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HEALTH SERVICES INTEGRATION: LESSONS FOR THE 1980s

Volume I

A Report of a Committee of the Institute of Medicine

June 1982

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NOTICE The project that is the subject of this report was approved by the Governing Board of the National Research Council, whose members are drawn from the Councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The members of the Committee responsible for the report were chosen for their special competences and with regard for appropriate balance.

This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an advisor to the Federal Government, and its own initiative in identifying issues of medical care, research, and education.

This volume is part of the final report of a study conducted under Contract No. 282-80-0043-SW, T.O. 2, with the U.S. Department of Health and Human Services, Public Health Service.

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PREFACE

Although there have been many attempts in the past--legislative and administrative--to improve coordination and integration of health services at the community level, many problems have remained. Concerned about correcting some of these problems, particularly those associated with the proliferation of categorical programs in the 1960s and 1970s, the U.S. Public Health Service in June 1980 commissioned a study of exemplary cases of health services integration. The U.S. Public Health Service was interested in learning how to decategorize or otherwise change federal policies and administrative processes to ensure that people's health services needs would be met without diluting the benefits of targeting scarce resources through categorical grants and entitlement programs.

The Institute of Medicine committee that was appointed to guide the conduct of the study on community integration of federally supported health services was blessed with an extraordinarily able project director, Helen Darling, and an excellent staff who worked very well with the committee.

The committee was carefully chosen to represent a wide range of experiences, disciplines, and points of view about health policy and health care. Private practitioners, health care administrators, health policy and health services researchers, health advocates, and individuals with broad policy experience at the federal and state levels labored hard and effectively together to develop a clear set of findings and recommendations from what appeared two years ago to be a very confusing picture.

Because the policy climate in 1982 is quite different from that in 1980, the findings are even more important, particularly those with respect to Medicaid, the need for local financial support, and the need for flexible federal support for comprehensive community health services. It is clear to me that a continuing strong federal role is essential--particularly in the funding of health services (Medicare, Medicaid) and in the funding of categorical programs for groups whose needs cannot or will not be adequately met at the local or state level (e.g., migrant workers, refugees, native Americans, etc.). The study is more important now for state and local policy makers than it might have been had the 1980 policies continued in place. The growing number of block grants provide states and local policy makers with the opportunity to meet local needs more efficiently and effectively, provided that federal and state funds are not reduced.

The study demonstrated that a variety of different models of coordination and integration are not only possible but desirable. Although many of the programs are facing critical funding problems, the contributions that these different approaches can make to health care cost containment must be appreciated and considered for further application.

The report is not the final word on integration of community health services, for issues will continue to emerge and new policies develop. Nevertheless, I believe the report and the background documents will prove valuable to those who must wrestle with these problems at the local, state, and national levels.

Philip R. Lee, Chairman
Committee on Services Integration

ACKNOWLEDGMENTS

Every study has its roots and continued sustenance in the ideas and work of many people. Because this study had a long, complicated planning stage, followed by a two-year period of research and writing, the Institute of Medicine Committee and the staff owe recognition and gratitude to many people whose efforts and contributions are not evident in the committee roster, the staff list, or the list of authors of papers in any of the four published volumes.

The study would not have existed without the early support and conceptual assistance of three people: Susanne Stoiber and Ronald Carlson at the Public Health Service, and Carleton Evans at the Institute of Medicine, now at the Veterans Administration. James McTigue, who became our project officer after Ms. Stoiber, is an experienced Public Health Service official and has been very helpful to us. At various points we were also assisted by Herman Schmidt and Joyce Johnson.

At the Institute of Medicine, we have benefited substantially from the continuing advice and assistance of Karl Yordy, Director of the Division of Health Care Services. William Lybrand and Bradford Gray have also been valued colleagues. Jennifer Kalkhof merits special thanks. She has been indispensable to the successful execution of this large, complicated study. I also want to thank the particularly dedicated staff members who worked long hours over many months under a great deal of stress, particularly at the end. They include Jessica Townsend, Michael McGeary, Sherry Snyder, and Rick Baltzegar. More recently hired or part-time staff members who have also earned special recognition include Linda Lipson, Barbara Dunham, and Susan Hahn. Deborah Blacker, a Fellow from the National Research Council, and Elayne Kornblatt, Ph.D., a consultant, deserve a great deal of credit for their field work as part of the research for six case studies.

Before we began the research and during the review period, we obtained useful advice on the issues that needed to be addressed, the research design, the conceptual framework, and the background papers from Linda Aiken, Jerry Charles, Carroll Estes, Helene Lipton, Hal Luft, Fitzhugh Mullan, Beverlee Myers, Bob Newcomer, Steve Schroeder, Anne Scitovsky, Steve Shortell, Jonathan Showstack, and Bruce Vladeck. Kate Bauer Sommers and Ilissa Light helped us in an early stage of the project by preparing a background paper and related materials. During the project very useful staff papers were also prepared for the committee by Beryl Radin, Merry-K. Moos, Roger Morsch, Mark Segal, and Richard Scheffler, assisted by Mary Haan, Deborah Haas-Wilson, Leonide Martin, and Mary Pittman Lindeman.

CHAPTER 1

INTRODUCTION

Statement of the Problem

Despite what seems to be the availability of a comprehensive array of health services and the large and growing public expenditures for health care, there are still people in the United States who do not always get the health care that they need, or who do not receive care that is efficient or effective. This report is concerned with one important set of reasons why this occurs--fragmentation and gaps in the financing and provision of personal health services, especially for those with low incomes.

Such fragmentation occurs when a patient has needs that a particular provider is not organized to meet, when multiple independent organizations must be involved in meeting those needs, or when a patient lacks the money to purchase needed services and is not eligible to receive them under the rules of particular programs.

Public interest in solving these organizational and financing problems has grown as the costs of health care have become an important factor in the overall inflation rate. Total health care expenditures in the United States in 1981 totaled $278.5 billion or 9.6 percent of the gross national product, approximately $1,215 for each person in the country. Not only is the expenditure large, but it continues to increase rapidly--up 71 percent since 1977, with a 13.5 percent average annual increase projected to 1985. (Freeland and Schendler 1981).

People in this country obtain health care from a host of providers, programs, and institutions. Health workers include 450,000 physicians, more than 1 million nurses, and many others, for a total of over 7 million, making the health industry a major source of employment in the nation. Health facilities include roughly 7,000 hospitals, 800 community health centers, and 18,000 nursing homes.

The federal government has substantial interest in what happens to health care in this country and the federal portion of outlays for health was $76 billion in 1981 (Table 1). The bulk of these expenditures derives from federal responsibilities, direct or indirect, for the provision or financing of health care for

TABLE 1 Federal Outlays for Health ($billions)

Major Programs	Actual 1970	Actual 1981	Estimated 1982	Baseline Projection 1983	Baseline Projection 1987
Health[a]					
Medicare	7.1	42.5	49.7	58.2	103.1
Medicaid	2.7	16.8	17.9	20.1	30.5
Other Health Services	1.3	4.5	3.9	3.7	4.6
Health Research	1.1	3.8	3.8	4.0	5.0
Other	0.9	1.8	1.8	1.7	1.8
Subtotal	13.1	69.4	77.1	87.6	145.0
Medical Care for Veterans[b]	1.8	7.0	7.5	7.8	9.1
Pay Raises	--	--	--	0.4	2.5
Total	19.4	76.4	84.6	95.8	156.5

NOTE: Details may not add to totals because of rounding.

[a]The outlays shown under Health include all those of budget function 550.
[b]The outlays shown here include all those of subfunction 703.

SOURCE: Congressional Budget Office 1982.

specified populations. There are numerous federal and other public programs designed to meet specific needs of persons who, it is assumed, might not otherwise receive health care or who might have difficulty paying for that care.

In spite of this substantial investment, many problems of health care organization and financing remain. Some programs are referred to as "categorical" because payment is available to providers only for specific services or for people who meet particular criteria. These categories often present barriers to the provision of continuous and comprehensive care, desirable characteristics of primary care as identified by the Institute of Medicine (Institute of Medicine, 1977). Even when people are entitled to a broad range of health services through reimbursement programs or vouchers, well-integrated care is not always insured as is evident in the services provided to Medicare and Medicaid beneficiaries. Barriers to individual efforts to integrate their own care often still exist. For example, services cannot be obtained when there are no providers to offer the services, or when providers will not accept

certain patients (e.g., those covered by Medicaid). Similarly, there are circumstances where people, for whatever reason (e.g., education, language barriers, transportation), cannot and do not take advantage of available services.

Origins of the Study

As part of federal efforts to reduce compartmentalization and fragmentation of health services, a study of exemplary cases of integration was contracted to the Institute of Medicine (IOM) of the National Academy of Sciences in July 1980 by the Public Health Service, U.S. Department of Health and Human Services. The Public Health Service wanted to find ways in which the federal policy process could be altered to ensure that people's needs would be met without reducing the benefits or weakening the intent of categorical grants and entitlement programs for those severely in need or for special populations, such as migrant workers. The committee appointed to guide the study found that services integration problems are not restricted to government programs nor to the medically needy. However, because the study had to be held to a manageable scope and to be most useful to public policy makers, the committee decided to concentrate its efforts on public programs aimed at the underserved.

This study was intended to document exemplary instances of the integration of health care programs into a better configuration of services to see what can be learned from the cases that might be applied in other places, and to make policy recommendations to the Public Health Service that could facilitate integration and coordination of health services. Because most of the health services grant programs of particular interest to the Public Health Service involve the provision of ambulatory care to underserved populations, the study was concentrated on ambulatory care projects.

The study did not specifically address the issue of whether services integration is compatible with strategies to encourage more competition among those providing health services. However, two of the case reports--Project Health in Oregon and San Luis Valley HMO in Colorado--were concerned with integrative financing arrangements that have the potential for being compatible with some of the proposed approaches to health care financing intended to stimulate competition. Indirectly then, there should be useful information from those experiences.

As discussed in Chapter 4, the committee believes that a medical care system that was explicitly constructed as a two-class system was not desirable. Therefore, this study did not consider whether services for the poor should be different from those for the nonpoor, although the findings and recommendations should provide

information to improve efficiency in the use of public funds for the poor.

The committee's specific charge was to:

- assess selected federal, state, and local (including the private sector) experiences in the coordination of services and the development of service linkages, particularly for health care benefits to targeted population groups, for management and administrative effectiveness and efficiency, and for control of program costs

- characterize integration efforts that appear to be most suited to various specific situations

- identify conditions that affect the attainment of the most effective integration of services

- make recommendations regarding steps that could be taken by the federal government to improve planning and administration

In fulfilling the charge, the committee delegated to the IOM staff the conduct of 22 case studies and reports. The case studies were intended to be useful to program administrators who want to integrate and deliver services under existing health and social service policies, programs, grants, and regulations.

The study's approach to the case studies and reports was aided initially by a statement on services integration made by Elliot Richardson when, as Secretary of Health, Education, and Welfare, he was pressing for national legislative action (1976):

> Services integration refers primarily to ways of organizing the delivery of services to people at the local level. Services integration is not a new program to be superimposed...rather it is a process aimed at developing an integrated framework....Its objectives must include such things as (a) the coordinated delivery of services for the greatest benefit to people; (b) a holistic approach to the individual and the family unit; (c) the provision of a comprehensive range of services locally; and (d) the rational allocation of resources at the local level so as to be responsive to local needs.

This description was helpful to the committee in its early tasks of defining the concept in operational terms and designing a feasible study.

The programs selected for study were mainly providers of ambulatory care in the public sector. Such programs are substantial

sources of care for the underserved in the areas examined, and often these are the only programs that have as one of their primary aims the provision of integrated health services of those persons. The committee chose the programs on the assumption that they could provide information of most interest to the public sector in the 1980s. The case study method was deemed best suited to an exploratory study in which there was an incomplete theoretical base to generate testable hypotheses and insufficient time and money to complete a more quantitative population-based study.

This report describes how state and local organizations have managed in quite different ways to reconcile conflicting interests, to overcome difficulties, and to bring together successfully the resources, facilities, people, and funds in public and private networks that make possible more effective and efficient organization of services. The study describes and tries to document the roles of advocates, administrators, providers, and politicians attempting to improve services for people in an economical manner. The cases described in this report show that these tasks are never easy and are never finished. In these times of reduced resources, the committee believes that these histories, analyses, and records of achievements and of difficulties encountered, false starts, and failures will prove to be useful.

The Committee and its Activities

The committee represents varied experiences in medicine, nursing, public health, community health centers, migrant health, medical education, health policy, health services research, medical care administration, state legislatures, and administration in federal, state, and local government, as shown in the biographical sketches (Appendix A). The committee had representation from the private, the public, and the nonprofit sectors.

The committee met five times over the study period: the first meeting was in December 1980; the last, March 30-31, 1982. The committee instructed the staff to conduct detailed analyses of six programs; less intensive studies of 16 other programs augmented the range of cases. A brief description of the studies and reports is contained in Appendix B. The rationale for this approach, the conceptual framework, and the methods used for both types of studies are discussed in detail in Appendix C and are described in Volumes II (case studies) and III (case reports).

At each of its meetings the committee discussed background papers and research reports on the cases under study by the research staff. During the last two meetings, the committee reached agreement on its findings and conclusions and decided what policy recommendations were warranted. The results of those deliberations are presented in the balance of this report.

Background papers on issues of importance to the committee were prepared by staff members or were commissioned from consultants in order to broaden the committee's understanding of particular topics. A selection of these papers is published separately as Volume IV.

Another major source of information for the committee was an open forum held at the National Academy of Sciences on February 8, 1982. A list of participants and a summary of their remarks are in Appendix D. Written submissions and tapes of the proceedings are available at the archives of the National Academy of Sciences.

Assumptions

The committee recognizes that problems of fragmentation are deeply imbedded in the organization and financing of American health care. This dilemma reflects a political system that encourages "disjointed incrementalism" and sometimes political stalemate (for an excellent summary statement on this subject, see Mechanic's quote at the beginning of Chapter 2). Attempts to deal with complicated issues in a free society will always be difficult, and debates will be constantly subject to the clash of various interests. The health system is important to all citizens in one way or another and is highly valued by most people. The health system also encompasses some of society's most affluent and best organized groups and some of the largest and most widespread industries and organizations. Any effort to change any part of the health system, its organization or financing, can arouse any one or all of the special interests in health. The committee tried to find ways to address the problems of fragmentation and compartmentalization without a fundamental restructuring of the health system.

Because there are so many resources involved in the provision of health care, some people assume that there are enough grants, program entitlements, and organizations that together cover virtually everyone for health care. Beginning in the early 1970s, observers increasingly began calling for improved coordination of services, more integration, and better management of services, sometimes implying that better coordination and integration were all that was needed because these changes would (a) save money and (b) create a leaner and better health system by reducing overlap and duplication. Duplication of services, excess hospital beds and equipment, maldistribution of physicians, administrative inadequacies, ill-advised federal policies, stubborn or mediocre bureaucrats, were considered as important culprits. Certainly in some instances these are problems that need to be attacked. But this study found that coordination will not solve all of the access problems. There are still some locations, especially those with limited Medicaid programs, where there are virtually no free or low-cost services and where the eligibility criteria and scope of benefits are limited. National surveys also show comparatively low utilization of health services by low-income children and minorities (Kleinman et al. 1981).

The Committee's Concept of Services Integration

"Services integration" has never been satisfactorily defined, as discussed in detail by Baumheier in Volume IV. The committee hopes to facilitate understanding by calling attention to examples of administrative arrangements or techniques that were aimed at improving patient care by combining grant funds, establishing coordinative arrangements or linkages, or creating networks for ensuring the flow of patients from one part or type of service to another.

The committee observes that services integration is good in principle, and its goals are often worth pursuing, but there are instances in which elements of fragmentation may serve worthy purposes. An example of "good" fragmentation may be health services to adolescents, who may make better use of services that they can use separately from parents or neighbors, so that their relationship with a health care provider remains confidential. The goal should be an optimal configuration of services that often will be achieved through better integration.

Some of the advantages of a highly integrated, comprehensive setting can be achieved through other organizational models, such as coordinating or network arrangements, including many that are informal.* New coordinating and/or regionalized arrangements often allow individual units--health centers, hospitals, voluntary agencies--to keep their institutional identity and negotiate as partners or equals while benefiting from sharing services, cost-effective purchasing arrangements, and shared personnel.

Earlier Integration Efforts

Many of the issues with which the committee grappled have been recurrent in U.S. history. Health services integration was first identified as a major problem in 1932 by the Committee on the Costs of Medical Care. But the complexities and frustration associated with fragmentation of care have grown with increasing specialization; significant increases in the number of grants, entitlements, and health programs; and the increased scale and complexity of organizations, including government. Previous attempts to resolve some of the problems are discussed in Chapter 2 and in Appendix F.

* The value of informal arrangements and working agreements tends to be underestimated and often is not acceptable to federal or state administrators. Such arrangements are difficult to document, let alone replicate or mandate. Yet some of the best arrangements are informal, and requirements (often federal) to have written agreements may force issues that cannot be drawn as a contract.

These efforts have been undertaken, among other reasons, to compensate for the lack of consistent national health policies, which leaves gaps in financial coverage or available care. In turn, the lack of national health policies is a result of the absence of a broad-based consensus on many policy issues: (a) whether health care is a right or a privilege, (b) what the appropriate role of government is in health care, and (c) what the best ways are to organize and finance health care.

Some Factors that Influenced the Findings and Recommendations

Political and Economic Environment

The field research delegated by the committee was conducted between March 1981 and March 1982. The committee's meetings--from December 1980 through March 1982--covered a period of great economic and political change. The programs under study were buffeted by shifts in health policy and were coping with worsening economic conditions, as well as recent federal program changes and budget cuts for categorical grants. But at a broader level, the study takes place in a context affected by four major influences that will substantially shape the future of health care in the United States.

First, the most important factors influencing health services and future policy directions are connected with the economy. They include high rates of interest and inflation, an economic recession and high unemployment, and stagnating or declining productivity. The general economic factors vary from state to state, but three of the cases studied were in states suffering from unusually high fiscal stress (Massachusetts, Michigan, and Washington). In some states the economic conditions and the rising cost of public programs have led to "taxpayer revolts" (e.g., Massachusetts and California), which in turn reduced state and local tax revenues or placed limits on expenditures.

Second, the continuing rapid rise in health care costs--a growing national problem since the late 1960s--is having a major impact on local health services. Health care costs, particularly hospital costs, have risen more rapidly than the consumer price index for many years. The deleterious effects of health care cost inflation have been exacerbated by the lack of growth in the economy, which previously had helped to absorb the impact of health care price inflation on the costs of the biggest federal and federal/state entitlement programs--Medicare and Medicaid. As the costs of Medicare and Medicaid entitlements have grown, mostly because of the rising cost of medical care rather than the increased number of beneficiaries or a broader scope of services, there has been a deterioration in the capacity and willingness of governments at all three

levels to raise the larger sums of money to pay for the increased costs of medical care, let alone to expand coverage in existing programs. Cost-containment policies are high on the political agenda. If these policies are successful, the subsequent slower growth in expenditures for health care is likely to result in substantial realignments and clashes in the health system as the nation's health groups (e.g., hospitals, physicians) struggle to preserve their roles and influence.

The third important contextual factor is the aging of the population, which increases its need for health care and social services. The growing numbers of elderly, especially those over 75, are well documented (Estes 1979; Kingson and Scheffler 1981). The rapid increase in medical costs and the substantial portion of Medicaid costs for services for the elderly reflect the growing numbers of elderly, their disproportionate burden of chronic illness and disability, and the incentive for physicians to treat the elderly in institutions whose costs are based on capacity for acute care. The integration or coordination of health, nutrition, and social services at the local level is particularly important for the elderly because of their multiple medical and social needs; because of the large number of the very old who are widowed, divorced, or never married and thus often have minimal social networks; and because so many are poor and lack the money to buy the necessary services. Projections concerning the future effects of these demographic and economic changes are striking. If rates of use by age groups remain roughly the same, according to Russell (1981), by the year 2040 there will be 1,621 hospital days per 1,000 population, as contrasted to 1,241 per 1,000 in 1975, and 12.8 residents in nursing homes per 1,000 population in 2080 versus 5.4 in 1975.

The increasing supply of physicians, a fourth factor affecting the context of the study, is already being felt in some places. Its possible effects have been described by Ginzberg and colleagues (1981) and Davis (1981).

The Changing Policy Environment

There were significant changes in the policy environment between the time this study was planned (summer 1980) and the time this report was written (June 1982), including:

- a significant reduction in federal expenditures for domestic social programs and health programs not based on entitlement (e.g., Medicare)

- decentralization of program authority and responsibility to states, particularly through a few block grants instead of multiple categorical grants

- initial steps toward deregulation of the health system and greater emphasis on market forces and competition to address problems of rising costs of health care

But the changes resulting from the Reagan administration and the Omnibus Reconciliation Act of 1981 do not affect the usefulness of this study, although the changes added to the number of questions asked in the field work and led to revisions in some of the types of questions asked. There are still numerous federal and federal/state grant programs and different entitlements, and problems of fragmentation will remain. Many of the questions of flexibility and accountability in administration are universal. Decentralization to the states or recentralization to central government have been serious issues since the founding of the country. Also, as seen in Appendix E, there is a history of "recategorization" of block grants, so the general grants may again become narrower in future years.

From 1980 on, there are likely to be substantial realignments in the health system, as the nation's health groups struggle to preserve a balance or achieve an appropriate mix between these acute care services currently reimbursable and other services that are not covered. The problems being faced in the 1980s are for the most part not new, although the fiscal and economic environments in which the problems are being addressed are different. Moreover, expectations that the problems can be easily solved through public policies have been lowered by 15 years of experience.

Organization of the Report

This report of the committee's conclusions and policy statements is Volume I of four volumes that present the entire product of the study. This first chapter of the volume has provided the general background for the study, some reasons for its focus, and factors that influenced the committee's view of the 1980s. The next chapter discusses background issues and earlier attempts to deal with problems of fragmentation in health care and to remove obstacles to more effective coordination of services. The emphasis is on those successes or failures that provide useful lessons for the 1980s. Chapter 3 summarizes the field research conducted by the staff of the Institute of Medicine. The chapter reviews the major findings of the 6 case studies and the 16 case reports. Chapter 4 presents the committee's findings and recommendations.

Volume II of the study present the six detailed case studies and a cross-case analysis. Volume III presents the 16 case reports and cross-case analysis. Seven papers commissioned by the committee are published in Volume IV.

CHAPTER 2

BACKGROUND OF SELECTED ISSUES AND PROBLEMS

Today's extent of fragmentation in the financing and organization of federally funded health services has been a long time in the making. Government responses to many different specific needs for health care over the years seldom took into account the effect that such programs could have on each other. This chapter reviews the growth of federal grant programs and the structural context in which they helped contribute to the current disjointed situation. It also reports differing viewpoints on various types of federal assistance for health, describes the present organization of federal health programs, and discusses some efforts by the federal government to lessen its influence for fragmentation. A more detailed history of federal grants is presented in Appendix E of this report; greater detail on federal efforts to overcome fragmentation is in Appendix F.

Sources of Fragmentation

Some problems in fragmentation of services and financing come from the government's efforts to meet needs or correct failures in the health system. As Mechanic (1981:8) has noted:

> Since government intervention takes place within the context of vigorous interest group politics and within a value system critical of such government intrusions, governmental inputs occur at the margins rather than at the core of problems....Government involvement comes not through a few broad strokes but rather hundreds of programs and thousands of guidelines and special criteria. Each program developed to attack some special categorical or administrative concern has its own specifications, conditions for eligibility and administrative guidelines....In each instance, the specific criteria and guidelines can be justified, but in the aggregate they often work at cross purposes and the cost invoked in monitoring and compliance can be staggering....

As of 1982, hundreds of laws authorize the provision of health services, economic assistance, or social supports for individuals with particular characteristics, needs, or entitlement. Public programs form part of a huge health care system that grosses more than $278.5 billion a year. It is still mostly private, although increasingly organized and financed by public funds (Roemer 1981). A complex mixture of public and private institutions and public and private financing makes the U.S. system particularly hard to analyze.

"Categorical" funding grew as government responded to specific needs for care, such as preventive services for maternal and child health, and services to crippled children and migrant workers. At no point did the Congress decide to provide services or financial coverage to everyone who might need them. Rather, each particular health problem, disease, or subgroup of the population had to be shown to be (a) a serious national problem that would not be solved without federal intervention, (b) deserving attention and help, and (c) in the national interest to remedy. With each decision, a categorical or entitlement program was created, usually after a concerted campaign to document unresolved problems, such as marked disparity in health status of whites and blacks, and bring them to the attention of the Congress.

The creation of special programs began in the eighteenth century with the establishment of the U.S. Public Health Service, which was intended to care for sick merchant seamen. Entitlements to direct care or payment for care from the government were expanded during the nineteenth century to support disabled veterans of the armed services. Entitlements increased further during the 1930s to meet the most pressing needs of victims of the economic depression. The trend toward specific programs to help one group or another--termed "categorical" because the recipient had to fit within a particular category--peaked during the 1960s and early 1970s.

In recent years few laws have been enacted to launch new programs, possibly reflecting recognition that piecemeal approaches to solving the health and related social problems of specific populations can result in piecemeal services, inefficiently organized and delivered. Problems are viewed as resulting not from the absence of services and entitlements, but from an absence of the coordination of services that are needed to ensure that the correct and least costly service is delivered at the appropriate place and time.

Lack of coordination between and among different programs is one of the roots of public criticism. On the service delivery side, the multiplicity of services in a given community may be offered in ways that are inconvenient, inaccessible, or simply unavailable to needy people. Services available to help a family with a constellation of problems--such as unemployment, alcoholism, child abuse, and undernutrition--may be located in seven or more public and private agencies, each occupying its own space and having its own eligibility rules, payment requirements, and hours of service. Each agency may

be staffed by professionals who rarely talk to staff of another agency and almost never share their records about a client. On the administrative side, each of these agencies employs staff to raise funds, to make its services known, and to record and report its activities and costs in ways that will satisfy the requirements of the many other agencies to whom they may be accountable at city, county, state, regional, and federal levels. This fragmentation both makes services hard to find for would-be clients and costly to offer for the agency.

The general problem can be illustrated by a brief look at federal programs for the elderly. According to Binstock (1979), writing in a National Journal Issues Book on aging, in 1978 there were 134 health and social programs designed to benefit people 65 and over. The programs can be categorized as:

- public financing (e.g., Medicare)
- direct service (e.g., care for the elderly, veterans, Indians)
- formula grants to states (e.g., Medicaid)
- project grants (e.g., nutrition programs).

Each of these major kinds of programs operates under different types of legal authority and has markedly different characteristics in terms of service delivery and administration. The federal Department of Health and Human Services has several major operating components, each providing services to the elderly (e.g., the Health Care Financing Administration; Office of Human Development Services [Administration on Aging]; Public Health Service). To complicate matters further, other agencies of the federal government are responsible for the many support service programs that directly bear on elderly people's health and access to health care. Examples include the Department of Agriculture (food stamps and nutrition programs), the Department of Housing and Urban Development (independent living for disabled people), and the Department of Transportation (access to health care facilities). Each of these departments often has an equivalent in state government and again in local government. There also is a third group of agencies that carries out certain functions for government--the private, nonprofit organizations.

Fragmentation may be the rule, not the exception. As one observer notes (Brody 1979:18):

> Health services for the aged are multiple, parallel, overlapping, non-continuous and, at the very least, confusing to the elderly consumer. Rarely do they meet the collective criteria of availability, accessibility, affordability, adequacy and accountability, or offer continuity of care in a holistically organized system. Planning for health services for

the aged is similarly confused. Parallel systems of services have their own planning mechanisms. As a result, the various planning efforts overlap, contradict, and are unrelated one to the other.

Causes of fragmentation often are built into the structures and processes of government, as the following paragraphs make clear.

The Legislative Process

The congressional processes by which programs are authorized, funded, and monitored have imposed basic structural problems. A number of authorizing laws have created a diversity of programs, each operating within its own framework of legally mandated and administratively defined regulatory responsibilities and constraints. The process contributes to these idiosyncracies:

- Different committees of Congress may initiate legislation authorizing programs dealing with the same issue. For example, during the early 1970s, 14 committees were responsible for initiating programs concerned with the problem of drug abuse.

- Congressional oversight of similar programs is provided by different committees.

- Congress deliberates on the reauthorization of related programs in different years, because of the review processes of different committees. Moreover, attempts at reform often cannot overcome the political ramifications: for example, changes in the welfare and food stamp programs, such as substituting additional cash assistance for food stamps (i.e., "cashing out"), would remove the program from the control of the Committee on Agriculture and move it to the Ways and Means Committee.

- Laws that create new agencies or assign responsibilities to existing agencies rarely call for mechanisms to coordinate the new services with those already being provided to the same population group by other programs or agencies.

- Programs are funded in a variety of ways, using a variety of matching formulas, grants, and contract mechanisms, and with a variety of funding application cycles.

- Each program has its own:
  - -- sponsoring bodies or other specified authorities to whom it must report, each with its own set of guidelines or regulations

-- eligibility requirements for the people it serves, relating to residence, age, sex, income, assets, home ownership, employment, marital status, previous employment, ethnicity, citizenship, living arrangements, etc.
-- benefits and benefit limits
-- client cost sharing and provider payment arrangements
-- reporting forms and definitions of service ("primary care," "visit," etc.)
-- audit cycles.

Administrative Requirements

There are hundreds of large and small administrative requirements for grants, contracts, and services under federal and state programs that are attached to grants and contracts regardless of the subject. There are many conditions of aid and direct orders that must be met if any federal funds are accepted,such as the Office of Management and Budget's Executive Order A-95, the Davis-Bacon Act, Civil Rights Act, and numerous other conditions. Many of these requirements frequently are viewed by local officials and health providers as expensive, unnecessary, and even counter-productive. Table 1 shows the number of these requirements, indicating how obtrusive other levels of government might seem to be. The effect of all of this is to greatly reduce the control of local governments over their own policies (Lovell 1981).

TABLE 1 Number of Federal and State Mandates by Year of Imposition or Major Amendment by Direct Orders and Conditions of Aid (DO and COA) for Federal and State Grants-in-Aid or Direct Mandates

Years	Federal		State	
	COA	DO	COA	DO
1941-1945	0	0	1	77
1946-1950	0	8	0	276
1951-1955	2	0	0	99
1956-1960	2	2	1	79
1961-1965	24	5	2	250
1966-1970	92	43	38	365
1971-1975	559	109	53	1,040
1976-1978	354	57	30	625

SOURCE: Catherine H. Lovell (1981) Evolving Local Government Dependence. Public Administration Review 41(January):189-202.

Organizational Tensions

In addition to the fragmenting influence of separate authorizing laws, appropriations, implementing regulations, and efforts to maximize revenues or shift cost burdens, other impediments to services integration include:

- tensions between federal or state agencies responsible for seeing that taxpayer money is spent only as stipulated by the authorizing laws, and the local or state recipient bodies who want maximum flexibility to administer programs

- pressures of constituencies that wish to preserve the autonomy of their own programs, even while advocating abolition or consolidation of other programs

- disparate objectives of those who see services integration as a means to cut expenditures for programs and those who see it as a means to improve the cost effectiveness of programs

- an organization's fears of losing control

- "turf guarding" by organization staff.

Federal Grants System

The federal grants system is in itself a major hindrance to integration of services. The history, growth, and rationale of federal aid to state and local governments--the federal grants system in general, with a special emphasis on health, and the advantages and disadvantages of the various types of aid are discussed in detail in Appendixes E and F. This history can be summarized as one of growing federal aid with each new grant program created by demands for specific problem resolution, reaching into more areas of life and covering more people, and having various mechanisms to encourage states to take care of some problems that they might not have addressed without federal grants. The federal grant system came under criticism as early as 1949 when the Hoover Commission called the system wasteful and duplicative. In 1955 the Commission on Intergovernmental Relations (Kestenbaum Commission) made several recommendations to improve and simplify the grant system. However, many of the problems of federal grants resist easy solutions, as revealed in a discussion of the development of the grants-in-aid system in the United States (see Appendix E, and Hovey in Volume IV).

In particular, categorical grant making reflects the problems and competing forces that affect reform of the grants system. Categorical grants tend to be reinforced by the political incentives that face Congress, and by the institutional structure of that body. Congress is highly decentralized; each committee is composed of numerous subcommittees. Organizational decentralization favors, if not impels, a decentralized and categorical approach to grant legislation. Career advancement within Congress, and reelection to Congress, depend to a large degree on the successful manipulation of the categorical grant system.* Consolidation is hampered by the spread of functionally related grants among many subcommittees. Although health grants tend to be focused in fewer committees, heavy committee workloads seem to preclude much active coordination (Advisory Commission on Intergovernmental Relations 1977, A-52). Moreover, there is a so-called "iron triangle" that generally favors categorical grants; it is composed of special interest groups, congressional subcommittees, and executive agency staff directing these programs. These forces have been relatively effective in the continuation of categorical preeminence. Federal executive and state and local lobby group pressure for block grants has not been able to reverse this situation, but it appears that the Reagan administration has had some success in challenging many of these iron triangles, at least in its first year (1981-1982). The benefits of recent grant reform may be impossible to discern because the amount of funds available for the grant programs has been so sharply reduced.

Various Views of the Federal Grants-in-Aid System

Since one of the objectives of the study was to find out how federal funding decisions could be modified to achieve more services integration, attitudinal data, particularly from those affected by federal grants, were examined. In this section, evidence is summarized concerning the reported advantages and disadvantages of various forms of aid from the perspective of different levels of government.

Federal Government

A survey of federal grant administrators, conducted during the mid-1970s, found them generally satisfied with their own categorical programs (Advisory Commission on Intergovernmental Relations 1977, A-54). They expressed a need for larger authorizations and appropri-

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* For a good presentation of this process, see Morris P. Fiorina (1977) Congress: Keystone of the Washington Establishment. New Haven: Yale University Press; and James L. Sundquist (1981) The Decline and Resurgence of Congress. Washington D.C.: Brookings Institution.

ations and for more adequate funding of their own administrative needs. Only 18 percent of administrators surveyed felt general revenue sharing or block grants would enable states to better meet program needs. At the time of the survey, administrative decentralization had been increasing (between 1969 and 1975), and survey respondents generally were favorably inclined toward it. Grant consolidation efforts were given mixed reviews, and this was generally due to the separate objectives of the merged programs (only 7 percent of the respondents had been involved in grant consolidation, mostly in the Office of Education). Forty-three percent of the respondents felt that the ability to transfer funds between categorical grants would help the grant system.

Public Health Service (PHS) respondents felt strongly that improvements in monitoring capabilities were needed. Only 4 percent of the PHS respondents felt that block grants were better than categorical grants. Forty-one percent felt that increased use of inter-grant transfers would be good.

State Government

State administrators, based on two surveys conducted during the mid-1970s, were dissatisfied with the extent of federal interference in categorical grants and felt that federal aid tended to skew state priorities and interfere with state roles (Advisory Commission on Intergovernmental Relations 1977, A-54). Respondents felt that project grants had more onerous conditions than formula grants (see "Client Viewpoint" for a definition of these two grants).* Generalist officials tended to like general revenue sharing, block grants, and other less-functionalist forms of aid. Respondents believed that strong political support for a program greatly diminished the changes that would occur with reduced federal management, highlighting the importance of constituency support in determining the fate of categorical programs transferred to the states. Uneven or lessened state-level constituency support for health programs is likely to result in substantial program changes, particularly where a national program has a relatively small yet nationally important constituency that is irrelevant in the context of state politics.

The National Governors' Conference was in favor of increased block grants, formula rather than project grants, elimination of matching and maintenance of effort requirements, fewer grant conditions, and the maintenance of federal expenditures for consolidated programs (Advisory Commission on Intergovernmental Relations 1977, A-54).

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* This study did not distinguish between the so-called crosscutting mandates, such as equal opportunity requirements, and the requirements relating to the specific purposes of a particular grant.

Almost all states reported that they were generally satisfied with the health block grant in 1975 (Advisory Commission on Intergovernmental Relations 1977, A-56). The major complaints concerned inadequate funding. Flexibility and simplicity of administration were viewed as the major advantages of the block grant. The disadvantages were low or uncertain funding and the inability of the block grant to generate enough political support to maintain individual programs. By and large, the states preferred that expansion in federal-state health grants be in the form of block rather than categorical grants. Still, there seemed to be a major concern that grant consolidation would generally entail budget cuts.

Local Governments

City and county officials have generally been dissatisfied with categorical grants because they have skewed local priorities and have been quite difficult to plan for (Advisory Commission on Intergovernmental Relations 1977, A-54). These officials felt that, contrary to conventional wisdom, block grants stimulated more local activities than categorical grants. More than three-quarters of the local officials felt that local nonmatch spending was affected by the particular block grant received. According to the survey, central cities were the most inclined to replace block grant funds with local funds, counties the least. Given the small number of block grants in existence at the time of this survey, the implications of this finding are not clear. Notwithstanding their initial preference for block grants, local officials indicated that the discretionary nature of state distribution of block grant funds led to increased local uncertainty.

In general, "red tape" seems to have been a more serious problem concerning state rather than federal involvement, particularly for project grants. In 1976, both the U.S. Conference of Mayors and the League of Mayors went on record in favor of increased grant consolidation. At the same time, they wanted mandatory pass-through of federal funds to localities rather than to the states, a decrease in program regulation, increased local control, and increased federal-local allocation. The limited scope and number of program categories was not seen as a major problem. Nor were fund allocation policies, performance standards, or centralized decision making. Rather, the major problems were the volume of paperwork, processing delays, and specific financial management requirements. General revenue sharing was not viewed as a substitute for the funding of particular objectives but rather as a supplement. During the present battles over grants it appears that mayors are worried both about funding cuts and the manner in which the states will administer these reduced funds.

Client Viewpoint

Formula grants* tend to reduce uncertainty for clients but may also spread available resources too thinly (Advisory Commission on Intergovernmental Relations 1977, A-52). Project grants may allow the targeting of resources to groups of clients most in need; however, these grants may maximize programmatic uncertainty and, hence, client uncertainty. The discretionary and limited funding nature of project grants may also lead to the exclusion of some client groups from the grant program. Block grants will tend to impose many of the same problems as formula grants. Still, low block funding may be compensated for by the adequate use of categorical grants. In the current grant system, all grant mechanisms suffer from many of the same problems when it comes to clients. Available evidence seems to indicate that the degree of political power that a client group has, at any level of government, will be the most important factor in terms of funds received. A group whose political power is relatively stronger nationally is unlikely to gain from the consolidation of its categorical grants into a state-administered block grant.

The advantages and disadvantages of various types of federal assistance are summarized in Table 1 in Appendix E and relate largely to differences in federal versus local priority setting, control, and administrative discretion; inflexible versus flexible requirements and use of funds; a focus on specific target groups versus classes of the population; ability to stimulate local expenditures; the level of involvement by federal, state, and various kinds of local agencies; and degree of competition for grants. Choices concerning the preferred type of grant are dependent on the aims of the program, the degree of risk that the funding source is willing to take, and the value the funding source places on each of those factors. In effect, there is no simple answer about the relative advantages of more integrated comprehensive kinds of funding, as contrasted to the use of more narrow categorical grants.

Organization and Financing of Federal Health Programs

In order to understand the programs studied and summarized in Chapter 3, a larger organizational context and data on financing of

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* Grants are called formula grants when the distribution of funds is based on a formula (e.g., population at risk and percentage of poverty). Project grants involve application and approval on a project-by-project basis. Sometimes funds are given out to a state on a formula basis, and the state redistributes them on a project basis.

federal health programs are provided in this section.

Most federal financing involves payment for privately produced goods and services. Out of a total of $278.5 billion expended in 1981 for health throughout the nation, federal government outlays were estimated to be $76 billion,* of which the largest amount was for hospital care at $46.4 billion. Medicare and Medicaid are the two largest federal health programs. Understanding their role is critical to the topic of health services integration, because these programs, especially Medicaid, are a major determinant of the services available to low-income people.

Medicare

Well over half of all federal outlays for health are consumed by the Medicare program, which was established in 1965 primarily for the elderly and is the closest thing the United States has to national health insurance for 25 million elderly and 3 million disabled citizens. Medicare provides hospital insurance through a payroll-tax-financed insurance fund. A voluntary medical insurance program (called Part B)** pays for physician services.

Medicare was originally passed as a health insurance program for the elderly to protect them from large medical expenses--a major fear of the elderly on retirement incomes. It has no means or income or assets test, because it was designed as part of an insurance and pension system financed primarily through earnings from employment. Medicare's growth--from $7.1 billion in 1970 to $42.5 billion in 1981, an average annual increase of 17.6 percent--has placed a considerable strain on the federal budget.

Medicaid

The Medicaid program pays for health services for people with very low incomes and few assets. For nearly 15 years, all states except Arizona have jointly participated in the Medicaid program, in

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* If figures on federal outlays include all health services and supplies and research and construction of medical facilities, they equal $80.7 billion.

** Part B is paid for by the individual's premiums (25%) and federal general revenues (75%).

which the federal government pays from 50 to 77 percent* of the costs of a minimum set of services. States may also contribute to optional services, which are more extensive. Table 2 shows the various services the states cover.

Medicaid provides financial coverage for over 21 million people, many of whom are needy children. Table 3 gives an enumeration of those who are eligible for Medicaid and the amount of money paid out in each category of eligibility in 1979. Of interest is the high percentage (37) of funds paid for services to those age 65 and over compared with their low percentage (15.6) of the eligible population. Conversely, children account for 46.3 percent of the eligible population yet spend only 15.8 percent of the Medicaid dollar.

Table 4 shows the distribution of Medicaid dollars by type of medical service. Hospital, nursing home, and intermediate institutional care services claim over 70 percent of the total expenditures.

