Urban and Regional Foundations for Health Planning

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FOR YEARS we have been pointing to that distant decade of the 1970's when all our troubles would be solved. But that decade has arrived and the troubles are not solved—and the constant word is crisis. It is doubly important, then, that health professionals, civic leaders, and consumers are responding to this need for decision (a meaning for the Greek word "krisis") by discussing regional public policy issues and searching together for solutions.

At the passing into a new decade it is customary to look back, take stock, and foretell the future. However, I wish only to point out that those who 10 years ago looked to the 1960's did not usefully predict where we would be today, at the vortex of the winds of change. No one forecasted the key social forces we now experience such as the strength of the civil rights movement, rise of concepts of "black," of "black power," of student unrest, the Vietnam War and its test of us, and the frustrations and impatience felt throughout the nation.

"Urban and regional foundations for health planning" is a formidable and arid set of words. Rather, words like "people," "crowded people," "technology," "expectations," and above all "credibility" perhaps more aptly describe our setting and concerns. We are trying to achieve some direction to our lives in a setting where it sometimes seems the more we spend the less we get, the more health officers and agents we employ the more trash and rodents seem to accumulate, and the more medical knowledge advances so it seems does dissatisfaction. To cope with these feelings, we turn to other abstractions—planning, interlocks, and systems approaches. I will touch on some of these—systems of urbanization, systems or milieus of planning, some health problem systems, and some methods.

At the outset, let me state that I approach this subject as a journeyman, pragmatically. And, as I wander through, look for no villains. My reference may be Baltimore because that is where I am. Although other persons' patterns and interpretations may be similar or different, the essence of the task must be people doing things for themselves, wherever they may be.

We often hear the word "systems." Some of us are reluctant to admit that we are part of a system. Our children sometimes attack a system of sorts at home and an even vaguer one outside. We hear angry and disillusioned voices saying "The system cons us." We are told that the American health care system is a nonsystem and also that the American health care system

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is a mess. From Houston, we hear periodically that "All systems are go."

In this discussion, my concept of systems is a series of parts functioning in relation to each other, pursuing unity, in a larger context.

Urbanization

Urbanization and urban crisis describe many things. Nationally, the fact that 90 percent of the population lives on 5 percent of the land mass (or 70 percent on 1 percent of the land) indicates crowding—not just land use but the emotional consequences or mental ill health of crowded, bustling communities.

If we learned that England and France or Scandinavia and the two Germanies were to be emptied of people in the next 30 years and that those people were to be moved to this country, I venture that there would be frantic concern and activity in finding jobs and markets and building suitable housing, educational, and health facilities for the new residents. Yet, in the next 30 years, without a dramatic immigration, the same thing is going to happen. With neither plans nor policies to deal with them, 100 million people will be added to this country in the next 30 years. We are adding a new city of Wichita every 4 weeks or a Memphis every 8.

The Baltimore region which I serve is part of the fast-growing northeast megalopolis. In the 300 years between colonial Maryland and 1930, the population grew to 1 million people. In less than 30 years that number doubled. It is quite possible that the next million could be added in less than 20 years. Today in our region 2 million people live in an area of 2,200 square miles—a density of more than 900 persons per square mile. That half-again increase will press 1,400 persons into that square mile. But that is not the whole story. The regional statistic includes both a county with 141 persons per square mile, and a city with density of 11,557. I note that all metropolitan regions are beginning to show like pressures.

Urbanization also means that we live in a land of paradoxes: magnificent parks and polluted rivers, great land mass and crowded cities, medical miracles and high infant mortality, ignorance and great institutions of learning, and national power and psychological malaise. This brings to mind Owen's fable (*1*):

> There once was a nation of 200 million people that was the most powerful country in all the world. At the national level the inhabitants were very rich; but at the local level they often turned out to be quite poor. And as luck would have it, they all lived at the local level. Seventy percent of the people were crowded into one percent of the land, which they called cities. One-fifth of the city people were the victims of poverty. Many of them lived in slums where the housing was unfit for living, the schools unfit for learning, and the air unfit for breathing .... But the cities continued to grow uglier and the frustrations greater .... And there were riots in the streets ....
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> If our Country is so rich, why are the cities so poor? And to this day, no one has been able to answer that question.

We cannot turn back the clock to a simpler, less harried time. We have learned, I trust, that new populations cannot be absorbed by casually "letting out the seams" to compensate for an urban bulge here or there, and that even greater "self-destruct" danger lies in increasing population pressures in ever-more constrained areas.

