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

JAMES H. CAVANAUGH, Ph.D.—*special assistant to the Surgeon General and director of the Office of Comprehensive Health Planning and Development, Public Health Service*

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.

At the same time, the legislation recognizes that the benefits of comprehensive health services may be available to some individuals, that individual physicians and dentists may have all the backup they need, but that, for the nation as a whole, comprehensive health services are not available and will not become available unless deliberate attention is directed toward the fulfillment of our national purpose as identified by the Congress. P.L. 89–749 is the tangible commitment of the nation's leading health agency, the Public Health Service, toward making this deliberate attention possible.

But the provision of comprehensive health services is beyond the scope of responsibility of any one particular group, certainly beyond that of the Public Health Service and public health in general. Its achievement depends upon a partnership, involving close intergovernmental collaboration, official and voluntary efforts, and the active participation of individuals and organizations.

A guiding assumption in the development of P.L. 89–749 was that while some health problems may be national in scope, their urgency and the best approach for meeting them differs from place to place—hence, the strong State emphasis.

A second assumption in this legislation is that further progress in improving the availability and quality of comprehensive health services requires planning—hence, the emphasis on planning.

A third assumption is that planning can best be done at the level closest to the people who need service, while at the same time it must cover a broad geographic base for effective handling of problems—hence, State and areawide planning and the tie-in between the two.

Another assumption in this legislation is that effective planning must involve those people providing health services as well as those people receiving services—hence, the composition of the planning council.

A fifth assumption in the legislation is that planning in the abstract can easily become a meaningless exercise unless there is a built-in capability to do something about problems disclosed, allowing planning to lend to accomplishment—hence, the backup provided by formula and project grants.

With this legislation as the foundation, the Public Health Service is now developing a national program that can be adapted to particular State needs, which will encourage and support orderly approaches to improvement of the status of the health of the individual, and which will be sufficiently flexible in approach so that we may select our major problems and target our resources.

Program Direction

To provide overall direction of this program, the Surgeon General has established the Office of Comprehensive Health Planning and Development. Policy advice and assistance in coordinating the program will be provided by the Comprehensive Health Planning and Development Board, a board of technical advisers made up of representatives from each bureau of the Public Health Service.

Many elements of the program are currently under study by this new Office, including (*a*) the development of financial flexibility within the program so that we may muster financial resources and use them where they are vitally needed, (*b*) the development of information systems which would enable us to obtain a picture of the health scene and identify problems, as well as to chart progress of programs and to evaluate effectiveness in reaching health goals, and (*c*) the encouragement of the development of planning processes that include consideration of environmental and personal health service aspects and that go beyond our present experience, which in some instances has tended to stress facilities planning.

We are looking at ways to avoid—however great the temptation may be—concentrating too heavily on planning techniques rather than the development of a planning process which exists for the purpose of improving health by assuring the availability and appropriate use of comprehensive health services.

We are also considering the development of ways to encourage programs that lead to comprehensive health services. For instance, if a screening program is to be supported, it must include adequate arrangements for treatment where necessary.

We have also been defining what this new program can really do. Through encouragement

and support of State and local comprehensive health planning, it can provide an overview of the health scene, making it possible for us to assign priorities to the areas with the worst problems and to initiate programs to reduce their problems. We must look for the weakest links in the health system and then try to strengthen them, which, of course, implies a continually changing program. We must also identify those areas which require other legislative support or support from other sources or both.

The program can also identify health needs, in concrete and undeniable form. Once weaknesses are identified, a chain reaction may be set off which will eventually lead to a solution. Some solutions to identified weak spots in the health system could come from this program itself, through the formula and project grant funds. Here, the main contribution may come from supporting activities which cannot be handled through some other public or private channel, or through demonstrations of programs searching for adequate solutions to an identified health problem. Other solutions to problems uncovered by the planning agency may come from other government programs, voluntary agencies, or through reassessment and reassignment of responsibilities of agencies or programs.

Through the partnership concept, the program will provide for a concentration of information and it will provide a channel for conveying information on needs. The composite picture of the nation's health problems would seem to be hard to evade once the problems have been disclosed and public and professional concerns are focused and expressed.

