application to the type of situations in which it was developed. The wide adoption of high-speed motors and group clinical procedures would alter some of the data presented. The methods developed for these and similar studies, the experience gained in conducting them, and the data collected should be useful as guides in developing the protocols for pilot-studies. To get the maximum from the proposed studies, therefore, full use should be made of past experience; caution should be exercised in the selection of the communities; sufficient uniformity should be adopted to permit evaluation of the variables under study; and as rigorous a design as practicable should be developed.

BIBLIOGRAPHY UTILIZED

1. Waterman, G.E., and Knutson, J.W. Studies on dental care services for school children, first and second treatment series, Richmond, Ind. Pub. Health Rep., 68:583-9, June 1953.
2. Law, F.E., Johnson, C.E., and Knutson, J.W. Studies on dental care services for school children; first and second treatment series, Woonsocket, R.I. Pub. Health Rep., 68:1192-8, Dec. 1953.
3. Waterman, G. E., and Knutson, J.W. Studies on dental care services for school children; third and fourth treatment series, Richmond, Ind. Pub. Health Rep., 69:247-54, Mar. 1954.
4. Law, F. E., Johnson, C. E., and Knutson, J. W. Studies on dental care services for school children; third and fourth treatment series, Woonsocket, R.I. Pub. Health Rep., 70:402-9, Apr. 1955.
5. Waterman, G.E. The Richmond-Woonsocket studies on dental care services for school children. Am. Dent. A.J., 52:676-84, June 1956.
6. Donnelly, C.J. The Sturgis, Michigan, dental care project for children. Am. J. Pub. Health, 45:1029-35, Aug. 1955.

THE ROLE OF DENTISTRY IN FEDERAL-STATE-LOCAL COMPREHENSIVE HEALTH PLANNING*

Lawrence F. Bennett, D.D.S., M.P.H.**

This paper presents an analysis of the impacts of P.L. 89-749 on the dental profession through 1967.

"You can't tell the players without a scorecard." Since this saying might maintain in a variety of situations, it should be interesting to apply it to the present status of governmentally sponsored dental programs. The number of specialized projects and grants available for all facets of health service now confuse so many observers that a scorecard is demanded.

Although not specifically designed to clarify confusion, Public Law 89-749, passed by Congress in November, 1966, has eliminated certain categorical appropriations, including a dental formula grant. Its passage may affect the dentist's role in comprehensive health planning. The principal objective of the review to be reported will be an examination of P.L. 89-749 for its impact on federal-state-local comprehensive health services and on dental treatment

* Submitted as an assignment while a graduate student of dental public health at The University of Michigan, School of Public Health

** School of Public Health, The University of Michigan, Ann Arbor, 48104

in particular. Included in this review of the recently available literature and legislation will be an assessment of the priority that has been assigned to dental services in comprehensive health planning.

Public Law 89-749,[8] to amend Section 314 of the Public Health Service Act, states, in part:

Findings and Declaration of Purpose

> Sec. 2. (a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close inter-governmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources – national, state, and local – to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.
>
> (b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of state health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.

To examine the cause for this lack of "flexibility," a brief history of section 314 will be presented. Starting in 1936, a series of categorical grants were established for certain health services. Under a number of legislative authorizations the following formula-grants (money available to states on a varied basis of matching) were established:[20]

Year of Authorization	Program
1936	General health.
1939	Venereal disease.
1945	Tuberculosis.
1948	Cancer; mental health.
1950	Heart disease; control of pollution of water.
1962	Chronic illness and aged.
1963	Radiological health.
1965	Dental health.

The following programs of project-grants (grants usually requiring no contribution by the state) were established:[20]

Year of Authorization	Program
1947	Venereal disease.
1960	Cancer.
1961	Radiological health.
1962	Tuberculosis; chronic illness and aged; neurology and sensory diseases.
1964	Mental retardation.

With the exception of the control of pollution of water, passed in 1950, and 15 percent of the grant allowed to mental health, the rest of these categorical grants were eliminated by P.L. 89-749.[8]

On March 16 and 17, 1966, hearings were conducted before the Subcommittee on Health of the Committee on Labor and Public Welfare of the United States Senate, Eighty-Ninth Congress, second session, on Senate Bill 3008 to amend section 314 of the Public Health Service Act.[10] Some statements and testimony from the hearings follow:

In a message to the Subcommittee President Johnson stated:

> I recommend to Congress a program of grants to enable states and communities to plan the better use of manpower, facilities, and financial resources for comprehensive health services.
>
> At present, the Federal Government offers the states formula-grants for categorical programs dealing with specific diseases. This leads to an unnecessarily rigid and compartmentalized approach to health problems. Our purpose must be to help redirect and reform fragmented programs which encourage inefficiency and confusion and fail to meet the total health needs of our citizens.
>
> I recommend a program to initiate new state formula-grants for comprehensive public health services. This program would begin in fiscal 1968.