There is substantial variability among the states on several dimensions of Medicaid. To qualify for coverage a person must fulfill certain requirements in addition to being below the poverty level, such as being what is termed "categorically eligible." This group includes those qualifying for Aid to Families with Dependent Children (AFDC), and elderly, blind, or disabled adults eligible for Supplemental Security Income (SSI) assistance. In addition, at the states' option, people may become eligible (as "medically needy") if they incur large medical expenses that are beyond amounts set by regulation and if they are categorically linked (e.g., the elderly). If effect, people have to spend down to a poverty level after incurring large medical bills. In such states as Massachusetts and California, the eligibility criteria are comparatively less restrictive. Thus a higher percentage of low-income individuals and families are included than in states with very restrictive eligibility (e.g., Louisiana, Mississippi, Texas). Some states (e.g., California) also provide coverage with state funds alone, covering an individual who is unemployed and needs temporary assistance. Most states restrict the number of eligible people as shown in Table 5, an average of 48 percent of poor children have Medicaid coverage nationwide, but coverage ranges from a high of 74 percent in the District of Columbia to a low of 21 percent in South Dakota.

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* The federal government's percentage is determined by a formula that reflects the relative wealth of the states. It is one form of assistance from the more affluent states to the poorer ones. The formula is redistributive; but, because poorer states tend also to have more limited programs, less costly fees, and so on, the actual per capita reimbursement to wealthier states is noticeably higher.

TABLE 2 States Covering Medicaid Services

FMAP[a]	BASIC REQUIRED MEDICAID SERVICES (● CN[b]; + Both CN and MN[c]) SEE ABOVE		Practitioners' Services									Drugs and Devices				Outpatient Services					ICFs			SNFs	Personal Services				Services for Age 65 or Older in TB Institutions			Services for Age 65 or Older in Mental Institutions			Total Additional Services	
			Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Rehabilitative Services	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Screening Services	Preventive Services	Diagnostic Services	Clinic Services	Emergency Hospital Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	SNF for Under Age 21	Personal Care Services	Private Duty Nursing	Christian Science Nurses	Christian Science Sanitoria	A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	A. Inpatient Hospital Services	B. SNF Services	C. ICF Services		
71	●	Alabama		●								●		●	●					●	●	●	●	●					●				●	●	12	AL
50	●	Alaska		●						●					●				●	●	●	●	●	●								●			10	AK
61		Arizona																																		AZ
73	+	Arkansas		+	+	+	+					+	+	+	+				+	+	●	●	+	●	●				+	●	●	+	●	●	21	AR
50	+	California	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+	+	+	30	CA
53	●	Colorado	●									●		●					●	●	●	●	●	●								●	●	●	12	CO
50	+	Connecticut	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+		+		+				+			24	CT
50	●	Delaware	●									●		●				●	●	●	●	●		●								●			10	DE
50	+	D C	+	+		+		+			+	+		+	+		+	+	+	+	+	+	+	+	+				+			+			19	DC
58	●	Florida		●		●	●			●		●	●		●					●	●	●	●					●	●			●			14	FL
67	●	Georgia	●			●						●		●					●		●	●		●					●	●	●		●	●	13	GA
50	+	Guam		+			+	+		+		+	+	+	+				+	+															10	GU
50	+	Hawaii	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+											20	HI
66	●	Idaho	●	●	●			●			●	●							●	●	●	●		●										●	12	ID
50	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+		+		+	+	+	+	+	+	+	29	IL
57	●	Indiana	●	●	●		●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●		●	●	●				●			24	IN
59	●	Iowa	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●		●	●	●	●	●								●			21	IA
54	+	Kansas	+	+	+	+	+	+	+	+	+	+	+	+	+				+	+	+	+	+	+		+			+	+	+	+	+	+	26	KS
68	+	Kentucky		+		+		+	+	+		+		+					+	+	+	+	+	+					+			+	+	+	17	KY
69	+	Louisiana			+						+	+	+	+					+	+	●	●	●	●					●			●	●	●	15	LA
70	+	Maine	+		+	●		+	+	+	+	+		+		+	+	+	+	●	+	+	+	+			+	+				+	+	●	23	ME
50	+	Maryland	+	+				+				+	+	+	+				+	+	+	+		+					+			+		+	15	MD
52	+	Massachusetts	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+			+	+	+	28	MA
50	+	Michigan	+	+	+	+	+	+	+	+		+	+	+	+			+	+	+	+	+	+	+	+			+				+	+	+	24	MI
58	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	31	MN
78	●	Mississippi					●					●									●	●		●				●	●			●			8	MS
60	●	Missouri		●			●				●	●	●		●	●	●	●		●	●	●							●			●			14	MO
64	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+						+	+	+	26	MT
58	+	Nebraska	+	+	+	+	+	+		+	+	+	+	+	+				+	+	+	+	+	+	+	+						+	+	+	23	NB
50	●	Nevada	●	●	●	●		●	●	●	●	●	●	●	●				●	●	●	●		●	+	●						●			20	NV
61	+	New Hampshire	+	+	+	+		+	+	+	+	+		+	+	+	+	+	+	+	●	●		+	+	+	+	+				+		●	25	NH
50	●	New Jersey	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●	●			●	●	●	27	NJ
66	●	New Mexico	●	●		●	●	●	●	●	●	●	●	●	●				●	●	●	●		●		●									18	NM
50	+	New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+	29	NY
69	+	North Carolina	+	+	+		+				+	+	+		+	+	+	+	+		+	+	+	+					+			+		+	19	NC
51	+	North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+		+						+			22	ND
50	+	N. Mariana Islands		+			+	+				+	+	+	+				+	+		+		+	+				+	+		+	+		16	NMI
55	●	Ohio	●	●	●	●	●	●	●	●		●	●	●	●				●	●	●	●	●	●		●		●				●	●	●	23	OH
64	+	Oklahoma	+								+	+		+							+	+	+		+							+			10	OK
56	●	Oregon	●	●	●	●	●	●			●	●	●	●	●			●	●	●	●	●	●	●	●	●		●				●			22	OR
55	+	Pennsylvania	●	+	+		●					●	●	●					+	+	+	+	+	+								+	+	+	16	PA
50	+	Puerto Rico				+	+	+	+	+	+	+				+	+	+	+	+									+						13	PR
58	+	Rhode Island	+	+			+					+	+	+	+						●	●		+					+						11	RI
71	●	South Carolina	●		●							●		●						●	●	●	●	●					●			●			11	SC
69	●	South Dakota			●		●	●	●		●	●	●	●					●	●	●	●		●	●								●	●	16	SD
69	+	Tennessee										+		+					+	+	+	+	+					+	+	+	+	+	+	+	14	TN
56	●	Texas	●	●	●						●	●		●	●					●	●	●			●			●	●						13	TX
68	+	Utah	+	+		+	+	+		+		+	+	+	+				+	+	+	+	+	+		+						+			18	UT
68	+	Vermont	+									+		+					+	+	+	+	+	+								+			10	VT
50	+	Virgin Islands					+	+	+	+		+	+	+	+				+																9	VI
57	+	Virginia	+	+				+	+	+		+			+				+	+	+	+		+				+	+			+	+	+	17	VA
50	+	Washington	+	+	+	+	+	+		+	+	+	+	+	+		+	+	+	+	+	+	●	+		+			+	+	+	+	+	+	27	WA
67	+	West Virginia	+	+	+	+		+		+		+	+	+	+				+	+	+	+		+		+			+	+		+	+		20	WV
58	+	Wisconsin	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+				+			27	WI
50	●	Wyoming		●				●			●			●							●			●											6	WY
●	20	●	14	14	10	9	11	10	7	7	11	19	11	18	12	3	4	6	12	18	24	23	12	19	4	5	1	7	9	2	2	14	8	11		
+	34	+	25	27	17	20	23	26	18	23	20	33	24	30	26	15	16	17	32	30	26	25	22	27	12	14	5	11	17	9	7	29	17	16		
	54	Total	39	41	27	29	34	36	25	30	31	52	35	48	38	18	20	23	44	48	50	48	34	46	18	19	6	18	28	11	9	43	25	27		

[a] FMAP-Federal Medicaid Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages effective from October 1, 1979, through September 30, 1981 are rounded

[b] Categorically Needy: People receiving federally supported financial assistance.

[c] Medically Needy: People who are eligible for medical but not for financial assistance.

SOURCE: U.S. Department of Health and Human Services (1982) The Medicare and Medicaid Data Book, 1981. Prepared by Donald N. Muse and Darwin Sawyer. HCFA Publication No. 03128 (April). Health Care Financing Administration, Office of Research and Demonstrations, Rockville, Md.

TABLE 3 Medicaid Recipients and Payments by Eligibility, 1979

	Recipents by basis of eligibility		Payments by basis of eligibility	
	Number	Percent	Amount	Percent
Total	21,536,440	100.0	$20,461,862,559	100.0
65 and over	3,353,869	15.6	7,645,214,783	37.4
Blind	80,070	.3	123,035,995	.6
Permanent and Total Disability	2,662,189	12.4	6,100,453,582	29.8
Dependent (AFDC under 21)	9,139,142	42.4	2,860,664,768	14.0
Adults (AFDC)	4,553,013	21.1	2,832,977	13.8
Other under 21	851,894	3.9	378,178,829	1.8
25-64	896,263	4.2	521,337,278	2.5

SOURCE: Calculated from data provided for this study by the Medicaid Program Data Branch, Office of Research, Health Care Financial Administration, U.S. Department of Health and Human Services.

Regardless of the coverage, the Medicaid program is costly to states. Its increases have become a major source of distress and political problems to governors in many states, and they are beginning to make changes in Medicaid coverage. During 1980-81 nearly all states reduced or considered reducing Medicaid benefits or the number of categories of people that it would serve (Intergovernmental Health Policy Project 1981). For example, the state of Washington began to make a series of major changes in the state's Medicaid program in March 1981, including the elimination of services (adult dental care), and of categories of eligibility (poor families with an unemployed parent in the house). An attempt was made to eliminate the medically-needy and the state-funded medically indigent programs, but a court order kept the programs going until a new "Limited Casualty Program" was implemented on July 1, 1981, which covered even fewer services (no dental, chiropractic, physical therapy, speech, rehabilitation services, or hearing aids) and fewer people. In addition, the Limited Casualty Program is capped at $25 million a year (a cut of $30 million) and requires the medically indigent to cover a $1,500 deductible (now lowered to $500). The combined impact of these changes, along with federal welfare changes, reduced the Medicaid program by more than 44,000 recipients

TABLE 4 Medicaid Payments by Type of Medical Service, 1979

	Number	Amount	Percentage
Total	21,536,440	$20,461,862,559	100.0
Inpatient Hospital			
General	3,759,941	5,650,696,425	27.6
Mental	78,381	779,103,557	3.8
Skilled Nursing Home	599,030	3,368,466,986	16.5
Intermediate Care Facility Services in Institutions:			
MR	115,165	1,492,599,956	7.3
Other	760,762	3,778,983,996	18.5
Physician Services	15,011,538	1,636,768,282	8.0
Dental Services	4,373,213	430,895,646	2.1
Other Practitioner	3,033,745	163,113,696	.8
Outpatient Hospital	7,505,966	833,577,258	4.0
Clinic Services	1,548,266	257,784,383	1.3
Lab and Radiology	5,347,516	185,774,510	.9
Home Health	358,784	263,533,593	1.3
Prescribed Drugs	14,187,585	1,202,785,947	5.9
Family Planning	1,200,037	108,780,773	.5
Other Care	2,647,018	291,397,516	1.4

SOURCE: Calculated from data provided for this study by the Medicaid Program Data Branch, Office of Research, Health Care Financing Administration, U.S. Department of Health and Human Services.

during 1981. Other states, which have never participated in the optional medically needy program (e.g., Colorado and Florida) are talking about covering specific subgroups (e.g., poor children) under a medically needy program, as is permitted by the Omnibus Budget Reconciliation Act of 1981.

Between 1970 and 1981, the amount expended under Medicaid--that is, the federal share of Medicaid--went from $2.7 billion to $16.8 billion. Medicaid programs or outlays are projected to continue to grow at high rates unless significant changes are made in the entitlements or the ways in which benefits are covered or calculated.

TABLE 5 AFDC and Medicaid Recipients Under 18 Years of Age; Average Monthly AFDC Payment

State	Poor Children* Receiving		Average Monthly AFDC Payment	
	AFDC	Medicaid	Per Family	Per Recipient
United States	44%	48%	$252	$ 84
Northeast				
New England				
Connecticut	52	54	315	104
Maine	50	48	213	71
Massachusetts	74	72	323	109
New Hampshire	41	51	234	81
Rhode Island	62	61	286	95
Vermont	48	49	282	92
Middle Atlantic				
New Jersey	54	60	287	89
New York	57	66	375	120
Pennsylvania	50	60	285	93
North Central				
East North Central				
Illinois	64	62	266	81
Indiana	36	34	191	64
Michigan	59	65	332	107
Ohio	54	57	213	72
Wisconsin	36	43	318	113
West North Central				
Iowa	35	37	281	97
Kansas	37	43	235	88
Minnesota	30	39	297	107
Missouri	50	45	178	60
Nebraska	24	23	263	90
North Dakota	22	22	248	88
South Dakota	19	21	203	70
South				
South Atlantic				
Delaware	52	56	215	74
District of Columbia	69	74	239	81
Florida	25	34	145	51

State	Poor Children* Receiving		Average Monthly AFDC Payment	
	AFDC	Medicaid	Per Family	Per Recipient
South Atlantic (cont.)				
Georgia	44%	43%	$107	$ 39
Maryland	53	60	193	67
North Carolina	32	39	157	58
South Carolina	34	37	87	30
Virginia	32	37	195	69
West Virginia	38	43	193	67
East South Central				
Alabama	42	39	112	37
Kentucky	30	33	168	16
Mississippi	47	40	52	39
Tennessee	37	44	109	39
West South Central				
Arkansas	26	31	148	49
Louisiana	43	41	128	39
Oklahoma	27	33	214	70
Texas	24	25	108	34
West				
Mountain				
Arizona	28	...	114	49
Colorado	45	46	208	74
Idaho	28	30	253	90
Montana	19	26	187	67
Nevada	31	29	184	66
New Mexico	30	33	161	52
Utah	35	36	263	90
Wyoming	19	20	205	78
Pacific				
Alaska	32	34	308	117
California	58	61	319	107
Hawaii	46	54	380	119
Oregon	36	47	282	102
Washington	48	51	301	105

* Poor children are defined as those under 18 years of age living in families with incomes (excluding Federal cash assistance payments) below the national poverty standard.

NOTES: Data are based on household interviews of a sample of the civilian noninstitutionalized population and on reporting by states. The percent of poor children receiving AFDC is the 1975 actual percent. The percent of children receiving Medicaid is based on 1975 poverty data projected to 1980 levels and 1980 estimates of Medicaid recipients. The average monthly AFDC payments are actual fiscal year 1978 data.

SOURCES: U.S. Bureau of the Census: 1975 Survey of Income and Education. Selected data: Office of Child Health, Health Care Financing Administration: 1978 reporting by states. Table 108 cited in Select Panel for the Promotion of Child Health (1981) Better Health for Our Children: A National Strategy, Vol III. Report to the United States Congress and the Secretary of Health and Human Services. DHHS (PHS) Publication No. 79-55071. Washington, D.C.: Department of Health and Human Services.

Categorical Programs

Of particular interest to this study are the so-called categorical programs. They represent a comparatively small amount of dollars, although important ones in the cases examined by the committee. The federal government spent $52.7 billion in 1980 to finance health services through primarily nonfederal providers. Of that amount, $49.4 billion was for Medicare and Medicaid. The total expenditure does not count the additional billions of dollars spent for direct delivery of services to the armed forces, veterans, native Americans, and beneficiaries entitled to Public Health Service hospital and clinic services, or expenditures on research and training, whether financed by grants or directly in federal facilities.

Categorical programs arrange and pay for the delivery of services from nonfederal providers to individuals otherwise unable to obtain care or a particular service (e.g., immunization, hypertension screening).*

In many ways the categorical grant system seems irrational, or at least very complicated. Table 2 in Appendix E shows the potpourri of grant awards in one state, Massachusetts, and illustrates the system--a collection of health fragments rather than a cohesive whole. A broad view of congressional and administrative intent in creating the current array of federal health programs makes it clear that this fragmented structure is, to a large degree, not the result of unplanned or irrational actions but rather the price of pluralism and, as mentioned earlier, the result of an unwillingness to ensure health care coverage--at least by a central government--for all citizens. Legislators have generally followed the predominant economic philosophy in the United States that the appropriate role of

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* The committee did not examine health service systems operated directly by the federal government--specifically, the Defense Department, the Veterans Administration ($67.1 billion in 1981), the Indian Health Service, or the Public Health Service hospitals and clinics. Those programs, for the most part, operate independently of other community health providers and institutions and, therefore, present a qualitatively different set of integrative issues than do the grant and health financing programs. However, the committee believes that these separate systems present important integrative questions that should be addressed, because at the community level they may represent substantial resources. Completely separate planning and provision of services seem unwise and unnecessarily duplicative in some instances. The veterans' health care system has been covered in considerable detail by another study from the National Academy of Sciences on Health Care for American Veterans.

the federal government was to fill in the holes left by the private market and state and local action, not to plan or orchestrate system activities. Consequently, legislators have enacted a series of federal health programs designed to be stop-gap measures for specific failures in the broader health care system.

Even though categorical grants are a source of fragmentation, they also have allowed for some modest integration efforts at the local level. They make it possible for local administrators to patch together services for people who would not otherwise get care. The image of many services out there in the nation may seem correct when viewed from Washington. But from the community level, it is apparent that there are people who need community health centers, health departments, and hospital outpatient departments and emergency rooms to get care. These operations finance many services out of categorical grants. All such programs--both formula grants and project grants--in 1980 cost $2 billion. Project grants, awarded on a discretionary basis, accounted for only $1.34 billion--as can be seen in Table 6 (Zwick 1981). The table also shows the wide range of topics and problems that such targeted grants cover.

Many of the programs that receive categorical grants also receive Medicaid reimbursement for services, which enables the programs to serve more people. For example, the Family Planning Program of the Alabama Health Department receives $3.7 million in Title X Family Planning funds but also is reimbursed about $450,000 by Medicaid. Patient fees provide another $300,000, but the program is only able to reach about 40 percent of the people estimated to be in need. Ironically, it is the little "gap-filling" programs that may make it possible for some particular program that is being reduced to continue to exist.

Attempts to Overcome Fragmentation of Services and Financing

For several decades there have been attempts by the federal government to encourage the integration and coordination of health services and to establish productive working relations among government units in the grants-in-aid system. Reports describing incipient problems in the federal grants system were issued as early as the late 1920s and were followed by others in succeeding years. The 1949 report of the Hoover Commission on the Organization of the Executive Branch on Federal/State Relations was a landmark paper describing the problems. However, full-scale reform efforts did not get under way until the mid-1960s.

The numerous legislative and administrative reforms (described in Appendix F) include, for example, the Intergovernmental Cooperation Act (1968) and the Joint Funding Simplification Act (1974). There have also been legislative/programmatic efforts to combine and target

Table 6 Health Services Project Grants, 1975 and 1980 (Expenditures in Millions of Dollars)

Program	1975		1980	
	Amount	Percent	Amount	Percent
Health planning: local programs	$ 16.7	1.7	$ —	—
Community health services	409.1	40.6	753.3	56.0
Adolescent pregnancy services	—	—	6.5	.5
Appalachian health demonstrations	23.3	2.3	21.8	1.6
Black lung clinics	—	—	4.5	.3
Cancer control	4.7	.5	23.5	1.7
Community health centers	196.6	19.5	320.0	23.8
Crippled children's services	3.5	.3	16.0	1.2
Emergency medical services	32.2	3.2	35.1	2.6
Family planning	94.5	9.4	155.9	11.6
Genetic diseases	—	—	11.6	.9
Health maintenance organizations	22.7	2.2	32.2	2.4
Hemophilia centers	—	—	3.0	.2
Home health services	—	—	5.0	.4
Hypertension services	.8	.1	19.9	1.5
Indian self-determination projects	—	—	16.6	1.2
Maternal and child health services	5.1	.5	29.4	2.2
Migrant health	23.8	2.4	39.7	3.0
Primary care demonstrations	—	—	9.8	.7
Sudden infant death syndrome	1.9	.2	2.8	.2
Prevention	56.3	5.6	115.5	8.6
Childhood immunizations	—	—	24.5	1.8
Communicable disease projects	34.2	3.4	—	—
Fluoridation projects	—	—	5.0	.4
Health education-risk reduction	—	—	6.0	.4
Health program for refugees	—	—	4.8	.4
Lead-paint poisoning projects	9.0	.9	11.3	.8
Smoking and alcoholism prevention	—	—	10.0	.8
Urban rat control projects	13.1	1.3	14.0	1.0
Venereal disease control	—	—	40.0	3.0
Regional Medical Programs	83.0	8.2	—	—
Mental health and substance abuse	403.2	40.0	451.3	33.6
Alcoholism demonstrations	—	—	4.6	.3
Alcoholism treatment and rehabilitation	79.9	7.9	60.8	4.5
Community mental health centers	197.6	19.6	217.3	16.2
Community support for the chronically mentally ill	—	—	7.2	.5
Drug abuse community services	117.9	11.7	145.7	10.8
Drug abuse demonstrations	—	—	2.5	.2
Drug abuse prevention	—	—	12.8	1.0
Mental hospital improvement	7.8	.8	.4	.1
Other	39.7	3.9	24.3	1.8
Child abuse and neglect	.4	—	13.5	1.0
Developmental disabilities	23.2	2.3	10.8	.8
Head Start	15.2	1.5	—	—
School health services	.9	.1	—	—
Total	$1,008.0	100.0	$1,344.5	100.0

SOURCE: Zwick, Daniel (1981) Federal Health Services Grants, 1980. Public Health Reports 96 (November-December):498-502.

federal resources in ways that would be more effective. Examples include: (1) Economic Opportunity Act, (2) Model Cities, (3) Appalachian Regional Commission, (4) State and Federal Assistance Act of 1972 (General Revenue Sharing), (5) Comprehensive Employment and Training Act (CETA), (6) Social Services (Title XX), (7) Housing and Community Development, and (8) Omnibus Budget Reconciliation Act of 1981.

There have been federal efforts to plan, provide, pay for, coordinate, or integrate health services or resources. Included in the legislative or programmatic list are (1) the Social Security Act of 1935 and its amendments, (2) the Hill-Burton Act of 1946, (3) the Partnership for Health Act and Amendments of 1966 and 1967, (4) the Health Planning and Resource Development Act of 1974, and (5) the Omnibus Budget Reconciliation Act of 1981.

Organizational and administrative changes also have been designed to bring order and consistent or complementary administration to public programs. These changes include (1) reorganization of the Public Health Service (1966-1968), (2) incorporation of Child Health/MCH (from the Children's Bureau) into the Public Health Service (1969-1970), and (3) reorganization of the Public Health Service/Bureau of Community Health Services (1974).

State and local governments have also played a role in reforms to achieve better coordination and integration of services, as was documented in state health departments (see Alabama, Volume II) and local health departments (see Denver Volume II, Suffolk County, Volume III). Other efforts have responded to federal initiatives (e.g., Partnership for Health Act and Amendments of 1966 and 1967) and to state and local initiatives (e.g., North Carolina Rural Office of Health Services, Volume III).

These efforts have been undertaken, among other reasons, to compensate for the absence of a consistent national health policy (or policies), which has left gaps in coverage or care. In turn, the lack of a national health policy is a result of the absence of a broad-based consensus on many policy issues, such as the role of government in health care. Without resolution of some of those issues, there will continue to be efforts to rationalize and systematize disparate pieces that will sometimes, or even often, not be compatible with each other. At the least, there will be administrative efforts to pull together the pieces, sometimes adding another layer of organization.

Appendix F discusses some of the problems of the grant system and explores the federal government's attempts to reduce "red tape,"* to increase local flexibility, and to otherwise improve the administration and effectiveness of federal grants. Some reforms or initia-

* The term refers to the red ribbon tied around government documents before they were "pigeon-holed" in storage cases. Flat filing in vertical file drawers was not widely used by the federal government until about 1910. See Herbert Kaufman (1977) Red Tape: Its Origins, Uses, and Abuses. Washington, D.C.: Brookings Institution.

tives apply to all federal grants and others are specific to health projects or grants. Unfortunately, most efforts have not been systematically evaluated. For those cases in which evaluation has been attempted, data were not available, were hard to retrieve, were inconsistent, or were not useful for evaluative purposes. The unevenness of available evaluative information is reflected here. Nevertheless, some lessons can be derived from earlier attempts to reform the federal grants-in-aid system, and from efforts to force greater integration of policies and programs at federal, regional, state, and local levels. Future attempts to improve the package of federal aid to states and localities and state aids to localities should be based on a hard look at the effects of earlier efforts.

Health Services Integration: Lessons for the 1980's
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CHAPTER 3

SUMMARY OF FINDINGS OF CASE STUDIES AND CASE REPORTS

In this chapter, the results of the field work of the staff of the Institute of Medicine are summarized. The six detailed case studies and the 16 more limited case reports are published separately in Volumes II and III, respectively. (A brief description of each case study and report is listed in Appendix B, and the methodology of each is discussed in Appendix C.) This chapter concludes with summary observations that were particularly relevant to the committee's recommendations presented in Chapter 4.

Staff members of the Institute of Medicine conducted six detailed case studies of health services activities or programs that were considered likely to provide good examples for policy recommendations to federal, state, and local officials and administrators. A comparative analysis of the cases was used to determine the factors that may be important in explaining their relative success.

The case studies entailed several kinds of field research. First, three visits were made to each of the six sites to study the organizational and administrative aspects of the services integration efforts. For each case, some 40 to 50 interviews and many informal conversations were conducted with officials and observers at the federal, state, county, and local levels. Second, all available documentary materials were collected. Third, in each case, interviews with clinical providers and patients and observations at the service delivery level were made by a separate clinical team. They sought to determine the effect of service integration on patient care by examining existing program and population statistics, by reviewing procedure protocols, and by interviewing providers and patients. One researcher "walked through" the admitting and treatment process in order to more accurately document the experiences of patients. All field visits took place between March 1981 and March 1982.

The six cases were selected to include programs that differ in origins, sponsorship, structure, funding, setting, and size. Some of the cases are state or local initiatives, while others are federally sponsored. Some are run by private nonprofit community-based boards, while others are administered by state and county health departments. Structurally, the cases range from single health centers

(Seattle) to highly centralized health center networks (Denver); and from state health departments organized around categorical bureaus (Alabama, Michigan) to functionally integrated and decentralized human services departments (Florida). Some of the efforts have major federal grant funding of various kinds (Alabama, Denver, Michigan) while others have virtually no federal funding (Jefferson County in Alabama, East Boston) except Medicaid. Some of the programs are rural and others urban. They are located in the South, Northeast, Midwest, and the West. They range in size from the Seattle health center's 17,000 encounters a year to Denver's neighborhood health program with over 350,000 encounters a year. Boston's health centers collectively average over 800,000 encounters annually.

In addition to the subjects of the six case studies, 16 other programs were selected for study to (a) expand the data base, (b) give the research staff more opportunities to make comparisons of similar cases, and (c) cover some important issues or populations that otherwise would have been neglected. Data for these reports were collected primarily from existing documents and from telephone interviews, rather than from field visits. With these data, staff members were able to write analytical reports, sometimes nearly to the level of detail achieved in the case studies.

It is important to remember that the subjects of the case studies and reports were selected with foreknowledge that they might be exemplary or might otherwise provide particularly valuable information. They do not constitute a scientific, randomly selected sample, nor do they represent a cross section of experience or include control groups. Therefore, this research cannot explain, in a causal way, why some programs were successful and others were not. However, it is hoped that the study of these cases will provide lessons for people interested in improving health service delivery in their own communities. The cases show what barriers were overcome to change the way in which services were organized. The researchers tried to determine the conditions favorable to change, and to examine some of the effects of those changes as reported by participants in the programs.

Case Study Descriptions

Alabama Maternal and Child Health Program

In 1977 a new director of the state health department's Bureau of Maternal and Child Health/Family Planning set out to revitalize the state's maternal and child health (MCH) program in order to reduce the very high infant mortality and related rates in Alabama. He set out to create an exemplary regionalized perinatal system on a statewide basis by mobilizing and targeting all possible state, local, and federal resources.

The targeting strategy included several kinds of services integration. First, the MCH and family planning staffs were merged. Second, multidisciplinary teams--each with an administrator, one or more nurses, a health educator, a social worker, and nutritionist--were placed in the state's six health planning areas to work closely with the providers of MCH and family planning services in the 58 local health departments. Third, coordinated service delivery to pregnant women and young children was provided through the development of interrelated protocols for prenatal, family planning, and pediatric services (family planning counseling in prenatal clinics in the seventh month of pregnancy and referral to family planning at delivery), and expanded pediatric clinics (well-child, immunization, and WIC on same day) in some places. Fourth, the bureau attempted to develop coordination and linkages with the private practitioners, federally funded community health centers, and other state and local programs. Fifth, the bureau tried to interest other state health department bureaus in cofunding related positions (for example, pay nutritionists half with WIC and half with MCH funds, or share nurses between the Bureau of Public Health Nursing and MCH), but this has only recently begun to happen with the impetus of the severe federal budget cuts beginning October 1, 1981.

At the same time, the strategy involved increasing certain categorical aspects of MCH funding in Alabama. Much of the MCH formula grant had been distributed automatically with other federal formula grant funds to the counties on a population basis, whether or not county health departments even offered MCH services. The bureau had to gain control over its funds before it could work out ways in which to coordinate or integrate them. By fiscal year 1981, MCH and family planning funds were distributed by formulas that included need and county health department effort, but the bureau was not able to take the next step, and reward high-effort departments with additional resources, due to funding cuts.

The bureau went after special federal funds and had an Improved Pregnancy Outcome and three Improved Child Health projects funded by the U.S. Department of Health and Human Services and the Appalachian Regional Commission to increase services in areas of higher need. The bureau successfully increased the first state funding for MCH services--for regional perinatal centers--to $800,000 a year (the state had previously matched MCH funds entirely with local health department appropriations).

The bureau concentrated its efforts on the poorer, more rural counties and did not try to do much different with places such as Jefferson County (Birmingham), which were already running large and integrated service delivery programs. The IOM research staff visited the Jefferson County Department of Health and studied its success in developing two large primary care centers (with county tax dollars) and its computerized maternity medical records system called OBAR. OBAR links the health department with the university and county hospitals' high-risk clinic and labor and delivery areas to ensure continuity of care for patients. The county health department's

reorganization around a geographically based Office of Health Center Administration to further cross-program integration at the health center level, and the conflicts this created with the traditional categorical bureaus such as nutrition and public health nursing, has important parallels with two other cases, Florida and Seattle.

The West Alabama District Health Department faces a more typical setting of scarce local tax and medical resources in its rural counties. While it lasted, the IPO project enabled West Alabama to establish maternity and pediatric services and to assign personnel flexibly to create an integrated MCH program.

The state bureau is currently facing some potentially devastating budget cuts in MCH and family planning. The cut is higher than the 25 percent cut in the MCH block grant because the bureau had been receiving MCH money from Title V discretionary funds, which were not calculated in the block grant base. Facing a cumulative cut of about $2.6 million, or 43 percent of its funding, over a two-year period, the bureau asked the state legislature to appropriate $1 million for maternal and child health. The legislature made a conditional appropriation that will only be funded to the extent state revenues exceed the level needed for the regular budget, but such growth in state revenues is considered very unlikely.

The Alabama case illustrates the impact that program leadership can have, even where other conditions favorable to success are absent. The bureau director set a general goal, was persistent, and made the most of what he had. He was entrepreneurial in devising various strategies and went after new federal and state dollars to fund them. However, one supporter commented that it would have helped if he had had a "Southern style," because many people thought he was just an empire builder.

The Alabama MCH program shows it is possible to integrate maternal and child health programs with family planning at the state and local levels and to coordinate them with related federal-state programs, such as immunization, EPSDT, and WIC, at the point of service delivery. However, federal funding and regulations were critical, not only to expand the supply of services, but also to provide the carrots and sticks the bureau needed in dealing with the rest of the state health department and the local health departments.

Alabama demonstrates the continuing need for categorical programs, even though they are more difficult to integrate at the operational level. Respondents consistently reported that if outside funds were not provided, and strings were not attached to govern their use, then basic health services such as prenatal care would not be consistently provided across the state.

The main obstacle at the state level was the reluctance of the health department and its governing board, the state medical association, to push the county health departments and local physicians to attack infant mortality more actively. This obstacle was overcome by persistence, invocation of federal regulations, publicity about the infant mortality problem, organization of state and local MCH support groups, and the support of a key member of the state board of health.

Federal funds and regulations were generally, but not always, helpful. The WIC program consistently resisted coordination. The ambivalence of federal officials about the role of public health departments in providing primary care helped destroy an effort to cofund a community health center with a local health department. On the other hand, there is a strong cooperative relationship between a community health center in Greene County and the West Alabama District Health Department, but this seems to be explained more by the attitudes of the health center director and the district health officer than state or federal policies and procedures.

The paucity of resources in rural areas still severely limits the capacity to integrate services at the local level. The Jefferson County Health Department, with access to a relatively rich tax base and a large medical center, has developed a fairly integrated maternal and infant care system with the county and university hospitals, and has physician-staffed primary care centers. Most of the staff in the five-county West Alabama District Health Department is budgeted by county, and there are too few nurses--one or two per county--to hold concurrent or unified clinics for women or children (prenatal with WIC; well-child with EPSDT, immunization, and WIC). Furthermore, the lack of physicians in the area makes it difficult to ensure access to medical services for those who cannot pay.

The budget cuts show a tendency in state administration toward distributing dollars on a statewide basis, especially if they are scarce (also revealed in interviews with state officials in Washington, Massachusetts, and Florida). The immediate result of this bias has been to use the new flexibility of the MCH block grant to cut back the children and youth and maternal and infant care projects in urban areas, which had their own categories in the old MCH legislation, in order to maintain services in as many counties as possible.

Boston Neighborhood Health Centers

In the mid-1960s, the mayor of Boston was faced with a crisis. The physical plant of Boston City Hospital, the city's 1,200-bed charity general hospital, was very badly run down and highly inefficient to operate. In 1964, the mayor commissioned a study of Boston's health institutions that proposed (1) a merger of the public health department and the hospital and (2) the development of neighborhood health centers as part of an integrated system of ambulatory, inpatient, and long-term care.

The board of the merged department, known as Boston Health and Hospitals (BH&H), endorsed the goal of promoting neighborhood health centers in 1968 after staff studies indicated a growing shortage of primary care physicians serving most Boston neighborhoods. The new deputy commissioner for Community Health Services and his staff developed what became known as the Sackett plan (named after then commissioner of Boston Health and Hospitals, Andrew P. Sackett, M.D.). The Sackett plan divided the city into primary care districts. Sackett and his staff, with the support of the mayor and health

leaders such as John Knowles, gained the agreement of Boston's private hospitals to take responsibility for developing and supporting neighborhood health centers in a particular district in late 1969. In the meantime, BH&H proceeded to establish seven neighborhood health centers affiliated with Boston City Hospital. Typically, the city loaned the building, stationed health department personnel there, donated in-kind supplies and services from Boston City Hospital, and ran state and federal programs in the centers such as family planning, maternal and infant care (MIC), and children and youth (C&Y) projects. The city established an "outreach" grant program to help fund the seven centers that grew to $2.3 million by 1980.

Boston Health and Hospitals had decided from the start that the city alone could not provide all of the health services that were necessary, and it deliberately encouraged community groups to mobilize resources from the private sector and the state and federal governments to set up additional health centers. Health centers were started and supported by private hospitals and a number of federal and state agencies, including the federal Office of Economic Opportunity, Model Cities, and the state health department's maternal and child health office. For its part, the city established a matching grant program in 1970 to help community groups negotiate with their backup hospitals for support.

By 1980, there were 25 neighborhood health centers in Boston, affiliated with 10 hospitals. All told, in one way or another, at one time or other, the city has played a role (funding, donation of facilities and in-kind support) in establishing or supporting at least 23 of the 25 centers.

The IOM research staff studied two neighborhood health centers in depth: the Brookside Park Family Life Center in Jamaica Plain, and East Boston Neighborhood Health Center. Like the city, the health centers were flexible and pragmatic. While maintaining a reputation for high-quality services, they both abandoned at an early date a policy of free care and moved to maximize reimbursement and to adopt sliding fee scales when it was evident that grant funds would not be stable or adequate for survival. They were eventually able to generate more than 80 percent of their revenues from patient fees and third party reimbursements, in part because of the broad scope of Massachusett's Medicaid program.

However, given their unique histories, the two centers were different in many ways, including their styles of service delivery. East Boston is crisply professional and medically oriented. Brookside has taken great pains to be more community-responsive than professional in style. Its physical surroundings are very plain, and the layout is more open. The East Boston facility is very stylish and much like the offices of a successful group practice, rather than a community facility that just happens to have doctors working there. The delivery structures are different. Brookside is organized into large interdisciplinary teams representing all specialties. East Boston is organized by specialty, and patients are assigned to a small medical team. The rhetoric at Brookside stresses

cross-disciplinary assessment and management, with periodic case conferencing. At East Boston, the primary care provider makes referrals as he or she deems necessary. Despite these differences of style and delivery structures, in practice there does not seem to be much real difference in the manner in which patients are handled at the two centers. Only exceptional cases are "case conferenced" at Brookside at short biweekly meetings, while multiproblem cases at East Boston do become the subjects of interdisciplinary consultations.

There is more involvement in community organizations and activities at Brookside than East Boston, while the East Boston center has engaged in a number of research projects and developed advantageous arrangements with a variety of hospitals. Both centers are alike, however, in providing comprehensive primary care services based on individual patient needs and not on the categorical requirements of funding sources. There is primary-provider continuity, a single record that all providers use, cross-disciplinary referrals, coordination, joint case management, and a single eligibility and payment system.

The main finding in the case study is that Boston city health officials succeeded in playing a significant role in the development of a series of primary care health centers in the neighborhoods of Boston. Their experience provides valuable lessons for policy makers, planners, administrators, and providers on how to tap multiple sources of support in a highly fragmented health arena by providing little bits of "glue"--a small grant here, a city building there, public health nurses on loan--to groups trying to pull together those resources into comprehensive service delivery programs.

The Boston services integration effort is not neat and tidy or easily described. It is not a centrally planned structural model that can be picked up and transplanted somewhere else without modification. It is a combination of a vision of hospital-linked neighborhood health centers and a willingness to use any and all means necessary to achieve some reasonable semblance of that vision. The pragmatic, ad hoc, and incremental strategy that Boston Health and Hospitals officials used to achieve their goal of blanketing the city with health centers turned out to be very appropriate, given the pluralistic diversity of the health arena in Boston.

The Boston experience shows it is possible to eliminate many categorical barriers to services integration when state and local health officers agree to permit commingling of categorical funds and the integration of categorical personnel. However, with a few notable exceptions like East Boston, few centers had significant proportions of categorical funding to contend with.

There are many positive features to the decentralized health center movement in Boston. Comprehensive primary care is widely available in Boston. Neighborhood health centers are very accessible and responsive to consumers. They offer a great variety of services, styles, and linkages with other service providers.

The health centers are strongly supported by their neighborhoods and, as a group, lobby effectively for their interests at the city and state levels. Their close community ties, resulting from their

origins, have led several of the centers into activities that probably would not have occurred if the city health department had elected to run the neighborhood health system itself. For example, one center is building a nursing home; another, congregate housing for the elderly. A third is part of a community center.

The health centers are unbureaucratic because they are small and generally exempt from city or hospital personnel, accounting, and purchasing systems.

The individual health centers have multiple bases of support and diversified sources of funding and have proved to be remarkably adaptable to changing environmental conditions. At the aggregate level, as conditions change, individual centers may come and go, but Boston will still have health centers.

However, the unsystematic and decentralized development of the neighborhood health centers has had its costs and negative aspects as well. For example, there is little consistency in the geographic location of the centers, which are grouped quite closely together in several neghborhoods. Furthermore, the pattern of health center locations and utilization tends to reinforce rather than transcend the localism of Boston neighborhoods, which are highly segregated along race, ethnic, and income lines (although some centers, such as Brookside Park, serve multiple racial and ethnic goups). On the other hand, competition may have beneficial effects on patients and on centers.

Some of the centers are very small relative to both the administrative overhead they must each support and the scale necessary to support specialized ancillary services. There are no multicenter consortia or networks in Boston as have been developed elsewhere to take advantage of lower overhead costs.

The centers have had to negotiate privileges independently with each hospital. Continuity of care into and back from hospital specialty consultation and inpatient care has developed slowly and unevenly and remains problematic.

It has been difficult to intervene when a center encounters administrative problems because of the value attached to autonomy, reinforced by multiple bases of support. The lack of coordination among federal, state, and local funding agencies has not helped. While the decentralized strategy of institution building may have been very effective in a time of expanding resources, it does not have the capacity to enforce a rational plan for cutting back the number of services or centers at a time of contracting federal grant support and state efforts to control Medicaid costs. These decisions are being made by each funding source without regard to what the others are doing or the net impact on the community.

Denver Neighborhood Health Program

The Department of Health and Hospitals of the City and County of Denver was created in 1950 by a merger of the public health department, a visiting nurse service, and Denver General Hospital--the

public hospital whose outpatient clinics and emergency room were the main source of care for Denver's poor people.

Between 1964 and 1970, officials in the Denver Department of Health and Hospitals (DH&H) conceived, built, and implemented a model health services delivery system called the Denver Neighborhood Health Program (NHP). The NHP consists of a network of two large health centers, six small satellite health centers, and mental health services, all backed up by Denver General Hospital and operated as a unified program by DH&H.

In 1966, the public health director in DH&H set up in a converted bakery the city's first--and the nation's second--health center, with funding from the federal Office of Economic Opportunity (OEO). The Eastside Neighborhood Health Center was designed to be a model of comprehensive, family-centered care, located in a neighborhood facility, staffed with neighborhood aides and a wide range of health providers, all working as teams to deliver community-oriented family health care.