Thus we have arrived at a point of transition. Americans have higher expectations. They want better education, better housing, better jobs, and better health care. The gaps between what is and what might be are more visible and more understood. Scientific knowledge and technological advances haunt us by implying that we know how to do better than we do. Questions of justice and individual and family fulfillment are being thrust as measures of our achievement. Health issues and solutions have returned to their place of a century ago—the political arena of public policy.

Seven years ago, the Surgeon General of the Public Health Service convened a rather unusual group to study and advise him on urban health affairs (*2*). I say unusual because rather than a typical gathering of blue-ribbon medical-scientific leaders, it consisted as well of systems engineers, political scientists, a mayor, a county executive, a Governor, and practicing physicians and health officers. They issued a small, but significant report, saying, among other things:

> That urbanization means change and complexity in the total environment of each person, and the interdependencies of his well-being with that of everyone else in the community. These conditions result from interrelationships which characterize each urban and metropolitan community as an open and unique system....

> That housing patterns, transportation networks, water supply and waste disposal facilities were the major determinants of urban growth and development. That design and engineering (including conservation) of water, air, and land must be health-oriented, lest we continue to worsen our condition in underusing some facilities and crowding others, pollution crises, economically deprived areas, urban sprawl and ugliness. . . .
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> That personal health services, including private medical care, should constitute basic systems of action to meet health needs. . . .

In short, the committee called for a departture from compartmental institutions, habits, and isolated activities and for a new leadership "not as centralized assumption or control, but catalytic: each one doing the best he can for the general health and welfare of the community."

For environmental considerations the approach was that of Dr. C.-E. A. Winslow, more than 30 years ago, when he said, in effect, that all bad housing, pollution, and so forth is as nothing compared with the feeling one is living and destined to live on the wrong side of the tracks!

Health Planning

The Surgeon General's committee was part of a wide national debate, study, and decision-making in health policy (which is still going on), which saw the enactment of Medicare and Medicaid, the Clean Air Act, and Regional Medical Programs. The voluntary movement's National Commission on Community Health Services called for national health goals and more effective planning and coordination in its report, "Health is a Community Affair." Indeed, out of this public policy crucible a national health policy began to emerge, and with the passage of Public Law 89–749 in the closing weeks of 1966 the Congress adopted such a goal:

> That fulfillment of our national purpose depends on promoting and assuring the highest level of health for every person, in an environment which contributes positively to healthful individual and family living.

If this goal is to be achieved, Congress declared, health planning is imperative. This legislative action meant that society "determined that the health system could no longer be left to its own devices to pursue a multiplicity of often unrelated ends, but must be defined and comprehended as an interrelated whole" (*3*) and then addressed in terms of priorities and objectives.

The planning activities mandated testify that ours should be what Dr. Mary Arnold, professor of health planning at Pennsylvania State University, calls a "planning society, not a planned society" (*4*). The involvement of all parties at interest and support of the individual family's planning speak to this dynamic. A planning society requires an informed citizenry, able to cope with uncertainty and continual change.

During the same period, in urban affairs generally, there was growing recognition that no one unit of local government could function alone, as an island. The problems faced were shared problems requiring shared solutions or intergovernmental cooperation. To accomplish shared planning and solution of shared prob lems, there emerged intergovernmental com pacts, councils, or associations of governments, such as the Regional Planning Council which is the base for areawide comprehensive health planning in the Baltimore metropolitan region.

The Regional Planning Council, established in 1963 by the Maryland General Assembly, is composed of the two top elected officials from each of the six local jurisdictions (Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties) and the chairmen of their planning boards. The Governor appoints a State senator and assembly delegate, two citizen members-at-large, and four other officials (State Planning, Roads, Port, and Transit). The majority of the council, then, are local elected officials.

Some people argue for directly elected regional governments. Our council represents an alternative, emphasizing cooperation among local governments—whose cooperation will be essential no matter what the regional structure.

New institutions, as the Regional Planning Council, represent earnest searching for new approaches to meeting urban and areawide issues, based on recognition by professional, political, and citizen leaders that there must be better ways of doing things. Perhaps more important, these leaders are determined to face

the future, daring to attempt to shape it. We now recognize the awful fact that our very responses to today's decisions, or our nonresponses, condition the shape and substance of tomorrow.

To return to health concerns, for the first time in history enough pieces of the health jigsaw puzzle are in one place to begin to fit them together. If, through lack of imagination, or wisdom, or courage, we do not accept this challenge, our children and grandchildren will not wonder where to lay the blame.

