The Program Implications of Administrative Relationships between Local Health Departments and State and Local Government

GORDON H. DEFRIESE, PHD, JEAN S. HETHERINGTON, JD, MPH, EDWARD F. BROOKS, MBA, C.ARDEN MILLER, MD, SAGAR C. JAIN, PHD, FLORENCE KAVALER, MD, MPH, AND JANE S. STEIN, MS

Abstract: A typology of organizational arrangements between state and local public health agencies was used as a framework within which the organizational environment of the local health department was studied for its effects on program development and implementation by local public health departments. Data collected in a national sample of local health officers were used in measuring the effect of four different patterns of administrative relationships on the selected characteristics of local health department programs. Important differences were observed among the four organizational types with regard to constraints on programs and program priorities, and health officers' perceptions of the primary functions of local health departments and sources of local health department funding.

These findings were then used as a baseline from which to consider the possible impact of recent federal health budgetary proposals (specifically, block grants) both on existing patterns of intergovernmental relations and on the funding and operation of local health department programs. It was determined that the most likely general development arising from these proposed changes in federal budgetary policy is that the administrative control of state health agencies over those at the local level is likely to be enhanced. Other likely developments include changes in the programs and priorities of local health departments related to reductions in overall funding levels for human services and forced competition for fewer dollars by an enlarged constituency. (*Am J Public Health* 1981; 71:1109–1115.)

In 1974, a group of researchers at the University of North Carolina surveyed the nation's local health officers. This survey compiled one of the few known sets of data within recent history on the organization, financing, functions, and staffing at local health departments as well as important personal and professional characteristics of local health officers.[1]

It now appears that the United States is entering a period of great change in the financing and organization of its public health system. The Reagan Administration has proposed that large block grants replace the present system of categorical grants which finance public health programs targeted on specific problems. A valuable exercise, then, would be to review portions of the 1974–1975 local health department survey, particularly those concerning organization, financing, and program development with the expectation that they will enlighten us as to some of the implications of this block grant approach for local health department program development in the future.

The survey of health departments revealed that there are several organizational patterns which represent the functional and administrative relationships between local health departments and state and local governments.[1] Using a modified and expanded version of this typology of organizational arrangements between state and local public health agencies, some consistent patterns can be seen among the four types of organizational arrangements with regard to certain elements of local health department program development and implementation. These findings are consistent with at least one approach to organization theory which holds that the environmental conditions which surround an organization have an important effect upon its internal structure and performance.[2] The "environmental conditions" in this instance are the intergovernmental relations between local health departments and state and local government.

Address reprint requests to Gordon H. DeFriese, PhD, Director, Health Services Research Center, Chase Hall 132-A, University of North Carolina, Chapel Hill, NC 27514. Ms. Hetherington is Research Associate; Mr. Brooks is Associate Director; and Ms. Stein is Assistant Director, all with the UNC Health Services Research Center. Dr. Miller is Professor and Chairman, Department of Maternal and Child Health; Dr. Jain is Professor and Chairman, Department of Health Administration, both at the UNC School of Public Health. Dr. Kavaler is Assistant Surgeon General and Director, USPHS Hospital, Staten Island, NY. This paper, submitted to the Journal December 15, 1980, was revised and accepted for publication June 3, 1981.

Editor's Note: See also related editorial this issue p 1103.

This paper presents the findings of our analysis of the 1974–1975 survey data with regard to the influence that different patterns of administrative relationships between local and state health agencies appear to have on local health department program planning and development. These data provide a baseline from which to consider the possible impact of recent federal budgetary and health program policy development on the current patterns of intergovernmental relationships between local health departments and state and local governments and the consequences of these relationships for the funding and operation of local health department programs.