Eastside was immediately inundated with patients, and OEO expanded its funding to start another health center. Within a few years, as other federal agencies joined the bandwagon, the NHP took on its present form and scale, experiencing, for example, more than 400,000 visits by more than 100,000 patients in 1971-72, supported by $11 million in federal funds. The program is still operating on a large scale, although it has remained very dependent on federal funding, which has been level for years and is now being cut back. In recent years, the costs of operating the hospital have also escalated. On June 1, 1981, the city imposed cuts of about 12 percent of DH&H's annual operating budget, which had a major impact on the service level of the NHP and on outpatient mental health services. The level of encounters is expected to decline from 350,000 to about 225,000 a year.

The NHP still provides a wide range of primary medical care services, although dental services and many ancillary services have been almost eliminated. At the health centers and stations, traditional categorical health department services are totally integrated into the regular care system: family planning is given as part of OB/GYN services, and immunizations are provided as part of routine pediatric care, for example.

The NHP is also part of a complete "system" of health care that includes secondary and tertiary care at Denver General Hospital, linked by a computerized information system for tracking patients.

In order to assemble and operate this unified, noncategorical delivery system for comprehensive ambulatory health care, DH&H pooled its various federal, state, and local funding sources. It was able to justify its bending and breaking of narrow categorical requirements that impeded integration by demonstrating success, as indicated by the number of encounters each funding source could take credit for and by passing periodic reviews of quality of care with flying colors, all at reasonable costs per patient. Eventually, DH&H's commingling of funds was regularized with an integrated grant from the federal regional office.

Through a process of pragmatic responses to a series of internal, community, and federal categorical challenges to its integration of programs, DH&H developed a distinctive nonhierarchical management structure that was conducive to coordinated service delivery across professional, programmatic, and institutional cleavages (akin to the more formal "matrix management" techniques used in the Florida Department of Health and Rehabilitative Services and, to some extent, in the Jefferson County, Alabama, health department).

While Denver Health and Hospitals was uniquely successful in developing an integrated public system of decentralized primary care and hospital-based specialty and inpatient care within a single organization, it was not able to achieve all of its initial goals. Categorical pressures and requirements and professional differences kept DH&H from fully integrating mental health services. The NHP's family-centered team approach was modified in the face of intractable problems, such as episodic utilization by many patients, physician specialization and limited ability to accept nonmedical people, and inadequate funding for support of a full range of services and personnel.

Denver Health and Hospitals was never able to develop a stable funding base for the Neighborhood Health Program. The state's Medicaid program was too limited to maintain the program, let alone expand it, in contrast with the experience of health centers in other case study states (Massachusetts, Michigan, and, at least until recently, Washington), and its medically needy program, although it goes directly to Denver General Hospital, only covers about half the costs of treating the medically indigent.

At the local level, the program has always been sustained by outside funding (although the city has increased its support when necessary from time to time), while city funds went to support Denver General Hospital. The leadership of DH&H has been able to maintain ambulatory care as the top priority, and to protect the NHP from becoming an adjunct feeder operation for teaching and research programs at Denver General Hospital. However, Denver General is a tertiary-care teaching hospital, the most expensive in the city. Hospital cost inflation, combined with the inpatient bias of reimbursement systems, resulted in a fiscal crisis that was resolved by sharply reducing the city's support of decentralized health and mental health services.

Ironically, one of the program's major successes in fostering services integration--the separation of patient financial status from clinical practice--is proving dysfunctional today, as the program faces a mammoth task of increasing patient revenues. Under great pressure, the NHP leaders had reluctantly introduced a centralized billing system in 1973. The system bills insurers or patients by mail, after the service is rendered, and has long had a very poor collection rate. However, introducing cash registers and tighter financial screening will require a revolutionary change in the free-care philosophy of the NHP and its staff. It would require

an equally revolutionary change in the department's management structure to permit stronger administrative control at the health center and station levels.

The major finding of the Denver case study is that it is possible for a public health department to conceive of and implement a highly innovative decentralized health care delivery system that is complemented and enriched by the department's responsibility for traditional public health functions and for a public general hospital. Denver has a "system" that integrates primary with secondary and tertiary care, and preventive with curative services, that an independent community health center, or even a network of health centers run by a health department without a hospital, cannot easily achieve.

It would be impossible to replicate the Denver NHP today. It is very much a product of its time and place. However, its experience can provide lessons for others in several areas. First, although Denver was faced with categorical program and funding restrictions that have been mostly eliminated or eased over the years, with organizational and administrative changes at the federal and state levels, those restrictions have not entirely disappeared. With block grants, state health departments are able to have a stronger say in the organization of health services at the point of delivery, and at least some state health departments will be reimposing categorical requirements long since eased by federal program officials. The NHP shows it is possible to integrate categorical programs by commingling grant funding while keeping state program officals satisfied with demonstrated results.

Second, the NHP's history indicates that nontraditional administrative structures involving multiple supervisory arrangements can be an effective alternative to the classic hierarchical administrative structure that impedes lateral coordination across programs and disciplines. Hierarchy only appears to be efficient and accountable if the combined impact of programs on patients is ignored.

Third, the NHP demonstrates the critical role that a coherent program idea or philosophy plays in motivating personnel to integrate their efforts in ways that cannot be clearly outlined on job descriptions or organization charts. The program's philosophy of maximizing access to quality services provided goal-oriented guidance for staff in the place of detailed written policies and procedures.

Fourth, the NHP shows that it is easier to implement a program with staff that joins out of a personal belief in the program's goals than with an incumbent staff that has to be reoriented. This points to the importance of recruitment and orientation policies.

Fifth, the NHP provides a number of lessons in adapting high ideals of preventive and continuous family-centered health care to the realities of patient, provider, and organizational behavior.

Sixth, the importance of leadership that is not only skilled, but persistent and aggressive, is evident. Furthermore, leadership skills include public relations and political know-how. DH&H leaders have had the temperament necessary to enjoy the "games" that have been necessary to maintain public and political support for the program.

Florida Reorganization of Health and Rehabilitative Services

In 1969, the state government of Florida was reorganized into a small number of major-purpose departments, including a Department of Health and Rehabilitative Services (DHRS). This new department combined about 10 previously independent departments and commissions--e.g, welfare, youth services, elderly, mental retardation, vocational rehabilitation, mental health, health--as co-equal bureaus under one roof. The reorganization did not result in coordination of independent service delivery systems at the local level and problems of fragmentation continued. A second major structural reorganization in 1975 took the bureaus out of the line of command and vested line authority in district administrators around the state, who were responsible for supervising and coordinating all the department's programs at that level. At the same time, most of the services were placed together in multiservice centers under the same managers. The immediate result was chaos as workers figured out who reported to whom and how cross-program coordination was supposed to work. By the time the IOM research staff visited Florida in 1981, however, the new system was working fairly well. (Imershein's paper, in Volume IV, on the Florida reorganization gives more information on how DHRS works at the local level today.)

This reorganized department was selected as a case for this study because it promised to give insights into attempts to integrate health with social services. But it was found that, even in the case of radical structural integration of social services, health staff resist integration with services that are not health related.

The primary health services delivery units are the county health departments. In the 1975 reorganization, these health departments were treated differently than the social services--they were not put under service networks or grouped in service centers with other programs under DHRS. There were a variety of political and practical reasons for this exemption. First, county health departments are authorized by state legislation that makes them part state and part county agencies, and attempts to change this law have been blocked by the health department and the medical association. Second, the medical association objected strongly to the inclusion of the state health department in DHRS and has agitated ever since to make it independent again. Third, the people regarded as being neglected in services were not public health department clients; therefore, there was little need felt to reorganize public health services. Fourth, the designers of the reorganization were from social services, not health. Fifth, as Imershein points out, most health departments did not really have individual clients for whom services had to be coordinated but were providing community services.

In addition, the reorganization was traumatic enough without also trying to reorganize the county health departments, which on the whole were functioning reasonably well, at least administratively. The assistant secretaries of the new departments were social service administrators and tended not to be comfortable supervising many of

the health functions. The county health departments have a dual accountability, reporting to both the district administrators and their county commissions. At the operational level, the county health departments are separately administered and located.

Palm Beach County Health Department, the site studied by IOM staff, is exceptional in the state. It is one of the few health departments that has a major primary health care program delivered in decentralized centers throughout its service area. The health department has been delivering primary care since establishing its first migrant health center in 1954. Now it operates six health centers. The program was begun by a health officer who came to West Palm Beach in 1951 with a vision of an activist community health agency using a wide range of health strategies, such as the health departments's police powers and environmental responsibilities to regulate living conditions in migrant camps.

Today, the clients of the health centers are the poor people of Palm Beach County, who are also clients of the department's social service network. The health center has close linkages with the county social services department, which screens all health department's patients for eligibility and pays for inpatient care from county general revenues.

The department's success is attributed to the leadership since 1951 of the health department director, who has been able to recruit and retain talented subordinates to operate the system. Part of the director's tasks included working closely with and educating the area's private physicians. The department also accommodates the private sector by referring specialty problems to area physicians and reimbursing them on a special fee scale.

The health department receives much more funding from the county than the minimum level mandated by the state. Thus the health department benefits from being considered a "county" agency in terms of funding coordination with other county agencies, and it would probably lose those benefits if it were taken over by the state.

The department long enjoyed county funding ($10 million) of its broad program of personal and environmental services, which was no doubt facilitated by the area's phenomenal economic growth since 1950. The county also contributes about $10 million a year to indigent inpatient care. The health department director, like the leader of the Jefferson County (Birmingham, Alabama) health department, has been able to convince the county commission to contribute substantial local revenues to support the service delivery program (including a considerable increase this year).

Although the department certifies poor people as medically eligible for county-subsidized inpatient care, there is no county hospital, and there are significant problems with continuity of care through the secondary and tertiary levels. Florida has a limited Medicaid program, and only one of 10 hospitals in the county (and few physicians) will take Medicaid patients. The meager Medicaid program also means that the department has to rely on direct appropriations from the county, patient revenues, and federal and state grants. In

marked contrast to the situation found in Denver, there is much effort to collect from or for each patient, and patients are screened before each visit by the county social services department; patients with insurance coverage or above a certain income are ineligible for care and are referred to the private sector.

The Florida experience suggests that there can be virtues in the separation of primary care delivery and social services delivery. The IOM research staff did not find much sentiment in the health department, the district office, or the community for bringing the health departments into the service network structure. Partly this was a problem of cost, because the counties provide a great deal--one-third to two-thirds--of health department funding. But partly it was a feeling that the services of public health were independent enough to warrant their own organization.

The department continues to be innovative. It implemented the first public sector prepaid health plan in the South after persistent negotiations with federal staff over two years, and is now running it with Medicaid funds that provide a more comprehensive set of services than the state's basic Medicaid program. As part of this project, the department is developing a cost-allocation accounting system that enables it to bill the appropriate grant program, much like the systems being developed in Seattle and in the Alabama state and Jefferson County health departments.

The main lesson of this case (and of Jefferson County, Alabama) is that it is possible for a public health department to piece together a comprehensive array of medical services from a variety of federal, state, and local sources through persistence and careful working with the medical society. The result, however, looks very different from the projects that were launched initially as comprehensive health centers with large flexible grants (as in Denver and Boston).

Michigan "Laboratory" for the Development of Integrated Health Services

In 1978, the federal Bureau of Community Health Services funded a small new staff unit in the Michigan Department of Public Health--the Division of Health Care Systems--to coordinate federal, state, and local primary care efforts in the state. The division worked with communities and federal officials to develop Rural Health Initiatives (RHI), seven of which were funded, and it encouraged integrated service delivery involving the RHIs, local public health departments, and other local providers with state funding.

The Division of Health Care Systems' efforts were impeded and frustrated by a number of factors beyond its control. First, the federal regional office opposed the state effort for several years--a position sustained by Washington office support. The regional office did not encourage the RHIs to work closely with the state, although many were grateful for the division's assistance in obtaining funding. This situation since has changed dramatically; for the 1982

fiscal year, the division staff has contracted with the regional office to act as the project officers for all federally funded health centers in the state. Second, the state health department is a proudly traditional public health department organized around categorical divisions, whose staff tends not to think or act across program lines and therefore does not encourage the local departments to merge their various clinic services with a primary care operation. Third, the strongest state-local tie is with the local health departments, and extensive plans were made to increase the state share of local services funding. However, the state's fiscal distress has already forced the department to make some decisions that indicate its preference for public health funding over primary care. For example, to maintain the level of current funding to local health departments, it proposed eliminating two of the three state-funded primary care centers and cutting the third. Fourth, the division has had to accept the fact that at the local level there are a number of practical matters facing health departments and RHIs that make it difficult for them to merge.

The division invested a lot of staff time in planning the Rural Health Initiatives that were integrated with local public health departments. It succeeded in working out a variety of coordinated arrangements--shared board members, shared staff, shared location, out-stationed staff, subcontracts, and so on--but it did not achieve full integration at the several sites it hoped would be models.

The IOM research staff visited one such site, the East Jordan Family Health Center in rural northern Michigan, and discovered a number of barriers to the full merging of RHI and health department efforts. For one thing, the small resources of the health department had to cover three counties, while the RHI covered only parts of two. For another, the health department offers free services to the whole community and the RHI is not free, although it has a sliding fee scale. Also, the public health nurse assigned to work in the RHI facility is not a primary care clinical nurse. She reports to the health department's nursing director and has many public health duties, such as home health. The directors of the two organizations, their respective staffs in the RHI facility, and RHI board members felt the division of labor was entirely sensible: primary care, upstairs; free immunizations, family planning services, WIC, etc., downstairs. They have managed to make a number of services available in one location; however, because of restricted hours at the health department, they are not always available at the same time.

East Jordan illustrates services integration by coordination of existing rural agencies. The health department and the RHI refer patients to each other, although the health department also makes referrals to other providers. Through personal interest, a psychologist at a nearby community mental health center supervises two new social workers on the RHI staff and provides services himself one day a week in the RHI.

Because of a dearth of physicians in the area, the RHI had to use National Health Service Corps (NHSC) physicians for staffing. They were given staff privileges at a nearby community hospital,

where they admit and follow their patients, and they refer patients needing higher levels of care to a regional specialty hospital.

The IOM research staff visited a second site in Michigan, Community for Health and Social Services (CHASS), a community health center set up in Detroit in the late 1960s and funded by the state through the Division of Health Care Systems. CHASS, however, is relatively autonomous because it has its own line item appropriation in the state budget and enjoys strong community and legislative support. CHASS is in the same building with staff of the state social services department but the two are not physically or procedurally integrated within the facility.

The Division of Health Care Systems faced many obstacles at all three levels of government in its attempt to foster integration of services. Its effort in programming federal primary care funds was resisted for three years by the regional office. The state health department itself is a traditional public health department, organized categorically, which regards local health departments as its chief clients. The division has had to negotiate repeatedly with various categorical programs that do not understand or value cross-program integration at the delivery level. Finally a major increase in state aid to local public health departments did not materialize, due to the state's fiscal crisis, which gave the division less influence with local public health departments than expected.

Seattle North District Family Health Clinic

The Family Health Clinic, located in the North District health service center of the Seattle-King County Department of Public Health (SKCDPH), was established in late 1979. It is a pilot effort to provide family-oriented ambulatory care to the medically underserved and Public Health Service (PHS) Hospital beneficiaries residing in North Seattle. One goal has been to demonstrate that primary care services can be delivered in a unified manner while at the same time meeting the reporting and auditing requirements of different categorical funding sources. A second goal has been to try to negotiate a new type of reimbursement arrangement with categorical funding sources, based on units of health services delivered rather than on staff positions paid for out of specific funds (e.g., Title V nurses), through the development of innovative accounting and encounter data systems.

The Family Health Clinic is a joint venture of the SKCDPH and the U.S. Public Health Service Hospital, with assistance and evaluation by the Department of Health Services in the School of Public Health and Community Medicine at the University of Washington. The project was initiated in late 1979 with a demonstration grant from the John A. Hartford Foundation. The SKCDPH and the PHS Hospital are also contributing major amounts of resources to the project.

Seattle is well known for the many innovations in health service delivery that have been tried there, but before 1980 the SKCDPH was a traditional public health department that only delivered the usual

personal health services, such as maternal and child health, immunizations, prenatal care, and WIC, in a categorical manner, e.g., in separate clinics, at different times, with separate records and staffs. The department had relinquished leadership in providing health care to Seattle's low income citizens to the community clinic movement of the 1970s, other than operating the MIC and C&Y projects that were started in the 1960s.

The project grew out of informal discussions between the head of the Seattle-King County health department and the director of the U.S. Public Health Service Hospital at the University's Department of Health Services, where they were both on the faculty. They discovered a mutual interest in setting up a primary care center. The health department had staff who wanted to decategorize the department's clinical services. A new mayor with an interest in health centers had just been elected and wanted the health department to become involved in primary care. The PHS Hospital was looking for opportunities to justify its continued existence and was already very involved in community health services in the city. It offered to provide a physician, a nurse practitioner, and a pharmacist. The North Seattle area was selected because many PHS beneficiaries lived there (across town from the hospital), few of Seattle's many community clinics were located there already, and the health department was moving into a new North District facility that was suitable for primary care delivery.

The health department met with state Division of Health representatives to try to work out a way for the department to use categorical family planning, venereal disease, and maternal and child health funds in a primary care setting. The state officials were resistant to integrating such categorical funds, and the federal regional office representatives present were reluctant to intervene. At that time, health department officials began to work with the university on ways to generalize service delivery while meeting categorical funding and reporting requirements. The coalition was able to obtain funding from the Hartford Foundation, which was initiating a program of health services financing experiments.

Internally, the department faced the problems any organization encounters in trying to introduce significant change, exacerbated by its status as a government agency. Staff in the North District service center resisted decategorization, and there were civil service and union problems. Changing the attitudes and behavior of the existing staff has proved to be a slow process. Another problem is the incompatibility of the city's computer with the system developed by the university and the PHS Hospital for the project.

Although the department estimated there were over 80,000 low-income residents in North Seattle, progress in building demand has been slow. PHS beneficiaries in North Seattle have not materialized in great numbers. They evidently prefer to go all the way to the hospital, and the providers there, worried about the future of the clinic, have not encouraged them to switch to the clinic.

Another obstacle facing the project has been the uncertain status of the U.S. Public Health Service Hospital. After the project began, the PHS Hospital was slated for closure by the federal government. The hospital's fate was up in the air for many months, until Seattle was able to obtain a transition grant to convert the hospital into a community hospital. If the hospital does not survive, the clinic's physicians will go, and the effort will fail unless the health department can find another way to support the physicians. However, Seattle and King County are facing their own severe budget problems, and significant additional funding for the project seems unlikely.

The block grants are having an uncertain effect on Seattle. While the health department has tried to convince the state that its innovative unit-of-service accounting and reporting system would be ideal for the state to use in tracking and accounting for the block grant funds, state health officials seem inclined to use their new flexibility in the use of federal funds to distribute them more evenly throughout the state. (In 1982, the state imposed a 31 percent cut in MCH funds to SKCDPH, for example--larger than the 25 percent cut at the federal end.)

The state Division of Health's staff has continued to have serious reservations about the project, both technical and substantive. They question the cost-accounting principles used to derive the unit costs that SKCDPH wants to be reimbursed for; they find that the unit-cost methodology does not meet the reporting requirements for Title X (family planning), and they feel the project's provider mix is too expensive for their purposes. They favor using the categorical clinic approach to service delivery for a number of reasons, including economies of scale, better quality control, advantages of specialization, the emphasis on prevention, and clearer financial and program accountability. As of June 1982, negotiations between the Division of Health and SKCDPH on a unit-cost reimbursement contract were continuing.

Cross-case Analysis: The Six Case Studies

General Environment

There are several aspects of the overall environment that influence the services integration efforts. The settings in which the services integration efforts took place varied greatly. Therefore, each project faced a different set of obstacles, opportunities, and overall constraints.

Urban-rural One significant environmental characteristic is whether or not the project is situated in an urban or a rural setting. Rural settings, encountered in Michigan and Alabama, have few resources compared with urban locations. At the same time there is greater personal familiarity among local policy makers, program administrators, and providers. Providers tend to be personally acquainted with the multiproblem patients whom a services integration

approach could benefit. In the two rural case studies the research team found that the idea of services integration came from the state. For example, in Alabama the Bureau of Maternal and Child Health/Family Planning was the impetus for changing county health department practices and for establishing linkages with community health centers; in Michigan the state health department primary care staff helped East Jordan broaden its initial concern beyond simply getting a doctor and prodded the local health department to become involved. Once the idea was locally accepted, the implementers of the services integration project developed a program by building linkages among existing agencies and institutions rather than try to do it all themselves.

This sort of cooperative approach among individuals long known to each other was less common in the urban settings. The relative richness and concentration of resources can create a more competitive environment in which it is more difficult to develop and sustain coordination among agencies. Urban programs seem more likely to try to provide all services at one site. Also, the geographic closeness of separate agencies can encourage integration, especially if there is overlap in their service populations. The greater concentration of patients makes that approach more feasible.

<u>Fiscal Conditions</u> The second major aspect of the general environment affecting the services integration efforts was the fiscal situation in the country and its effects on public policy and the public budget. The fiscal situation is felt at the state and local as well. The IOM staff saw effects in localities and states well before the effects of federal changes were evident. The Palm Beach County Health Department is the only project receiving either a local or a state revenue increase, but even that will not offset inflation and the federal program cuts. It is not that services integration as such can only take place under conditions of rich or expanding resources, although the case studies indicate that start-up funds are very important. But as the rural examples indicate, integrative efforts can be quite effective in situations with scarce resources.

The immediate impact of fiscal constraints is the diversion of the attention of program administrators from managing services and planning for future improvements to the process of budget cutting. It is clear that there will have to be major changes in the structure and pattern of services delivery. Achieving services integration with scarce and declining resources requires a different strategy than in times of expanding resources. Some administrators now are making organizational and service changes that have long been on their agendas but were previously impossible to make for political reasons.

The fiscal environment, of course, was quite different when some of the projects under study were conceived and initially implemented, leading to broad generational differences between the efforts of the 1960s and those of the 1970s. Efforts in the 1960s tended to lead to unified systems that offered a wealth of services under one roof, perhaps best exemplified by the Denver program, whereas efforts in

the 1970s tended to develop network systems of existing services. The later efforts are having the easier time of adjusting to the changing environment.

Tax Policies There are differences between states in "wealth" (Table 1) that affect the ability of state and local governments to raise revenues for health services, the ability of citizens to pay for health services, and the incentives for physicians to locate there. Such differences usually are marked within states as well, especially between rural and urban areas and between central cities and suburbs, but some states had larger proportions than others of rural population and/or poor residents (Tables 2 and 3).

TABLE 1 Tax Wealth and Tax Effort--Measures of Tax Potential vs Collection, 1979

	"Tax Wealth"	"Tax Effort"
United States	100	100
Alabama	76	87
Colorado	111	96
Florida	104	79
Massachusetts	91	145
Michigan	102	114
Washington	103	97

Tax Wealth is calculated using the Representative Tax System to estimate the amount of revenue that each state would raise if it applied average state-local rates to its tax base. Because the same rates are applied to each state's tax base, differences in the potential revenue that could be raised reflect only differences in underlying tax bases. The tax wealth number shown is an index number based on each state's per capita tax potential.

Tax Effort is an index number based on the ratio of actual tax collections to potential tax collections using the Representative Tax System.

SOURCE: Advisory Commission on Intergovernmental Relations (1981) Significant Features of Fiscal Federalism, 1980-1981 Edition. ACIR Report No. M-132 (December). Washington, D.C.: Government Printing Office.

TABLE 2 Persons, Families Below Poverty Level--
States, 1975

	Persons	Families
United States	11.4	9.0
Alabama	16.4	12.9
Colorado	9.1	6.3
Florida	14.4	11.0
Massachusetts	7.1	6.1
Michigan	9.1	7.6
Washington	8.5	6.6

SOURCE: U.S. Department of Commerce (1980) Statistical Abstract of the United States, 1980. Bureau of the Census. Table 777, p. 467. Washington, D.C.: Government Printing Office.

TABLE 3 State Personal Income, 1980

	1980 Provisional	Rank	Percentage of U.S. Average
United States	$ 9,458		100
Alabama	7,484	47	79
Colorado	9,964	12	105
Florida	8,987	26	95
Massachusetts	9,992	11	106
Michigan	9,847	14	104
Washington	10,363	8	110

SOURCE: Advisory Commission on Intergovernmental Relations (1981) Significant Features of Fiscal Federalism, 1980-81 Edition. ACIR Report No. M-132 (December), Table 55, p. 77. Washington, D.C.: Government Printing Office.

States and localities also differ in their willingness to tax what wealth they have. For example, Florida and Alabama not only are poorer than most other states, but also they make less effort to tax what they have. Massachusetts is a little poorer than average but taxes itself very hard compared with the other states (see Table 1).

The state tax systems and state-local tax systems taken together vary in their progressivity and elasticity or growth potential, and the shifting of social program costs from the federal level has different impacts across states and across groups within states (Table 4). The state of Washington has a very narrow tax structure based heavily on sales taxes (it has no income tax), and the state already is nearly bankrupt because of the recession. Alabama's tax structure is very unwieldy because each tax source is earmarked for specific purposes, and the slowest growing tax sources are earmarked for social programs (Table 5).

Having significant taxable wealth within the jurisdiction has been very important for some of the places under study, such as Palm Beach and Jefferson counties. Denver also enjoyed this advantage as long as it could annex territory as its middle class moved outward, but the passage of an act in 1974 to end this privilege may have begun the decline of Denver as a self-supporting community. Seattle is a graphic example of the fragmentation of services resulting from interjurisdictional disputes over whose taxes should pay for what. In that case the city-county health department was reorganized to establish a separate Seattle division that has to fund its activities from Seattle revenues only, although the county has the larger and broader tax base. Furthermore, the more local wealth supporting the program, the less affected it is by the current federal cutbacks.

The states vary in their willingness to contribute state tax revenues to social programs, and they exercise discretion over the size and coverage of Medicaid programs and of related social welfare programs.

- Welfare Programs In the Aid to Families with Dependent Children (AFDC) program, the research team found that the states had very different payment standards, and that the average monthly payment for a family of four ranges from $390 in Michigan to $110 in Alabama (as illustrated in Table 6). Two of the cases (Alabama and Florida) do not have the unemployed parent option and cover only single parents with dependent children. Some states supplement the federal welfare program for the elderly, Supplemental Security Income (SSI), and others do not.

- Medicaid Three states (Alabama, Colorado, Florida) do not have a medically needy option and cover only the categorically needy (those on SSI, AFDC, aid to the blind or disabled). Regardless of the coverage, it was usually difficult for health centers to negotiate for reimbursement,

TABLE 4 Summary of Significant Features of the State-Local Revenue Systems

	Incidence[a] 1976 (Family Tax Burden)	Tax Effort 1978		Diversification 1978 Source State-Local Revenue (%)					
				Taxes					
		State-Local Taxes as % State Personal Income	Per Capita State-Local Tax Revenue	Property	General Sales	Income	All Other	Charges & Misc. Revenue	Federal Aid
United States	Regressive	12.8	$ 888	21.0	13.1	13.9	13.2	16.7	22.0
Alabama	Regressive	10.2	566	6.1	15.6	10.0	18.4	22.5	27.4
Colorado	Proportional[b]	12.6	882	20.9	16.5	11.5	9.6	20.0	21.4
Florida	Regressive	10.6	699	18.9	15.9	2.5	20.6	21.4	20.6
Massachusetts	Regressive	15.1	1,098	31.1	5.4	19.0	10.0	10.6	23.9
Michigan	Progressive[b]	12.7	959	22.1	11.0	19.5	8.3	17.5	21.6
Washington	Regressive	12.7	929	18.3	25.5	--	15.4	20.7	20.0

[a]Based on comparison of estimated major state-local tax burdens for hypothetical families of four residing in the largest city in the state. Includes state and local income, general sales, residential property, cigarette excise and motor vehicle taxes. In determining incidence, the $10,000, $15,000, $17,500, $25,000, and $50,000 adjusted gross income classes were included. A state's tax system was considered progressive (P) if the tax burden (taxes a % of income) for the $50,000 class was 10 or more percent greater than the $10,000 class, regressive (R) if 10 or more percent lower than the $10,000 class, and proportional (PP) if the percentage difference was less than 10 percent, plus or minus.
[b]Except for $10,000 income class.

SOURCE: Advisory Commission on Intergovernmental Relations (1980) Significant Features of Fiscal Federalism, 1979-80 Edition. ACIR Report No. M-123 (October), Table 40, pp. 53-54. Washington, D.C.: Government Printing Office.

TABLE 5 Proportion of Revenues Earmarked for Special Programs by States in Fiscal Years 1954, 1963, and 1979

	Percentage of State Tax Collection Earmarked		
	1954	1969	1979
Alabama	89	87	88
Colorado	75	51	17
Florida	40	39	28
Massachusetts	56	54	41
Michigan	67	57	38
Washington	35	30	29
United States	51	41	23

SOURCE: Advisory Commission on Intergovernmental Relations (1980) Significant Features of Fiscal Federalism, 1979-80 Edition. ACIR Report No. M-123 (October), Table 55, p. 75. Washington, D.C.: Government Printing Office.

> and payments often have not covered costs. Also, overall reimbursement per recipient in a state may be so low that providers are reluctant to see Medicaid patients, or so high that they compete for Medicaid patients (Table 7).

It is quite possible that turning programs over to state control, or increasing state discretion over federal programs, will result in equally wide variations in programs across states.

Health Status and Resources Some states have larger health problems than others, as reflected in infant mortality and overall death rates (Table 8), and there are large differences within states in these rates according to race and geographical area.

Medical resources are not equally available and accessible across or within states (Table 9). All of the case study efforts were initiated in underserved areas, but the availability of medical resources shaped local strategies, such as setting up a separate public delivery system (Alabama) or trying to tie in the private sector (Boston).

TABLE 6 Aid to Families with Dependent Children, Recipients, and Payments, December 1980[a]

	Number of Families[b]	Total Recipients	Average Per Family	Ranking by Avg. Payment/ Family[c]	Recipients as % of 1980 Population[d]
United States	3,842,534	11,101,149	$287.77	--	4.9
Alabama[e]	63,246	178,322	$110.17	48	4.6
Colorado	29,467	81,031	257.63	25	2.8
Florida[e]	103,315	279,392	176.44	40	2.9
Massachusetts	125,232	347,830	349.70	10	6.1
Michigan	246,648	752,578	390.20	4	8.1
Washington	61,639	173,339	380.19	6	4.2

[a]Includes nonmedical vendor payments, unemployed parent, and AFDC-foster care data.
[b]Each child in foster care is counted as a family, resulting in inflated case counts in Colorado and Michigan.
[c]Of 50 states.
[d]Calculated with 1980 census data.
[e]Does not have unemployed parent coverage (eligibility).

SOURCE: U.S. Department of Health and Human Services (1981) Social Security Administration; Office of Policy; Office of Research and Statistics. SSA Publication No. 13-11917, ORS Report A-2(12/80). Washington, D.C.: Department of Health and Human Services.

TABLE 7 State Medicaid Recipients and Average Payment, 1979

	Number of Recipients	Percentage of State Population	Average Payment Per Recipient
United States	21,540,000	9.5	$ 950
Alabama	327,900	8.4	731
Colorado	150,600	5.2	1,082
Florida	435,800	4.5	784
Massachusetts	1,046,300	18.2	862
Michigan	897,700	9.6	1,155
Washington	273,600	6.6	1,062

SOURCE: U.S. Department of Health and Human Services (1982) The Medicare and Medicaid Data Book, 1981. Health Care Financing Program Statistics. Health Care Financing Administration, Office of Research and Demonstrations. HCFA Pub. No. 03128, Table 1.1, p. 4. Baltimore, Md.

TABLE 8 Death Rates and Infant Death Rates, 1978

	Death Rates[a]	Infant Death Rate[b]	
		White	Black and Other
United States	8.8	12.0	21.1
Alabama	9.3	12.1	23.4
Colorado	6.8	11.0	13.3
Florida	11.0	11.8	20.1
Massachusetts	9.1	10.5	17.0
Michigan	8.2	11.8	23.2
Washington	8.0	12.3	15.0

[a] Deaths per 1,000 population.
[b] Deaths within the first year per 1,000 live births.

SOURCE: U.S. Department of Commerce (1980) Statistical Abstract of the United States, 1980. Bureau of the Census. Tables 113 and 115. Washington, D.C.: Government Printing Office.

TABLE 9 Active Physicians, by State, 1970-1978

	Rate per 100,000 resident population	
	1970	1978
United States	150	182
Alabama	93	122
Colorado	186	212
Florida	139	189
Massachusetts	208	255
Michigan	121	149
Washington	153	186

SOURCE: U.S. Department of Commerce (1980) Statistical Abstract of the United States, 1980. Bureau of the Census. Table 169, p. 111.

Health Services Organization

Public Health Departments State and local organization for health services varies widely. The state health department may be organizationally separate or combined with other social programs. Organizational unification does not necessarily result in cross-program services integration at the delivery level, as in Washington, and organizational separation does not preclude extensive coordination between health and social services, as in Michigan. At the local level, nearly all public health departments offer preventive services, such as immunizations, family planning, and VD clinics, and some also run public hospitals (Denver), mental health centers (Denver, Jefferson County), and/or primary care centers (Denver, Jefferson County, Palm Beach County, Detroit, Seattle).

Some states contribute substantial amounts of state tax revenues to their health departments for personal health services, and others let their health department rely primarily on federal funding. One result is a wide variation in per capita state expenditures for personal health services (Table 10). Another result is varying vulnerability to federal funding cuts.

State-local relations are unique to each state in terms of the degree of authority the state health department has over local health departments, how much authority it chooses to exercise, how much funding of health comes from state as compared with local revenues, and whether there is a program of state aid to local health departments. There are states (not among the six) with no local health

TABLE 10 Federal and State Contributions to Noninstitutional Personal Health Program Expenditures of State Health Agencies (SHAs), Fiscal Year 1980, in Thousands of Dollars

	Total Noninstitutional Personal Health (in thousands)	Federal Grants & Contracts	State Revenues	Federal/ State Ratio	Per Capita Total SHA Expenditures on Personal Health	Per Capita State Funding of SHA Expenditures on Personal Health
United States	$2,331,837	$1,220,325	$964,560	1.27	$10.29	$4.26
Alabama	34,293	28,866	4,758	6.07	8.81	1.22
Colorado	32,182	19,100	13,083	1.46	11.14	4.53
Florida	63,984[a]	32,567	25,167	1.29	6.57	2.58
Massachusetts	49,938	24,850	25,089	.99	8.70	4.37
Michigan	129,332	57,812	62,851	.92	13.97	6.79
Washington	27,774	21,966	4,076	5.39	6.72	.99

[a]Does not include local health department expenditures included by NPHPRS as state expenditures.

SOURCE: Expenditure figures are from National Public Health Program Reporting System (1981) Public Health Agencies 1980: A Report on Their Expenditures and Activities. ASTHO Publication No. 61, Appendix Table 27, p. 113. Association of State and Territorial Health Officials, Silver Spring, Md. Per capita expenditures based on population figures in 1980 U.S. census.

departments, and states (Massachusetts) where state and local public health are virtually independent. Even when the state provides much local health funding, it may not attach standards and regulations in certain programs (Alabama). On the other hand, there may be an elaborate set of minimum basic services and standards (Michigan).

Health department relationships with chief executives vary, from the complete independence of the Alabama Board of Health (which is tantamount to the state medical association) to complete political subordination to the governor or mayor. In West Virginia, one of the case reports, the health department was reorganized, in part, so that the governor could gain more control of the health apparatus. Health departments may be several organizational layers removed from the chief executive, as in Florida.

Some state health departments consider private, nonprofit health centers to be alternative grantees for health programs (Michigan) while others have nothing to do with them (Alabama, Florida). All, however, have very close relationships with local health departments (except Massachusetts, which has none) and generally prefer them to community health centers.

The state health departments visited are basically categorical in their orientation, organization, and channels to the local level. The West Virginia Department of Health, described in a case report, seems to be the only state health department to integrate services at the local level. With few exceptions, however, categorical personnel (MCH, family planning, WIC, immunization, TB) or professional groups (public health nurses) at the state level have not supported efforts to integrate services at the local level.

One of the organizational factors postulated to have an impact on services integration efforts was the presence or absence of consolidated departments of human services, although the empirical literature suggests that the creation of umbrella human service departments rarely has an effect on the degree of actual coordination or integration at the service-delivery level. These departments were created during the late 1960s and early 1970s, in part to facilitate the coordination of interdependent services, although the chief motive in most cases was to increase administrative economy and efficiency by such means as reducing overhead and combining support services. Such departments are present in three of the six case study states: Florida, Massachusetts, and Washington. As it turns out, the health departments still operate as independent organizational units in Washington and Massachusetts, and there has been little change in their relationships with other services under the same departmental umbrella. In Florida, the reorganization went much further than simply putting departments under one roof; it actually eliminated them as organizational units and increased the coordination of social services at the local level. However, health services are still delivered by county health departments that are organizationally independent of the service networks.

Intergovernmental Grant System Federal policy with regard to services integration is not clear or consistent. There are unresolved tensions at the federal level between integrated

primary-care-oriented officials and categorical program officials. As a result, regional health officials in some regions have not supported local services integration efforts.

Federal categorical rules and regulations were seen by program integrators as annoyances--the price of doing business--rather than as major impediments. This price may be more than an annoyance, however, because multiple accounting and reporting requirements sometimes make categorical programs more expensive. The intergovernmental grant system can itself be a disintegrating force for state and local services integration efforts that try to combine various federal programs--each with its own administrative, funding, program, and eligibility requirements--into a coherent program that makes sense for an area's needs and populations. However, this system is not static. There has been some services integration at the federal level over the years, as discussed in Appendix F, culminating in the placement of most grant programs for personal health services under the Bureau of Community Health Services (BCHS), although the functional integration of those services within the bureau is not complete.

In general, the services integration projects under study have found it easier to coordinate their community health center and migrant health grants with National Health Service Corps placements as a result of BCHS efforts. BCHS' efforts to coordinate funding of health center services with the Farmers Home Administration program for constructing health center buildings has also benefited some of our cases. Success at coordinating community health center/migrant health grants with Title V maternal and child health and Title X family planning services has been much more mixed, depending on regional office and state health department attitudes and practices. Several of our cases were beneficiaries of the Title V Program of Projects device for routing concentrated amounts of Title V money to urban areas (Denver, Boston, Palm Beach County, Jefferson County, Seattle) where they could be used to help build an integrated program. These are the Children and Youth, and Maternal and Infant Care projects. It is already evident in Washington, Massachusetts, and Alabama that the state health departments will use the MCH block grant flexibility to combine those funds with the formula grant part of Title V and redistribute them statewide. In Washington, at least, the money may be recategorized by requiring that it be spent only on separate MCH clinics and staff.

Several of the services integration projects attempted to use MCH formula money to fund integrated services and were impeded by regional offices. Some of these conflicts occurred in the 1960s and 1970s and were resolved long ago as federal policy changed to encourage integration. One regional office MCH director still refuses to allow Title V grant funds to be combined with other funds in spite of BCHS encouragement of such practices. Another regional office has waffled on the issue and by default allowed the state health department to prevent such combining of funds. In other sites, Title V monies are combined smoothly and effectively.

The intergovernmental grant system also has differential effects, depending on whether the project sponsor is a private, nonprofit,

community-based corporation or a public health department. It is well known that it has been federal policy to bypass state and local health departments because they were not deemed innovative or responsive enough to community needs. As it turns out, the cases include a number of examples of innovative primary-care-oriented health departments. These show that public health departments are not incapable of initiating, implementing, and sustaining primary care services, although comparatively few do so. Although Palm Beach and Jefferson counties and Denver and Detroit have developed impressive health care systems, they are some of the few health departments to have done so. These particular departments' decisions to implement major service delivery efforts are no doubt related to the relative concentration of local wealth in terms of tax and medical resources, but many comparable areas do not even attempt to do what these departments have done. There are additional factors present in the department that differentiate our cases from the vast majority of public health departments which seek to do no more in personal health services than provide traditional categorical clinics. In North Carolina, when the state tried to enhance local health department primary care delivery, the private sector effectively halted the program. This indicates that outside opposition can be one reason that health departments rarely extend beyond their traditional role.

Community Health Structure, Public and Private The cases indicate that services integration efforts have to make some accommodation with the medical leadership in the area. The attitude of the medical community toward these efforts varies from case to case and ranges from active encouragement to uncomfortable tolerance. The larger the geographic area involved, the greater the zone of indifference within which program leaders can work without impinging on the values or interests of private practice. Still, one of the critical roles of program leadership in these efforts is to communicate with organized medicine. The physician manager of Denver Health and Hospitals during most of the 1970s says that his election as president of the county medical society was a sign of acceptance of his program. The directors of the health departments in Palm Beach and Jefferson counties have maintained close relations with organized medicine over many years. One of the interesting features of Alabama public health is that the board of health at the county and state levels is composed of the leadership of the corresponding medical societies. These boards of public health vary in their attitudes toward the public provision of care. At one extreme the state medical society is currently suing the Secretary of the U.S. Department of Health and Human Services to stop funding community health centers in Alabama. A more moderate position was adopted by a president of a county medical society who, when confronted with the start-up of state maternity and pediatric clinics, stated that the medical society did not like it but would not oppose it. An example of a more supportive medical leadership was found in Tuscaloosa: the medical society, though conservative, is an articulate defender of the need for medical services for those who cannot pay.