The central problem facing the American health enterprise is that health needs, and the effective demand for services to meet those needs, far exceed the resources. We do not have at our disposal the manpower, facilities, services, funds, nor, most importantly, patterns of organization that would enable us to do all things for all people at once. More than scarcity is involved in this gap. The gap is made up of lags by institutions, providers, and consumers in effecting change or in adapting to changes which have occurred. We are involved in the business of working the changes that will meet the health crisis we face. Of two concepts of comprehensive health planning, not necessarily compatible (one a system of ordering intergovernmental relationships, the other a means of achieving improved health services and outcome) I feel areawide planning's focus necessarily must be more on operational planning to achieve and implement strategies or plans of action and to assess their accomplishment.

Our aim is to work toward good health for every American. Our function is to strengthen the hand of each component involved in the delivery of care or in environmental services. We cannot be comprehensive, we will increase fragmentation, unless we assist, nurture, stimulate—indeed require—each component or operating unit of the health endeavor in our area to plan comprehensively. A useful ground rule would be that each component think through continuously, and decide within the larger community context, its role in improving or maintaining the health of a defined population. This ground rule enhances two essential approaches: looking outward and geographic-population relevance.

To meet our goal and achieve our function, we are, and must be, involved in partnerships with every element of the system—the physicians, the hospitals and other community institutions and agencies, State authorities, and voluntary groups. Implicitly required is a partnership with general government. Official health departments are essential but are not enough because they represent accustomed alliances and only a part of the system. The people's spokesmen are, and have been, mayors, councilmen, assemblymen, and Governors. Increasingly, the people themselves, assuring they are well served, are the new partners to whom we of the health establishment must look.

Comprehensive health planning activity is just beginning. It is having some problems, but they are to be expected for it has a tall order. I view the dynamic tensions and controversies around the organization or birthing of areawide planning agencies as testimony to the importance of the job to be done and to that instrument's potential.

In planning, we have to identify problems and design ways in which mixed and limited resources (whether from local, State, or Federal taxes, from fund drives, from our pockets, or from insurance companies) will have the best yield to meet the health problems of the people of the community.

In the Baltimore region, as elsewhere, there are great strengths on which to build: an increasingly evident readiness of health institutions, physicians, and community groups to meet the challenges of working together to solve community problems. Our Baltimore base, in an official agency of six local political jurisdictions, is already experienced in such health-related planning areas as transportation, land use, education, water resources, housing, and economic development. However based, comprehensive health planning must build on and interlock with such strengths to define priority objectives, develop a sound information base, devise effective strategies, and assure ways to carry out those strategies. Studies alone will not do the job.

We are subjected to much noise, but few significant messages about the locus of areawide health planning. The arguments that the organization "must be" a voluntary nonprofit corporation, or "must be" in local government, seem specious in the main. We, based in an official

planning agency, must secure the involvement, not mere participation or approval, of voluntarism. If the base is a health and welfare council, one must secure the involvement, not mere participation or approval, of the local governments. However based, interlocks with related planning must be achieved, as I have mentioned, together with true involvement of those who provide health services and of those who would be served by them.

Above all, we must keep planning relevant and realistic, focused on live issues. We must be continually on guard lest planning become merely an information system, important as that is, or a substitute for doing something concrete about health problems.

Some of the live issues—evolving from the deepening urban crisis of the health care system and increasingly less manageable problems of our environment—seem in Baltimore to be:

- Overtaxed emergency rooms; gaps in primary ambulatory care services.
- Discrepancies between the health status of the poor and the affluent.
- Threats of water scarcities, coupled with stress on present sewer capacities and the accelerating accumulation of solid waste.
- Extraordinary rises in the cost of health care.
- Revision of the "comfortable" image of medicine as practiced in past years by family physicians. With scientific and technological advance, the multivalent physician has been replaced by multiple physicians. How can we achieve personal patient-physician dignity and intimacy in an increasingly institutionalized setting which requires many primary participants?

People-centered strategies are needed. Until now we have viewed the bits and pieces separately. We have not really acknowledged in our plans and actions the effect the private sector has on the public (and health resources come largely from the private sector) nor how public responsibility can be assured in a largely private enterprise. Yet, public and private distinctions no longer seem very useful. How "public" is Medicaid or Medicare when their functions depend on voluntary actions of private patients and private providers? How "private" is a voluntary community hospital which depends on tax funds or tax relief? How "public" or "private" is the American Medical Association's income tax credit plan for health insurance?