Although most testimony supported the principles of the bill, the elimination of categorical grants and other revisions brought forth some of the following testimony:

James E. Perkins, managing director of the National Tuberculosis Association, stated:

> We believe the planning provisions which would be authorized would be completely consistent with the objectives of the NTA and we therefore approve this section. The support grants to state and local health departments would be of material assistance in increasing the capacity of those agencies to better carry out their responsibilities, and such expansion would help the tuberculosis and respiratory disease control programs. Certainly, amounts of grant funds should be increased appreciably over what is presently made available for basic services.
>
> However, it is our experience that in some instances in the past it was necessary to use funds appropriated for tuberculosis control to maintain the general health program of the state. Therefore, the support of the association for this new grant arrangement can only be made with the understanding that the support for tuberculosis control activities will in no way be endangered.

Dr. Bartholomew Hogan, deputy medical director of the American Psychiatric Association, testified in regard to mental health:

> We would suggest that if effective planning is to be achieved, coordinate status in making decisions should be accorded the mental health agencies, the public health agencies, and other health agencies. We know that it difficult to break with traditions in this matter, but the health of our people can only be improved if the public and private health agencies learn rapidly some new kinds of cooperation as well as some new degrees of cooperation.

> The second point to which the American Psychiatric Association would like to speak today is in support of a provision that a minimum 15 percent of the funds authorized in this proposal would be earmarked for mental health services and, of that amount, 70 percent would be available for community mental health services. This allotment of percentages, in effect, approximates the pattern of section 314 of the Public Health Service Act which these amendments would supersede.

Mrs. Fitzhugh Boggs of the National Association for Retarded Children reported:

> . . . it would be desirable to allocate a comparable percentage for mental retardation activities under the general heading of health, and we would suggest that there be a 10 percent allotment for mental retardation and related developmental disorders which could be used in one of several different ways. It might be used entirely by the state health authority or part of it might be assigned to some other state agency which in that state has responsibilities in functions related to health.
>
> . . . we suggested 10 percent for mental retardation and 15 percent for mental health. And we have made the purposes for which this could be used fairly broad, in the sense that, for example, it would include training of health personnel, people who are in the generic health services, so that they are better attuned to the needs of mental retardation.

A representative of the American Public Health Association stated:

> We question, therefore, the language contained in the bill which would make project-grants available to a public or nonprofit private agency or organization to develop health plans. We believe this planning should be done by a council which is broadly representative of the interest of the area.
>
> We believe the level of Federal support for basic programs should be increased 10-to-12 fold.
>
> The APHA supports the provisions of the bill which would authorize an interchange of personnel between the U. S. Public Health Services and states and local health departments.

The American Dental Association was represented, among others, by Dr. Donald J. Galagan, Dean, College of Dentistry, University of Iowa, who stated:

> The problem is that dental diseases are not dramatic. While they are universal, because of their low emotional intensity, state health agencies have tended not to put the emphasis on the support of dental programs which the association feels is necessary.
>
> Therefore, the Association would respectfully recommend that the committee consider earmarking a certain percentage for the support of dental programs.
>
> The Association would suggest as a possible percentage 5 percent of the formula grants.
>
> The American Dental Association recognizes the importance of many of the major goals of S. 3008. Certainly it is desirable to encourage the states

> and communities to make comprehensive plans in order to meet in the most efficient manner the health problems in their own areas. And certainly as a general proposition there can be no reasonable disagreement with the objective of giving to the states and communities great flexibility in implementing such plans.
>
> We do believe, however, that the new health services grant-program within proposed section 314(d) of the Public Health Service Act could be improved by providing specific authority for dental public health grants to state health authorities.
>
> The Association also sees much merit in the proposed interchange of personnel between the Department of Health, Education and Welfare and the state health agencies. This expanded personnel interchange program would be especially helpful to States which have not yet developed effective dental public health units.
>
> The Association's chief concern with S. 3008, however, is the proposed change in the grant system for state public health services. We are convinced on the basis of many years of unhappy experience with general health grants that Federal support for dental public health activities should be specifically authorized.
>
> The administration is proposing in S. 3008 a single-purpose grant for comprehensive state public health services. This is a significant departure from the special grant-programs that have evolved over the past 30 years or more. For almost that long the American Dental Association has urged a separate category for state dental health programs. In 1964, with Senator Hill's leadership, this objective was achieved. It is somewhat disheartening, therefore, to face this new plan which could dissipate dentistry's hard-won gains by weakening the foundation upon which the future of state and local dental health programs must be built.

Scanning the testimony, one will find that most of the objectives to the proposed law were not directed to the Act's main purpose, but to the unknown consequence of allowing each state to determine the priority (and corresponding support) of its various health problems. The American Public Health Association testified that project grants should not be available to public or nonprofit private agencies that are not representative of the area. The statements of the American Dental Association and the American Public Health Association suggest that exchange of personnel between the U. S. Public Health Service and state and local health departments would be of mutual benefit.