The hospital is another feature of the local medical scene that affects continuity of care. Again, the precise nature of the relationship between the hospital and the integration project varies, but some relationship has to be worked out. The Denver Health Department, which runs the Neighborhood Health Program, has its own hospital--an arrangement that permits the program to provide all levels of care except long-term care. Elsewhere, relationships with hospitals are problematic, even where there are public hospitals. Most of the time, if there is a public hospital, there is no cost barrier to patients, but the health center may have to give its patients over to the house staff. Chiefs of service in public hospitals are reluctant to give privileges to health center physicians, but many accommodations have been worked out, depending on the center, the particular physician, and the particular service within a given hospital. These arrangements also take time to work out. At the other end of the scale, in physician-poor, rural Alabama and Michigan, health center physicians, even NHSC physicians, are actively sought to staff local hospitals. In some Alabama county hospitals, such physicians are the only staff.

Physician supply is another obvious variable of importance for services integration efforts. Places like Denver and Seattle draw medical students and residents who then want to stay in town. The rural efforts usually have to recruit physicians from the outside, and there is much dependence on National Health Service Corps personnel in places like rural Michigan and rural Alabama. In rural North Carolina, the Area Health Education Center Program provides facilities and services to make rural practice more attractive to physicians. Inner-city projects in Boston and Seattle have also depended on the NHSC. Medical schools and residency programs not only attract physicians to the general area; but they sometimes also attract physicians to a specific site. The study team noted that in several sites (Denver, Jefferson County, Michigan) physicians had been introduced to the center during a residency rotation program. Medical schools also affect projects efforts for vertical integration. Where there is one medical school, close relationships can be worked out with the program on a citywide basis, but the presence of more than one medical school in Boston seems to contribute to the interorganizational competition and conflict.

Organizational Characteristics

Types of Organization The cases, and the various sites examined within them, have a variety of organizational characteristics. The relationship between these characteristics and the pattern of service delivery outputs is not easily discerned from our data, except where the delivery organization is a public health department. Health department involvement in primary care tends to develop incrementally from its existing pattern of categorical clinics toward comprehensive care by adding new kinds of clinics (e.g., adult medicine) and by

combining some previously independent clinics, such as maternity and family planning or family planning and VD. There is a gradual broadening of the perspective of the personnel involved, aided in most cases by people leaving or retiring early or transferring within the department.

In contrast, programs established to provide primary care have a different attitude from the beginning; they set out to provide comprehensive care to their target population rather than to provide services with limited categorical clinics. This difference in perspective is one factor that seems to impede cooperation between health departments and community health centers. They use different languages and operate from different assumptions about how care ought to be provided. Despite the differing views, vestiges of the categorical clinic approach are evident in Palm Beach and Jefferson counties. In Seattle, the physician and several midlevel practitioners were specially recruited from the outside, and many unsympathetic health department staff were transferred out. In Denver, the public health department was so small and recently established, and the neighborhood health program so quickly became large, that the health department was simply overwhelmed.

Health department origins also seem to be a factor in distinguishing services integration strategies. The health departments tended to take the "services integration through cooperation and division of labor with existing agencies" approach rather than the "services integration through unification under one roof" approach. (This idea that one's own effort comprises just a few of the pieces is probably reinforced by the noncomprehensive categorical clinic tradition.)

Implementation The research did not disclose a simple underlying dynamic or model that appears in all cases and that can be replicated nationally. Each effort took place in different environments that presented different sets of barriers and opportunities for each set of program innovators. Each effort had a different starting point in terms of the local resources already available and the prevailing fiscal environment. Particular events and personal factors made a difference.

These efforts were not usually based on a conscious master plan. Rather, program leaders were opportunistic. The resulting program was shaped by a series of independent actions by different organizations and people. No one sponsor or implementing organization had overall jurisdiction. Usually, the institutional turf was already divided up, and a variety of independent actors had to be linked to create a total program, such as community health centers with hospitals.

The factors that operated in each case were contingent rather than determinant. They were necessary but not sufficient to success. Therefore, the role of the local project leadership was critical in putting together the pieces, taking advantage of opportunities, and persuading the various independent actors to cooperate.

In most cases there has been continuity of program leadership, which is important in sustaining the development of an idea. When key people moved on, they typically ended up in related positions in the state or local governments or in the medical sector, where they were sometimes able to continue to work for the program.

Events or crises played major roles in triggering support for the services integration efforts and in helping it overcome institutional inertia. Such events included the Boeing "depression" in Washington state in the early 1970s, high infant mortality rates, blue-ribbon management efficiency commissions, civil disturbances of the late 1960s, and so on.

Effects of Services Integration on Efficiency and Economy

Even if services integration did not alter the circumstances of care for patients, it would be worth pursuing if it provided the same services at less cost, or more services at the same cost. But documenting productivity in the case studies proved a difficult task. The research team gathered a large amount of data on program costs, including revenue and expenditure budgets and Bureau of Community Health Services Common Reporting Requirements (BCRR) reports when they were available (seven of the ten service delivery sites visited filed out BCRR forms). However, the BCRR data were not always complete and up-to-date. In addition, they are not wholly reliable in that the science of defining and allocating overhead and indirect costs has not been perfected. Therefore, it is possible to report data in such a way that the program appears to meet the Bureau of Community Health Services standards, which are 4,200 to 6,000 on-site encounters per physician per year; average cost per medical encounter, between $16 and $24; and administrative costs, no more than 16 percent.

These standards are themselves the result of a policy decision by BCHS to stress medical services rather than the broad range of related services often provided by the OEO-type of model community health centers. The emphasis on the process costs of providing primary care services does not take into account the true overall cost effectiveness of such services, because cost savings on a broader level, such as reduced inpatient days, do not directly benefit the primary care provider. Even as our research has been under way during the past year, several of the case study sites have made budget decisions based on a cost-centered approach that have resulted in the cutting of services which do not pay for themselves directly, without regard to whether they save money for the overall system.

Denver Health and Hospitals has a larger system than any of the other case study projects; it includes all of the health centers in the area as well as the public health department functions and the public hospital. It therefore might be expected to take into account the trade-offs between funding preventive care, acute care,

and chronic services. Nevertheless, it has made proportionally larger cuts in the Neighborhood Health Program, including vision and hearing, dental, social work, and mental health services. It is possible that policy makers in Denver decided that the higher costs of inpatient care were more than offset by the more favorable reimbursement arrangements, but it is not clear that Denver Health and Hospitals knows the impact that its decentralized health service delivery system in neighborhood health centers has had on its patient's hospital utilization.

The determination of trade-offs between costs and benefits is a critical one for services integration, because it is said to promise that overall costs to the system, over time, will be lowered by making coordinated approaches to the problems of clients with multiple needs. However, if a single agency is under pressure to demonstrate its immediate effectiveness, it may make decisions that are not rational from the broader perspective of the health system.

In the case studies, the researchers found two approaches to services integration that have different implications for direct cost decisions. The first approach is typified by health centers with OEO origins. It stresses immediate on-site delivery of all needed services on an individual patient basis without regard to cost. The second approach perhaps is best typified by the Rural and Urban Health Initiatives, and by the public health departments that have become engaged in primary care by combining local funding with categorical programs. It recognizes that resources are scarce and therefore sees services integration as a network model, with a division of labor among existing health services rather than as a one-stop center. The former approach involves services integration by organizational unification; the latter achieves it by a network of interorganizational coordination.

One explanation for the difference in the two approaches is a generational one. The health centers of the late 1960s were part of a social movement taking place in a context of fiscal expansion and were sustained until 1980 by a belief in the imminence of national health insurance. The health centers of the late 1970s were founded in an era of fiscal restraint and of lessened community conflict with established institutions such as hospitals.

A second reason for having two approaches to health services integration may be the different reimbursement policies of state Medicaid programs. In some states, such as Massachusetts, the scope of services and the size of the population covered made it possible to sustain large multiservice health centers, even as federal health center support lessened. In other states, health centers have had to rely more heavily on continued grant funds or direct appropriations of some sort and have not been able to provide a comprehensive range of services.

Sponsorship is a third influence in integrative approaches. The original health center model was designed as a neighborhood institution under neighborhood control; it presumed distrust of hospitals and public health departments. Although the primary care and allied

health services often were much better integrated in the health center than would be the case in categorical clinics, the continuity of care from health center to secondary and tertiary institutions was problematic. The health department efforts are characterized by closer relationships with the private practitioners, and health departments historically have been careful not to compete with private medicine. Thus, integrating services through the division-of-labor approach--"You do this and we'll do that"; "You take those patients and we'll take these"--is a way of life for health departments. The Urban and Rural Health Initiative (UHI, RHI) outfits take the division-of-labor approach simply because they are not funded well enough to go much beyond a small solo or group practice model (unless they are in a state with a more generous Medicaid program). They therefore have to do a great deal of referring. It should be noted that the RHIs can often achieve a lot of services integration through sharing of resources. For example, physicians are scarce and valuable resources. The same physicians are used for the hospital staff, the school health program, and so forth. There is a lot of information sharing and program coordination because the professionals go from place to place.

The one-stop model, such as the Eastside Neighborhood Health Center in Denver and Brookside Park Family Life Center in Boston, is more complex. It provides informative examples of services integration at the patient level because of the wide array of services that can be mobilized by a team--physicians and midlevel practitioners, psychiatrists and social workers, nutritionists, and others. However, it is an expensive model, at least in terms of direct costs. Such health centers usually are private, nonprofit organizations that are heavily dependent on federal funding through grants and Medicaid; they therefore are vulnerable to federal policy shifts. Some of the centers, especially the ones we have studied, have developed good relationships at the local and state levels, but it is doubtful that they could continue in their present form with major grant cuts and Medicaid cutbacks, let alone primary care block grants and stringent Medicaid cost controls. Therefore, these centers may not provide appropriate lessons or examples for the 1980s.

Movement from primary to secondary or tertiary care works most smoothly for the health centers that were developed out of a hospital setting. Two case report sites, Sunset Park (Brooklyn) and Mile Square (Chicago), demonstrate the benefits of a hospital connection, which include sharing of staff, smooth referral, and return of patients to the health center.

Some of the early centers, such as those in Denver, provide the best examples of overcoming categorical obstacles simply by ignoring them, commingling or pooling their funds, forcing exceptions from state and federal authorities, and by demonstrating their ability to deliver services. However, these lessons, while highly interesting sagas, are not nearly so relevant, especially after November 1980, as they seemed to have been when this study was conceived.

The cases involving health departments provided perhaps the most relevant lessons for the 1980s, because they have been more concerned about implementing minimum programs with small budgets. Some, like Jefferson County (Birmingham), Alabama, have raised significant amounts of local money for primary care services. Others, such as the West Alabama District Health Department, illustrate how a health department can work well with a federally funded community health center even under adverse conditions. The Boston Health Department used small local grant programs to multiply health services which in turn attract other sources of federal, state, local, third-party, and patient revenues. At the same time, these programs illustrate the difficulties of building integrated service networks among independent agencies and organizations and of introducing primary medical care services into public health settings.

Financing and Retrenchment

There were some key financial factors that substantially influenced every program that the research team studied; almost every individual interviewed regarded them as important. First, the scope of benefits, types of coverage, provider payment amounts, and administrative styles of the state Medicaid program determined the extent of health services offered and the number and types of individuals who had financial coverage. The importance of Medicaid to health services for the poor has been documented repeatedly (see, for example, Budetti et al. 1982, Davis 1981, Wan 1982). The research team was impressed by Medicaid's importance as a relatively adequate and predictable source of operating funds. Second, many states were facing their own fiscal crises and were looking for ways to reduce their health outlays.

Medicaid's role was dramatized by the changes that were being contemplated at the time of the field work. Changes in Medicaid coverage can take several forms: (1) elimination of entire groups, such as medically indigent and AFDC unemployed fathers; (2) elimination of entire classes of benefits (e.g., eyeglasses, dental care, and mental health services); and (3) reduction in either coverage or payment allowed (e.g., number of covered patient days or amount of fee). Our research uncovered examples of all of them.

In a nationwide study of Medicaid, the Intergovernmental Health Policy Project found in 1981 that more than one-half of the states have moderate to serious funding problems in their Medicaid budgets and that nearly all states have made changes or are proposing changes to reduce cost by eliminating services, introducing copayments, reducing the number of persons eligible, or other mechanisms. Some states, such as Alabama, have delayed Medicaid reimbursement as a way of slowing down outlays. Others may join that group. There were reports of increases in retroactive denials, often made simply

in the course of tightening up procedures.* Other problems also were reported. Every additional burden for physicians and other providers reduces the number of providers willing to put up with the bother of Medicaid, thus further reducing providers of care for the poor.

Effects of Services Integration on Patient Care**

In general, the projects studied had little knowledge of their effects on patient health and made little apparent effort to obtain such knowledge. Projects in Boston and Alabama produced studies that correlated the presence of services with larger-than-average reductions in infant mortality in the area. Generally, however, the projects tried to provide services according to logical models and in line with assumptions about good care--the more comprehensive and coordinated, the better the services. The goals were to provide mainstream medical services plus as many other services as possible aimed at the special needs of poor people (e.g., transportation, outreach, food programs). The research team examined the programs in terms of organizational efficiencies and their effects on care delivery and on patient care as reported both in interviews with clinicians and in patients' evaluations of programs.

Use of Alternative Services Except for the categorical centers of West Alabama, most of the centers intended to be their patients' sole source of primary care. Their success in this aim depended to a large extent on the options available to the patients served. In Palm Beach County, income eligibility requirements were so strict that anyone who was eligible to use the clinic was too poor to go

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* After physicians send in bills, some are not paid because the service is not covered or proper procedures were not followed. Stricter enforcement of certain requirements can reduce outlays. For example, insisting on more paperwork, especially when payment is low, may mean that the physician will decide the payment is not worth the trouble.

** This section is based in large part on visits by the clinical team (see Appendix C) to the following service delivery sites for the six case studies: (1) Alabama (a) West Alabama District Health Department centers in the counties of Tuscaloosa, Bibb, and Greene (b) Jefferson County Health Department's Bessemer Health Center; (2) Denver, Denver Health and Hospitals' Eastside Health Center and the Hyde Park Health Station; (3) Florida, Palm Beach County Health Department's West Palm Beach health center; (4) Seattle, North District Family Health Clinic; (5) Michigan, East Jordan Family Health Center and Center for Health and Social Services (CHASS) in Detroit; and (6) Boston, East Boston Neighborhood Health Center and Brookside Park Family Life Center.

anywhere else. At all study sites except rural Alabama and Palm Beach County, patients had a range of options, and even poor people with no coverage had access to teaching-hospital emergency rooms and outpatient clinics, and sometimes, other community clinics. Most patients used a center for all of their primary care, although those individuals with options (particularly from Medicaid or other third parties) often used the centers only for general primary care and retained other providers for specific medical problems. Patients might use a familiar or nearby source of care rather than go to the center's designated backup hospital. The other source of care most consistently used was the emergency room.

Variety of Services in the Center The sites represented a wide range of available services, from centers offering only a handful of categorical clinics (West Alabama) to those offering complete primary care, some specialty care, and a number of allied health, mental health, and social services (East Boston and Denver's Eastside Center). Public health departments tended to have fewer, and more categorical, services than community health centers. Projects with flexible grant funds tended to have a broader range of services on site (e.g., Brookside and Denver).

Patients often were pleased with the comprehensiveness of services, particularly in the community-oriented centers. In sites with few resources, particularly Palm Beach County and Bessemer, patients simply seemed grateful for the services. In other sites, patients had praise for a variety of attributes, including "sophistication" in East Boston, friendliness at Brookside, cultural ties at CHASS (Detroit), and sensitivity in Seattle. While scarcity of services was distressing, patients were bothered more by the elimination of previously provided services, as in Denver.

Adequate staffing was critical in assuring availability of services. The difficulty of attracting primary care physicians, especially in the public sector, was widely reported. Many efforts to overcome this difficulty were observed, including the furnishing of teaching positions at university-affiliated referral hospitals, research programs, flexible or shorter hours to allow for time at home or continuing education, and various ways to provide higher pay (particularly contractual arrangements instead of salaries).

The expense and difficulties of attracting and retaining doctors led many centers to use midlevel practitioners. But some centers also had difficulty in attracting these staff members, particularly where personnel classification and government pay scales limited them to low salaries. Although a few of these midlevels reported initial difficulty obtaining recognition, nurse practitioners, nurse midwives, and physician assistants were appreciated by both their patients and their coworkers. However, their independence in practice varied significantly. The physician assistant in East Jordan functioned in a somewhat limited fashion with physician supervision. The nurse practitioners at the Denver and Seattle centers, on the other hand, were the functional equivalents of physicians and carried their own patient loads. At Brookside, nurse practitioners

worked as near equals on teams, providing well over half of the adult, pediatric, and prenatal care.

The practice of registered nurses also varied across the case studies; sometimes their training and expertise were underutilized, and at other sites they were given more responsibility than they felt they were prepared to handle. For example, in West Alabama and CHASS where physicians and midlevel practitioners were in short supply, nurses acted more as independent practitioners, running entire clinics with only minimal backup.

Organization of Primary Care and Categorical Services Many organizational factors affected patient accessibility to care within the center. Centers in Denver and Boston incorporated traditional categorical programs like VD, immunizations, and family planning into primary care services, while Palm Beach County in Florida and Bessemer in Alabama were more likely to offer these services in separate clinics and to refer patients out of primary care when they needed categorical services.

Administrators tried to overcome categorical barriers in many ways, including the cross-training of staff and the scheduling of clinics in ways to integrate care. West Alabama, for instance, tried to schedule all MCH programs on the same day.

Recordkeeping and computers also were used to overcome categorical barriers. Some sites had individual records that integrated information and forms from all clinics. The records systems in Seattle, Palm Beach and Jefferson counties, and state reporting systems in Florida and Alabama are attempts to link patient encounters with staff utilization and thus permit them to be charged to the appropriate grants.

Different services can be integrated (i.e., offered as part of a patient's regular clinic visit) without integrating administrative procedures. For example, in Seattle clients receive shots when leaving a doctor's appointment at the clinic and have no idea that the immunizations are not part of the clinic program. Administrative separation has advantages in some centers where a broader population is seen for some services, or where a program has different eligibility or reporting requirements. The key issues for patients are whether services are accessible at the same or convenient times, without a lot of extra time or paperwork.

Intake Procedures to enlist patients were fairly simple and varied little among the cases. A prominent exception was Palm Beach County, where, in order to meet strict eligibility requirements, patients had to be screened several weeks in advance to allow time for income verification by employers or other income sources.

Getting a routine medical appointment sometimes required a substantial wait. In nearly all centers, patients with urgent problems would be scheduled quickly, although the definition of "urgent" varied. Appointments for dental and vision care, however, were backed up at all centers offering these services. Despite limited eligibility requirements based on residency, income, and age, there often was a wait of several months to a year for dental care.

While all centers discouraged patients from coming to the clinic without an appointment, most had some mechanism to triage walk-ins and call-ins. One way was to assign a triage nurse or technician who had training and experience. In other centers these clients were handled by a nurse or other member of the patient's team, or by a staff member working with the patient's primary provider who might not have had special training but who did have the advantage of knowing the patient. Seattle had no triage personnel and accepted no walk-in patients. Consequently, the clerk who spoke to walk-in patients often sent them to the hospital needlessly when a center physician could have cared for them, or gave them clinic appointments later in the week when advice from a nurse could have been adequate.

Payment Charges and their collection ranged from $1 paid at the time of a visit for virtually all services in West Alabama to a complex billing system and sliding fee scale at Brookside and the centers in Denver. Level-of-pay determinations were usually based on income and family size, but some centers included expenses and other factors as well.

Lack of money was not a barrier to obtaining care in the centers, although not all patients understood the fees or payment mechanisms. Thanks to sliding fee scales, reported to be liberal by staff and patients alike (with the exception of Palm Beach County), charges by the center were fairly low. Furthermore, there were very few places where a patient's unpaid bills affected his access to the clinic. Payments were typically handled at the end of a visit, and most centers gave patients a choice of paying as they left or waiting for a bill or until the next visit. The person registering patients rarely knew anything about their balances. However, in East Jordan, patients with very large balances who cannot explain their inability to pay may be turned away; in Palm Beach County maternity clinics, county social workers can deny clinic clearance if patients do not keep up with payments.

Payment for medications is often a great concern, as they can often cost hundreds of dollars a month for some elderly and chronically ill patients. Some centers have tried to address this problem by establishing on-site pharmacies with discounts of their own, links for discounts with outside pharmacists, or by saving drug samples for poor patients. These efforts were not always sufficient, and staff members often reported that patients' lack of cash or efforts to conserve limited cash adversely affected compliance.

Continuity of Care Some centers encourage patients to choose one practitioner or one medical team, and many patients did so without such encouragement. Patients usually valued having one person or one group of people who knew about their care. This primary provider or team often takes total responsibility for center patients, including follow-up of no-shows and referrals, tracking long-term care, and chart reviews. Larger centers usually had routine mechanisms, while smaller centers tended to be more informal.

Horizontal Integration As used in this study, horizontal integration refers to the unified or coordinated delivery of the full range of primary care services appropriate for a particular patient.

Usually this involves the coordinated delivery of on-site services, although it may involve other organizations or providers. We also looked into the linkages between medical and nonmedical services, such as social work or other human services provided on site or by a colocated social service agency.

Allied health and ancillary services, whether located in or outside of the center, need to be coordinated with core (usually primary care) services. Brookside accomplishes this coordination by including representatives of all services on teams. Less formal versions of this approach, designed to improve links with mental health, were seen in East Jordan and East Boston.

Public health services--immunizations, family planning, VD care--were available in most centers, but were not always integrated into primary care. East Jordan attempted to get health department "designation" to give free immunizations, but failing that had to refer patients to biweekly immunization clinics in the health department office downstairs.

Nutrition and Special Supplemental Food Program for Women, Infants, and Children (WIC) programs presented integration problems in many sites. When WIC was not available on site, referrals of eligible women and children were problematic. When WIC and other nutritionists (e.g., MCH) were in the same center but operated separately, patients made duplicate visits and resources were wasted. Where WIC and regular nutritionists were together, as in Bessemer, the dietician was swamped by WIC certification and had little time for nutrition counseling. In Alabama, where WIC and MCH nutritionists are being cofunded to maintain at least one nutritionist at each site, MCH officials are concerned that WIC nutritionists will not be able to provide the quality of care that those with special training and experience in MCH can provide.

Although center personnel often suggested dental, vision, speech, hearing, and podiatry care, and sometimes made referrals, patients were often on their own to find the services. Having these services available within a center greatly facilitated referrals, but it did not solve all access problems.

Social services were available to some extent in all centers, except Seattle and East Jordan. In a few centers social services were a large component of the care, while in most they had an adjunct role. All centers performed traditional social work tasks--family crisis counseling, emergency food and shelter, getting patients into nursing homes--and referred patients to the social welfare system for screening and determination of eligibility (none of the social workers were permitted to determine Medicaid or AFDC eligibility). At some centers they also provided advocacy, particularly for linguistic and cultural minorities, to help patients gain access to entitlement programs, or made eligibility determinations for care at the center paid for by the county.

Coordination with mental health was a major concern for most centers visited. Quite often a community mental health center (CMHC) was located in the same building or next door, but this did not necessarily ensure referrals or information transfer and coordinated

case management. The sharing of administration or staff was more important in the coordination of services. For example, in Brookside, where staff members were supervised by outstationed CMHC personnel, mental health was fully integrated within the center. In Denver and in Jefferson County the programs were separately administered but under the same organization so that coordination was fairly good. In these two cases, those requiring inpatient care were routinely transferred to the appropriate facility. Even for the best coordinated programs, however, problems remained because of CMHCs' rigidly drawn catchment areas (which often did not coincide with those of health centers), limited availability of CMHC care, or past negative experiences with CMHCs.

Vertical Integration The case studies offer interesting examples of "vertical" linkages between the primary care site and secondary, tertiary, and long-term care. In Denver all care was provided within the same system. In Palm Beach County, referrals were made to outside providers but were arranged and paid for by the system; in East Boston, outside referrals were arranged but not paid for. In West Alabama, patients generally were expected to make their own arrangements. Variations were due to a number of factors, including the presence of absence of a public hospital and whether that hospital was administered by the health department; the presence of teaching hospitals with house staff and outpatient clinics; and patients' ability to obtain care in private hospitals through Medicaid or other coverage.

For patients who are admitted to hospitals, continuity with providers varied a great deal, depending in large part on whether health center physicians have staff privileges at referral hospitals. Emergency care and coverage during nonclinic hours were varied. Isolated East Boston operates its own emergency room 24 hours a day, but most centers offer a tape recording suggesting which hospital patients should use.

Patient Support Services Centers differed in the support services they provided for their patients. For most able-bodied people transportation was sometimes difficult but rarely a barrier. The elderly and infirm faced greater difficulties, but because most centers tried to link patients with services in the community, and social services were available to them, they were rarely unable to reach needed services. None of the centers currently offers transportation services, but a few will make ad hoc arrangements.

A few centers offered supervised child care; however, patients did not seem particularly concerned with this issue.

The many centers serving linguistic minorities made efforts to help them through the clinic. Although most centers encouraged patients to bring translators, the centers did have personnel from the community who could translate for them if necessary. Where there were smaller numbers of minorities (hispanics in East Boston, Haitians at West Palm Beach, and Southeast Asians at several of the sites), translators often were not available.

Studying a Dynamic Environment: Local Reactions to State and Federal Budget Cuts

When the research staff first went into the field, it expected to find that federal block grants and funding cuts were the most prominent issues. Instead, most areas were preoccupied with state and local fiscal problems. The team visited Seattle a week after the state of Washington dropped the "medically needy" category from its Medicaid program. In Denver the staff arrived during the week in which 325 positions were cut from the Neighborhood Health Program, virtually ending all (nonemergency) dental, vision and hearing, social, and transportation services. Boston was in the throes of coping with Proposition 2-1/2, which was forcing the city to cut about $80 million in the subsequent fiscal year. Those cuts were obviously much more salient to people than proposed federal changes, the final shape of which was unclear when fieldwork was in progress. Moreover, although local and state programs were often heavily dependent on federal funds, their administrators recognized that they could not totally rely on that money for routine operation. In programs such as the Comprehensive Employment and Training Act (CETA) and in mental health centers, there long had been threats or contractual stipulations that federal support would be eliminated.

Almost all of the places examined were coping with serious slashes or deficits in city or county budgets and/or severe state fiscal problems. The fiscal pains were particularly acute in such areas as Boston and California, where there have been dramatic reductions in the revenues available to local officials and in their future ability to raise revenues.

The research staff's findings on economic dislocations and the beginning of a roll-back of public services were confirmed by the reports of many others in the last 15 months. For example, a study of 275 cities by the Congressional Joint Economic Committee found that nearly 80 percent of the cities were facing a deficit. Even areas of economic growth have had to cope with inflation and the ripple effects of Proposition-13 politics. For example, Colorado has had a statutory 7 percent limitation on the growth of the state budget since 1977. Over $1 billion in excess revenues have been used as tax relief. However, due to the impact of the recession, there currently are no excess revenues.

Cities, in particular, reported concern that their problems were being ignored by states. States limited local jurisdictions, especially in their revenue-generating capacities. Furthermore, states sometimes mandated services but did not provide funds for them.

The research staff also heard early reactions to the federal block grants and grant fund reductions that were being proposed in mid-1981. Feelings about the proposals and federal grant-in-aid reform could be best characterized by the often cited Miles' Law--"Where you stand depends on where you sit." No one interviewed liked the particular budget cuts or believed that they would be offset by

decreases in administrative costs, although some applauded the spirit of and need for federal budgetary control.*

States favored grant-in-aid reform, at least in principle. But localities were leery of block grants to the states. Managers of private, nonprofit programs funded directly by the federal government were especially concerned that state controls would mean more dollars proportionately to other programs. Personnel of each program--primary care, mental health, alcohol and drug abuse--believed that they would lose out to the greater political strength of the others. The effects of the proposed cuts also were influenced by the resiliency of the local economy, its degree of dependence on federal money, and the extent of the local and state tax burden. The Northeast and Midwest states expressed particular concerns about their vulnerability and their inability to bounce back from federal cuts.

Both state and local officials had serious concerns about combining large cuts with federal grant reform. Even those who supported both the cuts (because they share the belief in the need for fiscal restraint) and the reforms (because there are serious problems with the way in which federal programs are administered) were unhappy with tying the two together. As one official asked, "How can you possibly make something work better, no matter what sort of managers you have ...if the first thing you have to do is lay off people and adjust quickly to some sharp reductions?" Few people saw it as a fair test for block grants or as a sound approach to intergovernmental relations.

The research team heard about the advantages of removing federal mandates, particularly ones such as the 155 different citizen participation requirements that are attached to various federal programs. But state and local officials were frankly skeptical that the mandates would be removed.

The study staff heard other concerns. Often federal funds covered salaries of staff members. Reductions eliminated the positions whose existence was tied to the grants and contracts, but not all of the responsibilities. Jurisdictions with already restricted job slots reported that they were particularly strained to meet the responsibilities.

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* Because most of the people interviewed were employed by the programs that were publicly funded, it is not surprising that they were generally opposed to the health program cuts. However, the IOM staff heard from elected officials or those involved in politics that there was general support for federal cuts. There also was a belief that the citizens who voted for Ronald Reagan and his policies were likely to be voting locally for similar policies. In short, the feeling was that the federal cuts could not be compensated for by local tax increases because it was believed that the voters would then turn against those who raised taxes locally. Correct or not, local and state officials did not report confidence that the "revenue opportunities" were promising.

State and local officials also reported that they knew they would be faced more directly with the pressure of special constituencies and interest groups (e.g., the elderly, the handicapped and disabled), who are more organized now, even in state capitals, and are accustomed to having certain services. Client groups were already protesting, seeking judicial redress, and pursuing administrative channels of appeal. While they probably will fail in completely overturning the budget cuts, the appeals require thousands of hours of high-level official staff time and large legal fees.

Least liked by the states was the proposed Medicaid cap. State officials reported that any constraints on the federal share while individuals were still entitled to services would make their costs continue to escalate. These officials asked most often for more flexibility, especially if there is a cap. They wanted to eliminate the requirement that clients be assured "freedom of choice" of provider, so that the state could change purchasing approaches and get more for the Medicaid dollar. The requirement was removed in the Omnibus Budget Reconciliation Act of 1981.

All officials voiced concern about the scantiness of information, at least in 1981, on how the block grants might be administered, who would allocate them, and what criteria would be used. Urban areas that did well under a more categorical system were apprehensive that they would not get as large a share from suburban-dominated legislatures; as if to confirm these fears, officials in jurisdictions outside the big cities reported that they were pleased by the prospects. The research staff was told that the arrival of block grants would pit against each other programs and agencies that had never been in direct competition before, and introduce a variety of community-based programs into the competition for state money.

The staff did not find much interest at either the state or local level in picking up responsibility for community health centers or migrant health, especially given the minimal opportunity to modify the programs. Officials were hesitant about taking on any new responsibilities. Furthermore, protests against large cuts would suddenly be directed at the states and localities, although they would have had no role in the decision making. It seems likely that local and state officials would be more interested in many of these changes if there were more time for implementing them. Certainly, if the overall budget reductions were not so severe, there would have been more appeal to the changes in federal funding to block grants.

The Sixteen Case Reports

The programs for study, briefly described in Appendix B, were selected by the same modified reputational approach used for the case studies, but they were chosen specifically to expand the base of the research beyond the six studies by allowing the staff to analyze a greater number of different types of projects. Included in the case reports are examples of health maintenance organizations,

community health center networks, a state-organized rural health program, and state and county health departments. On another organizational dimension, there are cases in which the project is organized by and tied to a hospital, cases in which all physicians in a health center have hospital admitting privileges, a case in which no physicians have hospital admitting privileges, and one in which health centers are staffed by midlevel practitioners with physician backup. The case reports include projects serving narrowly targeted groups--migrants, the elderly, inner-city poor--and others that serve all members of the community.

The case reports cover several different funding arrangements. At one end of the spectrum is a program funded almost entirely by the state; at the other end of the spectrum is a project that receives funds from about 15 sources, including federal, state, and city governments, and philanthropic foundations. Other projects depend mainly on federal Rural or Urban Health Initiative funds enhanced by categorical money, private insurance, Medicare, and Medicaid.

There are other ways of classifying the case reports--rural/urban, established/new, small/large, and so on. Within the case reports there are examples of many types of public sector forms of health care provision.

Although there is diversity among the projects studied, there has been a uniformity in the research approach to ensure a degree of comparability across reports. In each case these factors were investigated:

- project setting--demographic, economic, health status, and health resource data

- project history--why a program was initiated, who were major actors, key factors enabling the program to develop, and major obstacles in development

- funding--sources of funds, relative importance of different sources, ease of obtaining funds, ease of administering funds, reasons for pursuing or not pursuing certain funds, and impact of funding reductions

- external relationships--relationships with private physicians, federal agencies, state or local health departments, and other health and social services providers

- organizational structure--why specific structures developed, and the impact of structure on the way in which services are delivered

- operational details--staffing, services provided, costs, and reimbursement

- goals--initial goals and the extent to which goals were achieved.

The staff members who worked on the case reports were different from the researchers who did the case studies, a circumstance that makes the similarity in major findings between the case studies and case reports all the more striking.

Cross-case Analysis of the Sixteen Cases

Introduction The purpose of the case reports is to provide information that can lead to some conclusions about the environments, arrangements, procedures, or devices that positively or negatively affect the ability to integrate health services.

There are, however, certain important topics that are not addressed. The first, and most obvious, is the question of cost--are the services being produced cost effectively? Is there waste in the programs? Are there any specific circumstances likely to encourage cost-containing behavior? Cost data were collected, insofar as possible, from the sites studied, but the study staff found that both the reliability and comparability of the data were insufficient for firm conclusions.

A further reason for not drawing conclusions about the efficiency of programs is a lack of comparative standards--that is, what would be the cost of providing the same services to the same population in a different setting. Also, the programs studied are very diverse--urban, rural, new, old, large, small--and it is inappropriate to compare them. Rural programs have size constraints not applicable to urban programs, which both exclude them from possible economies of scale and decree a different mix of providers and services; new programs have start-up costs that older ones do not incur; and so on.

Another topic on which data were gathered but no conclusions drawn was staffing. Although the number of physicians and their specialties, the number of midlevel practitioners, the number of nurses, and the number of National Health Service Corps staff practicing are known for almost every program studied, the research team was not able to discover whether there were differences in cost, quality, or acceptability associated with different staffing patterns on health status. This report also omits discussions of quality of care and the effect of services integration. There are no adequate measures for either of these topics that allow well-founded conclusions.

The following sections describe some factors found to be important across many of the programs studied. However, because of the enormous diversity of circumstances across the nation, project managers or policy makers concerned with a specific geographic area, population, or service will find that many findings do not specifically fit their situations. In fact, one of the most clear findings of the case reports is that each successful services integration program is tailored to the environment and circumstances in which it must operate. The gross differences among programs (urban/rural, new/established, statewide/local, etc.) determine the appropriate

configurations of services. Successful policy makers or project managers also recognize the requirements of their own particular environments and adjust their actions and their programs accordingly.

Leadership Time and again the research team found that the success of a program could be, in large part, attributed to a single person. This was found to be particularly true during the early stages of a program. In many cases these leaders were described as having indefinable qualities--charisma, entrepreneurship, diplomatic skills, but they were also found to possess more specific abilities and skills.

The most commonly found quality was an understanding of how to work with the many people, programs, and agencies that can affect a project's development. In Multnomah County, Oregon, the leaders of the Department of Human Resources persuaded state legislators to appropriate substantial sums to develop a radically innovative program (Project Health), and neutralized or overcame opposition from county commissioners, hospitals, and medical schools, by ensuring the involvement of key officials every step of the way.

In North Carolina, a "leader" surfaced from academic circles who was able to pull together a network of academic, political, and private medical support for a statewide rural health program. With political sensitivity and understanding of power, he was able to assemble a sufficiently cohesive network of influential people to quell opposition before it coalesced, and to get legislation passed to establish the program.

In West Virginia, a director who understood how to deal with the medical and political environment was appointed to head the state health department. He defined the goals of integration and the tools to be used to achieve those goals--community organization, compromise with the private sector, involvement of all interested parties.

Although the quality of leadership is important, continuity of leadership also influences the success of a program. The West Virginia Department of Health and the California Rural Health Services Development Program both experienced changes in leadership after a few years. In West Virginia, the change moved the focus of integration efforts from primary care to mental health. This will almost certainly lessen the effectiveness of ongoing primary care integration efforts. In California, one part of the program had three directors in two years; another had three in five years. Certainly this has limited the achievements of the program. When complex service arrangements are being put together, it is important to allow sufficient time for obstacles to be overcome, utilization to build, relationships to mature. Leadership continuity can also be important in allowing the program time to develop and not be made to change direction.

Continuity of leadership is cited as one of the ingredients in the success of San Francisco's On Lok Senior Health Services, where the executive director and chairman of the board have been with the program since the start. Here again, the vision, the ability to

negotiate with agencies and to respond to political realities are some of the skills that have enabled a "leader" to develop and establish a successful program of services integration.

The Environment Almost every program, particularly during its development phase, was affected by such elements as federal, state, or local politics, others in the medical community, or local community groups. Many programs made accommodations to reduce opposition that could have been destructive to the program. The most politically astute program developers acted early to prevent the opposition from coalescing. In most cases there is evidence that considerable work went into wooing, placating, and engaging the individuals and groups that constitute the political environment.

Frequently, private sector health care providers viewed publicly funded care as a competitive threat, even when there was a real shortage of providers in their area, or when the funded program was to serve a population that the private sector did not want to serve. As a result, many publicly funded programs made accommodations with the private sector. In San Luis Valley, Colorado, a health maintenance organization with federal funding and National Health Service Corps physicians lost the cooperation of private physicians, both because the plan required physicians to bear financial risk and because a threat of competition was seen. As a result, the HMO reorganized, changed physician reimbursement from capitation payment to fee-for-service, and appointed a known conservative local physician to head the HMO and calm fears of public sector intrusion.

The Baltimore Community Geriatric Service has an excellent relationship with a local private hospital. A concerted effort was made to ensure that services were not overlapping or competitive.

In Southern Ohio, a federally funded network of community health centers generated potentially destructive private sector opposition at the outset. Today, the network will not open a center unless letters of support from physicians in the community have been received.

Accommodation with the private medical sector as well as the local community is the dictum in Kansas, where the Bureau of Maternal and Child Health develops programs to complement rather than compete with private physicians. In a state program based on local autonomy, responsiveness to individual county needs and flexibility in approach are the overriding concerns in local health department program development.

Funding For almost all programs targeted toward a poor population, Medicaid played an important role. It was the principal source of reimbursement for services to the poor, and the eligibility restrictions and services covered in each state were a major determinant of the number of non-Medicaid poor in need of services. This is the group most dependent on the range of categorical programs and flexible funds.

Each of the programs studied was at least in part publicly funded, many with grants used to provide unreimbursed services (outreach, transportation, social services) and to operate a sliding fee schedule to provide care to the people unable to pay full charges yet uncovered by insurance or categorical programs.

While such flexible funding can amplify the scope of services and people served, it is also important as the catalyst for initiation of services. It is fair to assume that a number of programs studied (e.g., Mile Square, Chicago; Florida Community Health Centers; Su Clinica Familiar, Texas; Southern Ohio Health Services Network) would not have developed without the opportunities created by the existence of federal funds.

In a second group of cases, already ongoing programs or efforts to integrate services were enhanced by the addition of special money. For example, in West Virginia, a unified state department of health had been put in place and a policy of services integration had been developed before federal integration money became available. However, with the extra money the department was able to hire staff specifically to further services integration, to develop funding packages as incentives to integration, and to mount educational efforts to inform providers of the benefits and tools of integration. At Su Clinica Familiar in Texas, private giving has provided equipment and staff to enhance services to migrants.

A third group of programs can be described as having pushed funding in new directions to achieve their goals. The best example of this is On Lok in San Francisco, where the program has been instrumental in getting day health care reimbursed under Medi-Cal and has devised a Medicare demonstration whereby all health services--including day care, home care, primary care, nursing home care, and hospital care--are reimbursed on a capitation basis.

The importance of start-up money should not be underestimated. An organization providing health care to a poor population needs a financially supported development period, because the provision of care that is not fully reimbursed is dependent on extra funds. Some health centers, by also serving a well-insured population, can eventually become self-supporting while providing free or reduced-rate care. However, in the absence of flexible funds, this is an option open only to the centers located near middle-class areas.

In the long run the ability to serve an insured or paying population is important. In North Carolina, rural health centers are established only in areas assessed as able to support them financially. The state provides start-up money; the community will eventually support the center. In Chicago's Mile Square, where OEO provided the seed money and later federal Urban Health Initiative grants sustained operations, the need to attain self-sufficiency forced the center to expand its service area to a population that would generate revenue.

Programs funded as demonstration projects have their own problems. These programs are often politically attractive and even draw national attention, but political support can vanish once the program proves successful, which makes continuation funding harder to obtain. This is what happened to Project Health in Oregon, and what On Lok has been able to counteract. After On Lok demonstrated that reimbursement for home care was effective and economical, the laws covering Medi-Cal were changed. But whereas On Lok had other goals and

moved on beyond that one concept to obtain funding for more activities, Project Health is finding it hard to sustain itself. The varying outcomes may be due in part to differences in the overall economic climate and federal policy interests when the two programs moved out of the demonstration phase. But more significant may be (1) On Lok's initiative in pushing innovation further by developing new concepts for demonstration after the first demonstration project was completed; and (2) On Lok's research component, which has documented and analyzed most variables of interest and has shown an ability to evaluate the innovations being funded by demonstration money. At Project Health, this was not so well done. These cases suggest that to move beyond a demonstration phase and sustain funding, research competence or new ideas are needed.

Methods or Styles of Integration Two different styles or methods of trying to achieve linkages among providers were observed in the case reports. For want of a better description, they may be characterized as top-down and bottom-up. Top-down refers to the creation of links as a response to a mandate--such as that contained in 330 funding--or a program manager's intention to develop a referral network. The excluded ingredient in the top-down approach is community involvement, and that ingredient is the essence of the bottom-up style of integration.