Planning's Social System

As we do with most of our words, we have banalized the word "planning." It means whatever we want it to mean—or nothing at all. But, given the crisis surrounding a particular set of conditions, planning can mean quickened threat or high hope for accomplishments. Thus, I learn from examining the social milieu or system of planning as described by Dr. Sol Levine in the Seminar on Comprehensive Health Planning held at Johns Hopkins University School of Hygiene and Public Health, October 16, 1969. It is perhaps trite to say that social systems in this country are pluralistic. There are many sources of power and foci for leverage: discussion, persuasion, bargaining, and consensus among these several interests.

In health and its interlocks with other influences and systems, we find not one but many shifting, emerging, or receding power structures. This shifting and variety is often a shock when we seek the simplest way. In urban health we may sometimes find the traditional power of philanthropy or government chary to commit itself at the cost of votes, damage to corporate image, or possible adverse response to the power broker. Today we find new power structures, often of the poor or the black bringing new cards and heretofore unfamiliar community techniques to the bargaining table. So be it. Health institutions and professionals interact on the basis of their needs and their place in a dynamic, changing situation. To use an old word, it is a political process.

We might generalize and say that to do their "thing," organizations, whether hospitals, schools, or orchestras have three needs: (*a*) subjects (clients, patients, students, audiences), (*b*) staff—professionals and their support, and (*c*) equipment, supplies, buildings.

Organizations also interact with each other to exchange or achieve those three goals or needs. Joint effort, or cooperative planning, for example, depends on three dynamics of such interaction:

FUNCTION. If a new function is undertaken, the needs change. From Federal money or an executive board's interest, a health facility takes on teaching responsibility and needs teachers—or full-time staff. Thus a balance is shifted. Whom must it accommodate? What role should it assume to get teachers?

TURF. Role and posture are determined by consensus of others about that organization's geographic or functional domain. Today, as the institution seeks legitimacy from its neighborhood, it is finding its neighbors no longer passive but extracting changes or "prices" for that legitimacy.

DEPENDENCE. The extent to which the needs can be supplied outside the local system. In part, since other "Mayos" have grown up around the country and world, the Mayo Clinic now seeks to strengthen its posture within Rochester and Minnesota.

The planning agency, then, must ask itself what it can offer. External pressures, crises, may give areawide planning a negative clout, but that's short lived. I am talking here of quid pro quo, of negotiation, of who gets what, and what must be given to get it. Areawide planning's role can be facilitator, stimulator, provider of technical assistance, and staff to community. It can review and comment, perhaps approve or disapprove. What in a particular milieu should be its style? What balances among these methods? If we adopt the principle that areawide health planning is not the agency but the force of the concerned community then we may be able to take such factors in stride.

Aspects of the Health Care System

Comprehensive health planning is directed at the quality of life, at the health of the individual and the family in their environment. But we will need to focus on manageable tasks. Today we require different approaches to pursue environmental and personal health service issues. While we lack knowledge in the natural and social sciences for environmental strategies, we do have a body of knowledge, institutions, and technology which can be directed to personal health or medical care services.

To illustrate, focus on the health care system and its improvement. A first strategy need is to bring coherence and integration to the present patchwork of programs. Such a strategy should begin with the concept that the goal of our total health resources is to deliver comprehensive personal health care to all citizens and to view the components of service delivery as a people-centered system. This means arranging the full range of services in relation to each other—from prevention through therapy and from ambulatory through long-term care. Having done so, we usually conclude that our facility deficits seem to be for primary ambulatory care and for humane places where the elderly may live.

We should consider the components of a primary ambulatory care system to be offices of physicians in independent practice, shared offices and group practice centers, health department clinic locations or services provided or supported by health departments in other settings, outpatient departments of general and special hospitals, community mental health centers, and health components of other human service centers. We do not normally make such a grouping. But if we are to be systematic, we must.

If we consider the system of population grouping, an imperative in our health strategy should be to improve the quality, effectiveness, and accessibility of health care for the urban and rural poor. Their needs and health deficits read like a litany. The poor, who need the care the most, obtain it least. Kimble, a geographer, not a "health person," has put the need thus (*5*):

In the social drama sickness has a strong claim to being the arch villain. It is bad enough that a man should be ignorant, for this cuts him off from the commerce of men's minds. It is perhaps worse that a man should be poor, for this condemns him to a life of stint and scheming, in which there is no time for dreams and no respite from weariness. But what surely is worse is that a man should be unwell, for this prevents his doing anything much about either his poverty or his ignorance.