The designation or establishment of a State health planning agency advised by the State health planning council, provided for in this legislation, will provide a focus for considering State health needs and for developing appropriate actions to meet those needs. The program, in effect, provides for a new kind of concentration of strength in the health field.

Partnership

It is important to underscore this new kind of concentration of strength. It will not reside in any single agency, institution, or organization representing a limited interest in the health field. Rather, it will lie in a partnership with all interests represented. The State planning agency will need the confidence of both private and governmental health agencies and institutions which are to be involved in, and affected by, its planning efforts. The wide range and special concerns of the many health programs and professional groups must be considered if a broadly based consensus for planning is to be achieved. For this program to reach its full potential, we must marshal a vital partnership—private and public—individual and organizational—local, State, and national—in creative action for health.

Comprehensive health planning is the critical component of P.L. 89–749, and its functions and relationships are the critical components of its consideration. The legislation develops a base for a vital step forward in comprehensive health planning, not as an end in itself, or as a new and different program, but as a dynamic process and means for identifying and delineating courses of action. In contrast to many previous health planning efforts, the planning elements of P.L. 89–749 are not limited in time, or to a collection of programs, or to a segment of the system, such as hospitals or nursing homes or air pollution.

The process and the agencies involved will provide the mechanism through which: (*a*) all health planning can be linked and strengthened and clarity of purpose secured, (*b*) health status can be measured, goals and objectives defined, priorities set, and actions planned, (*c*) interrelationships can be explicitly described and made more effective, (*d*) service, manpower, and facility needs can be identified and interrelated and program accomplishments assessed, (*e*) channels of communication and methods of cooperation can be strengthened between agencies and groups with mutual concerns, and (*f*) the people of a State, through their Governor and legislature—and the Surgeon General and the State and national health effort—can have the benefit of the best recommendations for action.

Comprehensive health planning will be difficult, and its progress can only be measured over a long period. Those involved in the process must rely heavily on data and plans from various operating agencies within the State; for example, health statistics generated in local and

State health departments; health manpower development data and planning in institutions, health professional schools, universities, and departments of education; health resource plans and analyses in Hill-Burton agencies and in local and regional planning agencies; health service use and cost information maintained by Blue Cross, Welfare Administration, and Vocational Rehabilitation programs. Thus, it is imperative that health departments, mental health departments, medical schools, and voluntary health agencies continue and strengthen their planning functions.

A regional medical program will continue to be responsible for developing and implementing plans and cooperative arrangements for heart disease, cancer, stroke, and related diseases in the geographic area it serves. The Hill-Burton agency will continue to be responsible for developing and submitting the State plan for federally-supported hospital and related facilities construction. The State health department and the State mental health department will continue to be responsible for planning to meet specific program needs. But all health planning must influence, and be influenced by, State and regional planning for community and economic development.

The key words for planning effectiveness are "complementing," "linking-up," or "interrelating," the necessarily differently focused efforts to make available the best of health services—personal and environmental—to all people. We must work toward interrelating programs that are oriented toward creating resources with those targeted to provide health services and with those that encourage innovation and demonstrate new methods. We must attempt to break down the unnecessary restrictive barriers among categories, and we must develop processes which provide for priority determination and decision on allocation of resources at levels closer to the needs of the people. To quote the Surgeon General, we must "use the Comprehensive Health Planning Amendments of 1966 as a means of reorienting Federal-State relations—and by extension, all relationships—within the health field."

We now have the mandate for local, State, and Federal health planning, to work toward strengthening the intergovermental partnership for health. This could be called the "alliance" approach to improving and extending health services. As such, it joins Hill-Burton's "construction" approach for health facilities, the "education" or "knowledge" approach of the Health Professions and Nurse Training Act, and the "economics" approach of titles XVIII and XIX in the Social Security Amendments of 1965.