The North Carolina Office of Rural Health Services and West Virginia's Department of Health most clearly illustrate the bottom-up style. In both states, there is emphasis on working with or through the community, which requires a heavy investment of resources. The rationale is that links, coordination arrangements, and services placed in and understood by the community will be well used and will endure. In North Carolina, thirty health centers have been established; and in West Virginia, links have been established among such providers as rural health centers, local health departments, and community mental health centers. In both states, community opinion has been sought and used in creating service arrangements.

The top-down style is found at the Southern Ohio Health Services Network, where the Bureau of Community Health Services mandates linkages, and coordinative links have been arranged; but, because these links come from above (a centralized administration) they are sometimes not well used in the community. The California Rural Health Program, which funded rural health centers, was intended as an integrating mechanism. But there was no systematic community-level effort to break down financial, social, and institutional barriers; so when integration occurred it was sporadic, resulting from personal efforts at the clinic level. However, mandated, top-down integration can be effective. BCHS-funded centers--e.g., Su Clinica Familiar, Sunset Park Family Health Center, Mile Square--have referral mechanisms to specialists, hospitals, social services, and so on, and incorporate numerous categorically funded services, which together provide a substantial array of services for clients.

Market Analysis For new or expanding programs, the quality of what would be termed market analysis in commercial operations is important for their financial survival.

A few examples from the case reports illustrate the importance of this preliminary step. In Baltimore, the Community Geriatric Service targeted the elderly of a small area of the city for services, but it became apparent that many of the people targeted did not need or were already receiving services. The program subsequently expanded its focus to include another area, but the initial targeting error delayed growth. Project Health in Oregon, where the county contracts with HMOs to provide care for the medically indigent, also suffered from miscalculations. The population initially being served was sicker than anyone had estimated, so plans being paid on a per capita basis were threatened with bankruptcy by high utilization. Program administrators took steps to rectify the situation, but not before some plans withdrew or were put out of business.

On the other hand, some programs did a thorough job of preoperational analysis and have been stable. The Southern Ohio Health Services Network benefited from a report on rural health needs by the local Health Systems Agency. In North Carolina, it is standard procedure to determine financial viability before a health center is developed. As a result, all of the 30 centers are still operating, although a few have needed small subsidies for longer than expected.

Models of Integration Among the 16 case reports are examples of several different models of integration that can be paired for comparative purposes: networks and comprehensive centers; health maintenance organizations and the brokerage system; vertical and horizontal integration.

The large comprehensive health center model is often developed in areas different from those that use the network model. Urban and rural programs generally use different integration models because of differences in geography and the size of the population being served. Urban areas have a population sufficient to support a wider variety of services so the large, comprehensive health centers tend to be in cities. In rural areas, administrators have to deal with small or widely dispersed populations. In these areas, the problem is to try to provide a reasonably wide range of services without creating geographic access problems. The trade-off to be considered for rural areas is the benefits of a large center--such as more flexible hours, economies of scale, more specialized providers--against ease of access. The North Carolina Office of Rural Health Services made the decision that ease of access was the overriding priority. This program develops small health centers staffed by midlevel practitioners.

Another pair of models--brokerage systems versus HMOs--exhibits another set of trade-offs. The HMO needs to maximize control over resources either by functioning as a financing mechanism and imposing controls on providers (in San Luis Valley, this was learned the hard way when the HMO failed to invoke cost-containment incentives; later, controls were imposed to ensure survival of an otherwise financially

unviable enterprise), or by having a broad array of providers on staff or under contract to the organization (On Lok). The latter method has the tightest control and theoretically the greatest pay-off in cost-containment potential. The brokerage system (Project Health, Oregon) has an organization buying private sector health care for a specific population. The broker cannot control providers as an HMO does.

In another dimension, some programs studied can be described as vertically or horizontally integrated; some programs offer both types. Vertical integration refers to close affiliations among the different (primary, secondary, and tertiary) levels of care. Horizontal integration refers to linkages among a wide range of providers of the same level of care--primary care, in the programs studied. Obviously, here the trade-off would be between broadening the scope of primary care offered and providing easy and immediate access to other levels of care. In fact, it appears that this trade-off does not have to be made. The programs most closely tied to other levels of care (Sunset Park, Brooklyn; Mile Square, Chicago; local health centers in Suffolk County) are more likely to have enhanced their primary care capability than to have been restrained by a concentration on the vertical direction.

One other model or organizational structure can be observed in the case reports. The California Rural Health Program, Kansas Bureau of Maternal and Child Health, Suffolk County Health Department, and West Virginia Department of Health are all administered from health departments operating with an organization chart that brings together diverse agency functions into a unified whole. In the latter two cases a health department was structurally reorganized explicitly to promote services integration. The question that the model raises is whether integration is enhanced or even affected by organizational structure. No clear answer can be found in the case reports, but there are indications that other factors are more important.

Responses to Reductions in Funding

Most of the programs studied are experiencing or anticipating cuts in funding from all levels--federal, state, and local. For many programs, this represents a loss of the flexible funds with which they provide unreimbursed services or care for people not covered by insurance programs and unable to pay full fees. Responses to such cuts vary among programs. A simple response has been to reduce unreimbursed care either by cutting such services or by restricting the number of sliding scale patients.

Some say that funding cuts will have positive effects--eliminating waste, reducing duplicated services, and forcing programs to integrate--and this is true to an extent. One program (Southern Ohio Health Services Network) has cut staff benefits, is seeking ways to cut other costs, and is affiliating with a hospital to share staff

and support services, which will eventually enhance the scope of care offered and more closely coordinate different levels of care. However, the administrative capability and foresight needed to react in such a constructive way may be rare. More often, funding cuts will result in contraction rather than expansion of services.

The Suffolk County Health Department developed a strategy to minimize overhead costs and thus maintain maximum operations. However, the community threatened with the loss of its center objected so vociferously that the department reversed its policy. As a result, dental services to children (for which there is no vocal constituency) and food and housing inspections were cut. There was also a reduction in some administrative functions such as planning and evaluation, which is thought by some to dangerously undermine the quality of decision making.

Strategies devised to deal with reduced funding depend to a great extent on the ingenuity of administrators. Some will try to increase earned revenues by aggressive billing or marketing to paying populations, but there are limits to how much can be achieved in that direction. Programs with well-diversified sources of revenue, like Sunset Park Family Health Center in Brooklyn, may feel the impact less than those with a narrow base of support. But programs that have put together ingenious packages of funds are those with enterprising management; these programs therefore are likely to develop enterprising strategies to deal with cuts.

Other Issues Although many factors appear to be important to integration efforts across a large number of the programs studied, there are other factors observed in only a small number of cases which nevertheless warrant mention here and are discussed in the following paragraphs.

Because a majority of programs in the study had significant amounts of federal funding, it would be surprising if the relationship with, and role of, federal officials had not received comment. In a few cases, the federal categorical program directors were regarded by local officials as being inflexible in their administration, therefore obstructing attempts to innovatively create packages of funds from a number of sources. In other cases, regional office personnel in particular were regarded as friends of the program. The San Luis Valley Health Maintenance Organization case reports that a federal regional officer wearing two hats--Community Health Center and Health Maintenance Organization--was helpful to the program because, with both perspectives, he was able to take a more comprehensive view of the interests of the program, and also present to officials in Washington persuasive arguments for the enhancement of the program.

Federal regional offices also provide technical assistance to programs. In the Southern Ohio Health Services Network, this was described as invaluable at the start of the program. (The North Carolina Office of Rural Health Services also provides massive infusions of technical assistance to rural health centers.) In sum, it is often not enough to fund a program. Technical assistance is extremely helpful, if not necessary, to program managers.

Comparison of the environment of the District of Columbia's Senior Care Program and that of Baltimore's Community Geriatric Service points up the importance of a local history of cooperation among agencies. The District of Columbia case describes an attempt to develop some cooperative arrangements among agencies that had never worked together in a city with no record of initiating such programs. Essentially, it did not work. Baltimore, by contrast, is a city noted for cooperation among agencies under the leadership of a mayor who throws his weight behind such activities. The Community Geriatric Service was successful in implementing most of the integrative arrangements it attempted.

Conclusions Derived from the Sixteen Case Reports

Given the diversity of the sixteen programs, it is interesting to note that a number of findings hold true across a number of different situations. Some of the findings refer to variables that are hard or impossible to manipulate, like the local political environment; others, like the provision of flexible funds, are open to intervention.

Although some findings held true across many cases, others were found in groups of cases; for example, the models of integration used in urban programs were different from those in rural programs. It is not possible to say before the fact that any one model is the right one for a particular setting. But from analysis of how the models work, it can be said that there are pros and cons to each, and that some appear to be more suitable in some situations than others. But, more importantly, the trade-offs must be realized and weighed, and the suitability of a model for a proposed setting must also be considered.

The programs studied range in age from 15 to only a few years. The findings and lessons therefore encompass an era that included substantial infusions of federal funds (OEO, community health centers, various categorical programs, etc.), and only recently has there been a real reduction of funds. The view into the 1980s shows a different picture. Although a substantial portion of categorical money will be consolidated into block grants, with a possible lessening of categorical barriers, the total sum of money will be smaller. As a result, more people will be left without a source of payment for services. There will be fewer services, and the flexible money, shown in the case reports to be so important to fill the gaps, is being curtailed. Analysis of the case reports shows that the Medicaid program has been the mainstay of many services and programs for the poor. Even as this study report goes to press, many state legislatures have on their books measures to cut the scope and coverage of Medicaid programs. Even the federal contribution to the program is in doubt. In almost every case report, it is clear that money--be it community health center funds, state or local funds, or funds for

migrant services--is the impetus for attempts to establish and integrate services. In only a very few cases is there any evidence that integration is seen as a way to maximize output from a given level of resources or rationalize the allocation of resources.

With fewer funds, one can expect fewer new programs and fewer services available to people not covered by specific public programs or private arrangements. Integration--whether it be coordination of services among agencies, referrals, combining funds to provide comprehensive services, sharing administration, or whatever--is unlikely to proceed in the absence of funds, unless it is shown to be in the best interests of the agencies themselves. If evidence is found that integration will enable them to produce more health care for the dollar, that might appeal to the self-interest of some, but even then other organizational imperatives are likely to overwhelm such interest. Still, it may be that in cost effectiveness lies the best hope for integration in the 1980s.

Summary of Findings Pertinent to the Committee's Conclusions

This section summarizes those findings from the six case studies and sixteen case reports on which the committee relied most heavily in developing its own conclusions and recommendations. However, staff research uncovered a number of important findings that, although not amenable to intervention by policy makers and therefore not directly useful to the committee in its deliberations, are worth mentioning here and serve to broaden one's understanding of some major factors in the integration of health services.

- Strong, effective leadership is a vital element in establishing and sustaining innovative health care programs.
- Continuity of leadership is important in guiding an organization toward its goals.
- Sensitivity to the interests and fears of medical and political figures and of the community is essential to ensure the support necessary for health care programs.
- Publicly funded programs need to make accommodations with private sector providers to ensure their cooperation.
- Working closely with the community in which a program is located helps develop necessary support.
- A history of cooperation among organizations in a community makes it far more likely that integrative efforts will succeed.

- Affiliation of a primary care program with a hospital significantly enhances continuity of care.

- Many models of integration are used across the country. Each has its pros and cons, and each is more suitable for some circumstances than others.

The research findings most pertinent to the committee's recommendations, which appear in Chapter 4, are as follows:

- The scope of each state's Medicaid program significantly affected the ability of programs to provide services to poor people.

- There are poor people who have no financial coverage through any program--Medicare, Medicaid, or categorical programs--yet who need care for acute and chronic conditions.

- Federal funds often played important roles--making it attractive to start a program, enabling construction of facilities, enabling a program to provide a wide range of services, enabling the program to serve people ineligible for assistance under specific programs.

- Many programs were supported by several sources of funds--federal, state, local, and, occasionally, private.

- The need for money to cover particular services for particular people was a continuing problem. The fiscal stress in most places (e.g., Washington State, Massachusetts) was causing cuts in services before the federal cuts voted in 1981 were felt.

- There was acute concern about the implications of any action for the local tax burden. Medical service areas often fall into a number of local political jurisdictions. Unequal tax bases and variations in class and race composition made cooperation in rational programming very difficult. No one wanted to make changes that would require new taxes or take away some other services that had vocal, organized constituents.

- Some intergovernmental grant reform was usually found. Often it was achieved informally by bending rules with tacit approval of federal or state officials, but sometimes it was formally accomplished.

- State health departments are frequently categorically organized and staffed by people whose interests rest with preserving separations among programs.

- There were specialists involved in program administration at the federal, state, and local levels who wanted to ensure that their interests and programs were not harmed (e.g., "MCH may lose out if primary care is paid for").

- There was competition among providers--not only private doctors opposed to publicly provided health services but also hospitals that competed with each other as well as with primary care centers for patients.

- The different data requirements of publicly funded programs resulted in costly administrative burdens.

- Programs do not generate data to analyze the impact of their service arrangements on patient care or patient health status.

- Attracting health manpower to rural programs or to programs serving low-income groups is difficult. The National Health Service Corps has helped many such programs.

- Funding cuts, first from state and local sources and more recently from federal programs, are being experienced by most programs. A common reaction is to eliminate unreimbursed services and become more aggressive in seeking third-party payment.

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CHAPTER 4

FINDINGS AND RECOMMENDATIONS

In conducting this study, the committee has sought to identify ways to achieve coordination and integration of health services, particularly publicly supported programs for low-income people. The primary instruments of the study are the case studies and reports summarized in Chapter III. In reaching its findings and recommendations, the committee drew heavily on those studies and reports and the findings stated at the end of that chapter. The analysis of the sources of health program fragmentation and previous efforts to lessen it (summarized in Chapter III), the commissioned papers (Volume IV), and the presentations at the Open Forum (Appendix D), as well as the varied experiences and perspectives of the committee itself also are sources for our findings and recommendations.

The committee commends the extensive materials contained in Volumes II, III, and IV to those who wish a fuller appreciation of the complex factors that hamper efforts to coordinate and integrate community health services. These descriptions, analyses, and viewpoints are, in the committee's view, major products of this study.

The committee has reached conclusions about some of the most important factors that inhibit or support services integration. We have agreed on a number of recommendations that intended to facilitate community efforts integrate and coordinate health services for the people most in need. Our conclusions and recommendations are grouped according to the two major audiences for this study: first, federal and state decision makers whose legislative or administrative policies set the terms and conditions within which integration and coordination of services must take place, and, second, program operators and service providers, mostly at the local level, who are engaged in the day-to-day organization and delivery of community health services. Both of the audiences are essential participants if the improvements that are the objective of this study are to be achieved; neither group alone can accomplish the task.

We make these recommendations in the context of a health care system largely structured as it now is. The committee believed major redesign of the system was outside the scope of its charge.

The committee also has made some additional observations and recommendations concerning (1) research, data, and manpower, and (2) the role of the voluntary sector that we believe will support the desired actions of the primary audiences.

Federal and State Policies--Conclusions and Recommendations

Effects of Gaps in Health Care Financing

Programs that finance health services for the poor often leave gaps in eligibility of some of the poor and in the types of services covered. These gaps result from deliberate public policy choices made by the federal and state legislative bodies, not from oversights of inept administrators. The committee concludes that such gaps seriously inhibit efforts to integrate and coordinate services.

In the aggregate the gaps in coverage are not large. For example, less than 10 percent of the noninstitutionalized population is without any kind of health insurance. Studies by Aday (1980), Kleinman (1981), and others show substantial progress in assuring care for most poor people in this country. But these studies also identified a small subset of the U. S. population that remains without access to needed care. The committee has found that conditions have worsened recently and the availability of certain programs is declining. The places examined in this study provided services for a large number of people who could not afford medical care in the private sector. These persons will be affected seriously by any further declines, and the integration of ambulatory services may be lost in a retreat to coverage of hospital services or of minimal ambulatory services. While affecting only a small proportion of the total population, the remaining gaps are important because they affect a large number of people who are most vulnerable to the effects of fragmentation of services.

To lessen these gaps some members of this committee would have preferred to recommend a national program of comprehensive health services or insurance. Other members would argue for improvements in the programs of health care financing targeted toward those unable to pay, including such financing mechanisms as vouchers for the purchase of private health insurance or enrollment in health maintenance organizations. There was difference of opinion within the committee concerning the optimal methods of financing or organizing the services, but all agreed that there were numerous examples of successful approaches in the cases examined. The committee concluded, however, that no matter what the preferred arrangements for financing, integrated and coordinated health

services cannot be achieved without sufficient local, state, and federal funds to pay for basic health care requirements. Other efforts to improve integration and coordination cannot overcome the effects of substantial gaps in health financing programs.

Need for Flexible Program Funds

The nature of funding available for health services programs has important effects on the achievement of better integration and coordination of services. Not only do gaps need to be closed, but the committee found in examining the case examples that a proportion of the funds provided to any service program must be flexible in their use, not restricted to narrow categorical purposes. In examining such cases as the Brookside and East Boston health centers in Boston, as well as other cases, the committee concluded that integration and coordination are more successful when the provider has available at least two of the following types of funds: (1) basic operating funds from local or state sources that are flexible and reasonably stable (e.g., earmarked revenue funds), (2) reimbursement from a relatively generous Medicaid program, or (3) sufficient flexible federal grant funds (e.g., community health center funds under Section 330 of the Public Health Service Act).

The committee recommends that the federal government contribute to services integration and coordination by continuing to be an important source of flexible program funds to states and localities by means of a Medicaid program at current levels or higher and by means of flexible grant funds that can be used for comprehensive health services.

Facilitating Flexible Administration of Categorical Funds

In reviewing the sources of fragmentation and the previous efforts to overcome them, described in Chapter II, the committee observes that categorical funding is likely to remain an important component of federal and state funding for health services in communities. This is a reality of our political system and its responses to particular interests. It represents an attempt to ensure strict accountability in the use of public funds.

Services integration can be positively or negatively affected by funding and administrative details that are determined by authorizing legislation. Requirements and guidelines resulting from laws and policies create inconsistencies and barriers when services are provided to people with multiple needs. There almost always are multiple reporting requirements, different grant applications,

plans, and service areas.* For example, the same family may have different eligibility requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); WIC; and Family Planning programs. Often the relevant legislation was passed because a persuasive case was made before the Congress that the target group had particularly severe problems and the advocates wanted Congress to ensure that the particular need was met even when localities have other priorities. In addition Congress has not always trusted local and state governments to pursue such objectives as civil rights enforcement, nor has the executive branch been trusted to carry out the specifics of legislative intent. Therefore, specific requirements are added to the law to make certain that the executive branch and grant recipients can be held accountable to carry out the law.

The committee was impressed by a number of frustrating admin-administrative problems faced by a comprehensive health care center that clearly affect it's ability to deliver integrated health services. As reported at the study's Open Forum and as seen in case examples, the problems include the following.

- Some categorical program managers adhered strictly to program rules, to the detriment of services. Requests to waive regulations were treated with suspicion.

- Proper program management was inhibited by delays and uncertainties in funding.

- Lack of uniformity in eligibility standards among categorical programs resulted in burdensome screening processes and difficulties in using computerized data systems.

- Lack of uniformity in reporting requirements among funding agencies resulted in costly data collection and report preparation.

- Decisions about whether to fund a program often were made on the basis of data inappropriate to the intent of the program being evaluated. Bureau of Community Health Services Common Reporting Requirements (BCRR) indicators

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* The federally funded Planning Reform Demonstration Project was an effort to determine the extent to which states could take over the federal planning and budgeting requirements. The results have been mixed, but one outcome suggests that the federal burden was less significant than the original complaints suggested and that a major benefit to the states was from the process of doing the planning and budgeting. Additionally, not all states were able to reduce the paperwork burden; in a few states it increased.

were frequently the subject of such criticisms, although they were also considered improvements over earlier versions.

The committee believes that a number of steps can be taken to facilitate the flexible administration of categorical funds so that services integration and coordination can be improved. The following are important policies we would recommend.

Explicit Federal and State Policies Encouraging Services Integration One of the reasons for the fragmented health care system in this country is the lack of consistent national policies regarding services coordination and integration. Where such policies exist they are given lower priority than other social goals represented by categorical programs. The results often are counterproductive for the groups most in need of services. Federal and state policies do not help local jurisdictions move toward a more cost-effective configuration of health services that more appropriately matches that area's health services requirements. Without some explicit policy commitment to the objective of services integration, problems of overlap and duplication or missing services will result inevitably from narrow adherence to categorical funding requirements by administrators even when problems are created for meeting people's needs.

The committee recommends that federal and state governments develop explicit policies that emphasize the importance of developing and implementing well coordinated health services programs. Much as the fiscal effect of laws are studied prior to their passage, the "fragmentation" effects of national and state legislation should be identified so that the need for coordination can be given equal attention as an objective of public policy.

The committee also recommends that all legislation authorizing specific health services programs contain a general provision stipulating "that the purpose of this bill will not be construed to be a barrier to the proper coordination or integration of services." Overly rigid interpretation of a congressionally authorized program should be considered poor management, and it should be clear to those who administer it that the Congress wants good coordination or integrated management wherever possible and appropriate.

Federal Assistance Reform Legislation The committee did not evaluate in detail the elements of the federal assistance reform bills currently before the Congress. The committee, however, has discussed some of the issues covered by those bills. Moreover, Hovey's paper in Volume IV discusses some important aspects of federal assistance reforms from a state-oriented perspective. Since many of the features of assistance reform legislation address problems identified in this study, the committee believes the goals

and philosophy of these federal assistance reform proposals are laudable and would encourage coordination and integration of health services.

Use of Categorical Funds for Other Purposes When Categorical Needs are Met Categorical programs are not always the only vehicle for provision of a particular service. A center providing comprehensive primary care may already be performing services mandated by categorical programs without resorting to categorical funding. The committee recommends that jurisdictions already providing a categorical service using general funds should have flexibility to use categorical money for other health services for needy people as long as the target population needs for the categorical service are being met. This would reward with funding flexibility the places that are already providing the targeted care. Other places that have no documented record of providing the services would be required to use the money in ways consistent with the categorical program requirements and report the use of the categorical services.

Use of Waivers Programs should be set up with ample opportunities for waivers as long as the proposers remain faithful to the intent of the authorizing laws. The study staff found that in a number of cases, such as On Lok and Project Health, waivers have been the key to innovation.

This study found that officials, sometimes will tend to protect themselves through narrow interpretation of the rules. They are usually strongly committed to particular program objectives but they tend not to take risks for purposes of broader program integration. Loyalty to a categorical program has virtues, but can be a barrier to coordinated care. Existing reward systems discourage action and risk taking toward the objective of coordination. The committee recommends broader use of "waiver" provisions. Waivers should be authorized in legislation as an appropriate mechanism to encourage creativity and innovation in the coordination and integration of health services programs.

Even where there have been waivers, the committee heard complaints about the time taken to persuade program officials that waivers were needed. The committee suggests that the use of waivers should not be surrounded by administrative barriers that can be overcome only by the most dedicated (or well-funded) programs. Rather waivers should be seen as a way to ensure that the broad congressional intent is protected. Program officials, especially at the federal level, should be encouraged to help applicants develop innovative approaches to meet congressional goals. There were a number of instances in the cases studied where federal, especially regional, officials worked with local and state administrators to plan and implement innovative programs. These cases demonstrate that, at least in the better situations, innovation can be permitted consistent with congressionally mandated program objectives. More

such innovations and adaptations are likely to occur, with less risk taken by individual officials, if the Congress makes clear that it values such behavior.

Simplified Grant Applications The committee found that some progress has been made in simplifying administrative requirements. As a further improvement the committee recommends that one simplified federal grant application package at least cover all health programs. If it is simple and flexible--an outline with narrative descriptions, standard budget forms, and so forth--it could fit any grant proposal. Proposal forms used by some foundations could serve as models. Programs that seek more than one federal grant should submit one description of their overall program, but with more detail on the aspect of the program for which money is being sought. The committee believes this not only will save time and money for proposer and reviewer but also will greatly ease the task of understanding what is being proposed, and how that differs from or fits with existing services funded by others. Even with the adequate time, staff, and copies of all relevant grant applications, this study's team often found it impossible to piece together a picture of what was going on and who was funding what in a project.

Requirements for decision making and accountability could be satisfied if a proposal were sufficiently clear in describing the context and the proposed program. The committee notes that there seems to be little evidence that many of the required documents are read or used. Also, when there is a need to make an evaluation, site visits are made because more information is needed to make judgments.

Single Audit Multiple audits of a health service program with multiple funding sources are a common requirement. A single audit that meets standard auditing practices should be acceptable to everyone.

Federal Responsibility for Populations with Special Problems

This study focused on the facilitation of local responsibilities for services integration and coordination. However, the exclusion of particular groups from categorical and entitlement programs, and the indifference of some states and localities to the needs of these groups, makes the committee believe that special federal attention should be given to the health needs of migrant workers and refugees.

Migrant Health Services Although health services for migrants and seasonal workers are often provided by health departments, and community health centers, the committee concluded that these groups and their families have special problems with services integration,

both in what they need and how services might be administered, sufficient to require that federal policy take these unusual circumstances into consideration. For example, the fact that migrants move from state to state makes medical coverage, school admission, and other eligibility requirements difficult to manage. The committee recommends that the financing and overall administration of migrant health care remain a responsibility of the federal government. Programs should be supported, which foster comprehensive and continuous care notwithstanding the problems created by the itinerancy of the client. Programs such as the East Coast Entitlement Project are good examples of the kind of programs that address these concerns.

Health Services for Refugees The case studies reveal special problems concerning financial coverage for refugee health needs. The committee concluded that the problems of refugees are national problems, because they are in part a consequence of national policy decisions. Solutions to the problems should not be left to individual states. The committee recommends that the federal government provide care or financing for health services for refugees and ensure the availability and coordination of services.

Linkage of Health and Nutrition Services

A key question in services integration and coordination concerns the extent to which related health services, such as nutrition supplements, are easily available and accessible to patients. In health programs serving low-income citizens, the ability to treat anemia and other nutritional deficiencies is considered essential. Not surprisingly, almost all of the programs examined in this study had nutritional services available on site or close by. Everyone interviewed considered these services to be valuable resources.

Although there may be opportunities for improved administration, the committee concluded that a nutritional program, such as the Special Supplemental Food Program for Women, Infants, and Children (WIC), is a necessary component of integrated services because it is a program that contributes to the nutrition and health of infants, children, and pregnant or lactating women. Health programs need this resource to treat serious nutritional deficiencies. There is considerable empirical evidence of WIC's value as a targeted nutrition program for high-risk infants and mothers (Kennedy et al. 1979; Kotelchuck et al. 1981; U. S. Department of Health, Education, and Welfare 1979). A Harvard University study (Kennedy 1979) found that of more than 1,300 pregnant women at high risk, those who participated in WIC had healthier pregnancies and delivered stronger babies than non-WIC mothers. The study also estimated savings of $3 in hospital costs for each dollar spent by WIC. The food stamps and

WIC are considered partial compensation for the imbalance in resources and health benefits throughout the nation, allowing the more affluent states to help bear the financial burden of feeding the poor, especially the children in the less affluent states.

The committee concluded that such programs are especially important in the more disadvantaged areas. WIC and food stamps help fill a gap in human services and add to the nutrition well-being of poor people.

Local Actions--Conclusions and Recommendations

Although policies of the federal and state governments set many of the rules and conditions, specific actions to integrate and coordinate health services for people in need of publicly subsidized services are taken by program operators and service providers in local communities. From the case materials and other sources, the committee has determined a number of conclusions and recommendations that are directed to program managers and providers. The findings summarized at the end of Chapter III contain practical advice for this audience, but the following are additional measures that will, in the committee's judgment, help achieve the objective of this study.

Providers of Last Resort

In discussing national and state policies, the committee noted the inhibiting effects of gaps in the financing of health services. Also important as a factor inhibiting services integration and coordination is the lack of available and accessible services at the local level, especially ambulatory services. If a base is to exist for the integration of services at the local level, it is the committee's view that a government jurisdiction must accept responsibility for ensuring that necessary services are available and accessible in a timely manner, irrespective of the patient's ability to pay. This is especially important for people who do not meet eligibilitycriteria for existing health programs. To carry out this responsibility the committee concluded that providers of last resort for ambulatory, emergency, and hospital care should be available so that every community is able to take care of health care needs that cannot be met otherwise.

Some members of the committee feared that a recommendation about providers of last resort could be misinterpreted as support for second-class medicine or a return to the almshouse. Yet, the committee recognized that there are jurisdictions where care is not available if an individual does not have the means to pay for it, and that this constitutes a barrier to services integration.

Palm Beach County Health Department (Florida) illustrates that quality services of a "provider of last resort" can be given in a cost-effective manner, and in arrangements that are acceptable to organized medicine and private practitioners and are supported partially by local tax dollars. In Palm Beach County the county Department of Social Services covers hospital care for patients until they can become eligible for Medicaid or Medicare. It continues to cover those who are not eligible for these programs. The administrators and providers are careful about money and are conscious of keeping costs as low as possible, but the need for a fallback system to provide care is recognized.

There are many health care providers that could function effectively as providers of last resort, including community health centers, an ambulatory care center of a health department, an outpatient service of a hospital, a public general hospital, a private hospital, or a contractual arrangement with private physicians where there are few providers (as in San Luis Valley HMO). Many health departments do not have a strong tradition of providing ambulatory care and, as is also true of community health centers, have not often expressed interest in functioning as a provider of last resort. Nevertheless, the committee identified successful examples of health departments and community health centers functioning in that role.

Roles of Health Departments

Whatever the contributions of various factors and providers to the improvements in health status and health services utilization in the last 15 years, the committee believes that the 1980s will be a time of accommodation to fiscal realities, which will mean consolidation of health resources at state and local levels. In considering the provision health services to all citizens and improvements in the organization of those services under these stringent circumstances, any serious examination must include the function of local health departments in working out the most cost-effective, organized arrangements that ensure the availability of good quality ambulatory care to people who have very low incomes. Health departments can be very useful in integrating services as was seen in Suffolk County (New York), West Virginia, Michigan, Seattle, Denver, Alabama, Boston, and Florida. The following are some of the functions that can be performed by local health departments in facilitating services integration and coordination.

Community Diagnosis and Health Planning To play an effective role in integrating services, health departments may have to be community diagnosticians, critically assessing present and potential health problems and marshalling public and private resources to meet identified needs. In many respects they are well positioned to do

so and have the proper legal basis for such responsibilities. The cases studied describe a number of health departments active in primary care provision. That potential should not be ignored when states and localities are planning health services for the underserved. But local government officials also can act as a self-interested group when worried about their budgets. The case studies bring to light the conflicts that a health department, with its own hospital and ambulatory care facilities, could have in coordinating other providers in the name of the public interest. Nevertheless, the process built into local governments can be employed to plan strategies for meeting local health needs.

Prevention of Disease Another role of the health departments is the prevention of disease, through such activities as water and food inspection and by providing such services as immunizations and family planning. But the research team found, as have others (e.g., Miller and Moos 1981), that people most in need of basic health services, because they live in poor, medically underserved areas of the nation, often also lack access to active public health agencies. To recruit and retain good public health officers is difficult when there are limited resources in the area, when the job is unexciting with low prestige and pay, when public officials and their families are often exposed to publicity, and when there are problems in getting anything done in government agencies because of what one respondent vividly called "the molasses" in the system.

The study's staff also found that some health departments prefer to undertake only the most basic public health protection services, such as water inspection, sewerage maintenance, and rabies control.

Providing Ambulatory Health Care State departments of health rarely are providers of primary care services. The role for states has been the provision of hospital services for the chronically mentally ill and the developmentally disabled, and the support of a variety of local public health services through categorical grants or general support grants. However, state health departments or other state-fostered activities,--as seen in West Virginia, Michigan, Alabama, and North Carolina,--can help shape the health systems at local levels, serve as conduits of funds to ambulatory care, and encourage services integration by the way they perform these roles.

National data, as well as the evidence from this study, show that the provision of medical care services is a major function of many local health departments. It was thought that after the enactment of Medicaid "mainstream" medical care would be provided to the poor as well as the middle class. Although this has occurred in some areas, others depend on local health departments to provide hospital, outpatient clinic, emergency room, and neighborhood health services.

Federal government action relating to local health departments has taken many forms. In some areas, preventive and screening services are offered in conjunction with providers of therapeutic care; in others, basis primary care services are provided (West Palm

Beach, Florida; Bessemer, Alabama); and in still others, complete programs of public care--at primary, secondary, and tertiary levels--are available.

The committee found strong examples of local and state health departments that were important in integrating services, including the provision of primary care. The committee recognizes that the exact arrangements and amount of public health department involvement in direct care vary substantially by geographic area, but health departments were found to play important roles in ensuring that (a) basic public health functions are provided, (b) unmet needs are identified, (c) interest in meeting such needs is aroused, and (d) those not receiving care in the private sector are treated.

Role of Community Health Centers

In many places, for a variety of reasons related to history and local preferences, health departments have shown little interest in the direct provision of ambulatory care. Therefore, to meet health needs, a variety of community health centers (CHCs) or projects were developed. For example, Su Clinica Familiar, in Texas, received a grant to provide primary care that the health department was not interested in providing. Although each of the 800 health centers in this country is different, community health centers generally emphasize family-centered, well-integrated primary care with particular sensitivity to the problems and needs of low-income people and minorities. Individual health centers have gone through stages of (a) instability (as in East Jordan, Michigan); (b) emphasis on the health center as a source of jobs, especially health career opportunities for neighborhood people (as in Boston, Mile Square, and Denver); (c) development of close ties with community groups and social services (almost all cases); (d) reaction to a sometimes hostile medical community and hospitals; and (e) enjoyment of resources sufficient to provide a full range of services, such as transportation, outreach, social services, and day care.

The committee found health centers that have overcome developmental problems, have created effective linkages with other agencies and institutions in their communities, and have met medical needs in low-income communities in an integrated manner. Brookside Park Family Life Center and East Boston Neighborhood Health Center, both in Boston, Massachusetts, illustrate these points well. Recent data from other studies (for example, as summarized by Davis 1981, and Freeman et al. 1981) also document these observations. The committee concludes, therefore, that community health centers can be effective instruments for health services integration and coordination.

As funding has declined, many of the community health centers have been forced to become more narrowly focused, delivering acute

primary care only, and reducing their function as integrators. They also have begun to concentrate (like their private medicine and hospital colleagues) on reimbursable services, eliminating the under-funded or so-called "soft services" such as counseling, which many proponents feel are some of their most distinctive characteristics.

Although early evidence of the effectiveness of CHCs has been mixed, recent studies (e.g., Davis 1981; Freeman et al. 1981; Okada and Wan 1980; Wan 1982; Goodward 1981) found more consistent evidence that CHCs contribute to the provision of health care to low-income people and that they have influenced the way in which medical care is delivered by other providers. According to Davis (1981), community health centers bring primary care to 6 million of the 20 million poor residents in medically underserved communities.

A number of studies have identified the special financial problems of health centers that seem not to be well understood by some policy makers, who attribute weak financial strength and low third-party billing rates and collection to mediocre management. The cases studied by this committee suggest that even the best management cannot compensate for the lack of financial coverage of many of the people who come to the centers. For example, the entrepreneurial and management skills of Florida Community Health Centers--with emphasis on bill collection and other ways of support services--could not compensate for the patients who were poor but ineligible for financial assistance. The committee's observations are consistent with a study by Brecher and Forman (1981) of the financial self-sufficiency of inner-city ambulatory care programs:

> Increasing Medicaid payment levels would not be adequate to make most inner city programs self-sufficient (this is because many persons visiting subsidized programs are not covered by any third party and are not viewed as having the resources to pay full costs directly); (2) coverage is a far more critical dimension of Medicaid policy than payment rates for the financial viability of ambulatory care programs; and (3) the relative reimbursement levels set by third parties for inpatient v. ambulatory services severely disadvantage ambulatory care programs because private groups delivering both of these are able to earn higher payments for in-hospital services and to use these revenues to offset the more limited ambulatory care payment levels.

This is a particular case of a general problem cited by this committee early in this chapter. It is important that the basic vulnerability of primary care programs to gaps in the third-party reimbursement programs be understood. The lack of fiscal strength

of community health centers and their weakening position are due to (a) cutbacks in their historic sources of support, (b) services provided to very poor people who often have no means to pay, and (c) gaps in eligibility and coverage for the people served and the services provided under third-party payers, particularly Medicaid programs in some states. Because of the changes made and proposed in Medicaid and other financing methods, services integration by these health centers will become increasingly difficult to achieve. It is not the committee's role to suggest that every health center must be supported by grant of other funds to cover these gaps. The committee does suggest, however, that community health centers will become fewer and less effective instruments for services integration as funding is reduced or eliminated. An analysis of these results should be a part of funding decisions at the federal, state and local levels.

Need for Stable Local Funding

The committee found that federal and state money alone may not always ensure well-integrated community care, regardless of the type of organizations used to provide that care. The cases present evidence that funding by local sources leads to closer ties with officials and related institutions, more stability, a stronger sense of belonging, and wider acceptance by the community. Anecdotal evidence from a number of community health centers also supports this observation (Robinson 1982). The committee concluded that local funds, as well as state and federal revenues, are important for achieving integration and coordination.

After examining the case studies and reports and hearing the speakers at the public forum, the committee also concluded that, in order to ensure integrated services, stability and predictability of local funding are important to help offset fluctuations in other sources. Ad hoc arrangements are particularly fragile. Programs are vulnerable if they are funded primarily by federal grants, particularly if the programs serve populations that are politically and economically weak.

The committee observes that responsibility and accountability to a political jurisdiction, either state, county, or city, linked to local funding have advantages, including easier administration and ability to be identified with and use the strengths of public officials and political figures. The committee notes two problems with this linkage, however. First, some states and localities have demonstrated indifference toward certain population groups. This indifference was an important factor in the development of targeted federal programs in the 1960s. Second, since local funding usually means a wider role for health departments in providing ambulatory services, we would observe that these departments, like all institutions, have their own special interests. For example, a

state or local health department's first priority may be to keep a network of local public health agencies operating with basic services. If overall budget cuts are necessary, the health departments might reduce local fundings to community health centers first, even if the centers are serving more people in an effective manner. To avoid these effects, the committee recommends that health departments, or whoever is given responsibility for realigning federal and state health grants, should be required to use objective criteria and an open process involving key community interests when funds are being allocated at the local level.

Minimum Services

The effective integration of services presumes the availability of a basic level of health services. The committee has not defined or listed what those services might be because it had neither the time nor the resources to fully explore that issue, but there have been several thoughtful examinations of those questions by others. For example, a consortium of public health leaders--state, county, local, and federal officials--has issed through the American Public Health Association (APHA) Model Standards for Communities (APHA 1979). Those standards are an inventory of essential county-local preventive health services. They represent an effort to specify outcomes by which the adequacy of these programs could be judged. Among other important aspects of this approach is a process by which a community may specify its own minimum levels of expectations. Two other excellent sources on minimum services are Thomas C. Schelling's "Standards for Adequate Minimum Personal Health Services (1979) and the Report from the Select Panel for the Promotion of Child Health (1981).

Traditionally, there has been concern among medical and health professionals that in identifying a set of essential basic services, the "floor" could become the ceiling and the specifications might be used as an excuse for cutting back services. Mindful of these fears, but recognizing that there are still some places in the country where such basic services are not ensured, the committee concluded that certain basic health services should be considered essential as the foundation for services integration, as well as for the enhancement of the physical and mental health of future generations. These should include at least preventive health services, adequate nutrition for mothers and children and basic mental health care. Adequate prenatal care, obstetric care, and family planning and immunization help avoid diseases and disabilities that are far more costly in human and financial terms than the costs of the programs themselves.

Information Systems

Computerized data systems that help patients through the care system, store data that help in patient care, and encourage referrals and follow-up are promising methods to facilitate the necessary reporting, which in turn facilitates the provision of integrated health care. Jefferson County (Birmingham, Alabama), has an excellent computerized patient record system for obstetrical care that tracks a patient through the health department's prenatal clinics, to outpatient specialty clinics at the university hospital, and to delivery at either the university or the county hospital (Wirtschafter et al. 1981; Koba Associates, Inc., 1981). The Jefferson County system was used as the basis for statewide record systems for maternity, pediatric, and family planning services in local health departments after one of its designers became the director of the state maternal and child health bureau. Subsequently, the state health department adopted a cost-accounting system that permits local health departments to fund clinicians and clinics with more than one categorical program, resulting in more efficient use of staff and in more integrated service delivery to patients.

In Seattle, the health department is experimenting with a computerized information system in its North District Family Health Clinic that also permits integrated service delivery in spite of categorical funding. In Palm Beach County, the health department developed an information system that tied together provider time records with patient records and patient eligibility information, which enabled the department to deliver more generalized primary care with a mix of categorical grants, county funds, reimbursements, and fees.*

The committee found a number of efforts, especially by health departments, to develop information and accounting systems that make it possible for more integrated service delivery to take place while meeting categorical program fiscal and quality assurance requirements. These usually were efforts to uncouple the funding source or patient eligibility status from the clinical treatment of patients. This was made possible in most cases by the existence of some source of noncategorical funding, such as a city or county appropriation or a federal health center grant, which could be used for those patients or services that could not be allocated to a categorical funding source.

* Another system, not studied in depth, was in Greenville, South Carolina, at the Appalachia II District Health Department.

Additional Observations and Recommendations

The following observations and recommendations are seen by the committee as augmenting the effects of the policies and actions recommended for federal and state authorities and local service providers.

Supply of Health Professionals

In the cases examined by this study, recurrent difficulties were found in the recruitment and retention of health professionals. Reasons included physical settings in geographically remote or poverty areas, relatively low pay, inappropriate and rigid personnel systems, burnout from treating people with so many problems and so few resources, and training that was highly specialized or dependent on availability of high technology. Health centers often were obliged to accept contract physicians who would work only part time (while they developed their own "private" practices elsewhere, as in Palm Beach County, Florida, and Bessemer, Alabama). Reduction of continuity of physician care was the result. The cases also revealed that the National Health Service Corps played an important role in providing professional staff in a number of settings. The research team found that an increase in physician supply eased the problems in some areas, particularly in Boston, Denver, and Seattle. Registered nurses, licensed practical nurses, and nursing assistants were also hard to recruit and retain.