On September 29, 1966, Senate Bill 3008 was reported out of committee with the following observations in regard to dental health:[9]

> . . . community dental programs are inadequate to provide services not only for children but also for adults and the aged. Expansion of dental programs are needed for preventive services as well as for treatment and restorative services in schools, in preschool programs and in nursing homes.

The observation of this committe supports the notion that the most pressing dental need is treatment for the young and the very old. Little consideration was shown for the remainder of the population.

The committee's observations were accepted by Congress and the bill was enacted as Public Law 89-749 on November 3, 1966. The law is divided into five main sections: the first three deal with comprehensive health planning, and the last two chiefly with grants to states for public health services. The implementation of the provisions of P.L. 89-749 is being accomplished through policies and regulations set up by the Public Health Service.[22] To receive federal financial assistance for conducting comprehensive state health planning, a state must submit, and have approved by the Surgeon General, a plan for comprehensive health planning.

A state's program must designate a single agency to conduct and supervise the functions to be carried out under the plan. The agency's personnel are not specified for professions with the exception of ". . . a full time position of comprehensive health planning director, requiring experience and/or training in health planning . . . " The program also must provide for a state health planning council[22] to advise the agency in carrying out its function in planning. The council's membership is to reflect the state's geographic and socioeconomic population with representation of minority groups. The planning council must include representatives of the state's governmental agencies, nongovernmental health organizations, local governmental agencies and groups of consumers.

The role of the consumer has been outlined:

> The **State Health Planning Council** must include . . . consumer representatives, who must constitute a majority of the Council membership. Although state or local public officials may be considered, most consumer representatives should be private citizens. No person whose major occupation is the administration of health activities or performance of health services can be considered as a consumer representative. This requirement also excludes as consumers all persons engaged in research or teaching in health fields.
>
> Members of the Council should be appointed for staggered terms, to ensure continuity, and members who represent nongovernment health organizations or groups or local governmental agencies, as well as consumer representatives, should be limited to nonconsecutive terms as necessary to ensure widespread participation and representation on the Council.

In order to be approved, a state's program also must include specific methods:

> 1. for coordinating the agency's planning activities with specialized health planning and other related planning operations, such as planning for the development of construction programs for health and medical facilities, regional medical programs, community mental health programs, environmental control programs, and other specialized programs, and with state agencies concerned with physical and economic planning;
>
> 2. for considering the most effective and efficient manner of meeting health needs in welfare, education, and rehabilitation programs;
>
> 3. for considering the special health needs of high risk population groups for whom preventive services and health care may be most needed.

The state's program must ensure that federal funds will not be used to replace or supplement the state's funds that previously were earmarked for comprehensive health planning.

The federal and state contribution also has been suggested:

> Although the Act and Regulations authorize up to 100 percent Federal financing of the costs of comprehensive state health planning from appropriations and allotments for fiscal years 1967 and 1968, it is anticipated and expected that states will commit state funds for financing as high a percentage of such costs as possible during these two fiscal years.

The federal authorization is 2.5 million dollars in fiscal 1967 and 7.0 million dollars in fiscal 1968.

Section 314(b) is concerned with grants for area-wide comprehensive health planning[23] that includes

> . . . the environmental, economic, social, and other conditions that affect the health of the population of an area and the related public and private environmental, physical, and mental health services, facilities, and manpower. The area within which such factors interrelate and are best planned for will typically be a metropolitan area consisting of a central city and its related surroundings.

Any public agency can receive these grants and organize local planning councils. These councils are not unlike the state health planning council in that the majority of the membership must be consumers of health and reflect geographic, socioeconomic and ethnic groups in the area. Grants made for these planning projects must be approved by the state's health-planning agency unless the state has no program. In this instance approval could come directly from the Surgeon General until July, 1968.

The rationale for area-wide health planning is stated:

> Comprehensive area-wide health planning is related to and should be coordinated with comprehensive state health planning. Area-wide programs will both contribute to the conduct and substance of state planning programs and benefit from the informational and goal and priority setting activities of the State agency. The area-wide program should identify health problems, needs and resources; recommend goals and objectives; and promote the development and effective utilization of the area's health resources. It should recommend actions to be taken by both public and nonpublic providers of health services.

The federal authorization is 5.0 million dollars in fiscal 1967, 7.5 million dollars in fiscal 1968, 10.0 million dollars in fiscal 1969, and 15.0 million dollars in fiscal 1970 to cover up to 75 percent of the costs of projects.

Section 314(c) covers grants for training, studies, and demonstrations in comprehensive health planning:[24]

> Highest priority for Section 314(c) support will be given to training activities which promise most immediately to increase the supply of health planners and to increase the skills of individuals prospectively or currently engaged in health and related aspects of comprehensive health planning.

Included in training grants are awards to academic centers for comprehensive health planning; grants for curricula in health planning, continuing education in planning, and traineeships for individual disciplines. The grants for

studies and demonstrations are concerned with technics of testing and the methods of providing comprehensive health planning. The federal authorization is 1.5 million dollars in fiscal 1967, 2.5 million dollars in fiscal 1968, 5.0 million dollars in fiscal 1969, and 7.5 million dollars in fiscal 1970.