Our challenge is to make the machinery of government and the total health endeavor more effective. Meeting this challenge requires a creative partnership, with both cooperation and competition of organizations and individuals. More than anything else, such a partnership must rely on a strengthened role of State and local governments, which will take on greater administrative responsibility as our nation grows. Our Federal task is to nurture and promote that role. Secretary John W. Gardner recognized this need in remarks he made to the Foreign Service Association in Washington in June 1966, when he noted that:

> If a durable and creative partnership is to exist between the Federal Government and any non-Federal agency or group, there should be strength and a reasonably clear sense of purpose on both sides of the partnership. The collaboration will never achieve its full potential if the non-Federal partner is weak or lacking in a sense of direction. As an example, the cities that have profited most strikingly from Federal urban funds have very likely been those in which local leadership and initiative were strong.

This is a time for regrouping in the health field, for replacing confusion with clarity in purpose and action, and for accepting and fulfilling the mandate which we now have.

What can we do now? At present, we in this new Federal-State partnership can begin to refocus our thinking, particularly in personal health services, from disease problems to individuals. We must consider, as we are doing in the Public Health Service, how to better organize personnel and activities in order to carry out our mandate. Where our assumptions, our action guidelines, and our boundaries are valid and constructive, we need to use them. Where they are outmoded and no longer useful, we must discard them and develop new ones.

We can also take steps now to select activities to be supported through formula and project

grants, and we can begin to develop the information systems which will be vital in evaluating the effectiveness of funded activities.

We have a tremendous task to do in our new partnership. To do it well, we must not only strengthen patterns of collaboration between established health resources in each community, but we must extend and include in this creative partnership practicing physicians, academic medicine, general government, Federal, State, and local agencies with health and related missions, and above all, the people we serve.

Most important, we must accept the consideration that this new partnership, if successful, will introduce on the American scene a constant feeling of dissatisfaction on the part of the whole health field and the public with the state of health in this country.

Role of Regional Offices

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Regional health directors are acutely aware of the responsibilities placed on regional offices by the Surgeon General for the implementation of P.L. 89–749. We are engaged in discussions of the reorganization of the regional office functions necessary to discharge the new responsibilities effectively and efficiently. Our discussions, and the decisions to be made by the Surgeon General and his Office of Comprehensive Health Planning and Development, concern:

1. The establishment, composition, and functions of Regional Office Review and Advisory Committees to advise the regional health director on grants to be made under section 314 (a), (b), (c), (d), and (e) of the act.

2. The use of Public Health Service employees in regional offices, States, and metropolitan areas as comprehensive health planning officers. Their roles include three primary areas: (*a*) assuring that all facilities and resources of the Public Health Service—perhaps ultimately all the Federal civilian health facilities and resources—make significant contributions to the comprehensive health plan of the State and area; (*b*) assisting with the formulation of State health plans to which the Service, within the national policy, rules, and regulations, can be responsive; and (*c*) serving as an effective communication channel between the State and the Surgeon General, identifying the health problems of national significance which must be assessed by the Surgeon General with respect to the need for additional legislation or appropriations or both.

3. The number and kind of representatives of Public Health Service bureaus and their programs that will be located in the regional offices as resource managers—managers of all Service resources that must be brought to bear on comprehensive health planning and program implementation, both State and areawide.

4. Identification of the roles of all the headquarters bureaus in support of regional implementation of section 314 of the act. The Surgeon General has mentioned the special responsibilities of the Bureau of Health Services in assisting regional health directors in the operating phase of the new program. Of equal importance is the Bureau of Disease Prevention and Environmental Control, which contains much of the Service's competence to judge the technical validity of project grant proposals for public health. The same can be said about the National Institute of Mental Health with regard to the many-faceted mental health programs of the country. The National Institutes of Health's regional medical programs have much to contribute to comprehensive health planning, and regional health directors will look to the new Bureau of Health Manpower for support in planning for health manpower.

With regard to formula grants, I can do no better than repeat a part of Deputy Surgeon General Leo J. Gehrig's testimony on Senate bill 3008, which was enacted into P.L. 89–749:

> S. 3008 embodies, therefore, a fundamental revision of the Federal health grant structure. Federal grant funds would be made available to States and through them to local communities, on a non-categorical basis for the provision of comprehensive public health services. States and communities would be able to use these funds to provide services which are focused on individuals and on families in their communities rather than on separate disease conditions. Through this flexible grant structure comprehensive public health services will be developed, expanded, and supported to maintain physical and mental health; to detect, pre-