<u>The committee concluded that the National Health Service Corps, by making significant contributions to the supply of physicians, dentists and other professionals in programs caring for the underserved, is an important instrument for facilitating integrated services.</u>

In the cases studied by the Institute of Medicine the interests of corps personnel were compatible with the needs of both the private sector and the public sector (see, for example, San Luis Valley HMO, Southern Ohio Health Services Network, North Carolina Office of Rural Health Services in Volume III). In addition to service in the corps as a federal employee, the corps now provides an option for repaying scholarship obligations through work as private practitioners or salaried practitioners in health manpower shortage areas (the so-called Private Practice Option, which is being encouraged now by the Public Health Service).* It promotes practices in areas that have few physicians or other providers

* During the 1980-81 cycle, some 400 scholarship recipients (almost 50 percent of those available) chose this option.

without the encumberances of federal employment or the salary costs to the federal budget. Review of the cases reveals problems with this option, however, if integrated services are to be provided. "Pure" private practice (fee-for-service practice) in many shortage areas is not economically feasible. Indeed, if this were not true the rationale for the corps would be weakened. The capacity of the corps to place health personnel where they would otherwise not be is the value of the corps for our objectives.

The long-term effects of the growing physician supply are not known. But the committee concluded that, at least in the short term ample problems remain for staffing health centers providing care to poor people or other hard-to-staff institutions (jails, mental hospitals). These problems suggest the continued need for a program assigning personnel on a subsidized basis in areas that will not be served by the private sector in the immediate future (see Kehrer and Sloan 1982).

Role of the Voluntary Sector

As part of the study, the committee examined selected aspects of the nonprofit (independent) sector concerning its potential for contributing to the availability or integration of health services (see Hahn in Volume IV). The committee found examples of volunteer organizations working to provide integrated services (see Appendix D) and learned about specific cases in which volunteer activities provided modest linking or gap-filling roles. For example, the Palm Beach County (Florida) Health Department has a continuing volunteer program that grew out of a massive effort in 1976 to immunize 100,000 people against influenza. In 1980, 400 volunteers contributed more than 12,000 hours by working in clinics, the business office, health education programs, environmental services, and so on. In Denver, voluntary agencies provided specific services, such as equipment for people suffering from particular diseases or health problems. In East Jordan, Michigan, volunteers provide hearing testing. At Su Clinica Familiar, physicians donate time; in Ohio, community members have given land to the Southern Ohio Health Services Network.

Volunteer work and philanthropy have dual roles: they help increase the health resources available and strengthen the connections between providers and the community. The interests and charitable insticts of individuals, nonprofit agencies, and corporations can be melded with health programs' needs on an ad hoc basis and around particular products and services. Individual companies may be willing to contribute drug samples, supplies, and medical equipment for use by low-income clients. Corporate donations can be used to fund specific services or purchase specific equipment for targeted medically needy populations. But the committee found that stable, predictable funds, not usually

obtainable from the voluntary sector, are important to public health departments, health centers, or outpatient departments if they are to provide integrated services. The committee concluded that expectations of the contributions of volunteers to ensuring integrated services should be tempered by organizational and fiscal realities.

Discrimination against Minorities

The committee did examine possible problems of discrimination in ambulatory health services as part of this study. However, many of the six cases and the sites where visits were made by the research team were in geographic areas with large minority populations. There are facts about the cases that the committee believes bring into question the degree of equality of treatment or equity of outcomes that have been reached in some of the geographic areas studied. For example, the health policy-making boards or groups in some places still have few or no blacks or other minorities, even where a substantial proportion of the population is minority.

The committee also did not pursue in any depth possible problems of discrimination, because a study of civil rights and health care has been recently completed by another committee of the Institute of Medicine. The Committee on Services Integration recommends that the reader review that committee's report, Health Care in a Context of Civil Rights.*

Need for Health Services and Policy Research

The committee observed that most of the programs examined by this study collected little information for analysis and internal planning and assessment. Programs such as Denver, which might benefit from information concerning the systemwide cost-effectiveness of specific services, did not gather and analyze data on those subjects, even on a special-study basis. Such data, about effectiveness and costs, however, may be crucial to a program's long-term existence. If, in times of reduced funding, health programs concentrate on reimbursable services as a key to short-term survival, such actions only emphasize the need for evidence of the overall cost effectiveness of different health investments. At least, the value of a "technology neutral" reimbursement system becomes all the more evident (for excellent discussions of these and related matters, see Butler et al. 1981, Moloney and Rogers 1979).

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* Available from National Academy Press, 2101 Constitution Avenue, N.W., Washington, D. C. 20418 (Publication No. IOM 81-04).

In the cases studied, after learning how decisions were being made about which services to eliminate and hearing the requests of public officials for a better basis for good decisions, the committee concluded that policy makers and program administrators are hampered in their efforts to determine an efficient deployment of health resources for ensuring cost-effective integrated services. They need more and better research and information about the effectivenss and efficacy of and about effects of public policies. Yet the committee found that expenditures for health services research, health policy research, health statistics, and technology assessment are being reduced at a time when the need for a sound quantitative base for decisions for effective services integration is the greatest.

The committee recognizes that there are problems in health services research, including difficulties in evaluating the results, problems in measurement, and insufficient relationship to clinical and biomedical research; yet in the committee's view, the benefits of research outweigh its limitations. In the absence of independently generated information, health policy research, and health services research, policy makers and program operators will become more and more dependent on vested interests for the data on which public policy and operational decisions are made.

Apart from questions of clinical efficacy and range of appropriate services, there also is a question of the most cost-effective organization for delivering services. Projects such as On Lok Senior Health Services in San Francisco, California (see Volume III) had a research component built into their activities from the start. As a result, On Lok can demonstrate to legislators the costs and benefits of its approach for the disabled, frail elderly. One accomplishment has been state legislation for medical coverage of day health care for the elderly. The evaluation of different configurations of services delivery is a vital component to developing a cost-effective delivery system.

In sum, we believe that coordination of services is important and can contribute to the creation of a leaner, more effective health system. But this multibillion industry is growing at a rapid rate and facing additional pressures from the use of new technology and an aging America. Solving the problems of providing essential health care at an affordable price, particularly to those not yet served, will be possible only if there is better information on which to base difficult decisions.

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APPENDIXES

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APPENDIX A

BIOGRAPHIES OF MEMBERS OF THE COMMITTEE ON SERVICES INTEGRATION

PHILIP R. LEE is a Professor of Social Medicine at the University of California, San Francisco School of Medicine, where he has served as Director of the Institute for Health Policy Studies since 1972. He served as Chancellor of the University of California, San Francisco, from 1969 to 1972. Prior to that he served as Assistant Secretary for Health and Scientific Affairs in the Department of Health, Education, and Welfare from 1965 to 1969 and Director of Health Sciences, Office of Technical Cooperation and Research, Agency for International Development, from 1963 to 1965. From 1950 to 1963, Dr. Lee was a member of the Department of Medicine, Palo Alto Medical Clinic. Dr. Lee received his M.D. from Stanford University School of Medicine and is certified by the American Board of Internal Medicine. He is a member of the Institute of Medicine and serves on the Editorial Boards of the Annals of Internal Medicine and the Milbank Memorial Fund Quarterly. He also has served as a member of the Board of Trustees of the Carnegie Corporation and the Mayo Foundation and is Chairman of the Boards of Directors of the Alan Guttmacher Institute and Population Education, Inc. Dr. Lee is the author of over 100 articles in the health field and he is coauthor of numerous books on health policy issues.

LEIGHTON E. CLUFF is Executive Vice President of the Robert Wood Johnson Foundation. He received an M.D. from George Washington University in 1949 and did postgraduate research in immunochemistry at Johns Hopkins University School of Public Health and Hygiene and at the Rockefeller Institute of Medical Research, New York. Dr. Cluff, who is certified by the American Board of Internal Medicine, has served as Professor of Medicine at the Johns Hopkins University School of Medicine and as Professor of Medicine and Department Chairman at the University of Florida College of Medicine, Gainesville, Florida. He has served on numerous committees of the National Academy of Sciences, including the Toxicological Information Program Committee and the Committee on Biomedical Research in the Veterans Administration, both of which he chaired. He is a member of the Institute of Medicine. Dr. Cluff has also served on the editorial boards of a number of professional journals. He is the author of many articles and books on various aspects of medicine, medical education, and clinical practice.

JOSEPH C. CZERWINSKI is currently a businessman in Milwaukee. He was a Representative to the Wisconsin Assembly from 1968 to 1981. He was chairman of the Assembly's Committee on Health and Social Services and of the Medical Education Review Committee. Since 1979, he has been consultant to the National Center for Health Services Research of the Department of Health, Education, and Welfare. He has served on various committees for the National Conference of State Legislators and is active in a number of local and state organizations, including the Wisconsin Council for Cancer Control and the South Division Civic Center Association. Mr. Czerwinski attended the University of Wisconsin-Milwaukee and LaCrosse State College.

FREDERICK WILLIAM DOWDA is a physician in private practice in Atlanta, Georgia, and a leader in organized medicine in Georgia. He is a past President of the Medical Association of Georgia. Dr. Dowda is active in numerous professional and community organizations. He has served on the board of directors of Model Cities Better Health, Inc., and was instrumental in setting up neighborhood health centers in Atlanta. Dr. Dowda received his M.D. from Emory University School of Medicine and is a diplomate of the American Board of Internal Medicine. He is currently a member of the AMA House of Delegates. He is a member of the Institute of Medicine.

H. JACK GEIGER is Professor of Community Medicine at the School of Biomedical Education, City College of New York. He received an M.D. from Western Reserve University and has an M.S. in Hygiene (epidemiology) from the Harvard School of Public Health. In addition to a teaching career at Tufts, Harvard, Stony Brook, and City College, Dr. Geiger has been consultant to numerous private organizations and government agencies. In the mid-1960s he proposed the Neighborhood Health Center program to the Office of Economic Opportunity and designed and implemented the first OEO health center grants for programs in urban Boston and rural Mississippi. In addition to his scholarly contributions to the study and improvement of health care in the United States, Dr. Geiger has traveled extensively and studied the health care systems of numerous countries in Africa, Asia, and the Caribbean and been advisor to a number of countries.

WILLIAM GORHAM is President of the Urban Institute in Washington, D.C., a position he has held since 1968. From 1965-1968 he was Assistant Secretary of the Department of Health, Education, and Welfare. Mr. Gorham received a B.A. in Economics from Stanford University, where he also did graduate work. He has served on a number of boards and committees, including the Board of Editors of the Journal of Public Policy, the Federal Panel on Social Indicators, and the President's Task Force on Child Development, which he chaired. He is a member of the National Academy of Public Administration and the author of scholarly and popular articles on policy analysis, the uses of research in public policy, and urban affairs.

CORNELIA T. JOHNSON is Director of the Hartford Office of the American Red Cross. She has held many positions in community health and social service agencies, including coordinating a training program for community health workers sponsored by Model Cities and the University of Connecticut, designing educational and recreational programs for nursery school children, and counseling single parents. Her volunteer board activities are extensive--Hartford Hospital Public Relations Committee, Catholic Family Services, Mental Health Catchment #23, Alliance of Black Social Workers, Community Health Services (founder), Primary Care Clinic, and others. Ms. Johnson has a degree from Skidmore College in Community Education and Adult Education. She has presented several papers to professional organizations and has published in Connecticut Medicine.

MARIA A. MATALON is Director of the Migrant Health Project of the Pennsylvania Department of Health. She received a B.S. in Nursing from Incarnate Word College in San Antonio, Texas. She is currently involved in the planning, development, and implementation of a statewide comprehensive health services delivery program for approximately 18,000 migrant and seasonal farmworkers and their dependents. Ms. Matalon serves as Vice-President of the Board of Directors of the National Migrant Referral Project in Austin, Texas, and is also Vice-President of the Board of Directors of Hamilton Health Center in Harrisburg, Pennsylvania. She represents the Department of Health on the Governor's Interdepartmental Council on Migrant Services.

WALTER McCLURE is President of the Center for Policy Studies. Most recently, he was the Vice-President of InterStudy and Director of its Health Policy Group. He received his Ph.D. in Physics from Florida State University. Dr. McClure has directed analytical and applied studies on a broad range of health policy issues, including improved competition, cost containment, economic regulation, and national health insurance. He has acted as consultant to the Department of Health, Education, and Welfare, various congressional committees, federal agencies and legislative committees in several states, medical societies, business associations, and others. He has given numerous presentations and published extensively on competition, regulatory strategies, excess bed capacity, and other critical health policy issues.

NORA PIORE is currently Senior Program Consultant to the Commonwealth Fund. She was Professor of Health Economics and Associate Director of the Center for Community Health Systems at the Columbia University School of Public Health until she joined Commonwealth in 1981. She has also been Special Assistant to the New York City Commissioner of Health, and Staff Economist, the Health Legislation Subcommittee, U.S. Senate Committee on Labor and Public Welfare. Her published research has dealt with the role of the nation's hospitals in providing ambulatory care; the changing mix of public and private health expenditures; and urban health economics and health manpower issues. She has been a member of the United States Committee on Vital and Health Statistics, the Guttmacher Institute National Council, the National Health Advisory Council, and the United States Public Health Service. Mrs. Piore received her B.A. and M.A. degrees from the University of Wisconsin. She is a Fellow of the New York Academy of Medicine and a member of the Institute of Medicine.

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APPENDIX B

BRIEF DESCRIPTION OF SIX CASE STUDIES AND SIXTEEN REPORTS

Six Case Studies

Alabama Maternal and Child Health Program is an effort to revitalize and reorganize the state health department's Bureau of Maternal and Child Health/Family Planning in order to reduce very high infant mortality rates. These state efforts were examined in detail in two local sites: the West Alabama District Health Department, which serves a poor, rural area; and the Jefferson County Department of Health, an urban area including the city of Birmingham.

Boston Neighborhood Health Centers is a decentralized network of 25 very different and fiercely independent but hospital-linked centers developed to meet primary care needs in the city with the encouragement and aid of the Boston Department of Health and Hospitals. Two of these centers were studied in depth--East Boston Neighborhood Health Center and Brookside Park Family Life Center.

Denver Neighborhood Health Program is a highly organized system of health centers delivering comprehensive primary care services rather than compartmentalized services distinguished by funding sources. The network is administered by the Department of Health and Hospitals of the City and County of Denver. The research team studied Eastside Health Center and Hyde Park Health Station.

Florida Department of Health and Rehabilitative Services was established as part of a major reorganization of state government and combined ten previously independent state agencies. Of particular interest to this study was the attempt to integrate health with social services at the state level and the local level. The Palm Beach County Health Department, with its network of primary care health centers, was examined to see local integration of federal, state, and local health and social agencies.

Michigan's Division of Health Care Systems was established in the Department of Public Health to coordinate federal, state and local primary care efforts in the state. Two local sites were studied: East Jordan Family Health Center in rural northern Michigan and Center for Health and Social Services (CHASS) in Detroit.

Seattle's North District Family Health Clinic is an effort to decategorize service delivery despite categorized funding. It is a joint effort by the city-county health department, the Public Health Service Hospital (now locally operated), and the University of Washington's School of Public Health.

Sixteen Case Reports

The California Rural Health Services Development Program was designed to improve the availability of primary care in rural areas through (1) funding primary care centers, which use the money in a wide variety of ways; (2) developing a California Health Services Corps, which floundered for a number of administrative and political reasons; and (3) establishing within the state department of health a coordinating unit which, because it had insufficient start-up time, had problems fulfilling its mandate.

Organized by the U.S. Public Health Service Hospital in Baltimore, the Community Geriatric Service was developed to provide comprehensive in-home assessment and coordinated services to disabled, homebound, frail elderly in north-central Baltimore and to build a community-wide geriatric service network.

Florida Community Health Centers, Inc., is a federally funded, centrally administered network of four primary care health centers in remote rural areas of south-central Florida serving migrants, seasonal farmworkers, and the rural poor.

The Kansas Bureau of Maternal and Child Health, an organization for a vast array of federal and state programs, has been the major impetus for development of a county public health system and expansion of services for mothers and children throughout the state. The Kansas program combines an integrated administrative structure with a locally determined and controlled delivery system that relies largely on federal and, quite significantly, county tax dollars.

Mile Square Health Center in Chicago is a large comprehensive primary care center serving a poor inner-city neighborhood. The center integrated public health nursing, primary care, mental health services, and hospital care.

The Office of Rural Health Services in North Carolina is a state-funded program to help establish financially self-supporting health centers in rural underserved areas. The program helps fund capital and operating costs, offers technical assistance and community organization for developing centers, which are frequently small and staffed by midlevel practitioners with off-site physician backup.

On Lok Senior Health Services in San Francisco is an organization that, through capitated reimbursement from Medicare, offers 300 frail elderly people a full continuum of health and social care in their own community with a minimum of institutional care.

Multnomah County Department of Human Services (Portland, Oregon) developed Project Health as a mechanism for buying health care for the medically indigent from mainstream, private-sector providers. The project acts as broker, contracting with comprehensive, prepaid plans so that patients get easy access to integrated care as well as a choice of plans.

The San Luis Valley Health Maintenance Organization is an effort stimulated and financed by the federal government to integrate public and private financing for health services and create a one-class system of health care in a six-county area in south-central Colorado.

The Senior Care Program in the District of Columbia was an unsuccessful federally funded effort to provide more coordinated care to the elderly through development of a comprehensive health care network including a city hospital and three community health centers, with linkages to aging service organizations in the community.

The Southern Ohio Health Services Network consists of six health centers and two dental clinics in rural and suburban underserved areas of Ohio. Funded in part by the Bureau of Community Health Services, the network is operated by a central administration where such activities as billing, grant writing, personnel functions, and recruiting take place.

Su Clinica Familiar provides primary care to migrant workers and medically underserved residents of two poor counties in South Texas. The organization grew and gained the acceptance of other local providers, and links with those providers have been forged through sensitive political and community work.

Suffolk County Department of Health Services (Long Island, New York) was created as a department incorporating numerous responsibilities: it attempted to integrate many services, especially public health, primary care, and mental health, and developed a network of health centers.

Sunset Park Family Health Center, funded by numerous federal, local, and private agencies, provides a wide range of primary health, mental health, and social services to the population of a depressed area of Brooklyn, New York. The center has a close, symbiotic relationship with a nonprofit hospital and has developed close ties to the community.

The privately funded Utah Network of Rural Health Programs functions as a resource, facilitator, broker and advocate for health care professionals, community leaders and organizations concerned with improving health care delivery in remote and rural areas of the state. The network was instrumental in creating an Office of Rural Health Services within the State Department of Health, which will assume the network activities next year.

After a reorganization that created an umbrella department for public health, mental health, institutional care, and primary care, the State of West Virginia Department of Health pursued an explicit policy of services integration. With funds from a number of federal agencies, several approaches to integration have been tried, including developing a regional health department and offering communities enhanced funding for integrated services.

APPENDIX C

METHOD OF STUDY

Helen Darling and Michael McGeary

Conceptual Framework and Definition of Services Integration

Integration of health services is a complex notion. Although the term is used frequently, it seems to mean something different to almost everyone who uses it. The term is invoked in frustration by top-level administrators, providers of health services, and citizens who see hundreds of programs, hundreds of thousands of health workers, and billions of dollars going into care that still does not always meet people's needs--certainly not in what seems to be a well-synchronized, efficient fashion.

Whatever its definitional and operational limitations, services integration remains a popular idea. It sounds like a plausible and desirable answer to problems of fragmentation of services and financing. Observers seem to feel that if problems do not result from the absence of money, people, or programs, then they must stem from inadequate coordination, integration, or linking. Still, no satisfactory definition of these terms is available.

Although this study began with an analytic framework, it quickly became apparent that the words "services integration," as used in the theoretical and empirical literature, refer to phenomena that vary substantially throughout the country and within states. Morris and Lescohier (1978), as well as many other students of the issues, captured the problem:

> Integration is often considered in current literature as akin to coordination and they are frequently used interchangeably, although the two words have distinct origins and differences in meaning. A common dictionary definition defines integrate as "to put or bring together parts or elements so as to form one whole; to combine into a whole." An integrated element is one which is united or undivided. By contrast, coordinate means "to place or arrange things in proper position relative to each other; to bring into proper order."

In this study we have found that in most people's minds, coordinating, linking, and integrating were all directed toward the same thing--making health services work more effectively for the consumer. Health services programs described as "integrated" tend to offer a comprehensive array of services--preferably with medical care (primary, secondary, and specialty backup), mental health care, and dental care--and have internal operations organized to allow the patient to move smoothly through the system.

Implicit in many people's vision of integrated services is the notion of responsibility by the provider or organization for the patient. This does not refer to responsibility in a narrow legal or contractual sense but to an operating assumption of the organization and, in the ideal model, in the minds of everyone working in the organization. For example, Iglehart (Volume IV) notes that "integration is a way of life" in one place he studied. McGeary and Darling (Volume II) have described it as an attitude or atmosphere in which staff at all levels make the effort required to do the job or to get what is needed for their clients. Other people's images include the concept of holistic care, whereby the patient is treated as a whole person who may also have mental health problems or serious occupational and family considerations. Finally, the image of integrated services includes recognizing the individual as a family member when evaluating and addressing the individual's problem. An individual can also provide an important link between a health center or program and a family that may also need services.

In practice, however, such integrated arrangements are rarely seen in the care of special and low-income populations and are not necessarily the highest priority--or even desired by--the population served. The label of services integration is attached to a potpourri of activities, organizations, and connections that do little of what is discussed above. For example, the notion of services integration frequently means a simple increase in the supply of services. It may refer to the construction of a multiservice center that includes many social services and few, if any, health services. Services integration may also refer to a network of providers organized to minimize duplication and ensure high quality. Finally, services integration may refer to overcoming problems in financing and coverage, so that providers can diagnose, treat, and palliate the health problems of patients without financial concerns.

Despite a long history of efforts to improve coordination and integration of services and the unexciting results of most of them, interest in the concept remains high, and the pursuit of more "integration" or better coordination continues. In addition to the ambiguity of the concept, it is not apparent that the problem is the right one, or that what we call integration problems ought to be the primary targets for reform. For example, Brown (Volume IV) observes that many of the problems have little to do with integration or coordination; most "integration problems" are consequences of policy choices that have been made by society.

> "Coordination problem" is a diagnosis that should be used precisely and sparingly. To speak of a coordination problem implies that two or more social units "ought" to reach an agreement with respect to a matter which they perceive as a common concern. Here, as in ethics, "ought" implies "can"; that is, it implies that the units have the ability, power, resources (and so on) to reach an agreement and implement it. That social service agencies and hospitals sometimes fail to make arrangements that would allow alcoholics to receive proper treatment may or may not be a coordination problem. If the situation merely reflects short-sightedness or indifference by one or more agencies, it is one; if it reflects refusal of third-party payers to cover such services or congressional unwillingness to enact national health insurance benefits paying for treatment for alcoholics, it is a policy problem, not a coordination problem. Many seeming coordination problems are spurious in this sense: on closer inspection they turn out to be explained by policy choices, that is, by "macro" decisions that tie the hands of the social units contemplating coordination.

It is this latter point that served as a base for some of the empirical questions in the study. We were concerned with disentangling the question of availability of services from accessibility to those services. That is, we asked if services were available. If so, was access to the services limited in any way (e.g., because of inadequate financial coverage, hours, transportation, language) or was it limited "simply" by poor coordination between administrative units? The latter set of faults is of quite a different nature than the former problem of availability of services.

These issues are by no means only academically intriguing. First, the policy and program planning implications of each are quite different. Second, we believe that changing organizational structures is worthwhile primarily if the change improves the way services are delivered to people, as documented by reliable data. But defining and studying services integration is as difficult as ever. As Dewitt John concluded after reviewing many services integration projects funded by the U.S. Department of Health, Education, and Welfare, "No definition of services integration has ever gained general acceptance, and the meaning of the concept has changed in the hands of different advocates and practitioners" (John 1977).

The literature provides a taxonomy of integrative mechanisms first developed in 1972 (Gans and Horton 1975) and elaborated on by subsequent studies (John 1979). More recently the literature has begun to differentiate among levels of integration--coordinated service delivery, interagency administrative linkages, structural

reorganization, and executive policy management (Redburn 1979, Agranoff and Pattakos 1979). We have combined the various dimensions into a typology, shown in Table 1, which has served as a framework for the collection of data and for the discussion of findings. A detailed discussion of services integration and an assessment of the research on it is given by Baumheier in Volume IV.

Defining the Research Methodology

The case study approach is the most appropriate method of study for several reasons. First, while health services integration has been studied, concise definitions of terms and identification of measurable variables have not yet been adequately articulated. Therefore it would be difficult to construct hypotheses to test with a quantitative methodology.

Second, from the review of integration and complex organization literature, it is clear that the environment and historical context is important to any analysis of integration. The case-study approach allows researchers to study services integration in an open system (March and Simon 1958, Thompson 1967). The services studied are viewed as operating within organizations that exist in highly complex, dynamic, and heterogeneous environments. Researchers can thus begin to discover underlying conditions and actions that promote or inhibit integration at the community level.

Third, to a large extent, health services integration is a process rather than just a structure. Because so little is known about the processes, a case study can better capture how it works than can a statistical snapshot. In addition, perceptions about changing environments, wide-ranging organizational options, individual perceptions, and decision-making processes are not easily studied with questionnaires. A qualitative, case-study approach is employed as an appropriate method to begin to define these complicated roles, relationships, and resulting integration.

Site Selection Criteria

A list of approximately 200 potential sites was prepared by the staff--some from a review of the literature and other suggestions based on a modified reputational approach. The Committee on Services Integration narrowed the list to 100 and from there began to identify a list of criteria, problem areas, and examples that ought to be included in the cases selected. The staff continued its review of the relevant literature to make certain that all key variables were identified and that any new research that would expand our theoretical and empirical base was not overlooked. During this on-going review, cases were added. The staff took the list of 100-plus cases, developed criteria, and began to define the types of cases that needed to be included.

TABLE 1 Typology for Study of Services Integration

	Levels of Integration		
	Delivery of Services at the Patient Level	Organization and Administration of Services	Policy and Decision Making
Taxonomy of Integrative Mechanisms	• Core Services Linkages Outreach Intake Diagnosis Treatment Referral Follow-up Transportation • Case Coordination Case conferences Case team Case coordinator	• Fiscal Consolidated funding Joint budgeting Fund transfer Purchase of services • Personnel Consolidation of personnel administration Joint use of staff Staff transfer Staff outstationing Joint training Colocation Joint staff meetings • Administrative Support Recordkeeping and data systems Grants management Central support services • Organization Single Provider Network of independent providers Integrated system of formerly independent providers Federated health and human services agency Unitary health and human services	• Planning and Programming Joint policy making Joint planning Joint programming Information sharing Joint evaluation • Governance Private Public Mixed

SOURCE: "Levels of Integration" adapted from Agranoff and Pattakos 1979. "Taxonomy of Integrative Mechanisms" adapted from John 1979.

Final decisions on site selection criteria were then made by the committee. There were two sets of criteria--one for six in-depth case studies and a second set for selection of smaller case reports. Selection for the six case studies included the following criteria:

1. The case had to have been reported by informed observers or in the literature to be a "successful example" of services integration.

2. The case had to represent, or be a part of, a larger complex system of health care. This would not only ensure that we would have good instructive cases (since it is obviously easier to accomplish something when the initiative or setting is simple), but it would also uncover failures and other false starts and thus help us deal with some of the possible biasing effects of looking only at reported "exemplary cases."

3. Within each case at least two program or administrative levels (local-federal, local-state) were to be involved, and three levels were preferred.

4. At least one case was to have been actively started and/or operated within a politically or socially hostile environment. For example, the state was not committed to or was actively against the proposed programs.

5. The case was to have, as one of its concerns and missions, the provision of services to those most in need, such as, low-income citizens, minorities, elderly, children, or migrant workers and their families.

6. At least two of the six cases were to be state-level activities, and two were to be in metropolitan areas.

Additional selection criteria for the sixteen case reports included:

1. The case should either (a) expand and refine our understanding of the six case studies by providing more examples of some of the issues covered in the six studies, or (b) add information about special or unusual organizational arrangements that were not present in the six, particularly private-sector linkages.

2. The case reports would include at least one health maintenance organization and a range of other financing arrangements.

The committee wanted to be certain that the case studies and case reports represented a range of examples: different regions of the country; urban, suburban, and rural areas; special populations; different levels of government; different kinds of financing; regulatory climates; fiscal health; and of organizational configurations. They also wanted examples from areas with high or low state involvement in delivering or paying for health services. In addition, it was agreed that cases or programs that were directly affiliated with a member of the committee would not be included. At least two outstanding community health centers--which met all the other criteria --were excluded on that basis alone.

Site Selection

As stated earlier, the names of over 200 projects, organizations, or locations were collected from a variety of sources, including the research literature, members of the committee, staff from the Bureau of Community Health Services and the Health Services Administration, and knowledgeable people in the health policy research field. Information on each site was gathered from secondary sources, such as grant applications, reports and evaluations, and other research studies. In some cases of special interest, letters were sent to ask for additional current information. Staff members prepared files on each potential site and indexed them by project, state, and site for committee review. Fifty cases were selected for further examination, and fact sheets were prepared on each.

Finally the pool of sites was cut to 30--six were selected for detailed case analysis, and the remaining sites were studied to expand the data base since they were examples of special populations, financing mechanisms, and geographic area. Eventually, eight of the 30 were eliminated because they were duplicative, there was too little available information, or they were too narrow in focus (e.g., a computerized information system was the integrative mechanism). The final sites included six intensive case studies and 16 case reports. The cases are described briefly in Appendix B.

Data Collection--Case Studies

Data were obtained in the following categories of interest in each of the case study sites:

1. Profiles of organizations involved in the services integration effort

2. Environmental factors
    a. Socioeconomic and health characteristics of the area
    b. State political and administrative structure
    c. Sub-state (county, city, etc.) political and administrative structures

3. Health resources
   a. Health manpower facilities and services
   b. Related services (social, transportation)
   c. Fiscal resources and use of funds.
   d. Intergovernmental health program relationships

4. Services integration project characteristics
   a. Services
   b. Staffing
   c. Utilization by type of patient and by site
   d. Patient procedures
   e. Funding

5. Services integration project history
   a. Initiation
   b. Implementation
   c. Significant events or shifts
   d. Major barriers, major sources of support

Much of the background information was gathered from project or program applications, annual reports, budgets, interviews; minutes and public hearings; project or program consultants and outside studies, reports, and evaluations; newspapers (and interviews with reporters); and regulatory and reimbursement data, such as Medicare cost report, Certificate of Need applications, and so on.

For the six in-depth case studies, the data have been collected through interviews in addition to the extensive documentary analysis. Two staff members visited each site three times for at least two or three days conducting interviews and collecting additional written material. During the first field visit major people involved in or knowledgable about the services integration effort were interviewed. During the subsequent visits some informants were reinterviewed in order to fill data gaps or clarify information and new respondents were also interviewed. One visit was conducted by a clinical team to determine the impact of services integration on health services delivery and patient care. The methodology employed three steps: review of center reports; interviews with administrators, center personnel, and patients; and interviews with community representatives.

A semi-structured interview guide was used to focus the content of interviews in order to ensure comparability and allow for variability. The protocol was reviewed, analyzed, refined, and adapted by the staff and consultants as part of the field research training and after the first round of interviewing.

Interviews were conducted with a significant number of people in each site in order to understand the complex events and relationships that have and are occurring. At least 30, and usually 50, people were interviewed at each site, in order to understand the facts in each case by a process of "triangulation" because no one person would be in a position to understand all that goes on. In the end a composite picture was developed of the relationships and dynamics in each site for the case study. The interviews were aimed at obtaining

an understanding of the different outlooks, attitudes, and actions among different types of participants related to the services integration efforts. After each visit staff members prepared site visit reports. These reports form the basis of post-visit staff meetings to review progress and identify further research needed via telephone, mail, or future visits. Drafts of case studies were sent to interviewees for review and comment.

Data Collection--Case Reports

The method for collecting data for the 16 case reports was different from that of the six case studies. A staff member interviewed respondents on the telephone. Approximately 10-15 interviews were conducted for each case report. In a few cases the researcher was able to visit the site and conduct personal interviews. This was possible if the study site was close, if the researcher was in the study site area for some other reason, or if key people from the site were in Washington, D.C. on business. Some personal interviews were conducted for approximately half of the sites. Documents and other written materials, similar to those collected for the six case studies, provided additional information for the analysis of the case reports. Drafts were sent to all informants for review and comment.

Study Variables

For purposes of this study, the broad philosophical statement on services integration presented by Secretary of Health, Education and Welfare Elliot Richardson. He was pressing for national legislative action and provided this initial framework as an approach to the research problems (Richardson 1976).

> Services integration refers primarily to ways of organizing the delivery of services to people at the local level. Services integration is not a new program to be superimposed...rather it is a process aimed at developing an integrated framework....Its objectives must include such things as (a) the coordinated delivery of services for the greatest benefit to people; (b) a holistic approach to the individual and the family unit; (c) the provision of a comprehensive range of services locally; and (d) the rational allocation of resources at the local level so as to be responsive to local needs.

This description shows that services integration involves multiple objectives that vary in importance to different groups and organizations involved. An early task of the study was to define the concept in operational terms.

Environment

Thompson (1967) describes organizations as open systems continuously adapting to their changing environment. From his work we noted the importance of the following factors:

- The general economic and social setting. (Is the site in a declining economic area? Is the state/county/city/town under fiscal stress? Are there racial cleavages, etc.?)

- Political structure. (Are services integration efforts more likely to occur and succeed in states and localities with "reformed" political structures, which are more prevalent in the West and South?)

- Health and medical institutions and organizations in the site. (What kind of actors are there within the health policy arena and what relationships have they had?)

- The intergovernmental arena in which each site is operating. (What does the federal grant system look like from the community level? What mediating role is played by intervening levels of government? Are the experiences of those attempting services integration with federal initiative and support different from those who are trying it "naturally"?)

History

We were interested in finding out if there were previous cooperative relationships among the organizations which created trust, or mistrust. We were told, for example, that it was impossible to understand Denver's current primary care system without reference to a 20-year history of cooperative ventures among the various institutions there. In Boston, the presence of many long-standing, prestigious institutions made cooperation harder to achieve.

Organizational Complexity

Everyone in an organization does not have the same goals or priorities (March and Simon 1958). Furthermore, discretion at the service delivery level is inevitable and difficult to control administratively. It is more likely to be shaped by professional norms or the immediate needs of service deliverers to manage their jobs and get through the day (Lipsky 1980, Weatherly 1979). If the various dimensions of services integration--services delivery, interagency linkages, policy management, and organizational structure--are likely to be given different priorities by various levels in an organization, how are the activities of each level related, and do

they make a difference at the client level? The politics can stem not only from "selfish" motives, such as institutional self-protection and priorities, but also from genuine differences over values and priorities. (Litwak and Hylton 1962; Levine and White 1961; Warren 1967; and Broskowski 1980.)

Leadership

Someone has to realize that action is needed and then take the initiative in contacting and negotiating with other organizations (and other subunits of their own organization) in order to put together a services integration project. We sought to determine the characteristics--personal, professional, organizational, job-related --of such entrepreneurs. Is there a difference between those who act "naturally" and those who act from federal impetus? Are there settings which inhibit or favor such behavior? What are the problems and barriers faced by these people? For example, Selznick (1957) talks about organizational leadership in a turbulent environment.

Implementation

We have been aware that implementing services integration is a process that is likely to continue long after formal agreements are made, especially at the services delivery level where individual attitudes and behavior are critical. The complexity of the intergovernmental system itself causes administrative problems and delays and permits those with different attitudes toward services integration to have their say and delay or alter programs. Pressman and Wildavsky (1973) were the first to analyze implementation--that is, the gap between expectations and actual results--as a special problem. In order to address these questions, we have tried to determine:

> Motivations--where did the idea come from? Who was involved and who was not? What was intended by the different actors and institutions? Looking across sites, are there environmental or historical factors which seem to facilitate integration which are present in some sites and not others? Do similar types of actors in different sites have similar motivations based on their organizational or professional affiliations?
>
> Results--what resulted in terms of (a) inputs, such as increased federal or private funds, new kinds of personnel, reduced or moderate costs relative to outputs; (b) moderating factors, or intervening variables, especially organizational structures and

management practices and interorganizational relationships; (c) outputs, such as the amount and types of medical, health, and related services; and (d) outcomes, which refer to the redistribution and, hopefully, the integration of outputs in terms of client categories, such as multi-problem, aged, and so forth.

Health Services Delivery and Patient Care

In the six case studies a clinical team of researchers attempted to assess the effect of integration on the delivery of services and on patient care. The data limitations and measurement problems in this type of analysis are severe. Nevertheless, the team sought to understand how the plans to integrate services were actually implemented and how that system worked for the clients. How do structures and processes facilitate or impede access to good health care?

Ideally, of course, we would have liked to have been able to take health status indicators as our dependent variables and measure the impact on them of alternative service delivery systems, nonintegrated vs. integrated, but we were not able to do that because of the lack of available data. However, we know that this is the ultimate test conceptually in our theoretical model.

Individual clients were identified and their experiences documented in a manner that was to test the functioning of the delivery system along various dimensions recognized as important in the delivery of appropriate and timely health care and indicative of effective health services integration. These perceptions and experiences were documented and analyzed within a structured frame of reference including four major areas of inquiry:

- availability and accessibility including outreach community education activities; lack of information and psychological barriers;
- the quality and scope of services available as viewed by both clients and providers;
- follow-up, including the effectiveness of linkages not only to other needed health services but to the broader social service system that may be required; and
- case management.

Collection of Data on Possible Alternative Recommendations

There are several commonly proposed alternatives to local integration of services approaches, such as consolidated grants, block grants, and special revenue sharing. As part of our field studies, we gathered information on experiences and attitudes toward the existing federal, state, and local system.

We tried to sort out views from the interviewees about several different dimensions of the current aid system and proposals to change it--the level of funding (do they oppose block grants because they think funding will be reduced even though they strongly support the administrative features of block grants?); the flexibility in administering or accounting for grants (is increased administrative flexibility worth the price of lower funding levels?); and the designation of the recipient (are block grants opposed because they would go through state and local governments where some organizations feel they would have little success in getting funding?).

Another issue explored in our interviews was how respondents judge the relative problems and obstacles in dealing with federal, state, and local government funding. Eliminating "bureaucrats" at the federal level, and federal level administrative requirements and standards, does not mean they will necessarily disappear. They appear, to some extent, at the state and local levels. Administrators will also still be accountable to their constituents, if not to the federal government. This leads to the obvious question: What barriers and obstacles will state grant administration systems place on local efforts to integrate or coordinate health and related services? We have asked those involved in services integration what their experiences with state funding have been and what their attitudes toward a larger state role in grant administration would be. We have asked the same about local administration.

Limits of the Study

It is important to remember that the case studies and reports were selected because they are considered to be exemplary or worth studying for the lessons that might be revealed. They do not constitute a scientific, randomly selected sample. The cases do not represent a cross section of experience or include control groups. Therefore, this research cannot explain, in a causal way, why some programs were successful and not others.

Generalizations are necessarily limited because the case studies and reports are in different geographical, social, and political environments. Examination of two or more cases in the same environment would fine tune observations about more integration efforts and organizational dynamics.

However, it is hoped that the study of real life cases will illuminate what happens when change is initiated and provide lessons or clues for people interested in improving health service delivery in their own communities. The cases show what barriers were overcome to change the way services were organized. The researchers tried to determine the conditions favorable to change, and examine some of the effects of those changes as reported by participants in the programs.

The Pros and Cons of Integration

While this is a study of methods for achieving the benefits of the integration of services, integration cannot be assumed to be an unalloyed good. The study addresses the pros and cons of more integration as well as the ways and means. Where possible, the committee has attempted to identify the financial, organizational, and service costs and benefits of various degrees of and approaches to integration.

Research in these matters is important. It is clear that the absence of coordination, integration or appropriate linkages costs money in the administrative waste and duplication of services that may result. When people fall through the cracks of programs, there is human loss, which costs society in other ways. But integration and coordination activities represent large investments of time and energy that should be considered beneficial and worth the costs. The costs must be expended only if there is "a research base that provides justification beyond the rhetorical" (Agranoff et al.).

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APPENDIX D

SUMMARY OF VIEWS PRESENTED AT OPEN FORUM

The IOM Committee on Services Integration sought the views of individuals and organizations concerned with the question of improving health care by coordination and integration of services. An Open Forum was held on February 8, 1982, during which the committee heard many speakers and had an opportunity for discussion with them. Other persons and organizations shared their views in writing. All of these statements, oral and written, are briefly summarized in this appendix, beginning with speakers at the Open Forum (in the order in which they appeared), followed by those who provided only written testimony. Although many points are recurrent, this summary provides a useful picture of the divergent points of view considered by the committee in reaching its findings and recommendations.

Complete copies of the statements delivered and submitted to the committee at the Open Forum, and tapes recording oral statements and discussions, are available in the Archives of the Institute of Medicine, National Academy of Sciences, Washington, D.C.

Testimony at Open Forum

Thomas W. Chapman, M.P.H., President, Provident Hospital, Inc.

Mr. Chapman's testimony described two examples of how a small community hospital with limited resources has integrated needed services into its regular operation. Provident Hospital is a 271-bed, acute-care facility in Baltimore City serving a predominantly black population, a large percentage of whom are poor.

Recognizing untreated high blood pressure as a major health hazard in the black community, Provident in the fall in 1979 secured support from the Heart Association and cooperation from local churches and physicians and started its Church Hypertension Project. The purpose was to train lay volunteer church nurses to accurately measure, screen, and monitor high blood pressure and to offer appropriate referral and educational services to those afflicted. The project had been so successful--growing in numbers of churches, volunteers, doctors, and patients involved--that Provident planned a similar program for diabetics in the future.