Section 314(d) sets out policies and information on grants to states for comprehensive public health services:[25]

> The Act provides grants to the states for support, development, and expansion of public health services with priorities and goals established by the states.
>
> This is a departure from the earlier categorical restrictions on Public Health Service grants which earmarked funds for use in meeting specified disease problems.
>
> The Act requires that at least 15 percent of a state's allotment shall be available only to the state mental health authority for provision of mental health services under the state plan.
>
> Although this legislation removes categorical restrictions on the use of formula-grant funds, it in no way implies that the activities previously supported by such grants should be discontinued or deemphasized.
>
> Only the state health and state mental health authority of each state, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa are eligible to receive an allotment under Section 314(d) of the Act.
>
> Where a state comprehensive health planning agency has been designated pursuant to Section 314(a) of the Act, and where such agency has adopted planning recommendations pertaining to services to be provided under the state plan for public health services, the state plan must provide for furnishing such services in accordance with such recommendations.
>
> The following standards shall be applicable to services furnished under the plan: (1) the plan must show that preventive, diagnostic, treatment, and rehabilitative programs shall include special attention to the health needs of high risk population groups in terms of age, economic status, geographic location, or other relevant factors. In addition, preventive services should be based on sound epidemiologic principles. (2) The plan must set forth the anticipated impact on the health of the people in terms of the specific objectives toward which the activities are directed. (3) Services under the plan must be provided by or supervised by qualified personnel, such qualification to be determined by reference to merit system occupational standards, state and local licensing laws, and specialty board requirements for health professionals.

The federal authorization is 62.5 million in fiscal 1968 with the federal share ranging from one third to two thirds depending on a determination by the Surgeon General of the state's per-capita income.

Section 314(e)[26] replaces authorizations for development of "out-of-hospital community health services" and categorical grants for projects that formerly were covered by annual appropriation acts for control of cancer, mental retardation, neurological and sensory diseases, radiological health training, and venereal

disease and control of tuberculosis. Grants for these purposes can be made in accord with 314(a). The federal authorization is 62.5 million dollars in fiscal 1968 "to cover part of the cost."

Section 314(f) is concerned with the interchange of personnel between states and the federal government. The Secretary of Health, Education and Welfare is authorized to exchange Departmental employees with state employees in health-related occupations for a period not to exceed two years.

Concepts of Comprehensive Health Planning in Relationship to P.L. 89-749

The Surgeon General has stated that the purpose of the law is to break down restrictive barriers among categories.[30] He has stated further, although the single state planning agency does not have any authority, if it does its job well, it will be ". . . influential in the fundamental decision on where the state's health dollar should go . . ." Since this program does not fit into the existing pattern of the Public Health Service, a new office of Comprehensive Health Planning was created. The Surgeon General decided that management of the programs under the new grants would be located in the regional offices of the Service.

Cavanaugh,[5] director of the office of Comprehensive Health Planning has stated:

> . . . the elements required to ensure comprehensive health services are clearly seen to lie beyond the ability of any individual practitioner to provide, any single mechanism to finance, or any single group or agency to plan or organize.

He added that governmental collaboration, official and voluntary efforts, together with active participation of individuals and organizations will be needed in the program. He then called for an identification of the weaknesses in health care that must be strengthened, and demanded that all segments form a partnership in which all interests will be represented. He concluded ". . . that this new partnership, if successful, will introduce on the American scene a constant feeling of dissatisfaction on the part of the whole health field and the public with the state of health in this country."

Although P.L. 89-749 has been in effect for approximately one year, there seems to have been no dramatic change to date. Approval of a grant still will be made by the office of the Surgeon General. As was stated in the review of section 314(a), a single state agency must be designated by the governor. Few states have designated these agencies.[17] Since the guidelines of the Public Health Service for formula-grants have been changed,[14] the money that has been received under this new act has been handled under different procedures than were in effect before P.L. 89-749.[12, 32]

This act, however, has eliminated the 1965 formula for categorical grants to states (including a grant for dental public health of one million dollars a year). The role of dental public health in the proposed comprehensive health planning has not been stated specifically.

Since comprehensive health planning and care seem to be a major concern of P.L. 89-749, it appears sensible to attempt a definition of its scope. Stewart[29] states that comprehensive health planning is less concerned with targets and more concerned with direction than formerly: "The changing aspirations of society require translation into changing goals for health . . ." Although this

definition is broad, the statement itself would seem to require additional interpretation.

Michael[16] says that comprehensive health planning is a continuing process of assessment, formulating goals, and the preparation of programs relative to health. This planning in turn will provide a guiding framework for the preparation of categorical plans and programs. Michael's suggestion of a continuing process of health planning would seem to be consistent with two other opinions.[11, 19]

The American Rehabilitation Foundation[4] lists some activities for getting started on comprehensive health planning: tooling up and establishing systems of information, working with a recognized health problem while tooling up the system, and developing a planning body to act as an arbitrator between professional groups.

