The Comprehensive Health Planning Laws from the Local Viewpoint

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MANY YEARS AGO, identifying the responsibilities of different levels of government for the planning and provision of health services was very simple. There was the Federal Government, which was created by the States, and there were the States. There were local governments, of course, but they were legally held to be creatures of the State, and thus no one had to bother about local government.

The delineation of responsibilities probably never was that simple, and the interpretation of the Constitution that relegates the Federal Government to subservience to the States has been less popular since the Civil War. However, the distinctions seem very uncomplicated compared with the present situation.

How did we get where we are now? To answer that question fully would take a very thick monograph, but I will discuss a few high points and our experience in Philadelphia.

Federal grants for health services were made primarily to States until the present public health generation. The States did not have to involve local government and in many cases chose not to do so.

Increasingly over the past quarter century, some Federal grants in selected categories were made directly to local governments. Philadelphia has a 25-year history of Federal help in venereal disease control, has received Government aid almost as long for tuberculosis control, and has several years of experience with direct Federal grants for such activities as immunization, air pollution control, and maternal and infant care.

Impact of Federal Grants on Local Agencies

With the advent of Federal grants directly to local governments, many partisans of strong local government and strong local health departments were happy. Federal money was no longer allocated only to States; it could be granted directly to the local official health agency.

However, broadening the definition of eligibility for Federal grants for health services continued. When the authorization for comprehensive health services grants for children and youth was included in the 1965 Social Security Amendments (Public Law 89–97), medical schools and their affiliated teaching hospitals became eligible. This authorization gladdened some people in the medical schools; they saw it as freeing them from restrictions imposed by local government.

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Some people in local health agencies who had cheered earlier at being freed from State restrictions now championed the need to coordinate and set priorities if "everyone" was to be given a direct project grant. Philadelphia, with five projects for children and youth, one for each medical school except the osteopathic school, had real need for coordination.

The process of making Federal grants to groups even closer to the people continued. In the 1967 Social Security Amendments (Public Law 90–248) some categories of child health services grants could be made to "any public or nonprofit private agency, institution, or organization." Consequently, persons in the medical schools, who had rejoiced at their own direct access to Federal funds for health services, bewailed the new policy of giving grants to "unqualified" groups.

The examples discussed relate to the general trend in health services. I have not attempted to describe the rapidly increasing and rigidly compartmentalized categories of Federal grants for health services. Somewhat similar patterns of increasing complexity and fragmentation were developing in Federal grants for training, research, and construction.

There are many versions of what reversed the pattern from increasing fragmentation and categorization to comprehensiveness. Having received progress reports on the change as it occurred, I favor Gaines' story, in which the key element is a 1964 rebellion of administrators primarily in State health departments, but also including persons from Federal and local health agencies (*1*).

By the spring of 1966, when Senate bill 3008 was introduced as the Comprehensive Health Planning and Public Health Services Amendments of 1966, the bill became the prime topic of conversation in health agencies at all levels of government. People in local health agencies were interested to note that government at the State level was involved since the State had to designate a State agency for health planning functions. The bill did not say that this State agency had to be the State health department.

On the role of local government, the bill specified that the State health planning council was to ". . . include representatives of State and local agencies . . . concerned with health" as well as others. This legislative requirement was later detailed in an information and policy statement (*2*) which stated that the State health planning council must include local governmental agency representatives and explained, "These may be selected from among such agencies as local health, welfare, and education departments, mental health agencies, local governments. . . ."

In contrast to the mandated role for State government, if not necessarily for the State health department in developing the statewide plan, no mention was made in the bill about local government, let alone the local health department, in section 314(b) on areawide or regional health planning. The law's omission of local official agency interests was at least partially overcome when a later information and policy statement (*3*) said that, to be eligible for a grant for comprehensive areawide health planning, "The agency or organization must provide for representation of the major public and voluntary agencies, organizations, and institutions concerned with physical, mental and environmental health services, facilities, and manpower in its board of directors or on an advisory council."