Mr. Chapman's second example was Provident's "Lifeline" program, a 24-hour home emergency service for needy disabled or elderly people. In establishing this program, the hospital gained support from clubs and organizations throughout Baltimore; city agencies offering nutritional, medical, and financial aid; police, fire, and ambulance departments; local television stations; and individual volunteers. At the time Mr. Chapman delivered his statement, "Lifeline" had been in operation for ten months and was slated for expansion in late spring 1982. Its success and that of the Church Hypertension Project demonstrate how services integration, coordination, and linkages can help to meet the challenges in health care today.

Ruth Watson Lubic, CNM, Ed.D., General Director, Maternity Center Association, New York City

Dr. Lubic discussed the Maternity Center Association's Childbearing Center, an innovative out-of-hospital maternity care project established by private sector initiative to alleviate documented consumer dissatisfaction with traditional in-hospital care. She shared with the committee the barriers and problems experienced by the Childbearing Center, emphasizing the concerted opposition of the New York City medical community, and sought the committee's advice and recommendations on how such successful, innovative--but non-traditional--health programs can be accepted by and coordinated with the mainstream system.

Katherine S. Lobach, M.D., Director, Comprehensive Family Care Center, Bronx, New York

Dr. Lobach distributed some organizational charts prior to making her presentation to the committee. The Comprehensive Family Care Center started in 1967 as a children and youth project, but received sufficient additional funding in about 1972 to expand to adult care for the families served, by 1982 reaching around 7,500 users. Its two major sources of funding have been Title V and Section 330 grants. Over the years, programs have been added, resulting in an integrated system of some five or six programs--through which patients can procure many of the services they need under one roof with a minimum of difficulty, and providers can make internal referrals and use a team approach to the delivery of effective health care.

From the standpoint of administration and management, however, the integration process has been extremely complex, frustrating, demanding, and at times almost unworkable. The various agencies funding the center had differing and often conflicting regulations and reporting requirements; in some cases meeting the qualifications of one led to disqualification under another. Even though some flexibility was allowed and the center was able to develop simplifying formulas, the problems encountered remained formidable. Based on

this experience, Dr. Lobach made a plea that written regulations should include some allowance for waivers of provisions that inhibit integration of health services.

In response to questioning from the committee, Dr. Lobach estimated that from five to ten percent of the center's total budget is spent on the costs of overlapping and conflicting reporting requirements. She feels that such costs could be reduced and compliance problems alleviated if the persons enforcing the regulations were allowed more flexibility to demonstrate their essential good will.

Dennis Filipovich, Director, Bureau of Professional Health Services, Pennsylvania Department of Health

The Pennsylvania Department of Health is the administrative agency for block grants coming into the state. In his oral testimony, Mr. Filipovich shared with the committee the department's experiences in attempting to consolidate former categorical programs into block grants. This attempt has been complicated by a lack of sufficient data or information about existing programs to make meaningful programmatic or fiscal decisions for the future, and by the fragmentation of health agencies in both rural and urban settings in Pennsylvania.

As a strategy to improve the situation, the Governor has chosen to establish a human resources commission to coordinate health programs presently being operated by eight separate agencies of the state government, each demonstrating a high degree of parochialism. The Governor also plans to name a statewide block-grant coordinating committee and agencywide block-grant advisory committees, in order to allow broad-based input, concurrence, and cooperation in block-grant applications and directions.

Major impediments to these coordination efforts have been the massive uncertainty as to the impact of the new federalism, and lack of flexibility in converting categorical programs to block grants.

Mr. Filipovich summarized his state's strategy as an intense planning effort to maximize coordination and minimize service cuts as a result of reduced dollars.

Gabriel Stickle, Senior Vice President for Planning and Administration, March of Dimes Birth Defects Foundation

Chosen for their relevance to the committee's deliberations and for their unusual concern with preventive services for risk populations, rather than with traditional patient care needs, two joint ventures of the March of Dimes shared the focus of Mr. Stickle's testimony.

In response to the debate and anxiety created in 1970 by the results of a cytogenetic study of the residents of Love Canal in upstate New York, the March of Dimes joined with four federal

agencies--the Center for Disease Control, the Environmental Protection Agency, the National Institute of Environmental Health Sciences, and the Occupational Safety and Health Administration--in organizing a conference held January 26-27, 1981, in Washington, D.C., for the purpose of producing "Guidelines for Studies of Human Populations Exposed to Mutagenic and Reproductive Hazards." The project was undertaken as a first and necessary step in minimizing mistakes and achieving adequate controls, not in the expectation of solving the complex problems involved. It illustrates, however, the high degree of interaction possible among federal agencies and members of the scientific community through the initiative of a voluntary health association.

In another cooperative project, the March of Dimes is working with the national PTA and four professional societies--the American College of Obstetricians and Gynecologists and its Nurses Association, the American Academy of Pediatrics, and the American Academy of Family Physicians--to address certain problems associated with pregnancies in young adolescents. To Mr. Stickle's knowledge, this will be the first community-based, research-oriented public health action program to be undertaken cooperatively by several national professional societies and a voluntary agency. If successful, it will contribute to the solution of a serious public health problem and will demonstrate a new and effective strategy for the coordination and linkage of health, education, and social services.

<u>Herbert W. Oglesby, Assistant Commissioner, Office of Management for Community Health Services, Virginia Department of Health</u>

As spokesman for the Virginia Department of Health, Mr. Oglesby presented four recommendations to the committee. First, he suggested that state governments would be the most desirable agents for implementing actions to integrate the use of federal, state, and local funds for comprehensive public health services. He supported this recommendation by discussing Virginia's extensive and successful experience in funds integration. The few barriers encountered arose from numerous program controls specified by each federal health program. Therefore, his second recommendation was that the committee view the block grant concept as important in health services integration, even though it should not be expected to create significant dollar savings at the state level. Economies can be realized but will not offset the recent cuts in federal funding.

Virginia's third recommendation was that the Primary Care Block Grant statute be reviewed and amended to change funding and timing restrictions which are severe handicaps to the legislation's implementation in the states. Under the present law, there is little incentive for the states to attempt the improvements in integration and coordination that could be achieved.

Finally, Mr. Oglesby recommended that the committee contact the Association of State and Territorial Health Officials, which has for many years operated a voluntary state health reporting system. Its

reports offer detailed information on the variations among states in the use of federal, state, and local funds to support health programs.

Margaret Whyte, President, Mental Health Association of Maryland, Inc.

The goals of the Mental Health Association of Maryland--a volunteer organization--are to promote mental health, prevent mental illness, and assure quality care for the mentally ill. Ms. Whyte, as its spokeswoman, enumerated successes of the association in advocating legislation, supporting research, and educating the public in mental health problems. Volunteers in local chapters have helped to establish many vitally needed mental health services in their communities.

Ms. Whyte saw the continued success of her association as severely jeopardized by a threatened sudden diminution of federal support. Many of its programs were begun with the support of demonstration grants, the withdrawal of which would be catastrophic. She stressed the necessity of a continuing federal presence to serve as a program exchange and monitoring force assuring standards and quality control. The serious obstacles to volunteer efforts--such as resistance from the professional community and timidity from supporters--can be overcome if continued federal support, technical assistance, and grants are provided.

John B. De Hoff, M.D., M.P.H., Commissioner of Health, Baltimore City Health Department

Dr. De Hoff differentiated local health departments from other health care providers, citing their official nature, their health responsibilties throughout their political subdivision, and their mission orientation as providing the base on which coordinating authority can be built. He presented the Baltimore County Health Department as a successful example, tracing the history of its coordination efforts since 1964. Today the beneficiaries of these efforts--Baltimore hospitals, medical schools, health care centers, etc.--who were initially skeptical of "another layer of bureaucracy" --acknowledge that their services have improved, as have their relations with state and federal authorities, and that they have received substantial assistance in grant applications and awards.

Dr. De Hoff attributed the success of the Baltimore coordination activities to their emphasis on people, under the leadership of Mayor William Donald Schaefer. All programs must benefit patients. He also cited the stronger, more centralized management role developed in medical programs operated by the city. He recognized that full-scale integration activities such as those in Baltimore may be beyond the present capabilities of small health departments, but made clear

his belief that the potential and the authority do exist. He recommended that schools of public health should adapt to modern needs and changing operations, and that management authority in health departments should develop orderly relations among local counterparts and field agencies and provide skilled professional personnel.

He concluded by inviting the committee to visit Baltimore City to view its successes in major integration, coordination, and linkages.

James E. Deaton, Jr., Director, Office of Program Management, South Carolina Department of Health and Environmental Control

The South Carolina Department of Health and Environmental Control delivers services through 134 clinic sites in 46 counties in the state. In 1969 the department was reorgnized into 15 substate districts, three of which are already conducting integrated clinics and eight more of which are expected to be integrated by 1983.

Mr. Deaton presented the above introduction to his oral testimony on South Carolina's efforts to encourage health services integration throughout the state. They have consolidated çomputer management information systems, streamlined records-keeping, and instituted personnel cost accountability. In addition, they have formed an "integrated services committee" to evaluate and foster integrated services. The remainder of Mr. Deaton's remarks concerned the results of evaluations undertaken by this committee.

These results suggest eight requirements for integrated services: adequate planning time, enthusiastic staff and administrative support, personnel intercommunication at all levels, cross-program training, even distribution of workloads, efficient space allocation, post-clinic conferences, and accurate record-keeping.

Health services integration offers advantages to both patients and staff, and is desirable and justifiable in terms of improved care at reduced cost. These conclusions are supported by a study of one of South Carolina's integrated clinics, undertaken to determine comparative figures on staffing, numbers of patients served, and costs for various components of the clinic before and after integration.

Mr. Deaton's final point was that his state's efforts are hampered by the new federalism policy, under which the states have been promised funding cuts and deregulation, but have received only the cuts without the regulatory relief. "We are getting the stick, but we are not getting the carrot; and we need more of the carrot to be able to continue our efforts in integration."

Sally Austen Tom, C.N.M., Government Liaison, American College of Nurse-Midwives

In representing a professional organization of United States certified nurse-midwives, Ms. Tom gave a brief history of nurse-midwifery and testified to its proven effectiveness in terms of both cost and quality of care. Despite widespread acceptance, demand, and

support, however, obstacles do exist. Since the issuance in late 1979 of a General Accounting Office report identifying six obstacles to greater utilization of certified nurse-midwives, some of those cited--such as restrictive state licensing and limited third-party reimbursement--have been eliminated or alleviated; but physician resistance persists in many places and forms. Instances amounting to restraint of trade have attracted the attention of Congress and the Federal Trade Commission, and litigation has become the response of last resort.

In conclusion, Ms. Tom asserted that removal of barriers to increased utilization of certified nurse-midwives would be an important step toward integrating and improving health care for mothers, babies, and childbearing families in the United States.

Along with the written version of her statement to the committee, she submitted documents expanding on points made in her brief remarks.

Robert Lewis, Administrative Director, Charter Oak Terrace/Rice Heights Health Center

Mr. Lewis discussed the impact of recent federal policies on two community health centers in Hartford: Charter Oak Terrace/Rice Heights Health Center and Community Health Services, Inc., with emphasis on the former. He began by citing the advantages of community health centers in providing to their localities needed care, employment, and organized leadership, and offered comparative data as evidence of the improvement in community health center management over the period from 1974 to 1979.

He continued by listing specific reductions, both implemented and contemplated, in federal funding for primary care health programs and by projecting the effects of these reductions on the Charter Oak Terrace/Rice Heights Health Center. All effects were adverse on both the quality and quantity of health care which the center would be able to continue to offer. He concluded by listing the measures being taken by his organization to confront and, if possible, counteract the undesirable consequences of current federal policies.

Gerald W. Robinson, M.P.H., Executive Director, Hartford Area Health Education Center, Inc.

Mr. Robinson presented three case examples--the Hartford Neighborhood Health Centers Consortium, the School Health Plan, and the Community Health Teams--to demonstrate the successful operation of the Hartford Area Health Education Center (AHEC), and to support his premise that the AHEC concept offers significant present and future advantages to local health service delivery systems by creating and supporting health education and training programs that enable multiple sectors of the community--both providers and consumers--to understand and meet the needs of unserved and underserved clients.

Before discussing the case examples in detail, Mr. Robinson briefly traced the history and evolution of the AHEC concept and its shift in emphasis from exclusively rural to urban-based programs. He then outlined the structure of the Hartford system, citing the two organizational entitled involved: the University of Connecticut Health Center in Farmington and the Area Health Education Center in Hartford.

Mr. Robinson concluded by stating that decreases in federal spending threaten to disrupt the coordination achieved through the AHEC concept. He predicted that in the near future there will be fewer students and health service programs to link and fewer incentives and resources to coordinate them. It is critical, therefore, to preserve the AHEC concept. He recommended that student health education and training programs be recognized and encouraged and that the AHEC concept receive continued and expanded support.

Renee Jenkins, M.D., Member, Executive Council, Society for Adolescent Medicine

The Society for Adolescent Medicine is an 800-member national organization of health professionals and behavioral scientists. Its purpose is to develop, synthesize, and disseminate scientific and scholarly knowledge unique to the developmental and health needs of adolescents. Dr. Jenkins spoke for the Society's Executive Council in addressing service integration issues as they affect adolescents.

Interaction of one health problem on another is especially significant for adolescents, and treatment is most successful when connected to social networks such as educational, employment, and family service programs, and to the juvenile justice system. Services integration, therefore, is favored by the Society and promoted by many programs at both federal and local levels. The traditional medical model, however, is insufficient to cover the span of services needed to be included for adolescents.

Another major concern is that, in the process of integrating health services, care be taken not to limit access or delay treatment for adolescents by imposing restrictions involving parental consent.

Dr. Jenkins' final point was that current models used in evaluating health care programs in terms of cost effectiveness or immediately measurable results are not adequate or useful for adolescent medicine, in which disease prevention and health promotion are as important as treatment or cure.

In response to committee questioning, Dr. Jenkins enlarged on the Society's position with regard to parental consent for adolescent health care, emphasizing the danger of alienating the very high-risk young people most critical to be reached.

Janet D. Perloff, Ph.D., Director, Division of Health Services Research, American Academy of Pediatrics

In a statement co-authored by John P. Connelly, M.D., Dr. Perloff discussed an issue deemed critical by the American Academy of Pediatrics (AAP): physician willingness to provide services to Medicaid-eligible children. Included in her submission to the committee were supporting documents describing in detail the methods and findings of research referred to in her testimony.

Dr. Perloff addressed three questions: What are the implications of failure to coordinate public and private-sector objectives and actions? How do public decisions regarding Medicaid affect physicians? How can better coordination of the two sectors be achieved?

She first considered the consequences of physician failure to provide services to Medicaid-eligible children and found them to be adverse in terms of both cost and quality of care. Thus, it would seem that the participation of office-based physicians should be encouraged; yet, studies--including one undertaken by AAP--show limited or declining participation in some states and wide variation from state to state. Among the contributing factors identified by research were state policies on reimbursement level, relative speed and efficiency in handling claims, and amount of interference with medical judgment.

In summary, the AAP study found that many state Medicaid policy decisions imply economic or professional costs for physicians, and that participation is discouraged as these costs mount. Public-private partnership in health care thrives, however, where such costs are kept to a minimum. The AAP research indicates, therefore, that coordination of public and private efforts is critical to ensuring private-sector participation in Medicaid, which is in turn critical to Medicaid's objective of providing access to high quality, comprehensive care at the least possible cost.

Debra Haffner, Director of Counseling and Education, Planned Parenthood of Metropolitan Washington, D.C.

As a local, voluntary, nonprofit family planning agency providing education, counseling, and medical services to over 13,000 clients annually, Planned Parenthood of Metropolitan Washington supports the concept of services integration, but is committed to the continued existence of free-standing and categorically funded family planning centers.

In her oral testimony supporting the above statement of position, Ms. Haffner first emphasized Planned Parenthood's active participation in coordinative mechanisms with local government agencies and community service providers, by serving as an entry point into the health care system for many women and by maintaining a referral network of over 350 health and mental health agencies in

the metropolitan area. Two of its programs operated in cooperation with the District of Columbia government were suggested as service integration models.

Noting that many speakers at the Open Forum had talked about their successes, Ms. Haffner chose to discuss the failure of Planned Parenthood's Woodson High School Project, in order to point the moral that staff continuity and community support are essential to successful integration.

Family planning services integration is not always appropriate or justified, however. National studies have indicated the need for multiple service models to serve the maximum number of women in need. Planned Parenthood supports this conclusion and feels that proposals for placing family planning and primary care into a single block grant will lead to large numbers of women who prefer to receive services at a free-standing site being denied access to high quality reproductive care.

Carlos Lozano, D.D.S., M.P.H., President-Elect, Association of State and Territorial Dental Directors, and Chief, Bureau of Dental Health, Texas Department of Health

Dr. Lozano made an oral statement during the Public Comment portion of the Open Forum and later submitted his remarks in written form. He cited dental care services as the best example of fragmentation in health care, after pointing out that dental care has never been successfully integrated into medical or health care. Among the problems hampering service integration, he mentioned inadequate funding, lack of accessibility, absence of referrals, program rivalries, and duplications.

He urged that coordination and integration of dental care with other health services should be encouraged and sanctioned at all levels of government, and that preventive treatment should go hand in hand with curative care. He also recommended that existing providers should be sought and consulted before new services or programs are established, and that federal, state, and local jurisdictions should include dental organizations when health services are originally established, and should avoid competitive or repetitive programs.

Written Testimony

Cecilia Abhold, Sister of Providence, Administrator, East Coast Migrant Health Project

In a letter response to the committee's invitation to submit written testimony at the Open Forum, Sister Cecilia Abhold stated that negative and often uncompromising attitudes toward the farmworker population represent the greatest difficulty faced by the East Coast Migrant Health Project (ECMHP) and its staff in efforts

to integrate health services for migrant and seasonal farmworkers along the eastern seaboard of the United States. Among other problems in coordination and delivery of health care are available-but-not-accessible services--because not known, not reachable, too infrequent, or untimely--and transportation difficulties. The benefits of a Migrant Referral System promoting portable health records have been limited by only partial implementation. Sister Cecilia predicts that the availability of fewer dollars in the future will increase competition among health care providers, not necessarily leading to better use of the dollars. She fears that the ECMHP will be unable to compete on a state level and that the gains made could be lost in a few short years.

Despite the problems she discusses, Sister Cecilia feels that the ECMHP has met with more success than failure since its inception in 1970, due to the caliber of its staff and their continuity with the project. The documents accompanying her letter--describing the project's past activities and accomplishments and its objectives for the future--support this conclusion.

Beth Darrough Dixon, Ph.D., Program Development Specialist, Oklahoma State Department of Health

Dr. Dixon submitted for discussion a brief paper entitled "Overcoming Barriers to Service Coordination: A Practical Essay on 'Turfism' and Interdisciplinary Conflicts," presenting the views of the author and not necessarily reflecting the policies of the Oklahoma Department of Health.

The state of Oklahoma has developed a community-based home care program--Oklahoma Eldercare--which seeks to address the problems of old and frail persons living at home. In operation, the program forms linkages with local providers and coordinates their multi-faceted services. Strategies employed in implementation of this plan have been many and complex. Barriers to successful operation have emerged, and methods of overcoming them have been devised. Dr. Dixon's paper discusses "turfism" and interdisciplinary conflicts as potential obstacles to service coordination and offers several solutions to problems involved.

Kristine M. Gebbie, Assistant Director, Human Resources; Administrator, Health Division; Department of Human Resources, Portland, Oregon

In her letter incorporating comments on the issues involved in health services integration, Kristine Gebbie stated that the most serious problems impeding integration in Oregon have been lack of assurance of timely receipt of federal funds and the imposition of separate standards, limitations, and reporting requirements by each funding source. It is Oregon's position that health services should

be integrated and that Congress and the state legislatures can assist the process by removing rules, regulations, policies, and practices which interfere.

Oregon initially welcomed the current federal move toward block grants, as affording increased flexibility, but has been discouraged by ill-considered implementation of the new policy. Rapid and indiscriminate cuts in funding have created a crisis for state and local health administrations. The situation has evolved so quickly and crudely that delivery of services has been almost totally disrupted in some instances, and appropriate planning and maintenance have become impossible.

Richard L. Kozoll, M.D., M.P.H., Director, Presbyterian Medical Services Checkerboard Area Health System

In a letter reporting his inability to attend the Open Forum, Dr. Kozoll stated that he has very strong feelings about integration of health services at the local level, and that the Checkerboard Area Health System in Cuba, New Mexico, has been a model effort to implement such integration. An article describing the system and its efforts is attached to his letter.

Michael L. Mann, Health Services Administrator, Alabama Department of Public Health

Mr. Mann's brief written statement makes the following points: Patients seeking public health services in Alabama must contend with clinic schedules providing different services at varying times, depending on the availability of space, staff, demand, and funding. Efforts to coordinate health care in the state are chiefly hampered by lack of a mechanism for fiscal accountability in federally funded programs. A system implemented in October 1981, however, has given local management personnel latitude to re-establish work assignments, clinic schedules, and clinic designs, and has achieved some improvement in comprehensiveness and accessibility of services. Strategies to overcome fragmentation include cross-training of personnel, developing a means of fiscal control, publicizing clinic changes, expanding service hours, and delegating supervisory control to the local level. Duplication of patient records has been a problem, but Alabama has investigated the possibility of combining all records into a single filing system in order to improve continuity, release needed space, and increase overall productivity.

Alabama supports integration of programs that are related or serve a common clientele. Federal, state, and local governments can best promote integration by eliminating constraints, such as restrictive and rigid funding and regulation. At present there is insufficient flexibility to permit maximum efficiency at the state and local level. Federal block grants will advance integration by increasing accountability for measurable program outcomes.

John T. Tierney, Associate Director, Health Planning and Resources Development, Department of Health, Providence, Rhode Island

Mr. Tierney's comments, submitted in letter form, were based on experience in the implementation of Public Law 93-641 in Rhode Island.

The greatest single obstacle to service integration in Rhode Island is the "piece work" or fee-for-service approach to financing, which is the predominant payment method and which works against linkages. Among the initiatives undertaken in the state to further service integration are formation of Health Maintenance Organizations (HMOs) to provide single patient records, one-stop service, and group practice; development of geographic networks of health care providers; and establishment of a long-term coordinating commission.

Opinion surveys conducted as part of the first State Health Plan indicate that lack of transportation is one of the key accessiblity problems for the poor and elderly. To improve service delivery, Rhode Island has established "free-standing emergency rooms" to provide physician services at more accessible locations than hospital emergency rooms and at more accessible hours than physicians' offices. One drawback, however, has been duplicative diagnostic testing and costs. A system of sharing test results would reduce inconvenience and expense.

Categorical funding encourages fragmentation and complexity, whereas block grants can serve to promote coordination and linkage. The block grants, however, must be funded at realistic levels, or the result will be disintegration. Ongoing federal cuts will accelerate the demand for coordination but will also make health services less available to the poor and elderly--the population groups with the greatest health needs.

Bailus Walker, Jr., Ph.D., M.P.H., Director, Michigan Department of Public Health

Dr. Walker submitted a written statement offering the committee observations and recommendations based on the Michigan Department of Public Health's experience with a project funded by a Primary Care Research and Demonstration grant, one objective of which was to develop demonstration models at the local service delivery level which would consolidate categorical funding for various health care services and programs into integrated, comprehensive local primary care systems.

The Michigan project demonstrated that health block grants improve the potential for integration through consolidating administration of health programs at the state level. There is, however, little reason to believe that integration will substantially reduce program costs, since the dollars saved through streamlined administration and reduction in duplicative procedures do not begin to offset recent federal budget cuts. Reductions in grant support combined with increasingly inadequate Medicaid reimbursement will

mean that public agencies cannot continue to meet their responsibility to serve high risk and medically indigent populations as in the past.

Dr. Walker's group does not feel that federal guidelines restricting primary care block grants are a barrier to integration, but rather function to assure that services remain comprehensive and accessible. Michigan would find it necessary and desirable to institute similar state level guidance should the federal direction be removed.

K. Ann Wall, R.N., M.N., Program Nurse Consultant, Division of Maternal and Child Health, South Carolina Department of Health and Environmental Control

In response to the committee's invitation to present testimony at the Open Forum, K. Ann Wall forwarded for informational purposes a copy of a preliminary study undertaken in South Carolina to evaluate the effectiveness of existing integrated service delivery systems.

In a brief "Foreward," the study is defined as a description of practical clinic flow models depicting nonintegrated and integrated Maternity, Child Health, and W.I.C. health services delivery systems. Existing systems were studied to identify types of integration and clinic flow patterns within integrated systems, and to assess benefits and staff satisfaction after integration. Questions regarding the content of the study or its use may be directed to Ms. Wall.

APPENDIX E

Selective History of Federal Grants*

Categorical Grants

Many authorities trace the origins of the categorical grant system to the Morill Act (1862), which established the land grant colleges--a program that was considered "under administered." In response to the problems with the Morill Act, the Hatch Act (1887),** the first annual cash grant to the states, intended to support state agricultural stations, was enacted with increased administrative control. There were several other categorical programs enacted in the late nineteenth century, which were important as precedents, although by 1902 these grants represented less than 1 percent of all state and local revenues and only 1 percent of all federal expenditures.

The pre-Depression years of the twentieth century saw a major expansion of the categorical grant mechanism. The passage of the Sixteenth Amendment, enacting a federal income tax, radically altered the fiscal capacity of the federal government by increasing the funds available for distribution through grants-in-aid. New legislation supported state forestry and agriculture, highways, and vocational education. The Sheppard-Towner (Maternity) Act of 1921, established to decrease infant and maternal mortality, was regarded by some critics as unconstitutional. The Supreme Court did not rule on this case but denied plaintiffs standing to sue. Another Supreme Court decision, Massachusetts v. Mellon and Frothingham v. Mellon (262 U.S. 447 (1923)), reinforced the right of the federal government to increase its activist role indirectly, through fiscal federalism. The development of categorical grants in this period, with an increase in federal intergovernmental expenditures from $7 million in

* This Appendix, edited by Helen Darling, is based on a summary of reports of the Advisory Commission on Intergovernmental Relations listed in the bibliography. The summary was prepared for the committee by Mark Segal.

**The Hatch Act of 1887 should not be confused with the Hatch Act of 1939, 1940, which regulated the political activities of federal employees.

1902 to $232 million in 1932, was characterized by an increasing concern with adequate administration and was marked by the introduction of such modern grant devices as formal distributional formulas and state matching requirements.

The Depression and President Franklin Roosevelt's New Deal, which spurred major growth in federal programs generally, caused a major increase in categorical grants. By 1935, federal assistance to states and localities totaled $2.2 billion--a figure not reached again until 1950. The most significant grants-related legislation was the Social Security Act of 1935, which enacted categorical programs for old-age assistance, aid to the blind, aid to dependent children, unemployment compensation, maternal and child health, crippled children, and child welfare. Title VI of the Social Security Act created a general health grant to state health departments. Three of these grants were open-ended matching grants, with federal expenditures constrained only by client limits. The state match ranged from 0 to 50 percent, depending on the particular program.

An important feature of the new programs created by Social Security is that they institutionalized the concept of recipient entitlement to funds. Recipients meeting specific program criteria were entitled to funds as a matter of "right," albeit a legislative rather than constitutional right, and hence subject to the winds of political change. In general, formula grants tend to embody this characteristic of entitlement, and project grants preserve governmental discretion in fund disbursement.

These categorical grants programs were marked by increasingly sophisticated administrative control, with increased planning, reporting, and oversight requirements. As a consequence of the Depression-induced fiscal collapses of state and cities, federal aid was for the first time directed at the cities, bypassing state government.

After World War II, the modern era of federal grants-in-aid began. Having declined during the war years, these grants began a steady increase. The 1950 total of $2.2 billion had doubled to $4.8 billion by 1958. As a percentage of the Gross National Product, federal aid rose from 1.0 percent to 1.4 percent by 1962. Among the programs enacted in this period were ones that dealt with airports (1946), urban renewal (1949), urban planning (1954), and air pollution (1963). These programs were illustrative of the increasing emphasis on direct federal-local grant relationships, with the states' role minimized or eliminated. The Highway Act of 1956, which established the interstate highway system, with a 90 percent federal share, typified the increasingly "low match" demands of federal grants.

During this period, the grant system was increasingly subjected to scrutiny and criticism. The Hoover Commission (1949) was generally critical of the then-current grant system, seeing its development as "haphazard." The commission felt that the categorical nature of the expanding health role was undesirable (Advisory Commission on Intergovernmental Relations 1977, A-56). It recommended decentralization and a return to dependence on general health grants.

The Kestnbaum Commission on Intergovernmental Relations (1955) was less critical of the system. It felt that categorical grants in the health field had generally stimulated recipients to spend more than they would have without the grant, but that these grants should not have an indefinite life span. As the grants achieved their goals, they should be phased out. The commission also recommended the institution of more flexible administration, particularly with reference to the states and localities. It also recommended that funds be allocated according to uniform formulas. Concerns about the growth in categoricals seem to have two main elements. Some concerns were focused on the problems of management, control, and coordination as paramount. Other concerns were focused more on the implications that the expanding federal grants-in-aid role had for American federalism. These latter concerns were heavily imbued with ideology.

In 1961, the Advisory Commission on Intergovernmental Relations (ACIR) issued a report which in many respects echoed the recommendations of the Kestnbaum Commission (ACIR 1977, A-56). It recommended health grant consolidation, with the omission of mental health and maternal and child health from the consolidation. The latter exception derived from the separate administrative locations of these programs at the state and federal levels. While deciding against the recommendation of a health block grant, the ACIR did suggest that fund transfers between categorical health programs would allow needed flexibility.

Also in the early 1960s the National Commission on Community Health Services addressed what it considered an "inadequate health system," calling for the creation of an intergovernmental "partnership for health" (ACIR 1977, A-56). This commission wanted planning, organization, and service delivery to be comprehensive. It called for an increase in general health formula grants, and a decreased emphasis on categorical project grants.

By 1966, the original general health grant, Title VI of the Social Security Act of 1935, was dwarfed by categoricals. The general health grant represented only 6 percent of Public Health Service grant funds (ACIR 1978, A-52). The categorical approach to health grants was seen by its proponents as providing the best way to target funds, to avoid the necessity of dealing with the states, and generally to expand and institutionalize the federal commitment, both fiscal and philosophical, to health care.

The ACIR has characterized the mid-1960s as the "categorical explosion." Others, such as Michael Reagan, have called this period in the development of the grants-in-aid system one of "creative federalism" (Reagan and Sanzone 1981). The period from 1964 to 1968 was one of proliferating categorical grants, increased use of project grants, and an increased variety of matching ratios. The diversity in the types of grant recipients increased, with both private, nonprofit organizations and local governments receiving categorical grants. Attendant with these changes was an increasing inflexibility in administrative and fiscal requirements, and an expansion of planning requirements (ACIR 1978, A-52).

The preeminent role of the categorical grant is in many respects a function of the general U.S. dependence on federal intergovernmental aid (ACIR 1978, A-52, Chapter 11). The rapid postwar proliferation of these grants is in large measure a reflection of the rapid expansion in the role that government, and in particular the federal government, has played in our society. In the United States there is often a divergence between the ability of a government jurisdiction to carry out government functions and its ability to raise revenues. State and local governments have tended to rely heavily on sales and property taxes--revenue sources that are not very sensitive to growth in the economy, as is the income tax. Thus, although the federal government has a far stronger fiscal capacity than the states and localities, it does not have the constitutional (written and unwritten) legitimacy to engage in the direct provision of many services. Grants-in-aid act to compensate for this imbalance.

In addition, so called spillover effects, which distribute the benefits of local programs beyond local boundaries, tend to diminish state and local incentives for action and provide normative justifications for federal action. Federal distrust of states and localities, particularly in many areas covered by the new social programs of the sixties, contributed to the use of narrowly defined categorical grants, with extensive strings attached. Concomitantly, multiple titles in grant-authorizing legislation, which created many categorical programs in a given broad functional area, permitted the reconciliation of multiple and competing interests at the national level.

Between 1963 and 1967, the percentage of the federal budget going to grants increased from 7.7 to 11 percent, and the percentage of the GNP from 1.5 to 2 percent. Health was one of the three functional areas that posted the largest increases (ACIR 1978, A-52). In 1963, health grants totaled $450 million; in 1966, they totaled $1.2 billion; and in 1969, $3.2 billion. In 1966, 16 health categoricals were consolidated into two programs under the Partnership for Health Act. While some saw this as the beginning of a new approach to health grants, it actually represented an ultimately anomalous and temporary departure from the norm of categorical grants.

Problems

The mid to late sixties witnessed an increasing litany of grants-related complaints from state and local officials. The primary complaints concerned the inflexibility of fiscal and administrative requirements and the lack of uniformity in program requirements. At the same time, federal officials were increasingly concerned with improving interprogram coordination. James L. Sundquist has discussed some of the factors involved in this increasing dissatisfaction with the then-current grant system (cited in ACIR 1978, A-52). Prior to the 1960s, grants were focused primarily on helping states and localities meet their own goals. Matching tended to be 50-50, and administrative controls were relatively loose. In the sixties,

federal priorities became increasingly predominant, with nonfederal matches declining and administrative controls tightening. This predominance of federal goals reflected the perceived failures of the states to deal adequately with many social and economic problems. It reflected as well a federal distrust of the ability or willingness of state officials to spend federal funds responsibly in the absence of strict guidelines. In those instances in which federal goals had been important in the past, Sundquist asserts that they were generally congruent with traditional state and local goals, such as roads and schools.* Earl M. Baker has written that many of the pressures for earlier categorical grants originated in the states (ACIR, 1978, A-52). These factors, plus the increasing tendency to bypass the states in the grants mechanism, tended to make traditional intergovernmental relationships obsolete. Thus, we can see that beyond the direct effects of increased federal predominance on paperwork and red tape, there were the more subtle changes in program priorities. With federal priorities superimposed on their own, it is no wonder that state and local officials would find program requirements increasingly onerous.

The Richard Nixon administration inaugurated what it called the "New Federalism"--an emphasis on broader and more flexible funding forms, such as block grants, special revenue sharing, and general revenue sharing (GRS). According to Carroll Estes (1979:172), "Revenue sharing was the Nixon administration's major hope for slowing down the growth of federal categorical grant-in-aid programs and for redistributing political power from national policymakers to local ones." She states that the major arguments given for the initiation of new federalism proposals in the form of revenue sharing were:

1. state and local governments needed fiscal aid because of their inability to continue to increase property and sales taxes or to raise other revenue in proportion to their increased expenditures;

2. a redistribution of federal revenues through revenue sharing would result in an overall increase in funding available for state and local programs;

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* This description of change has been challenged by the authors of the ACIR volume on categorical grants. They assert that many of the earlier federal grants also embodied national goals, such as a better system of roadways. Still, Sundquist's observations capture what appear to have been real shifts from state and local to national goals. Perhaps the nature of national goals changed, with the "new" national goals far more emphatically "national" than the "old" ones. In addition to this qualitative evolution in grant goals, the quantitative expansion in nationally oriented categorical programs led to a relative expansion of the national at the expense of the state and local.

3. growing administrative and programmatic fragmentation at the national level had made government programs less responsive to the needs of the population;

4. states and localities could allocate resources more effectively;

5. the increasing and disproportionate concentration of power in Washington not only was expensive but made bureaucrats insensitive to local needs.

There were three types of revenue sharing: (1) funds allocated to both state and local level (GRS); (2) funds allocated to state level only, with decisions about distributions at the state level (Title XX, Urban Mass Transit); and (3) funds allocated to local level (Comprehensive Employment and Training Act--CETA), Community Development city/county).

Still and all, categoricals continued as the predominant form of federal intergovernmental assistance. In general, Congress was hostile to the block grant concept, with this grant form seen as having too few program conditions and as serving to reduce the legislative discretion of the Congress. By 1972, general revenue sharing was not seen as a replacement for categorical grants, as many of its early advocates had envisioned, but rather as a supplement. By 1975, there were 442 categorical grants (ACIR 1978, A-52).

In the 1970s, inflation eroded the real value of grants, and the economic slowdown reduced the amount of federal revenues available for programmatic and intergovernmental expenditures. Still, health grants grew at an above average rate. By 1975, they represented 17.7 percent of all federal aid to states and localities. As the growth in aid decelerated, with the so called "fiscal dividend" gone by the early seventies, distributional questions became increasingly "zero-sum," with the gains of one set of recipients representing the losses of another. Regional variations in grant receipts were often unrelated to regional variations in many quantitative measures of need. Political pressures increased for the inclusion of yet more government jurisdictions in grant programs.

Dissatisfaction with the federal grant system seemed to grow during the mid-1970s. Skepticism about the extent to which federal programs could successfully meet their goals increased (Pressman and Wildavsky 1979). By 1976, Congress had begun to consider "sunset legislation," under which grant programs would expire in the absence of favorable congressional review. Still, by mid-1977, there was a sharp increase in aid. Under the Carter administration, state and local fiscal dependence on the federal government increased.

Block Grants

As one consequence of the proliferation of categorical programs in the 1950s and 1960s, integrated grants and grant consolidation

became increasingly discussed options (ACIR 1977, A-60). In 1949, the Hoover Commission recommended grant consolidation in highways, education, public assistance, and public health. During the Eisenhower administration, grant consolidation proposals, including block grants for health, were put forward, and defeated. Congress was "basically hostile" to block grants during the 1950s and early 1960s, feeling that consolidation would lead to funding decreases for favored clienteles and jurisdictions. With individual programs lumped together and rather invisible to the average observer, it was difficult to maintain interest in and support for programs from politicians and the public. Between 1960 and 1972, only two block grants were passed, the Partnership for Health Act of 1966 and the Omnibus Crime Control and Safe Streets Act of 1968 (Safe Streets Act). During this period, other consolidation and block proposals were put forward, but they were unsuccessful in the Congress. Some education and vocational training grants were consolidated, but new categorical grants were still enacted to replace the old. Richard P. Nathan, in discussing the reluctance to consider block grants, asserts that only a small minority were concerned with these consolidation and block grant reforms, and most of this minority were strongly against these reforms (cited in ACIR 1977, A-60).

The Nixon administration attempted to deal with the lack of previous block grant success through a new strategy. Concurrent with the successful general revenue sharing proposals, the administration proposed a number of special revenue sharing grants. These grants were similar to previous block grants, but had substantially fewer federal "strings" attached. Unlike general revenue sharing grants, they would have replaced existing categorical programs. These proposals were generally ignored by Congress, yet the two revenue sharing proposals appear to have "rekindled" congressional interest in grant consolidation and block grants.

Block grants seem to have presented the opportunity for a degree of federal activity lying between the specificity of the categorical grant and the lack of focus inherent in general revenue sharing. Apparently, special revenue sharing was not seen as representing an acceptable balance: there were too few strings attached to suit the Congress. One ACIR publication (1977, A-60) notes three major advantages inherent in block grants:

1. "Pressures from nationally organized special interests can be deflected." Congress can delegate allocation decisions to state and local government, yet still retain a measure of politically important credit for legislation.
2. "The block grant reduces the influence of the federal bureaucracy on the recipients' use of funds."
3. "...opportunities always exist for redirection if Congress wishes to use them."

These block grant characteristics can promote the striking of "an acceptable balance between the achievement of national goals and the enhancement of recipient flexibility" (ACIR 1977, A-60). While the

desirability of such an "acceptable balance" is an unarguable tautology, it is obvious that some of the purported advantages of block grants imply rather extensive value judgments. It is not altogether clear that health concerns will be advanced through the deflection of "pressures from nationally organized special interests." This is particularly true if one's general concerns for health care represent an amalgam of concerns for a variety of specific health-related areas. For example, a desire to address the problem of hypertension is unlikely to be better served by a block grant than a categorical grant.

Partly as a consequence of changing attitudes toward block grants, three new block grants were established in 1973-74. This was not special revenue sharing, however. The grants were the Comprehensive Employment and Training Act (CETA), the Housing and Community Development Act, and amendments (Title XX) to the Social Security Act of 1935. In fiscal year 1976, block grants constituted some 9 percent of all federal aid to states and localities (Nathan, cited in ACIR 1977, A-60). Categorical grants were and still are the dominant mode of federal grant policy.

Block grants have had a number of common objectives. Three of the most common objectives have been economy and efficiency, program enlargement, and decentralization (ACIR 1977, A-60). Other objectives have been coordination, targeting of resources, innovation, and generalist control. It is apparent that in practice these goals are bound to conflict with each other. In actual performance, no precise definition or compilation of characteristics can cover all of the existing block grants. While similar concerns tend to link them, each block grant is the product of a unique set of circumstances. Each reflects the then-current wisdom regarding block grants and the particular characteristics of the functional area in question.

The Reagan administration has demonstrated a commitment to a "New Federalism" reminiscent of that of the Nixon administration. However, President Reagan has been rather more successful in convincing the Congress of the efficacy and desirability of block grants than were presidents Nixon and Ford. The Congress has approved--though not without a number of major clashes and modifications--block grants in health, education, and social services.

Block grants for the Reagan administration are less a mechanism for the more efficient and effective disbursal of federal funds to the states than they are a way station toward the goal of reduced federal, and indeed all government, involvement in the lives of U.S. citizens. The funding cut of approximately 25 percent that accompanies the Reagan health block grants is illustrative of this goal of devolved and lessened government activity. These cuts are in excess of those that would generally be justified as a result of simply creating block grants out of categorical grants. The proposed funding cuts have dampened state enthusiasm for block grants and raised fears among local governments that they will fare badly as the states attempt to allocate scarce resources.

In addition to these concerns, there are some very practical problems in the development of a block grant program. Hovey (Volume IV) explains the steps involved:

1. The programs to be consolidated must be defined, normally in terms of some organizing concept, such as preventive health or social services.

