural-controlled legislature, which severely limits the States' ability to help the metropolitan areas which have special kinds of health needs and problems. Often it is therefore necessary that these metropolitan communities have access to other financial resources to enable them to bridge this default. Those with university resources are training centers for rural areas as well.

In our concern for strengthening one level or one source of responsibility, we must carefully strive to see that we do not curtail our resources and breadth of development to the extent that we slow down or limit our potential progress in the dynamic development of research, training, and service, and the broad health potential.

The Agricultural Extension Service, which is a Federal, State, and locally financed program including research, teaching, and service, has proved over the years that if the ultimate and major control is at the local community level, the State and Federal resources will be best used to fit the requirements involved.

By MARVIN STRAUSS, *research associate, Public Health Federation, Cincinnati, Ohio, and lecturer in community planning, University of Cincinnati.*

IN HIS DISCUSSION of the question, "Where are Federal grants leading public health?" Dr. Ingraham charges that the present administration of Federal grants "strikes at the roots of our political system" because it bypasses the State health department to make grants to local health departments and voluntary health agencies, and because it threatens to reduce State governments to "field outposts for a monolithic Federal bureaucracy." This argument is presumably based on the premise that the Constitution, or perhaps tradition, establishes clear-cut responsibilities for Federal, State, and local governments and specifies the relationships between them.

However, as political scientist Morton Grodzins has pointed out, "The American Federal system has never been a system of separated governmental activities. There has never been a time when it was possible to put neat labels on discrete 'Federal,' 'State,' and 'local' functions . . ." (*1a*). "Functions are not neatly parceled out among the many governments. They are shared functions" (*1b*).

Our own study of legal and jurisdictional influences on the delivery of health services in the interstate Cincinnati metropolitan area supports this view of "shared" functions. Indeed, it is obvious that the concept must be broadened to include voluntary health agencies, professional societies, health training institutions, hospitals, health planning agencies, and many other health-related agencies and organizations.

Perhaps the problem lies in Dr. Ingraham's philosophy of statewide planning, which implies control of all health activities by the State health department. He wants no local health department or voluntary agency going off in an independent direction. However, there is no surer way to stifle progress than to adopt such a system in which an agency adopts a "master plan" and has the authority to enforce it. A master plan is out of date on the day it is published; planning must be a continuing process of adaptation, initiation, and accommodation if progress is to be made. A progressive State must incorporate provision for what in cybernetics is called "negative feedback," that is, novel behavior which stimulates innovation.

It appears that Dr. Ingraham would like to inflict on the local community the very controls and limitations and rigidities which he deplores.

Indeed, all of the criticisms which Dr. Ingraham makes of the "Federal bureaucracy" are often made of the "State bureaucracy" by community health agencies at the local level. In fact, they might carry his logic a bit further: if the idea of "50 State laboratories of thought and action is still valid," it would seem that the idea of 212 metropolitan area laboratories is equally valid.

We might question several other points raised by Dr. Ingraham:

1. *That States lack an adequate tax base.* Some political scientists have argued to the contrary that States have not fully used their taxing powers because of competition for indus-