Background

During the 1960s and, to some extent, the 1970s, the United States experienced a period of increased centralization of power and control over public programs from local-to-state-to-federal government; program authorization and financing had usually flowed in the opposite direction from federal-to-state-to-local levels. The vehicle of this involvement was most frequently the federal grant-in-aid. James Sundquist[3] points out that this involvement signaled a transformation of the federal system, as the role of the states and communities became one of assisting the federal government in achieving *federal* objectives, instead of one of using federal funds to achieve *state and local* objectives.

Similarly, state involvement vis-a-vis local communities increased during the same period, even though, according to legal tradition, states have always had a complete right of domination over their local governments.[4] The findings of one study of state centralization which looked at three different measures of power (financial resources, responsibility for governmental services, and size of state and local bureaucracy) revealed that an upsurge in state centralization could be observed, particularly in 1969, no matter what measures of power were considered. The conclusion of that study was that, "Our localities are increasingly dependent upon larger governments for money, resolution of policy issues, reallocation of resources, and even for delivery of many public goods and services."[5]

Only a small body of literature appears to exist that examines the effects of the increased centralization of the past two decades on the programs and priorities of local government and local government agencies. One study found that the number of "mandates," or the quantity, range, and scope of requirements imposed by the federal government on state and local governments as well as those imposed by state governments on local governments, had increased over the past two decades. This study concluded that mandates are altering the scope and focus of local government actions as well as the priorities of these governments.[6]

State influence on local governmental and public service affairs, however, is felt more strongly in certain functional and programmatic areas where state involvement is greater. According to the Advisory Commission on Intergovernmental Relations (ACIR), such functional areas as "highways, welfare, health-hospitals and environmental concerns are 'intergovernmental' in nature" and thus in the interest of both local and state governments.[7] Health is, therefore, a functional area in which one would expect a great deal of state activity and involvement. However, the extent of state mandating in all areas, including health, still differs greatly from state-to-state.[6]

The decisions and priorities of local governments, or their agents, such as local boards of health, also influence the structure and performance of local health departments. Townsend[8] found local boards of health and local political office holders to be salient influences upon the administrative decisions of local public health department directors. (Other sources of influence included recipients of health department services, local health department staff, professional public health worker groups not employed in the local health department, local political elites, and local health interest groups.)

The Reagan Administration's block grant approach to health programs signals a new and as yet unstudied pattern of intergovernmental relations in public health. Under this approach, program planning, implementation, and administration are to be placed almost solely under the states' control; the federal government is to help finance many of the states' health programs through two large block grants, one of which would include a number of existing health *services* programs, while the other would include a number of existing *preventive* health programs.* Funding available under the block grant is proposed to be as much as 25 per cent less than is now available for included programs. The states' use of federal funds is to be subject to only very general federal guidelines. States must not use federal funds for programs other than those which are included in the block grant, but may fund individual programs within the block at lower or higher levels, or not at all. States also would not be required to contribute (match) the level of funds required under current programs. The result will be an even greater decrease in overall funding for health programs. Thus, the Administration's block grant approach will place a great deal of power and responsibility in the hands of the states at the same time that an overall decrease in federal funds for support of public health programs will occur.[9,10]

The implications of this new development for public health programs offered by local (and state) health departments have yet to be analyzed thoroughly. The data from the 1974–75 national survey of local health officers suggest important implications of existing administrative and funding arrangements for local health department programs when a "block grant" approach is implemented.

*Although President Reagan's budget message of March 10, 1981 specified a list of programs targeted to be included under the two block grants, it was apparent at the time of this paper's writing that the actual configuration of these grants or the number of block grants was subject to change before they reached their final form. The important fact, however, is that block grants in some form would likely be accepted by Congress along with large budget cuts in the health programs involved.

Data and Methods

With the assistance of the state health officer in each state, an inventory of all "local health departments" was compiled upon which the 1974–75 survey was based. The survey requested information from the local health officer about his/her health department's jurisdiction, organization, finance, functions, and staffing as well as information with regard to the training, salaries, and other characteristics of local health officers themselves. A response rate of 68 per cent was obtained from this national survey of local health officers.

