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-

try, local political pressures, rural domination of the legislature, and so forth.

2. *That States have "superior" knowledge of problems.* Many cities have health departments better staffed, with larger programs than the State health departments, and might therefore have knowledge "superior" to that of the State health departments. Similarly, specialized voluntary agencies might have superior knowledge about a specific health problem.

3. *That State health departments "deserve" a greater share of Federal research funds.* I fail to understand this criticism. Presumably, State health departments would earn a greater share of Federal research funds if they employed competent research staff and submitted worthwhile projects. A State health department's failure to obtain research grants can hardly be blamed on the "Federal bureaucracy."

There is no doubt that Federal grant programs could be improved. Congress could appropriate funds in such a manner as to promote long-range planning; categorical grants could be replaced by a more flexible grant mechanism, and so on.

But in answering the question, "Where are Federal grants leading public health?" it is essential to consider such crucial questions as these:

1. What is the significance of Federal grants which encourage and require planning at the State, local, and areawide levels?

2. Are Federal grants helping to develop significant new health knowledge, and are they helping the nation to apply and to benefit from new health knowledge?

3. Are they increasing the supply and quality of public health manpower, and raising the stature of the public health professions?

4. Are they helping to focus attention on community health needs which might otherwise be overlooked or to provide perspective which might otherwise be ignored?

5. Are they helping to set and achieve higher health goals? Are they expanding or limiting health horizons?

6. Are they helping to achieve more effective and efficient health services and to improve the organization and administration of health services?

7. Are they helping to solve the special problems of interstate metropolitan areas?

8. Are they helping to place health research, training, and services in an effective relationship?

9. Are they stimulating voluntary agencies to reexamine their roles and undertake new and more significant functions?

10. Are they strengthening citizen involvement in the planning and provision of health services, including involvement of those who are actual and potential recipients of services?

That is, we must ask if Federal grants are helping the nation, the States, and local communities to achieve better health, whether the ends justify the means, and whether the means are adequate to the ends.

REFERENCE

(*1*) Grodzins, M.: The Federal system. *In* Goals for Americans. The Report of the President's Commission on National Goals. Prentice-Hall, Englewood Cliffs, N.J., 1960, (*a*) p. 268; (*b*) p. 266.