Although the activities reviewed may be valid components of comprehensive planning, they do not seem to provide an accurate definition. In "Introduction to Comprehensive Health Planning,"[11] Getting lists three major aspects of community planning.

(1) The intra-agency planning by the staff with consultants and advisors;
(2) The community health planning wherein the public, the agencies and the healing arts participate;
(3) Comprehensive health planning on a regional and state basis.

He talks of the necessity of a plan and a design for action, and warns that too *many* plans are ". . . expressed in glowing generalities that lack precise and clear definition . . ." The plan must be a joint endeavor formulated by representatives of the agencies concerned as well as the medical, dental, and nursing professions. He lists four main components in planning: development of the program, delineation of its activities, its management and supervision, and the determination of evaluatory processes. He designates the determination of priorities as one of the most difficult problems; and he concludes that both the public and the professions should have a voice in the assignment of the importance of the problems. He thinks that the process of planning never is completed and, hence, needs constant evaluation.

On comprehensive health planning, he cites Public Law 89-749 as emphasizing three concepts:

> First, is the realization that no community is self sustaining and that the archaic pattern of delivering health services on the basis of small local political governmental units is inadequate.
>
> Second, that health is a concern of all, the consumer as purchaser of health services as well as the health professional or provider of service. Third, that it is inefficient and ineffectual to plan and deliver a variety of health services by a host of governmental and voluntary agencies without coordination of their programs.

Getting expresses the opinion that this "partnership for health," in the coming decade, challenges all concerned to develop plans to deliver health services of high quality, that are accessible and available and can be provided in an efficient manner to everyone. Apparently, when he refers to the coming changes in the next decade, he realizes that P.L. 89-749 only opens the door a little. Many factors must be brought together by people working together.

Getting and Wenzel[13] state that the Michigan Community Health Service Study used 246 identified decision-makers and influential persons in six regional

task-forces and one state-wide group called the Committee of Forty. The study constituted an attempt to get citizen-leaders throughout Michigan to work together for improvement of community health services in their own areas. The underlying philosophy of the study was consistent with the approach of P.L. 89-749. Since this study was reported as an effort to utilize "decision makers," the absence of consumer representatives on the task forces may not be significant, although P.L. 89-749 demands that the membership of planning councils (state and area-wide) must consist of 51 percent of consumers of health services.

Consideration of representation by consumers also was lacking in a recent publication of the National Association for Health and Welfare Councils.[31] It points out that councils are aware that citizens hold the power of initiative and can veto matters of social action. It recognizes that social need essentially is a state of the public's mind and is reflected in the degree to which community leaders are cognizant of community problems and the extent that they are willing to work for solution of these problems.

Although the organization of most state agencies and planning councils has not been accomplished, some of the purveyors of health services have formulated guidelines for the implementation of the new law.[3, 6] The American Hospital Association,[3] for example, states that the institutional providers of health services must take part in planning, not only for their own institutions but also for the total community in which the institutions are located, and that health-planning areas of appropriate size should be defined. To assist the state's agency for health planning, an advisory council of lay and professional members selected for their leadership should be created.

Another type of organization, representing localized groups of hospitals also has undertaken planning. Getting[12] reports that federations of hospitals have the organization necessary to implement this planning. The Columbus Hospital Federation[6, 32] has designated the "types of projects to be encouraged" under section 314(e) by its Bureau of Health Services. These projects include nursing homes, models of community health service, and rural programs. Although both of these service-organizations indicate that their goal is comprehensive health service, the emphasis on institutionalized care and special projects is their primary interest.

Dentistry's Role in Comprehensive Health Planning

The National Commission on Community Health Services[19] (created by the American Public Health Association and the National Health Council) was given the responsibility of reviewing health needs and resources, and for evolving "far-reaching proposals" for the development of community health services during the "next decades." The special task force assigned comprehensive health care[18] states that comprehensive health planning includes maintenance of health, prevention of disease, and the provision of diagnosis, treatment and rehabilitation that are continuous throughout life. Such services also must be made available to all people in all areas and must be based on a number of types of health services. The services will include such specialized treatment as can be provided for dental, mental and occupational health. The report demands that dental care be a part of all programs with a special priority to provide care nationally for children and for the indigent, handicapped and homebound population. Fluoridation, as a preventive measure, also was assigned a high priority. The task-force reports that health-planning sometimes can assign certain func-

tions usefully to other members than the physicians in health-teams. The personal physician, however, appears to have the responsibility to bring the individual consumer into the integrated program of comprehensive health services.

The completed report of the Commission[19] views the potential dividends from the dental health component of comprehensive personal health service's as great if the program includes prevention, early diagnosis and treatment, regular maintenance, and continuous efforts to educate the public. At the same time definite emphasis of the role of the physician as a supervisor and planner of any health program becomes obvious. The labeling of dentistry as a "specialized" discipline, along with occupational health, and the emphasis of its clinical role along with its omission as an integral part of planning, appears to limit the role of dentists in comprehensive health planning unless they demand and defend a role vigorously.