Various findings from the survey have already been reported.[1,11–13] In the first of these papers, three "patterns of organizational structure" were discussed: 1) centralized; 2) decentralized; and 3) shared organizational control. These three terms were used to characterize the operative administrative relationships between local health departments and state and local government. Examples of states which appeared to fall within each category were given.[1]**

After further study and consideration, it has been determined that the administrative relationships between local health departments and state or local governments (particularly local and state boards of health), can be described better by an expanded fourfold typology. This revised typology includes the three original organizational types, as well as a fourth category of "mixed centralized and decentralized structures of organizational control" (see appendix).

In the present paper, the patterns of operative administrative relationships between local health departments and state and local governments described in the fourfold typology are examined together with the observations of local health officers with regard to the following selected characteristics of local health departments:

- sources of local health department funds;
- influence on health department programs;
- primary functions of local health departments; and
- selected constraints on agency activities.

With the aid of these data, consideration is given to the possible implications of the new Administration's move toward block grants and probable program funding cuts for current patterns of intergovernmental relations and local health department programs.

**The New York State Health Commissioner later objected that his state had been wrongly classified as a "decentralized" state when it should have been classified as a "shared organizational control" state.[13]

Current Program Development and Implementation in Local Health Departments

Sources of Local Health Department Dollars

The data displayed in Table 1 clearly indicate that local health departments in states with "centralized" public health organizational structures are funded in a manner very different from the other three organizational types. Both state and federal support are more important to the overall budget of "centralized" departments, providing nearly 50 per cent of their budget. In "decentralized," "shared," and "mixed" forms of organizational structures, local public health agencies are more dependent upon local sources of revenues for the support of programs, although local health departments in "shared" and "mixed" structures do rely on federal and state funds for over one-fourth of their budget. It is, therefore, likely that program directors of "centralized" departments, more than those under other administrative arrangements, will be influenced more readily by forces external to the local community.

Influence of Selected Individuals and Agencies on Local Health Department Programs

The data in Table 2 clearly demonstrate that local health officers in all four structural arrangements tend to view themselves as relatively important influences on local health department programs and priorities. On the other hand, the state board of health tends to be considered relatively unimportant in all modes of administrative organization, even in "centralized" organizations.*** State health departments (and presumably state health officers) are considered very important in all organizational arrangements. While

***The finding that health officers from all modes of administrative organization consider the state board of health to be a relatively unimportant influence on their health department programs may be due to the fact that some states have no state board of health at all or that such bodies, although in existence in a number of states, may be quite powerless.

TABLE 1—Sources of Local Health Department Dollars by Pattern of Organizational Structure*

Sources of LHD Dollars	Patterns of Organizational Structure			
	Centralized %	Decentralized %	Shared %	Mixed %
Federal Per Cent	11.8	8.6	6.1	7.1
State Per Cent	36.5	12.0	24.0	20.2
Local Per Cent	44.6	67.4	61.6	62.6
Fees-for-Service Per Cent	4.5	6.8	4.3	3.9
Per Cent from Other Sources	1.1	2.5	1.3	3.0

*Percentages reflect averages of estimates by individual health officers of the proportion of department revenues from various sources; thus, columns do not add to 100 per cent.

TABLE 2—Attributed Influence of Selected Individuals and Agencies on Local Health Department Programs by Pattern of Organizational Structure*

Selected Individuals and Agencies	Patterns of Organizational Structure			
	Centralized %	Decentralized %	Shared %	Mixed %
Health Officer	67.8	67.8	67.0	59.8
Local Board of Health	18.9	63.2	69.1	67.7
State Health Department	76.0	56.4	60.9	57.5
Consumers	32.8	25.3	28.2	32.3
State Board of Health	18.3	13.2	11.8	17.3
Local Government	40.8	45.9	37.6	41.7
State Legislature	36.4	15.5	13.6	8.7
Other	6.2	7.4	3.6	5.5