2. The basis for allocation must be established, typically on a formula basis.

3. Transition provisions must be developed, typically including some form of partial or complete hold harmless provisions dealing with situations in which the new formula produces major differences in funding from the patterns of the old categorical programs.

4. Earmarking, requirements for continued support of certain providers, and so forth, must be specified.

5. New administrative provisions, dealing with such matters as auditing and reporting, must be specified.

Each of these steps can involve considerable controversy. As the debate over the block grant proposals showed in 1981, it is possible to combine some programs and to label the result as a block grant while retaining many of the features of categorical grants.

In the following section, a list of advantages and disadvantages of different forms of federal grants is given for the convenience of the reader (Table 1). The list is followed by a long table for the state of Massachusetts that illustrates graphically how many categorical programs a large state can have (Table 2). It should also give clues to the sheer number of administrative chores that are connected to getting, using, managing, and overseeing the many projects involved.

TABLE 1 Advantages and Disadvantages of Different Forms of Federal Aid

I. Categorical Grants
   A. Advantages
      1. Stimulate recipient expenditures.
      2. Allow for federal control and accountability.
      3. Allow for the furtherance of national goals.
      4. Congruent with Congressional structure.
      5. Reduce fungibility of grant.
   B. Disadvantages
      1. Sum total of categorical grants can be unsystematic and uncoordinated.
      2. Inflexible fiscal and administrative requirements.
      3. Overemphasis on federal priorities.
      4. Overemphasis on narrow specialist administrators and their priorities.

II. Project Grants
   A. Advantages
      1. Enable targeting of groups in need.
      2. Efficient use of limited funds.
      3. Maximize federal bureaucratic discretion.
      4. Enable federal-local or federal-nonprofit grant relationships.
      5. Maximize competition for funding, perhaps increasing proposal quality.
      6. More stimulative than formula grants.
   B. Disadvantages
      1. May skew local priorities.
      2. Wasteful and time consuming competition.
      3. Too much federal bureaucratic discretion.
      4. May bypass the state government.
      5. A particularly onerous source of "red tape."

III. Formula Grants
   A. Advantages
      1. Minimize administrative discretion.
      2. Entitle classes of the population.
      3. Reduce uncertainty at the client and recipient government levels.
      4. Minimize potentially wasteful grant competition.
   B. Disadvantages
      1. Less stimulative than project grants.
      2. Formulae may be inadequate and may skew allocations in undesired ways.
      3. Given limited funding, may spread funds too thinly.

IV. Open-ended Formula Grants
    A. Advantage
        1. May ensure maximum funding for entitled classes of clients and for recipient governments.
    B. Disadvantages
        1. Can lead to major interstate variations in program level and federal contribution. This happened with Medicaid.
        2. May lead to virtually incontrollable federal contributions for funded area.

V. Formula/Project Grants
    A. Advantage
        1. Enable middle ground between formula and project grants where adequate bases for formula allccation are available at the state level, but where administrative discretion at the sub-state level is desired.
    B. Disadvantage
        1. Would tend to suffer from some of the problems adhering to both project and formula grants.

VI. Block Grants
    A. Advantages
        1. Maximize recipient discretion.
        2. Enable increased program and policy coordination at the state and local level.
        3. Administration by generalists and politically responsible officials.
        4. Reduced influence by the federal bureaucracy.
        5. Slower growth than with categorical grants.
        6. Reduced federal personnel and paperwork costs.
        7. Increased administrative simplicity and flexibility.
        9. Favored by the states.
    B. Disadvantages
        1. Reduced recipient accountability to the federal government.
        2. Recipients can terminate programs previously funded by a categorical grant, reflecting local prejudices.
        3. May place cities at a disadvantage if grants previously received now are included in a state administered block grant.
        4. Reduce effectiveness of constituency support at the now decentralized levels of allccation.
        5. Underfunding and funding uncertainty.
        6. Subject to recategorization and diminution of the preeminence of the block grant in its functional area.
        7. More supportive than stimulative.
        8. Increased difficulties with monitoring and evaluation.

TABLE 2 Public Health Service Grant Awards
State Tables - 1980 - Obligations'

State: Massachusetts
PHS Component: Health Services Administration

Reported as of: 09/30/80

Program Title	No. of Awards
Crippled Children Services	3
Family Planning Projects	13
Community Health Centers	23
Maternal and Child Health Research	1
Maternal and Child Health Services	9
Maternal and Child Health Training	5
Migrant Health	1
Family Planning Services Training	1
Family Health Center	1
Emergency Medical Services	4
Sudden Infant Death Syndrome Information and Counseling Program	1
Comprehensive Hemophilia Diagnostic and Treatment Centers	1
Supplemental Security Income Disabled Childrens Program	1
Hypertension Program--Formula Grants	1
Home Health Services Grant Program	6
Genetic Disease Testing and Counseling Services	1
Indian Health Scholarships	3
Hospital-Affiliated Primary Care Centers	1
Total - Health Services Administration	76
Total - Massachusetts	76

TABLE 2 (continued - Page Two)

PHS Component: Center For Disease Control

Program Title	No. of Awards
Comprehensive Public Health Services-Formula Grants	1
Occupational Safety and Health Research	1
Occupational Safety and Health Training	3
Childhood Lead-Based Paint Poisoning Prevention	3
Urban Rat Control	1
Disease Control	2
Alcohol Research Programs	1
Fluoridation Project	1
Health Education - Risk Reduction Grant	1
Project Grants - Health Programs for Refugees	1
Total - Center for Disease Control	16
Total - Massachusetts	16

TABLE 2 (continued - Page Three)

PHS Component: Alcohol, Drug Abuse and Mental
Health Administration

Program Title	No. of Awards
Alcoholism Prevention, Treatment & Rehab. Health Services	1
Drug Abuse Community Service Programs	3
Predoctoral National Research Service Award	10
Mental Health Research Grants	79
Mental Health Clinical or Service-Related Training Grants	72
Alcoholism Treatment and Rehabilitation/ Occupational Alcoholism Services Programs	22
Drug Abuse Demonstration Programs	4
Alcohol Formula Grants	1
Mental Health-Childrens Services	7
Drug Abuse Prevention Formula Grants	1
Predoctoral National Research Service Award	2
Alcohol Research Scientist R & D Awards	3
Alcohol National Research Service Awards for Research Training	1
Alcohol Research Programs	6
Alcohol Clinical or Service-Related Training Grants	5
Predoctoral National Research Service Award	1
Drug Abuse Research Scientist R & D Awards	3
Drug Abuse National Research Service Awards for Research Training Grants	2

TABLE 2 (continued - Page Four)

PHS Component: Alcohol, Drug Abuse and Mental
Health Administration (continued)

Program Title	No. of Awards
Drug Abuse Research Programs	29
Drug Abuse Clinical or Service-Related Training Programs	2
Mental Health Research Scientist R & D Awards	20
Mental Health National Research Service Awards for Research Training Programs	25
Special Alcoholism Projects to Implement the Uniform Act	1
Mental Health-Community Centers-Comprehensive Services Support	20
Total - Alcohol, Drug Abuse and Mental Health Admin.	320
Total - Massachusetts	320

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APPENDIX F

History of Selected Federal Attempts to Overcome Fragmentation of Services and Financing

A major criticism of the grants system is the fragmenting effect it has at all levels of government. But fragmentation (or as some may call it--pluralism) existed even without the grant system. A 1966 Bureau of the Budget (BOB) study describes the governmental framework in which the grant system evolved (U.S. Bureau of the Budget 1966:4-5):

> At one end of the spectrum, problems emanate from the fragmentation of State and local government units--cities, counties and a host of special and more or less autonomous school, water and sewer, recreation and other districts. As a result of constitutional and statutory limitations, few State, county or city chief executives are in a position to control all the public activities in their jurisdictions. Instead, they are faced with limitations on their appointments, taxing authorities, planning powers, and other steps they can take to carry out their theoretical responsibilities for governing a specific area. The average governor or mayor has only limited authority to deal with his state or local problems since significant authorities are vested in independently elected or appointed school boards, water districts and the like. Yet the Federal Government must to a large degree depend on these units of government for developing a coordinated approach to meeting their needs and priorities since it is responding to their requests and applications for assistance and the services and benefits involved are being delivered by State and local, not Federal agencies.
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> At the other end of the spectrum, problems emanate from a fragmentation of federal effort. Involved are differing congressional committees and agencies with distinct jurisdictions, clientele and institutionalized methods of approaching an issue. The result is a complex of legislation, appropriations and regulations proceeding down differing, often isolated paths.

The BOB study described some major problems in administering grants. At the federal level, there were multiple agencies and committees administering or overseeing multiple, duplicative, and overlapping federal programs. Assistance grants had become increasingly narrow in scope but more complex in requirements. Allocation patterns in states and localities often did not match the need. Federal planning requirements were complex and often inconsistent with state and local jurisdictions and their plans. Information about grants was not easily accessible. Federal agencies in the field were not organized in any logical or consistent ways and therefore did not facilitate cooperation, collaboration, or even provide adequate information to those involved. Federal program funds did not filter consistently through the levels of government; some programs bypassed state governments, others passed both state and local governments sending money directly to local private agencies. This leapfrog approach exacerbated the problems of an already fragmented governmental structure, further complicating communication, planning, and implementation.

At the state and local level, continued the BOB study, many problems were caused by this fragmentation of jurisdictions and authority. Chief executives in states and cities not only had little control over much of the money channeled into their area but often did not know that money had arrived.

The Council of State Governments issued a study, also in 1966, expressing the discontent of states with the grant system. Their major criticism was the "inflexibility in rules, regulations and administration" (Advisory Commission on Intergovernmental Relations 1977:9). Federal requirements were sometimes inconsistent with state laws, and programs were poorly coordinated. Cities, of course, suffered many of the same as well as other problems of the grants system--rigidity, duplication, overburdening application and audit procedures, and long review periods by federal agencies. Furthermore, pressures from state and local constituencies to pursue the seemingly "easy money" of some grants, regardless of previously stated priorities, undermined ongoing planning efforts.

Legislative Efforts

One of the first major congressional efforts to improve coordination in the administration of grants among all levels of government was the Intergovernmental Cooperation Act of 1968. According to its main provisions (ACIR 1977:98):

> Governors and state legislatures were to be informed of grants-in-aid coming into their states.
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> States no longer needed to keep federal grant funds in separate bank accounts.

Federal grant agencies were to schedule the transfer of funds to states so as to minimize the time elapsing between disbursement and use.

The agencies were to coordinate functional planning requirements under separate federal assistance programs so as to incorporate them into local and regional comprehensive planning efforts.

The president was to establish rules and regulations to govern the formulation, assessment, and review of federal grant programs with areawide significance to the end that the programs promote sound and orderly development.

Through this act, state and local governments and others were able to review whether or not the proposed federal grants were consistent with their respective policies. It was a first attempt to balance the views of the generalists on the local and state level, who were concerned with many overlapping social and economic problems, with those of the specialists from the federal level, who designed narrowly focused grant programs. As one BOB official who helped draft the act put it, "The intent is to permit a governor (or some official acting for him, such as the State Budget Officer) to request a Federal program agency to cut him in on correspondence on grant program, so that he will be given such facts as it (the Federal program agency) makes available to the State program agency" (Tiller 1968).

In 1969, the three-year Federal Assistance Review (FAR) was initiated to standardize, simplify, and decentralize the administration of grants; it did not alter the basic structure of the categorical grant system. It operated under the direction of the Office of Management and Budget (OMB) and the agencies participating in the Domestic Council.*

The primary vehicle for the reorganizations were federal regional councils (FRC) established in 1972. These councils were to serve as links between the federal government and the regional-state-local area, and to coordinate functions in their respective areas. Their jurisdiction was consistent with the 10 standard regions (with standard headquarter cities) which was also proposed under the Federal Assistance Review program. These 10 regions and federal

* The council, another federal effort to coordinate urban affairs, was composed of the departments of Agriculture; Commerce; Health, Education, and Welfare; Housing and Urban Development; Interior; Justice; Labor; Transportation; the Office of Economic Opportunity; the Environmental Protection Agency; Small Business Administration; Civil Service Commission; General Services Administration; and Office of Intergovernmental Affairs.

regional councils attempted to organize the previously varied, overlapping, confusing, and irrational jurisdictions imposed over years of administration of separate federal programs.

The councils concentrated on simplifying administrative procedures, reducing application time, giving states and localities greater authority, joint funding, and grant consolidation. Through their efforts, there was a reduction in paperwork and the time required for processing of grants. For example, it was found that the average number of calendar days required for processing Health Services Research and Development Grants from the Department of Health, Education, and Welfare was reduced from 270 to 150 days, a reduction of 44 percent (Office of Management and Budget 1975). Similar reductions were found in other federal departments and agencies.

The Advisory Commission on Intergovernmental Relations (1977) summarizes other major federal programs that attempted to simplify, standardize, and coordinate the grants-in-aid system:

> The Planning Assistance and Requirements Coordinating Committee (PARCC) was organized by HUD and later associated with the FAR effort. It developed recommendations to eliminate duplication of planning efforts, to clarify planning goals, and to simplify and standardize planning requirements attached to grant programs.
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> The Joint Financial Management Improvement Program (JFMIP) established governmentwide cooperative efforts to improve the financial management of federal funds.
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> The Interagency Audit Improvement Group (IAIG) developed audit standards and the concept of the expanded audit. It also sought to promote acceptance of the non-federal audit and emphasized the need to avoid costly and annoying application of audit efforts.
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> The Commission on Governmental Procurement (CGP) was created to analyze and clarify the confusion in federal/non-federal procurement and assistance relationships.

The Joint Funding Simplification Act (JFSA) of 1974 began as a pilot project called the Integrated Grant Administration Program. The purpose of the act was to enable state and local governments to coordinate their efforts directed at one goal by combining the resources from more than one federal agency program. A 1979 GAO evaluation of the act speaks to the disappointing results. Since the act was passed in 1974, only seven new projects had been added; 10 projects were initiated during the pilot project years. Despite the low activity, continued the GAO report, the act is valued as a

means of packaging related programs and of simplifying the administration of grants. The governments and agencies that had taken advantage of the joint funding process became strong supporters of its continuation (U.S. General Accounting Office 1979a).

The GAO study cited several reasons for the low level of activity under the joint funding program. Under the management of the Office of Management and Budget, there was little progress because there was a lack of adequate and timely leadership, support, and oversight. Consequently there were long delays in joint funding regulations after passage of the act, less than complete success of OMB training program, lack of adequate information, limited monitoring and enforcement, and assignment of minimal staff. Second, GAO also found a limited commitment by federal agencies. JFSA was a low priority; the benefits to the federal agencies were long term and indirect and with no immediate short-term payoffs. Third, JFSA was a voluntary process; there were no incentives to participate in the program, and if federal agencies did participate, there was no formal way to handle conflicts among them. Fourth, there were some legislative barriers, since some acts (e.g., the Older American Act and the Rehabilitation Act) were prohibited from participating. Last, the GAO found that many federal agencies were inexperienced with OMB circulars, improperly used them, or simply did not adhere to them.

GAO suggested that joint funding could be effective when given proper federal support. It also noted that successful outcomes of these complicated arrangements takes time; it is a process of give and take. The benefits found in those areas participating in joint funding included: one planning process, unified social service delivery systems, better administration, greater flexibility among staff, and a simplified cash flow.

The Joint Funding Simplification Act expired. As explained by Hovey in Volume IV:

> Its provisions have been included in Title III of the various versions of the federal assistance reform legislation. That legislation was reported out of the Senate Governmental Affairs Committee in 1980 and passed the Senate but did not pass the House. Comparable legislation, the Federal Assistance Improvement Act of 1981 (S. 807), had been reported out of committee to the full Senate, but as of December 1 it had not been considered on the floor nor considered in the House.
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> Title III would
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> - require the president to issue guidelines for implementation, including the requirement for consultation with beneficiaraies as agencies implement the legislation;

- require agency heads to identify programs suitable for joint funding, review administrative requirements to eliminate those that would impede joint funding, and create various procedures to facilitate joint funding;

- put the Office of Management and Budget in a central coordinating role;

- encourage agencies to process applications expeditiously;

- promote uniform procedures for application review; and

- permit the commingling of funds from different grants by the grantee.

There are a variety of other reform proposals that fall within the general rubric of improving grants administration without affecting the fundamental nature of the categorical programs. These proposals include

- Audit Requirements: State and local officials have pressed, with some success, for the substitution of state, local, and/or private audits for federal audits and for uniform approaches among federal agencies. Additional movement in this direction is indicated by Title II of the federal assistance reform legislation.

- Certifications: Current federal grant programs dictate (sometimes inconsistently from program to program) state and local personnel procedures, data processing use, indirect cost reimbursements, purchasing procedures, and so on. The fundamental position of state and local officials is that one uniform federal minimum standard should be set in general terms and that a single certification of a jurisdiction's procedures should satisfy the requirements of all federal programs. Failing this, state and local officials would at least like federal agencies to have uniform requirements.

- Crosscutting Requirements: There is clearly demonstrable inconsistency in the administration of crosscutting requirements (e.g., affirmative action and historical preservation) from federal agency to federal agency and considerable state and local concern with the delays and paperwork associated

with these requirements. These problems are addressed in the federal assistance reform legislation and are being continuously addressed administratively by the office of Management and Budget.

- Simplified Planning Requirements: Typically, federal grant requirements involve comprehensive "plans" and have required detailed applicataion documents that are resented as excess paperwork by state and local officials. Potential partial remedies include allowing the submission of a single plan to accommodate the requirements of several programs, reducing the frequency of plan submissions, and reducing the number of elements required to be included in such plans. This has been recently tested in a Planning Requirements Reform Demonstration Project (Boe 1980).

- Other Individual Reforms: This list does not cover the many other subjects touched on by grant reform proposals. Other aspects include federal aid information systems, systems of review and comment (such as Circular A-95), changes in matching and maintenance of effort requiements, and administrative details such as property accountability. Each of these has various advantages and disadvantages and supporters and detractors.

Administrative Efforts

By 1966, the Bureau of the Budget was becoming increasingly concerned about the budgetary complications and inconsistencies of the grant system and their difficult task of keeping track of the growing number of categorical grants. Their study in 1966 of federal assistance programs and a 1967 study of federal agency field organization and operation helped convince BOB officials that it needed to play more of a management role. In 1970, BOB was renamed Office of Management and Budget and its staff was enlarged, reflecting its hopes for a stronger management role. An Office of Executive Management was created in 1967 with a division of operational coordination and continued to work with the Federal Regional Council and Federal Assistance Review effort.

In an effort to gain some administrative control over the grants system, OMB issued a number of circulars to simplify and standardize grant administration. In the circulars OMB exercised its cross-governmental authority and set up mechanisms to carry out legislative mandates as specified in the Joint Funding Simplification Act. (In 1973, administration of those circulars was transferred to the General Services Administration, where the circulars were called Federal Management Circulars. Administration of the circulars returned to OMB in 1976.)

ACIR (1977) listed some of the more important circulars.

> FMC 74-7 (formerly A-102) helped reorganize financial management by standardizing 15 areas of grant administrative requirements and set limits on the amount of information federal grantor agencies could require.
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> FMC 74-4 (formerly A-87) was an attempt to outline which costs were allowed in federally supported programs.
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> FMC 73-2 (A-73) established procedures for audit of federal programs attempting to streamline the process and make it more efficient.

There was a mixed reaction from participating groups--grantees and grantors--on the effectiveness of these circulars. In general, all felt that the circulars had led to some improvements in grant administration but with qualifications. ACIR (1977:258-259) summarized some of the varying reactions:

> A review of the experience under the circulars also suggests that they have not been complete successes and that they need different kinds and degrees of improvements to attain their potential. While they have shortcomings in the substance of their provisions, their major deficiencies are in the manner and degree of their interpretation and implementation.
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> On substance, for example, some federal administrators feel that the procurement provisions of FMC 74-7 place too much trust in the adequacy of state and local procedures and safeguards. Others feel that this circular imposes too much standardization on federal programs, with too little regard for the differences that are vital to the achievement of individual program objectives. On the cost circular, staff members of the GAO, who are in the midst of an appraisal of the circular's effectiveness, have voiced concern over the clarity of the concepts incorporated in the circular and some states charge that the audit standards in FMC 73-2 are not as standardized as claimed.
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> Regarding implementation, public interest groups are concerned that GSA and OMB have not held Federal agencies' feet to the fire sufficiently, and have relied too much on the complaints as the

chief, if not sole, means of monitoring compliance. Federal grant administrators have complained that GSA interpreted the circulars too rigidly and without regard to the realities of day-to-day operations. Moreover, some observers feel that GSA and OMB do not put enough weight behind circular provisions which merely encourage rather than require certain practices.

Other OMB circulars were designed to strengthen state and local authority vis-a-vis federal agencies. Poor communication among the levels of government and the inadequate flow of information from the federal government to state and local government made it nearly impossible for the latter two to influence federal decisions. OMB attempted to remedy this through Circular A-85, which gave chief executives in state and local governments an opportunity to comment on federal proposals affecting intergovernmental relations, including rules, regulations, standards, procedures and guidelines, and major organizational changes.

Better known is OMB Circular A-95, which was a major effort to include the interests of state and localities in planning federal assistance projects and further to create mechanisms whereby federal projects were consistent with the plans of regions, states, and localities. It had four major provisions (ACIR 1977).

- Part I, which established the Project Notification and Review System (PNRS), was the best known and most influential of the four parts. PNRS was a process by which state, regional, and local governments were given the opportunity to review and comment on proposed applications for federal grants that affect physical development and human resources. Some 200 Federal programs were involved. Ideally, it could have strengthened the planning and decision-making capabilities of affected jurisdictions by impelling them to consider the impact of Federal programs on their jurisdictions. It could have also enhanced their ability to influence that impact.

- Part II established the framework for a similar review and comment system applicable to direct Federal development projects. A system was not prescribed, but use of the PNRS by Federal agencies was encouraged. If functioning effectively, it could have had beneficial effects on state, areawide, and local bodies similar to those of Part I.

- Part III gave governors the opportunity to review and comment on state plans required under Federal programs. It encouraged state comprehensive planning and gave the governor and his generalist aides a handle for exerting policy influence over functional specialists.

- Part IV provided for the coordination of Federal planning and development districts with substate districts. It encouraged states to exercise leadership in establishing a system of substate districts which could have provided a consistent geographic base for planning and coordinating Federal, state, and local development programs (ACIR 1977).

The four parts have had varying effects, according to an ACIR (1977) evaluation, but Part I is the most important in attempting to coordinate areawide planning and coordination. ACIR noted that the effectiveness of A-95 rests first with the degree to which state, regional, and local officials take advantage of the opportunities detailed in the circular and, second, with the mechanisms established by OMB and federal agencies (and to a lesser degree, lower levels of government) to make the opportunities accessible. On both counts, ACIR found a lack of commitment and involvement. Part of the question was whether federal agencies would set up adequate mechanisms or whether OMB would have to be much more aggressive in the implementation of A-95.

The General Accounting Office (1979b:18), in its report to Congress on A-95, stated that

> ...parties which may be affected by proposed federally assisted projects did not always have a chance to review and comment because: (1) projects that had significant impact on area and community development were not subject to the review and comment system prescribed by the circular and (2) participants in the review and comment processes were confused as to which projects were covered, when projects were to be submitted, how much time they had for review and when the process was completed.

Rothenberg (1981) further documents the weakness of A-95. She described three major problems: (1) inadequate and unpredictable funding, (2) inadequate review time and a low level of staff expertise, and, most seriously, (3) poor federal compliance. Regarding compliance, she cited two government studies:

> A 1975 GAO study found "a pervasive series of breakdowns in PNRS," problems "so severe that clearinghouses have questioned whether Federal agencies agree with the fundamentals of intergovernmental cooperation." In OMB's 1977 survey of clearinghouses, respondents repeatedly complained of federal circumvention, and a later OMB investigation of randomly chosen applications unearthed no agencies complying with all A-95 requirements. Specifically, the analyses show three types of

agency violation: 1) applicant bypass of one or more clearinghouses, 2) premature funding of proposals before receipt of review comments, and 3) failure to inform clearinghouses of major agency actions or to explain applications funded against clearinghouse recommendations.

Interestingly, A-95 is no longer being enforced. There is little reason to believe that its demise will make any difference, at least in terms of actual services integration at the community level.

Regionalization and Integration

In addition to legislative and administrative efforts to simplify and standardize the grant system, there have been many attempts to design programs that, by definition, would serve an integrative function. The Appalachian Regional Commission, Community Action Programs of the Office of Economic Opportunity (OEO), and Model Cities are three prominent examples.

The Appalachian Regional Commission (ARC) directed special assistance programs for approximately 400 counties in 13 states. The commission was structured to encourage a cooperative relationship between the federal government and participating states. The Office of Economic Opportunity and local community action programs carried out President Johnson's War on Poverty; money was channeled to poor communities primarily through local nongovernmental agencies. Model Cities, similar to OEO, called for planned and comprehensive programs to invigorate inner-city communities, but the program was directed through local governments rather than independent agencies.

These programs targeted funds to specific populations to address wide-ranging social and economic problems. It was felt that these integrated approaches to solving problems within defined geographic areas would be more effective than the disjointed single-problem approach of the categorical grant system. The stories of the implementation of these three projects demonstrate how difficult it is to translate good ideas into practice.

Language from each of these three programs speaks to the intent to integrate or coordinate resources in local communities in order to end the confusion and waste seemingly inherent in the overlapping programs of federal categorical programs, state and local projects, and independent agencies. The Advisory Commission on Intergovernmental Relations, in its review of these programs based on its own and other research, draws some conclusions about the realization of that goal.

Generally, the three programs had only limited success in targeting their resources and coordinating programs in the designated communities. The categorical grant system was intransigent even when confronted by these large-scale attempts to coordinate projects.

The reasons for this intransigence are complex and vary not only among the three programs, but also among the communities in which each of the three was implemented.

First, in each case, older federal agencies involved in the three programs resisted cooperating with the newly created federal agencies responsible for implementation. Regardless of the wide variety of tactics tried by OEO, HUD, or ARC, they enjoyed little cooperation. This fragmentation at the federal level made it nearly impossible for local planning agencies in the three programs to coordinate activities, since local groups were able to seek funding from other federal agencies without regard for the planning effort.

While coordination is a laudable goal and sounds rather benign, it is, in fact, a complex process that challenges the status quo and redistributes power. Programs that bypassed local or state government created other problems. For example, the community action program empowered local community groups at the expense of local government. In addition, grants to cities or counties that ignored states created difficulties when seeking cooperation or funds from these states in the implementation of the project. Federal programs designed to coordinate activities at a local level never addressed these politically charged realities.

Second, implementation of programs and comprehensive plans varied markedly across the country, making it difficult for federal programs to develop procedures that had universal applicability. In addition, the task of comprehensive planning proved more difficult than anticipated. Although comprehensive planning was theoretically possible, planners and others questioned whether it was possible in practice. Success of the programs was found to vary with the commitment of local chief executives, over whom the federal program had little control. Gubernatorial or mayoral interest tended to vary with the size of the state or city served by the program.

Along these lines, regional organizations and area planning agencies are established in very competitive environments. Existing state and local governments, planning groups, sewerage, school and other decision-making bodies, and private sector interest groups (formal and informal) have always been planning, providing services, governing, coordinating, and so forth. Superimposing an areawide or regional planning group can often add another layer of bureaucracy as it attempts to simplify. Martha Derthick (1974) suggests that such regional groups must therefore adapt to existing political environments rather than attempt to change them.

Finally, coordination was not a singular aim of these programs. Each was attempting to address major social and economic problems in depressed communities. With other goals, such as community participation, and other tasks, such as administering large and complex multifaceted programs, the goals of coordination became less prominent.

Revenue Sharing

General revenue sharing, as described earlier, has been another mechanism to transfer more easily federal funds to state and local communities. Its effect has not been easy to assess. GAO issued numerous reports to the Congress from 1973 to 1976 dealing with matters ranging from the impact of the funds in states and localities. A general theme that runs through all of the reports was that "flexibility inherent in the revenue sharing program has made it extremely difficult, if not impossible, to measure the impact of the funds on specific activities and programs of the recipient state and local governments" (U.S. General Accounting Office 1979b:27). However, the case studies contain a variety of circumstances in which general and specific revenue sharing (e.g., community development block grants) were significant in building health service delivery systems (e.g., Boston, Seattle, and Denver).

Coordination of Health Programs

Block Grants There are other federal programs, specific to the health system, intended (directly or indirectly) to integrate services. The first, in 1935, was the Maternal and Child Health program, which provided funds to be matched by the state, for pregnant women, infants, and children, and for crippled children. This program was primarily an attempt to provide services to a medically neglected segment of the population.

In the following decades there were categorical grants for many separate health programs and specific populations. As the number of programs grew, the problems of coordination increased. In 1966, the Partnership for Health Act was passed to break from the ad hoc pattern of grants and begin planning and coordinating services.

There were five major sections to the act, providing funds for: (a) state comprehensive health planning; (b) areawide comprehensive health planning; (c) training, studies, and demonstrations in health; (d) public health services for physical and mental health; and (e) health services development.

Section 314d of the Partnership for Health Act was a milestone in the federal grant system since it authorized a single block grant to replace 15 categorical formula grants. It was hoped that consolidation would reduce duplication and fragmentation and encourage states to develop comprehensive health services by allowing them greater flexibility with federal dollars. In practice, while state public health officials liked the block grant system, it did not result in the integrated or comprehensive health system intended. First, the actual dollar allocation was about the same as under the categorical system. Therefore, if states had commitments to existing programs, there was no additional block grant money for other programs or for efforts to integrate existing programs. Second, even if states did use 314d money to fund other than existing programs,

tracking that money was difficult. In its evaluation of the block grant system, the Advisory Commission on Intergovernmental Relations found that the money was merged with other sources of funding, making 314d funds unidentifiable and therefore relatively untraceable. Flexibility of block grant money is preferred by the managers, but it also limits their ability to document accomplishments with those funds--that is, maintain accountability to funding source--and therefore is hard to defend in budget hearings. Politicians, when approving expenditures, like to see results. The more hidden the expenditure, the more likely it is to stand still while other earmarked funds are approved.

In spite of the merging of funds (and consequently small or nonexistent designated 314d state staff), states tended to report that the block grant funds did have a separate role in their health programs. States also reported that block grants, as anticipated, gave them greater flexibility, although limited by the lack of an increase in funds under the programs.

A major tension in the block grant, according to ACIR, was "striking an appropriate balance between providing relatively restricted financial support for state and local programs, and promoting national health care priorities." For example, even in the beginning 10 percent was earmarked for mental health.

Subsequent amendments to the Partnership for Health Act show the tendency to recategorize the block grant program. First, Congress began to require expenditures on specific health programs within the block grants. Second, there was much more growth in other health programs than in the 314d grants.

Health Planning Comprehensive planning as an integrative mechanism was included in the Hill-Burton Act of 1946. In order to build hospitals in rural areas, and later urban areas, states were given funds to survey hospital needs and then to allocate to hospitals for construction to meet the defined needs. Through the program, several billion dollars were distributed as grants or loans to hospitals. The act was a bonanza in the construction of hospitals in underserved areas but had a limited effect on areawide planning.

The second major planning effort was initiated through the Partnership for Health Act, specifically sections 314a and 314b, which created the Comprehensive Health Planning Agencies (CHPs). The first section provided funds for state planning (called "a" agencies) and the latter for areawide planning ("b" agencies). As Lawrence Brown explained (Volume IV), the designated planning bodies, from the states and areas, did write lengthy plans, but they proved difficult to translate into practice. The theory of comprehensive planning has yet to be successfully translated to the specifics of individual areas or states. Even had plans been realistic, the CHPs had no authority to implement their plans.

Compounding the inherent weakness of the CHPs was the lack of linkage between the block grant funds (section 314d of the Partnership for Health Act) and the planning process and agencies. Even if the states had received more money under the block grants, it was

unclear how those funds were to fit into the planning effort. Decisions about the allocation of 314d funds tended to be made in state bureaucracies rather than in areawide planning agencies, thereby undercutting the practice of the planning act.

The planning effort was continued and strengthened through the Health Planning and Resource Development Act of 1974 (Public Law 93-641). Under this act, five-year Health Systems Plans and more detailed one-year Area Implementation plans were to be developed. Capital programs or new services were to be reviewed and judged, in part, on their consistency with these state and areawide plans. In practice, again, theory collided with reality. Institutions tended not to develop facilities or new programs because they were consistent with HSA plans but because they fit in with the institution's long-range plans. The inability of comprehensive health planning to balance institutional needs with area or statewide needs continued to plague the planning process.

Merging of Bureaucracies The Bureau of Community Health Services (BCHS), a unit of the U.S. Department of Health and Human Services, was created in 1973 to simplify the administration of several health programs by consolidating such functions as evaluation and grants administration and to facilitate the coordination of services by placing them under one federal roof. Included are Maternal and Child Health, Family Planning, Community Health Centers, Migrant Health, Black Lung, Home Health Care, and the National Health Service Corps.

Within the bureau, two integrative programs, Rural Health Initiatives and Urban Health Initiatives, were intended to improve the management and coordination of federal funding. The rural program combined resources of community health centers, migrant health programs, Appalachian health, and the National Health Services Corps to enable rural areas to better package federal programs to meet area needs. Urban Health Initiatives encouraged city planners to meet medical needs in underserved urban areas, especially drawing resources from community health centers, National Health Service Corps, and Family Planning grants. There was an additional emphasis in both programs to link what was being established with existing health resources in the community.

Other BCHS programs encourage integration with health programs out of the BCHS structure and with other governmental departments. As described in BCHS documents, examples include:

- An agreement between DHHS and USDA that makes Farmers Home Administration loans available for construction and renovation of DHHS primary care centers in medically underserved rural areas. Loans were made to 64 projects in 1979, and 70 to projects in 1980.

- An agreement between the Alcohol, Drug Abuse, and Mental Health Administration and the Health Services Administration assures the provision of mental health services to

users of primary care projects. In 1980, BCHS awarded $1.5 million in supplemental mental health "linkage" grants to 65 community health centers.

- Improved Child Health Projects (ICHP) to develop an integrated and coordinated system of comprehensive health care through utilization of all available resources and to develop additional services and assistance necessary to impact on related multi-county areas of states with significant problems in infant mortality and morbidity.

- As part of Title V grants, state Crippled Children's Agencies are required to work out effective referral arrangements with primary care projects.

- All state health departments are grantees under the WIC program. Many of these turn over the administration to the state Maternal and Child Agency which may subgrant to local or other agencies. About 90 percent of BCHS operational projects are subgrantees or have referral agreements with local grantees.

- Special grants have been made to improve pregnancy outcome in 34 states that have excessively high incidences of infant mortality. Extensive integration of state, local, and grant resources is involved with a focus on prenatal care and other services for pregnant women and particularly for teenagers.

- Under a joint agreement between DHHS and DOL, disadvantaged rural residents are trained as health support workers (nurses aides, clinic clerks, etc.) in rural areas. The agreement also provides for the placement of Job Corps health trainees from rural areas into DHHS projects.

- Under an agreement with the Department of Education, migrant students are being tracked by the computerized Migrant Student Transfer System so that expanded health services can be made available to them using Migrant Health Program resources.

Several of the case reports (Volume III) prepared as part of the committee's work were outgrowths of federal efforts to coordinate services and programming activities (see, e.g., the D.C. Senior Care Program, and Baltimore Community Geriatric Service, which were funded through an Administration on Aging and Health Services Administration interagency agreement and demonstration project).

Mental Health In 1963 the Mental Retardation and Community Mental Health Center Act was passed to provide care for the mentally ill at the community level. Grants were made for planning construction and staffing of the centers. Federal funds required that the

centers provide 12 mandated services; the plan was to offer a continuing series of coordinated programs at the community level. Federal, state, and local programs are adopting a strategy of coordination existing programs, and that orientation includes the coordination with health programs. In 1978 the President's Commission on Mental Health and legislation, Health Services and Centers Amendments (Public Law 95-626), mandated coordination of physical health and mental health services (Goldman et al. 1980).

Further in 1978 the Bureau of Community Health Services (BCHS) and the Alcohol, Drug Abuse, and Mental Health Adminstration (ADAMHA) financed plans to link the services of Community Mental Health Centers with those of BCHS-supported primary care programs. Grants (maximum of $30,000) were awarded to 55 sites. The money was used primarily to fund a mental health professional to act as a liaison between the two programs. Burke and Burns (1981) summarize some of their findings on the assessment of this integration effort:

1. No single approach to coordination can be specified by central administrators; local program directors need flexibility to adapt programs to their own conditions, and in some cases to adjust to changes over time. In Boston, a study conducted by Dr. Jonathan Borus for the Primary Care Research Section confirms that programs change in important ways over a period of several years.

2. If the administrators of health and mental health centers can agree during a planning phase on mutual goals and on general procedures for reaching them, implementation can follow more easily. Without such prior agreements, however, a great burden is placed on the linkage worker who is trying to operationalize the program in the face of uncertainty or covert conflict. In some cases the burden becomes unbearable.

3. These prior agreements should account for both the administrative and clinical needs of each center, so they should reflect the perspectives of clinicians who will be working with the linkage worker at each site as well as the administrative and financial mechanisms for supporting and supervising the linkage worker. It seemed that the most stable programs had also provided ways for administrators and their linkage workers to collaborate in modifying the program as necessary once it was established.

4. With such great burdens on the linkage workers, an effort to provide both clinical and administrative support seems to be necessary. Providing clear orientation to the two systems and professional support as the linkage workers develop their clinical roles were cited as steps needed to improve the difficult adjustments in the first month. For linkage workers who might not have worked in general medical

settings before, especially by themselves, and for those who have not tried to develop new programs or negotiate roles across organization boundaries, a more formal program of instruction might be useful in the future (for example, directed by the NIMH Staff College).

5. Building in opportunities to develop the program over time was also cited as necessary, and the importance of this observation was clear because the initial grants were so limited. At the Federal level, steps were taken early to help accomplish this goal, by increasing the grant ceiling to $45,000 and by broadening the range of acceptable mental health partners to include alcohol and drug abuse programs and non-Federal mental health programs in addition to CMHCs. Later efforts, including the provision for linkage in Section 206 of the Mental Health Systems Act of 1980, and the block grant approach to funding health and mental health services, also encourage great latitude in designing local programs to achieve health-mental health coordination.

Rich (1982) studied health-mental health linkages at broader, planning level. They surveyed Health Systems Agency planning directors and CMHC directors to assess the level of coordination and planning.

> Preliminary findings have shown that there is considerably more coordination taking place between service providers than the literature or our state level interviews had led us to expect. Furthermore, the CMHC respondents consider greater service coordination desirable, with approximately 80% of them expressing an interest in more service coordination with general hospitals, and 75% of them suggesting ways they would like to improve the continuity of care between community and institutional mental health service providers. Administrative integration is both less frequent and considered desirable less frequently than the coordination of services provided by administratively distinct agencies. This is consistent with the historical development of health and mental health care as separate systems in terms of practitioners, institutional providers and funding, and with the fear expressed by many CMHC directors that mental health care would "get lost" in a fully integrated system.
>
> In contrast, CMHC's and HSA's tend to have the relatively low level of contact with one another that the literature led us to expect. Since mental health planning is only a small part of HSA responsibilities, it theoretically gets a limited amount

of attention. Likewise, CMHC's are service providers for which macro level planning is like to be of relatively small concern. Interestingly, HSA and CMHC respondents differed on the amount of coordination they reported taking place: nearly 89% of the HSA respondents were able to name specific ways in which they had coordinated plan development and implementation with CMHC's, while only 57% of the CMHC respondents could describe any such coordination. This suggests that HSA respondents are either over reporting or that such coordination for them is more noticeable, both explanations suggesting that coordination between HSA's and CMHC's is more relevent to HSA's than to CMHC's. Nonetheless, health service providers coordinate activities with CMHC's more frequently and in a greater number of ways than do HSA's.

HSA and CMHC respondents have also rated the various motivations for coordinating with each other differently. For HSA respondents the exchange of expertise in planning and mental health was ranked first as a motivating factor, with 48% of them considering it of the highest importance on a four point scale. In contrast CMHC respondents ranked it fourth with only 24% of them rating it of highest importance. For the CMHC respondents, state and federal mandates were the highest ranked motivation for coordinating with HSA's, with 58% of them rating it of the highest importance. Only 33% of the HSA respondents rated state and federal mandates so high giving it a rank of four.

Although state and federal mandates and the exchange of expertise in planning and mental health are important coordination motivations for both CMHC's and HSA's, mandates are more important for CMHC's and the exchange of expertise is more important for HSA's. Since CMHC's are subject to mandated HSA Proposed Use of Funds and Certificate of Need reviews, CMHC directors' motivations for pursuing coordination emphasize the review aspects of the health planning system. The importance HSA's assign to the exchange of expertise, however, indicates that HSA planners pursue coordination more in the interest of the plan development process.

Despite these and other efforts to integrate services, the grants system is still purported to be confused, duplicative, and sometimes counterproductive. In order to remedy this and to drastically reduce

the federal expenditures for nonentitlement social programs, President Reagan is proposing to substantially revamp the federal system through a combination of consolidating health programs into state block grants, sorting out, and swapping programs with states. The block grants include alcohol, drug abuse and mental health; maternal and child health services; primary care; and preventive health. These changes may lessen some of the past complexities and confusion and will undoubtedly improve administrators' flexibility. However, the reductions in grants do not permit a true test of the advantages of block grants over categorical grants. The block grants will uncover new problems as states struggle with new fiscal constraints, new responsibilities, and attempts to reestablish priorities.

From a services integration perspective, block grants and swaps of whole functions have many of the virtues of the most flexible arrangements. But the reductions in dollars available mean that some of those services will be discontinued. Moreover, shifts from a national political arena to state arenas have differential effects. Programs that serve the middle class will do all right, but programs that serve the poorly organized groups that tend to be people who are disliked or left out--the poor, the disabled, the unentitled--will not do well in most states. One difference between a categorical approach and the block grants is the difference in the constituencies and their relative strength in 50 states.

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