Many of the categorical grant programs were to be consolidated eventually into a program of formula grants to the States for comprehensive public health services. Many persons in local health departments which were already the recipients of some direct categorical Federal grants got scant comfort from the bill's statement, ". . . such [formula grant] funds will be made available to other public or nonprofit private agencies, institutions, and organizations . . . to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; . . . ."

The anxiety at the local level that the bill would strengthen the States at the expense of localities was not relieved when they were told that Senate bill 3008 required that in the allocation of funds within the States at least 70 percent of the formula grants to States for comprehensive public health services was to be ". . . available only for the provision . . . of services in the communities. . . ." The partisans of local government noted that the bill spoke of providing services in the communities, not by the com-

munities. Their gloom was deepened when the requirement of 70 percent for services in the communities was eliminated sometime between the introduction of Senate bill 3008 and its passage as Public Law 89–749.

During the hearings on Senate bill 3008, little or nothing was heard from any witness representing local government interests, but extensive testimony was given by Federal and State groups. Some local boards of health in various parts of the country did pass resolutions recommending that the State health department be appointed the official State health planning agency and that there be local health department membership on the advisory health planning council.

There was fear expressed at local levels that it would not be politically realistic to expect to have local tax funds brought in if there were no requirement for local government to be involved otherwise. Some wondered if a new philosophy were developing in which local funds were no longer felt to be needed. This was said despite the statement in Public Law 89–749, "Such [Federal] funds will be used to supplement and . . . to increase . . . and not to supplant such non-Federal funds."

Public Law 89–749 was signed by the President on November 3, 1966. The vast interest in the comprehensive concept as well as remaining concern about some of the specific aspects, including some of concern primarily to local governments, led to the introduction of further amendments on March 1, 1967, as House bill 6418.

Emergence of Regional Planning

The National Association of Counties and the National League of Cities submitted statements at the hearings on House bill 6418. Another organization offering testimony was the American Public Health Association. The association's 1963 policy statement says (*4*), "The local health department is in an especially strategic position to do long-range planning." This statement includes "regional planning of health services" as one of the "areas of planning responsibility particularly suitable for local health department attention."

The Senate Committee on Labor and Public Welfare was probably aware of the Report of New York City's Commission on the Delivery of Personal Health Services (*5*) which stated, "The planning power is central to the fruitful exercise of public authority in the development of comprehensive community health services. . . . The public interest—and every principle of good government—argue that this power should be exercised by a government agency. It is so designated for the level of State government by Federal legislation." The report recommends that the official health agency of New York City, the Health Services Administration, be designated to organize the regional comprehensive health planning agency for the city.

Perhaps the committee was following the advice of one of the "Corson Reports" which stated (*6*), "The local health department forms the logical agency in the community to provide the leadership and staff assistance for the Community Health Planning Council."

The members of the committee may have been influenced by the desires of the Federal Government, perhaps best expressed by Surgeon General William H. Stewart (*7*) when he said in late 1966, ". . . recent trends have dictated a clear mandate that all government—city, State, and national—has a fundamental responsibility for assuring that the people's right to health is fulfilled to the greatest possible extent."

The Senate Committee on Labor and Public Welfare dealt squarely with some of the concerns of local government in regard to areawide health planning by stating (*8*), "Some criticism was made of the existing program, on the grounds that it has not been as responsive in some cases to the needs of local governmental units as it could have been, and that the planning activities have not been coordinated with the activities of local governmental units." The Committee's report noted, "The bill [House bill 6418] requires appropriate representation of the interests of local government in the areawide planning activities where the recipient of the grant is not a local government agency."

In regard to formula grants to the States for public health services, the committee observed that the requirement of 70 percent of the grant for services in the community was restored. Unlike a similar provision in Senate bill 3008, the

70 percent requirement was in the bill signed December 5, 1967, which became Public Law 90–174.

Developments in the Philadelphia Area

With all these laws, many information and policy statements explaining the laws, and speeches clarifying the policy statements, what has happened regarding comprehensive health planning in the Philadelphia region? In December 1966 there was discussion within the Health and Welfare Council and some consideration was given to holding a large conference in the spring of 1967 to explain to community leaders concerned with health the opportunities under the new Federal legislation. This conference was never called because of lack of community interest, a situation which is quite different from the present desire of almost everyone related to the health field to be directly involved. Then some of us in the Philadelphia Department of Public Health began to search for a way to get things moving in this region. We discussed the matter with State Secretary of Health Thomas W. Georges in June 1967, and he encouraged our department to take the initiative regarding comprehensive health planning to draw together persons in the Philadelphia area.