Woefle[33] predicts changes in four activities for health. They constitute increased emphasis on (1) research, (2) prevention, (3) comprehensive health care, and (4) alterations in professional education. Of comprehensive health care, he says, specialists can best contribute their knowledge if they work as a group, but each profession must decide for itself how to increase its potential. He suggested that dentists encourage forms of practice to provide optimum health for individuals. He, too, seems to consider dentistry's main contribution to be clinical in nature, since he fails to discuss the role of dentists in the planning stages of health programs.

The Surgeon General[30] has suggested that the two items of priority for dental participation are preventive dentistry (fluoridation of water and topical application of fluorides) and effective use of auxiliary help. He states that the U. S. Public Health Service will help provide education for dentists in these areas of immediate concern. He, too, fails to discuss the role of the dentist in comprehensive health planning.

Diefenbach,[7] Assistant Surgeon General and Director, Division of Dental Health of the U. S. Public Health Service, avers that no federal program has been aimed at the total dental problem. Many dental programs can be left to local option and result in no program whatever. He suggests that dentists should be "fighting for the inclusion of comprehensive dental care in all such programs," and to accomplish these objectives, work together. The plans of the state agency for comprehensive health planning, it should be noted, must be approved by the regional offices of the U. S. Public Health Service.

The director of the Bureau of Dental Health Education of the American Dental Association[28] agrees that the report of the National Commission on Community Health Services is oriented toward medical care but does include dental care. He recommends that the state dental associations promptly plan to meet the requirements for manpower, perform surveys, and "assume leadership in planning and developing programs." He continues by saying that dental associations must be intimately associated in the planning for each state "if the programs are to be acceptable to the profession and beneficial to the public."

Hine, while President of the American Dental Association,[15] stated that he noted much change in the past quarter century and that a greater emphasis now was placed on studying ways and means to prevent and control disease. He continued by stating that the profession is obligated to take part in planning the types of programs for dental treatment and in the selection of those populations to be treated through governmental assistance. But unless it acts now, it may lose the initiative, and may find that solution of problems associated

with furnishing dental care will be offered by others without the assistance and counsel of the dental profession.

It seems again that the primary reason for planning is to keep control of the dental portion of comprehensive health. This attitude may reflect the views of the private practitioners who constitute the majority of the membership of the American Dental Association.

Putnam[25] reminds, although earmarked funds for dental programs have been eliminated by 89-749, the struggle that obtained these categorical grants will serve the dental profession as a strong foundation for the work which lies ahead. Of the 47 states that have submitted lists of urgent health problems to the Surgeon General, 36 have designated dental care as one of the five programs in top priority. He thinks that dentistry should place representatives on the state and area-wide planning councils, and organize planning committees to advise the state's governor. "It is important," he says, "to let the governor know that the dental profession is with him, is going to support him, and is ready to move into a position of leadership." P.L. 89-749 underwrites the planning process and provides for flexibility in planning.

To protect the dental health of the people, dentists must provide much more than the technical competence. They must assume a heavy and growing social responsibility. This new program was enacted as a logical and inevitable outcome of several decades of experience in marshaling the natural resources of this country for better protection of people's health. It is essential that dental health be recognized as an integral part of the comprehensive health care of all individuals. By becoming a fully active partner for health, the dentist safeguards this objective and also assumes his appropriate social role in safeguarding the health of a nation's people.

When 36 out of 47 states list dental care as a priority for health, omission of dental planning in a state's plans should lead the state dental association to object vigorously. Putnam's charge to dentists to assume "leadership" and a "growing social responsibility" for gaining inclusion in comprehensive health planning should seem valid to all dentists. Seldom have dental services been included in health planning without strong support for their inclusion by the profession.

On June 20, 1967, Wilson,[1] chairman of the Council of Legislation of the American Dental Association, appeared before the House of Representatives' Committee on Interstate and Foreign Commerce to testify and submit amendments to H.R. 6418, a bill to amend and extend authorization for grants under section 314 of the Public Health Service Act. The testimony stated, "A major concern is that the bill makes no attempt to define what is meant by comprehensive health services." The membership of the state health planning councils also was reviewed. "It is the Association's conviction that no council could be considered 'comprehensive' unless its membership includes representatives from all of the major health professions." At this time, amendments were offered to require state plans to include all categorical grants that had been supported in fiscal 1967 and that the state planning councils include dentists. On September 26, 1967, Christensen,[2] Director of the Washington office of the American Dental Association, submitted a statement of the Association on Senate Bill 1131 and H.R. 6418, amendments to section 314 of the Public Health Service Act, before the Senate Committee on Labor and Public Welfare. The testimony of this paper was essentially the same as on H.R. 6418 on June 20, 1967.