The poor need simply the medical services which are proved and widely available to some people but not to them. In other words, the widest expressed health care demand in our country today is not for artificial organs or transplants but rather for the now-commonplace results of laboratory and clinical research of 25 or 50 years ago (*6*).

Financing and Delivery Systems

The problem of costs enters all our deliberations in the health care field. If community public priority determinations are to be made and rational choices planned, runaway medical

price inflation is neither rational nor acceptable as a choice for public expenditures. And, unless we find a way to solve the problems of increased costs, we may lose our ability to meet other pressing needs. Health dollars, after all, can only buy what is there to be bought.

For a long time it was widely believed that the predominant barrier to good health care was financial—that given sufficient money anyone would receive the care he needed. Acting on this assumption, the nation invested heavily in financing medical care through Medicare and Medicaid, enabling millions to pay for care they urgently need and could not otherwise afford. But this vitally important step has increased demand for medical care and has enormously stressed the capability of the American health enterprise. Increased demand and patient loads, imposed on a relatively static and limited supply of health resources, have produced strong inflationary pressures and costs have shot upward. In short, while necessary, putting more money into the health system raises still other problems.

Further, where we put our money determines the shape and functioning of the system—"Willie Sutton's Law" of going where the money is. We need to understand the effects of what we are doing and, based on this understanding, hopefully achieve better balance in our health investments. For this understanding we have fairly good national data, derived from a variety of sources. We need regional, more localized data. At present, when we pursue such local information, we step into extremely sensitive areas. Planners must find the incentives for individuals and institutions, payors, and vendors to provide local parallels to the gross national health expenditure or investment picture.

Patterns of expenditures are revealing. For some time, health professionals have pointed out the need for greater attention to primary, ambulatory care. Crowded emergency rooms and citizen frustration indicate this need too. Economists tell us that as a result of the cumulative impact of our present financing mechanisms and service patterns, the system is swinging still further to institutional modalities. Here, I am not concerned with rising hospital costs. They should rise, with expanding technology and rising salaries. (The hospital orderly or aide is ill-equipped for involuntary philanthropy.) But, we must be challenged to seek out viable alternatives to this hospital leviathan—to develop components in the system which can intervene before the expensive modes are called upon.

In terms of people, thinking of Medicaid and medical indigency, we observe that as medical prices rise more people become medically indigent. Fearing the State treasury or Federal bank will be broken and responding to taxpayer revolts, governments are tempted to fiscal ceilings. Fiscal determinants do not reflect particular human health needs. Thus another system of issues appears. We say our hope is in our children and in young families. Yet our greatest involvement is in the care of the elderly. Nationally, about 31 percent of Medicaid funds are spent on nursing home care (about 25 percent in the Baltimore region).

Our physicians, hospitals, and health agencies are performing valiant and vitally essential services and have much to be proud of. They are doing more things well, for the benefit of more people, than ever before in history. But the enormous need for health care which has now become manifest, and the heightened expectation by all the people that these needs shall be met, have generated overwhelming pressure on our ingenuity and ability to fulfill these expectations.

Health care is an individual and family affair. It takes place in the community, and it depends on local resources acting locally—the health worker in the neighborhood, the physician, nurse, or dentist in an office or clinic, and the hospital surgical team. Because of the particular personal and local nature of health care, whatever we do must ultimately be responsive to community problems and community needs. In this context, we must search for changes in financing methods which help provide inventions for improved patterns of care. To be useful, resources must be relevant to local need and made available in ways that encourage local adaptation and synthesis.

Some Planning Method Systems

The data base. In addition to institutional workload statistics, which are many, countless other sources of data afford clues to where

health problems are and perhaps where intervention might be productive, for instance:

- Generally census tract demographic (vital statistics) information is available—but it needs to be interpreted and arranged.
- Travel time distances to and from any location were developed in our agency for transportation, mass transit, and market studies. They can be translated for health services planning. Physicians' offices are also facilities.
- Institutions, paying agencies, are just beginning to find out whom they serve and where their clients live. These and other utilization studies need to be encouraged.
- School dropout and crime rates give clues to mental health. These rates should be linked to use of mental health facilities.