*Local health officers were asked: "In establishing your local health department program priorities, what person or groups have strong influence? (circle *three strongest* influences)." Data in this Table reflect the percentage of respondents who listed a given source of influence among the three strongest. Percentages in either columns or rows will not add to 100 per cent.

they are most important in "centralized" organizations, they are of at least moderate importance in the other organizational forms. Local boards of health are also viewed as rather important influences upon the programs and activities of local health departments in all structural arrangements except those in "centralized" structures.‡

The state legislature is viewed as only moderately important in "centralized" organizations and of practically no importance in the other three types. Furthermore, local governments and consumers are thought to be no more than of moderate influence on health departments of all types.

These data seem to indicate that local health officers view themselves as having a relatively high degree of administrative autonomy (if the high degree of influence can be interpreted this way), but they otherwise give credit to very different individuals and entities in sharing this highest level of influence on departmental programs.

‡The finding that local health officers in "centralized" structures do not feel that local boards of health are important influences on their departments' programs may be due to the fact that in many such cases local boards of health do not exist.

Perceived Primary Functions of Local Health Departments

The data in Table 3 reveal that all public health departments at the local level view working toward the prevention of disease as part of their mission. There are three findings which suggest differences in "primary functions" of the four types of organizational structures: 1) "shared" structured departments are more involved in environmental surveillance activity; 2) "mixed" forms of organization are more involved in public health education; and 3) "centralized" organizations are more involved in direct patient care delivery while giving less emphasis to local health code enforcement. Health departments with stronger local control and influence appear to have placed more emphasis on local code enforcement.

The direct delivery of medical care services is a matter of considerable significance to the understanding of the position of local health departments in their local health care

TABLE 3—Perceived Primary Functions of Local Health Departments by Pattern of Organizational Structure*

Services Provided	Patterns of Organizational Structure			
	Centralized %	Decentralized %	Shared %	Mixed %
Environmental Surveillance	69.8	66.5	81.8	66.1
Disease Control	39.2	30.8	33.1	33.1
Disease Prevention	81.4	73.1	68.7	76.4
Direct Medical Service Delivery	40.1	25.8	18.2	20.5
Coordination of Services	20.1	25.9	20.7	22.1
Public Education	19.8	22.0	24.3	32.3
Health Code Enforcement	24.1	46.4	40.7	44.1
Statistical Record Compilation	11.3	15.0	18.5	13.4
Other	1.7	4.9	1.5	1.6

*Local Health Officers were asked: "What are the primary functions of your Health Department? (Please circle the *three most important* functions)." Data in this Table reflect the percentage of respondents who listed a given function among the three most important. Percentages in either columns or rows of this table will not add to 100 per cent.

environments. The fact that local governmental and advisory bodies are not considered by "centralized" organizations to be of great influence on their programs may account for their relatively low organizational commitment to provide "traditional" health department services, such as local code enforcement, as contrasted with a relatively high commitment to less traditional services, such as direct medical care. Departments having "decentralized," "shared," and "mixed" structures do not seem to deliver direct medical care services as frequently as "centralized" organizations.

Perceived Importance of Selected Constraints on Agency Activities and Programs

According to the data in Table 4, the constraints perceived to be of greatest importance in all four organizational forms are familiar ones: personnel, facilities, and funds. Although some minor variations exist, other constraints appear to be relatively less important in comparison.

Patterns of interest among other responses pertain to the constraints imposed on local health departments by state health departments, local governments, and local boards of health. As might be expected, the directors of "centralized" organizations perceive the state health department's priorities as being of relatively high importance while constraints placed on them by local governments and local boards of health are of less importance. On the other hand, departments which function within "decentralized" structures tend to perceive constraints imposed by local government as being of greater importance than those imposed by local boards of health and state government. "Shared" and "mixed" structures tend to encourage the attribution of greater significance to state health department priorities, local government, and, to a lesser extent, state boards of health, as constraints on the activities and programs of local health departments.