Senate Bill 1131 would increase the appropriation for section 314 approxi-

mately 15.2 million dollars in fiscal 1968 and authorize such sums as will be necessary for the next four fiscal years. Senator Hill suggested that a new position be created for an Under Secretary of Health in the Department of Health, Education and Welfare: "This office will have the responsibility for organizing and directing our national health activities and will provide national policy leadership for the health programs of the Department."

On December 5, 1967, H.R. 6418 and S. 1131 became public laws.

Some Discussion

The elimination of most specific categorical grants by P.L. 89-749 has been justified by government as a means to allow states more flexibility in dealing with their health problems.[8] Individual states now must submit their plans for approval by the Surgeon General's office and the plans must outline priorities and include the extent of emphasis that will be given each health program. At the local level, area-wide planning councils will keep the state's planning-council informed about local health problems. The state's planning-council, in turn, will act as an advisory body to the state's planning-agency. Both the area-wide and state-planning councils are unique in that 51 percent of their members must be consumers of health services.

Because it is the governor's responsibility to designate the state's agency that will handle the new program, it would seem that any action taken by this agency would reflect his interests. There seem to be some built-in constraints, however, when one reflects that each advisory council is to have a majority of consumers of health services in its membership. It might be naive of the state's chief executive to conclude that he could ignore the planning-council's recommendations and expect to get support from the U. S. Public Health Service. Another restraint on state planning will be the regional office's power to approve plans that conform to its concepts of P.L. 89-749.

Now that dentistry's categorical grant has been abolished, new approaches must be used to ensure the inclusion of dental services in each state's plans. Although many states list dental care in their top health priorities, the reduction of budgets and dental services often go hand in hand. If dental services are to become an integral part of P.L. 89-749, there should be active participation by both dentists and dental societies in the planning-councils and state agencies. There also should be active lobbying for the inclusion of dental services in any comprehensive health planning.

In this review of literature there have been many statements on what comprehensive health planning will do and who will do it, but there seems to be few actual definitions of what it actually is. Michael[16] states that it is a continuing process of assessment, formulating goals and preparing programs relative to health while the National Commission's Task Force[18] states that it is maintenance of health, prevention of disease, and providing diagnosis, treatment, and rehabilitation continuously throughout life. These two definitions would seem to range from a social idea to a clinical setting with the idea of continuity as the common concept. One dictionary,[34] in part, defines **comprehensive** as "to cover completely;" and for **health**, "the condition of being sound in body, mind or soul;" and for **planning**, "detailed programs of action." Adding "continuous" to this definition, provides a framework that will house most opinions of the content of comprehensive health planning. It must be remembered, however, that an attempt to define a concept must assume limitations.

The question then becomes "How does one limit something that is comprehensive?"

Since dentistry is broadly accepted as one of the health professions, its inclusion in comprehensive health planning seems to be mandatory. The more important question becomes, "How active a role will dentistry assume?" In most of the literature on health planning, dentistry is not included; or, when it is mentioned, its role seems to be relegated to the promotion of fluoridation or clinical treatment. Some spokesmen for the dental profession speak in behalf of participation in planning as a means of keeping control of dental programs[15, 28] while another opinion[35] states a more liberal view to the effect that it is dentistry's "growing social responsibility." In the past, little consideration has been given to dental care in comprehensive health planning. To expect a radical change in the future because of a legislative act is unrealistic. Dentistry's role in comprehensive health planning or any other health program will be determined in large part by the profession itself. The task remains for dentists to demonstrate through leadership, statesmanship, and diplomacy, not only the part (quantitative and qualitative) that dentistry will assume, but the effectiveness of its participation in comprehensive health planning.

Four Conclusions

1. P.L. 89-749 has not defined **comprehensive** health planning, and has resulted in apparent confusion about definition and participation in the planning.

2. To date, most states have not implemented this legislation, with the exception of designating their state health planning agencies.

3. P.L. 89-749 has established a new organizational network, with strong representation from consumers of health services, to handle planning of future federal-state programs developed under its grants.

4. Since the categorical grant of the state dental division has been abolished, other methods and plans will need to be formulated and pursued vigorously to ensure the inclusion of dentists' thinking in comprehensive health planning.

BIBLIOGRAPHY

1. American Dental Association. Statement of the American Dental Association on H. R. 6418; Partnership for Health Amendments of 1967, before the Committee on Interstate and Foreign Commerce, U. S. House of Representatives, June 20, 1967. Chicago, American Dental Association, 1967. 6p.
2. _____. Statement of the American Dental Association on S. 1131 and H. R. 6418, Partnership for Health Amendments of 1967, before the Committee on Labor and Public Welfare, U. S. Senate, Sept. 26, 1967. Chicago, American Dental Association, 1967. 4p.
3. Principles to guide development of state wide comprehensive health planning. Chicago, American Hospital Association, 1967. 5p.
4. American Rehabilitation Foundation, Inc. Getting started on health planning. Washington, Government Printing Office, 1967. 13p.
5. Cavanaugh, J. H. Comprehensive health services. Pub. Health Rep., 82:399-403, May 1967.
6. Columbus Hospital Federation. Types of projects to be encouraged by Bureau of Health Services under section 314(e) of P.L. 89-749. Columbus, Ohio, Columbus Hospital Federation, 1967. 3p. mimeog.
7. Diefenbach, V. L. The national dental health agenda. Am. Col. Dent. J., 34:15-21, Jan. 1967.
8. Eighty-Ninth Congress, Public Law 89-749. An Act; Comprehensive Health Planning and Public Health Services. Amendments of 1966, enacted Nov. 3, 1966. Washington, Government Printing Office, 1966. 11p.
9. _____. Senate. Report No. 1665 to accompany S. 3008 from Committee on Labor and Public Welfare, U. S. Senate, Sept. 29, 1966. Washington, Government Printing Office, 1966. 40p.