Emergency services. Many persons are concerned about emergency services—those for whom the emergency room is the family physician, those who heroically provide services there, and the administrators and trustees. Too often, as in present Hill-Burton legislation, this service is viewed alone, rather than as part of a system. From a base study of emergency room utilization, strategic and holistic planning calls for reviews which include (*a*) alternative hours and locations for outpatient department, health center, physician services, (*b*) communications and air and ground transportation networks for sick and injured, (*c*) bringing ambulance services into the delivery systems—not just for highways, and (*d*) the pros and cons of a separately funded but complete emergency system.

The emergency medical service-system problem seems ideal for areawide health planning. It is basic to achieving primary care strategies, it is recognized by most all parties as a key problem, and at the outset its change is one of the least threatening to those involved. Its solution depends on effective regionalization, across jurisdictions, linking many and varied institutions.

The emergency medical system also seems to afford a likely place for a regional medical program—areawide health planning collaboration. To achieve qualitative improvement and better organization of care, the voluntary professional cooperation-peer sanction style of a regional medical program is essential. The regional medical program can act as a broker between physicians and education institutions and as a "governor" for quality standards. Under such aegis, highly specialized health care capabilities (as fixed or mobile coronary care) could be developed. In this cooperative alliance, comprehensive health planning would aid in mobilizing community support, including the political, financial, and managerial aspects to provide the environment and agenda for this qualitative improvement.

Consumers and the Advisory System

Much is asked about the comprehensive health planning advisory council system, about consumer-local government-provider relationships. As we view health system problems, it seems important to me to realize that each adviser-participant is bringing to the table special competence, but comes to the table as a layman. (At best, the consumer is an expert in consuming and in using institutions, the pediatrician in child development and using institutions, and the mayor in politics and the political impact of institutions and their use.) No one has the answers. If there were answers, we would not be at the table. It is true that in particular dimensions we have the technology, but somehow—and we have seen that money alone is not the answer—we have not yet been able to make it effective. In systems jargon, we call on a multidisciplinary approach, one that is hopefully better than the sum of the disciplines involved. That is the approach we should have in the advisory structure.

In the Baltimore region we are building a Citizens Advisory Council of less than 30 people—15 citizen-consumers and 12 citizen-providers. A larger group seems unwieldy and a smaller membership incapable of reflecting the divergences of the 2 million people living in the region or the multiple interests of the 2,000 physicians and 800-odd health and related associations and institutions. We have worked with existing community groups and with looser-formed groups of interested health providers to elicit their nominees for advisory roles. Our objective is to be open and to afford the widest possible opportunity for involvement. Since comprehensive health planning is

a political as well as a planning process, strong organizational backing and interested participants are essential.

In short, our concept is that consumers and providers will generate panels which select advisory council members who appoint specific project or problem teams.

To establish health planning as a continuous activity of cooperation, interaction, goal achievement, and evaluation, the Citizens Advisory Council will help the Regional Planning Council mold a permanent structure tailored to the Baltimore region and make policy and operational decisions in order to:

1. Develop the organization for comprehensive health planning.
2. Determine priority health problems affecting people within the region.
3. Form and carry out strategies for meeting health needs by supporting and assisting action programs and, above all, by coordinating and developing links between existing institutions and programs.
4. Develop guidelines for reviewing programs and proposals and for determining the priorities for funding expanded or new health facilities and services.
5. Provide information and assist institutions and agencies, neighborhood groups, and communities to aid their decision making in health matters.

Conclusion

We who are involved in comprehensive health planning are embarking on an exciting and at times frustrating adventure. I believe areawide health planning agencies—with a mandate from an involved advisory council of consumers, local governments, health service professionals, and providers—can and must become a vehicle for synthesizing health issues and resources and for achieving community responsibility in health affairs. The style of areawide health planning in developing health goals, policies, and strategies must be as catalyst, knitter, stimulator, and encourager. To do so requires nurture of similar activities in more local areas of the region as neighborhoods, for example. It requires the ability to influence, and be influenced by, planning in the larger region of which it is a part. No longer can we merely plan "for" or provide services "to." If we are all not "with" it, we must listen, find out why, test, and together forge anew.

We are striving to encourage not one partnership but many. Engaged with us are physicians, medical societies, hospitals, insurance carriers, labor unions, organized and unorganized consumers, and a myriad of interrelated activities in fields which have an impact on health.

In health affairs today, we are tackling one of the most complicated experiments in intergovernmental, interprofessional, interpersonal, and public-private relationships ever undertaken in American history Its real test comes in our communities. We must adjust our individual aspirations and fit them into the larger social setting. If we are to succeed, we must meet our responsibility—we have no other choice.

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Tearsheet Requests

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