Implications of Anticipated Block Grant Funding on Intergovernmental Relations in Public Health

Although the data reported here were collected several years ago and deal only with the attitudes of local health officers on selected issues, they do provide some degree of baseline against which the changes likely to occur in federal and state govenmental funding of public health programs can be measured. There are two respects within which these data are important in the current period: 1) they allow us to anticipate the effect of proposed public health funding formulae on intergovernmental relationships between local health departments and agencies of state and local government; and 2) they provide a means of anticipating the likely impact of these changes on the programs of local health departments. Although they are related, these are quite separate issues.

The data from the 1974–75 survey, along with what is currently known (early 1981) about the probable shape of federal block grant programs in the human services area, would suggest that the relative influence of state governments, including state health departments, will be enhanced. Even programs that now involve direct federal-to-local allocations of funding (e.g., community health centers) will likely become part of the new federal-state-local block grant arrangement. The added complication of considerable reductions in the overall levels of funding for human services programs will mean that more constituencies will be forced into competition for a smaller total dollar allocation and that many more constituencies will be making their cases before the same administrative/fiscal agent. If state health departments are designated as the fiscal agents for public health block grant programs (and there may be some latitude given to the states on the assignment of this responsibility), then we would expect that those organizations that have already-established linkages with these state agencies (and especially where the local public health agency has some degree of administrative accountability to the state agency), should be in a more favored competitive position with respect to the allocation of block grant funds. Thus, we would expect local health departments in "centralized" organizational structures to be in a more favored position under a block grant funding arrangement.

Despite this likely position of competitive advantage, block grant funding may present far more serious financial problems for centralized departments. Since local health departments in "centralized" states are more dependent on

TABLE 4—Mean Importance of Selected Constraints on Local Health Department Programs by Pattern of Organizational Structure*

Selected Constraints	Patterns of Organizational Structure			
	Centralized	Decentralized	Shared	Mixed
Lack of Staff	1.5	1.6	1.7	1.7
Lack of Facilities	1.8	1.9	2.0	2.0
Lack of Funds	1.4	1.5	1.4	1.5
State Health Department Priorities	1.8	2.0	1.8	1.8
Local Government	2.1	1.8	1.9	1.9
Local Board of Health	2.5	2.0	2.0	2.0
Medical Society Influence	2.3	2.2	2.2	2.0
Legal Constraints	2.5	2.3	2.3	2.2
Lack of Consumer Influence	2.5	2.4	2.3	2.4
Other Professional Groups	2.6	2.5	2.5	2.3

*Scale ranges from 1 to 3: 1 = very important; 2 = somewhat important; and 3 = unimportant.

funding from state and federal sources (nearly 50 per cent of their funding), these agencies could suffer most from significant changes in program priorities and funding allocation decisions. Because of their relatively lower level of dependence on federal and state funding, the local health departments of "decentralized" states might be expected to experience relatively little *direct* effects of these changes. Departments in "shared" and "mixed" structures, which receive over one-fourth of their funding from state and federal sources combined, may actually find themselves being more dependent on state health priorities than at present as they compete for scarce funds.

Decentralized departments may experience "indirect" effects of these changes as local governments experience cutbacks in other areas of federal and state governmental support. If changes in support for local highways, schools, or other public services are reduced, health agencies may be forced to incur funding reductions as well. The absorption of current federal-local programs within proposed block grant funding formulae, as mentioned above, will naturally affect the attribution of influence to state agencies over current "decentralized" health agencies and programs. Future studies of local health departments and their directors may be expected to reflect these reorientations.

In summary, the most likely development from any block grant formula arrangement is the enhancement of administrative control by state health agencies over those at the local level. There may be opportunities here for the introduction of more effective forms of planning on a statewide basis as well as the opportunity for stimulating a cooperative relationship between the local health department and related programs and agencies at the community level.