10. _____. Senate. Hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare, U. S. Senate, on S. 3008, March 16 and 17, 1966. Washington, Government Printing Office, 1966. VI + 153p.
11. Getting, V.A. Introduction to comprehensive health planning. Paper presented at the Mississippi Valley Conference on Tuberculosis, Grand Rapids, Michigan, Oct. 4-6, 1967. 24p. mimeog.
12. _____. Personal communication, Oct. 16, 1967.
13. Getting, V. A., and Wenzel, R. L. The Michigan community health services study. Paper presented at the annual meeting. Michigan Public Health Association, Grand Rapids, Michigan, May 19, 1967. 9p. mimeog.
14. Greene, J. C. Personal communication, Oct. 16, 1967.
15. Hine, M. K. The challenge of wise reform. Am. Col. Dent. J., 34:71-83, Apr. 1967.
16. Michael, J. M. Comprehensive health planning. Paper presented before the annual meeting of the Washington State Public Health Association, Oct. 3, 1967. Seattle, 3p. mimeog.
17. Michigan Public Health Association. Resolution passed by the 1967 House of Delegates; Comprehensive health planning. Newsletter, 17:2, July, 1967.
18. National Commission on Community Health Services. Comprehensive health care, report of the task force on comprehensive personal health services. Washington, Public Affairs Press, c1967. 94p.
19. _____. Health is a community affair. Cambridge, Mass., Harvard University Press, 1966. XIV + 252p.
20. Ninetieth Congress, House of Representatives. Report of the Committee on Interstate and Foreign Commerce, House of Representatives with minority views to accompany H. R. 6418, Aug. 3, 1967. Washington, Government Printing Office, 1967. 89p.
21. Ninetieth Congress. Hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare, U. S. Senate, on S. 1131 and H. R. 6418, Sept. 25 and 26, 1967. Washington, Government Printing Office, 1967. VI + 225p.
22. U. S. Public Health Service. Partnership for health. Information and policies on grants to states for comprehensive health planning; Section 314(a) Public Health Service Act, as amended by Public Law 89-749. Washington, Aug. 15, 1967. Washington, Government Printing Office, 1967. 20p.
23. _____. Information and policies on grants for comprehensive area-wide health planning; Section 314(b) Public Health Service Act, as amended by Public Law 89-749. Washington, Government Printing Office, 1967. 19p.
24. _____. Partnership for health. Information and policies on grants for training, studies, and demonstrations in comprehensive health planning; Section 314(c) Public Health Service Act, as amended by Public Law 89-749. Washington, Government Printing Office, 1967. 12p.
25. _____. Information and policies on grants to states for public health services; Section 314(d) Public Health Service Act, as amended by Public Law 89-749. Washington, Government Printing Office, June 15, 1967. 13p.
26. _____. Information and policies on grants for health services development; Section 314(e) Public Health Service Act, as amended by Public Law 89-749. Washington, Government Printing Office. July 20, 1967. 14p.
27. U. S. Public Health Service, Division of Dental Health. Sources of federal funds which can be used in support of activities in dentistry. Washington, Public Health Service, 1966. V + 19p.
28. Putnam, W. J. The impact of comprehensive health planning on dentistry; presented at the annual meeting of the American Dental Association, Washington, D. C., Oct. 29-Nov. 2, 1967. 12p. mimeog.
29. Sandell, P. J. Community health planning. Am. Col. Dent. J., 34:22-6, Jan. 1967.
30. Stewart, W. H. Partnership for planning. Pub. Health Rep., 82:395-99, May 1967.
31. _____. Trends in national health programs. D. C. Dent. Soc. J., 41:44-5, 56, June 1966.
32. U. S. Public Health Service, Division of Community Health Services. The role of health and welfare councils in comprehensive community health planning. Washington, Government Printing Office, June 1966. 16 p.
33. Vivino, Angelo. Personal communication, Oct. 16, 1967.
34. Webster's Seventh New Collegiate Dictionary. Springfield, Mass., Merriam, c1967. 22a + 1221p.
35. Wolfle, Dale. Summary of the panel discussion, optimum health for the individual in the social order: planning the good life. Am. Col. Dent. J., 33:43-8, Jan. 1966.