The first regional meeting was held in August 1967. Attending this or later meetings of what has come to be called the Ad Hoc Committee on Regional Comprehensive Health Planning were representatives of such groups as the Delaware Valley Hospital Council, Hospital Survey Committee, Greater Delaware Valley Regional Medical Program for Heart, Cancer and Stroke, Blue Cross of Greater Philadelphia, Jefferson Medical College, Philadelphia County Medical Society, Bucks County Health Department, Philadelphia Department of Public Health, Health Insurance Council, Health and Welfare Council, United Health Services, Regional Council of Elected Officials, and the Delaware Valley Regional Planning Commission.

A basic question was how much of southeastern Pennsylvania should be covered, so the Pennsylvania Health Department has been involved from the start. The region might extend into southern New Jersey, so continued discussions have been held with the New Jersey State Department of Health. The Regional Office of the Public Health Service will have major responsibility for decisions on a grant application for regional comprehensive health planning, so their representatives also have been involved.

The group soon grew to more than 25 persons and could not meet frequently, so an executive committee was selected to handle business between meetings of the full ad hoc committee. It soon became apparent that staff and money would be required to prepare the application for a Federal project grant.

Fortunately, a number of the participating agencies have contributed money. Among the contributors are the Hospital Survey Committee, Health and Welfare Council, United Health Services, Hospital Council, Blue Cross, Philadelphia County Medical Society and Dental Society, Montgomery County Medical Society, and the Philadelphia-Montgomery Tuberculosis and Health Association.

The Health and Welfare Council has offered to be the repository of the contributed funds. Professional and clerical staff and space to house them was contributed by the first three agencies listed among those giving cash as well as the Philadelphia Department of Public Health. The Regional Medical Program gave services. The contributed staff consisted of one health planner full time for several months and part-time service of several other professional health planners or administrators plus related secretarial assistance.

The staff, guided and directed by the ad hoc committee, developed a project application which was submitted to the Pennsylvania Department of Health in August 1968 and went to the Public Health Service in September. Before these steps could be taken, several problems had to be resolved or at least dealt with. The area of the planning region was limited to southern Pennsylvania after representatives of southern New Jersey decided to attempt to set up their own region. Sources of the non-Federal matching funds had to be identified and a basis developed for apportioning the share of each source. Another question was whether the Philadelphia Department of Public Health could or

should maintain a leadership position in this effort or would a consortium of health agencies become dominant. The reality of providing the required majority of consumer representatives had to be faced.

What will happen next? What does all this mean to the official health agencies, the voluntary health organizations, and even more important, to the people in the Philadelphia region? Of course, no one can predict the future and how the various groups will interact.

However, I believe Stewart probably put it best in his speech at the 1967 National Health Forum (*9*). He said, ". . . it must be emphasized that comprehensive health planning does not represent the imposition of a master plan by Government upon the people. . . .

"As for the role of Government in the process, it is the servant and not the master. Government in the city, the State or the Nation can be, first, an effective instrument for gathering pertinent information; second, an instrument for assembling and allocating resources; third, an instrument for assessing progress and reflecting changes in social aspirations. But the broad decisions are made by the people themselves, and the operating decisions are made by those who are charged with doing the work. Government can synthesize and catalyze; it cannot dictate."

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(*7*) Stewart, W. H.: Partnership for planning: Extension of remarks before the National Advisory Health Council, Nov. 28, 1966; National Advisory Council on Regional Medical Programs, Nov. 27, 1966; and the Surgeon General's joint conference with State and Territorial health authorities, mental health authorities, hospital and medical facilities construction authorities, and mental retardation construction authorities. Washington, D.C., Dec. 6, 1966, p. 2.

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(*9*) Stewart, W. H.: Comprehensive health planning. Address to the National Health Forum of the National Health Council, Chicago, Mar. 21, 1967, p. 11.