REFERENCES

1. Miller CA, Brooks EF, DeFriese GH *et al:* A survey of local public health departments and their directors. Am J Public Health 1977;67:931–939.
2. Lawrence PR, Lorsch JW: Organization and Environment: Managing Differentiation and Integration. Homewood, IL: Richard D. Irwin, Inc., 1969.
3. Sundquist JL, Davis DW: Making Federalism Work: A Study of Program Coordination at the Community Level. Washington, DC: The Brookings Institution, 1969.
4. Dye TR: Politics in States and Communities, Third Edition. Englewood Cliffs, NJ:Prentice-Hall, Inc., 1977.
5. Stephens GR: State centralization and the erosion of local autonomy. J of Politics 1974;36:44–76.
6. Lovell CH, Kneisel R, Neiman M, *et al:* Federal and State Mandating on Local Governments: An Exploration of Issues and Impacts. Riverside, CA: Graduate School of Administration, University of California, 1979.
7. Advisory Commission on Intergovernmental Relations: State Mandating of Local Expenditures. Washington, DC: US Govt Printing Office, 1978.
8. Townsend W: The Effect of Social Groups upon the Variety of Local Health Department Services. Doctor of Public Health Dissertation, University of Pittsburgh, 1968.
9. Gottschlich LO: Millions may lose care: the administration's proposed budget. Health Law Project Library Bulletin 1981;6:51–58.
10. Health Systems Report 1981;10:3–4.
11. Miller CA, Gilbert B, Warren DG, *et al:* Statutory authorizations for the work of local health departments. Am J Public Health 1977;67:940–945.
12. Brooks EF, DeFriese GH, Jain SC, *et al:* Local public health departments and their directors in North Carolina and the United States. NC Medical J 1976;37:293–298.
13. Miller CA, Moos MK, Kotch JB, *et al:* Role of local health departments in the delivery of ambulatory care. IN: Role of State and Local Governments in Relation to Personal Health Services, Jain SC (ed). Am J Public Health (supplement) 1981;71:1–95.
14. Leavy WF: On the state of New York's public health organization. (Letters to the Editor) Am J Public Health 1978;68:273.

APPENDIX

Classifying State Health Departments by Form of State-Local Administrative Structure

At the outset of the 1974–75 survey, each state health officer was contacted to provide lists of the local health departments in their respective states and a current copy of their state's public health statutes. During the winter of 1974–75, these statutes were examined by members of the study team and organization charts reflecting the statutes' descriptions of state-local public health administrative structures were drawn.

A comparison of the charts developed from the statutes with the actual organization chart provided by the health officers or their delegates from ten states indicated, as expected, that the statutes could not be relied upon to provide accurate indications of actual health department organization. Telephone calls to state health officials in three additional states—Massachusetts, Missouri, and Pennsylvania—were made to clarify their public health organizational structure. Massachusetts and Pennsylvania were selected because they were unique in different respects. Massachusetts had over 100 local health officers (an apparently complex organization), yet its statutes provided little information that could be used to draw an organization chart that reflected the public health structure, particularly at the local level. Pennsylvania's statutes were currently being revised and, therefore, were of little use in reflecting public health organization. (The telephone call and a letter from the deputy commissioner in Massachusetts indicated that the Commonwealth was also entering a period of reorganization.) Missouri, by contrast, was selected because its public health organization appeared stable and its statutes were clear with respect to organization structure. A telephone call to the state health director's office confirmed that Missouri was one of only a few states whose statutory organization resembles its actual organization.

Organization charts were obtained from the remaining 34 states by sending each state health officer or a deputy with whom we had previous contact a copy of the chart we had drafted with information from the applicable statutes and a form cover letter.* The letter noted that our chart "may not

*Delaware, Rhode Island, and Vermont did not have local health departments. The deputy commissioner in Massachusetts also received a letter requesting an organization chart, but, as he had just previously been contacted by telephone, his letter varied from the form cover letter sent to other states.

accurately reflect the current functional organization of public health services" in the state. It requested that the respondent "correct our chart to conform to the actual organization of public health agencies at all levels."

Responses (some provided after making follow-up telephone calls) were used to classify states by organization type as described in this paper. Definitions of each organizational pattern and the list of states belonging in each pattern are as follows:

Centralized Organization: Local health units that function directly under the state's authority and are operated by a state department of public health or a state board of health, sometimes through regional administration and sometimes with the help of a local advisory board. (Examples: Arkansas, Connecticut, Florida, Hawaii, Louisiana, Maryland, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Dakota, South Carolina, Tennessee, and Virginia.)

Decentralized Organization: Local government (a city, township, county, or some combination) operates a health department either directly or with the intervening authority of a local board of health. Advice and consultation are offered by the state health department to the local board of health, the local health department, or both. (Examples: California, Idaho, Illinois, Iowa, Kansas, Maine, Massachusetts, Nebraska, New Hampshire, North Carolina, Ohio, Oregon, South Dakota, Texas, Utah, and Washington.)

Shared Organizational Control: Local health departments are operated by local government either directly or through a local board of health. In certain circumstances these same health departments also fall under the authority of the state health department. For example, a state health department may retain appointive and line authority over local health officers who are also responsible to local boards or commissions. In some cases, local departments are required to submit program plans and budgets to the state health department in order to qualify for federal and/or state funds. (Examples: Alaska, Colorado, Georgia, Indiana, Kentucky, Michigan, New Jersey, New York, Oklahoma, and West Virginia.)

Mixed Centralized and Decentralized Structure of Organizational Control: Local health services in the same state may be provided either by the state health department or by local governmental units or local boards of health. (Examples: Alabama, Arizona, Missouri, Pennsylvania, Wisconsin, and Wyoming.)

NCHSR Computer Tapes Available from 20 Health Services Research Projects

The National Center for Health Services Research undertakes and supports research, demonstrations, and evaluations on problems in the organization, delivery, and financing of health care services; serves as the focal point for coordination of health services research within the Public Health Service; and disseminates the findings of health services research to policymakers and decisionsmakers in the public and private sectors. The following computer data tapes and documentation from 20 projects supported by the NCHSR are for sale to the public and are applicable to a wide variety of research, training, and other health care activities.

- AAMC Longitudinal Study of Medical School Graduates of 1960
- ADTECH—Impact of Administrative Technology on Acute Bed Need
- Automated Problem-Oriented Medical Information System (PROMIS)
- Clinic Simulation Model
- Determinants of Service Intensity Data Tape: Reabstracted Professional Activities Study Data and AHA/AMA Data for 17 Study Hospitals
- Emergency System Simulator: Overview, User's Guide, Flow Chart (Software Tape)
- Experimental Health Services Delivery Systems Family Health Survey
- Financial Planning Model for Health Maintenance Organizations
- Health Services Utilization and Expenditures, 1970 Survey
- Hospital Management Systems Demonstration
- ICDA-8 Abbreviation Tape, List Programs, and Update Program
- Long-term Care Alternatives: Section 222, Day Care and Homemaker Demonstrations
- Medical Group Practices Study
- Neighborhood Health Center Household Surveys
- New Medical Care Delivery System
- The Nursing Home Simulation Model Users Manual
- Patterns of Ambulatory Care: Evaluation Research Project—Clinic Data Base Tape
- Plan: A Computer Model for Planning Locations, Capacities, and Schedules of Outpatient Facilities
- Responses of Canadian Physicians to the Introduction of Universal Medical Care Insurance: The First Five Years in Quebec
- World Health Organization/International Collaborative Study of Medical Care Utilization

The computer tapes and documentation vary in price. NCHSR has a pamphlet—DHHS Pub. No. (PHS) 81-3287—which describes the data sets, explains their availability, and lists current prices. The pamphlet may be requested from: USDHHS/PHS, Office of Health Research, Statistics and Technology, National Center for Health Services Research, 3700 East-West Highway, Hyattsville, MD 20782.