

COMPREHENSIVE HEALTH PLANNING IN THE UNITED
STATES: A REVIEW OF PUBLIC LAW 89-749

Thesis for the Degree of M. U. P.

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CAMILLA J. KARI

1976

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ABSTRACT

COMPREHENSIVE HEALTH PLANNING IN THE UNITED STATES: A REVIEW OF PUBLIC LAW 89-749

By

Camilla J. Kari

In recent years, there has been a growing interest in health concerns by Americans, an interest expressed in aspects ranging from fad diets to air pollution. Interest has also extended to the health care delivery system itself, where the supply rarely matches the need. Recognition of these two important facets of health was acknowledged by the federal government in 1966, with the passage of Public Law 89-749, Comprehensive Health Planning.

In order to properly appreciate the difficulty of its ordained tasks--to develop a holistic context for health, and to coordinate public and private health resources, are tasks which had never been undertaken before, elements of health planning as a discipline must be examined. All of the parameters of the health care delivery system are mentioned in order to highlight the magnitude of P.L. 89-749's mission.

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The law is then set in historical perspective, showing the gradual awakening of social consciousness which led to its development.

Comprehensive Health Planning's actual experience in implementation is then examined. The concept of health in government offers valuable lessons in terms of bureaucratic conflict and cooperation. CHP was instituted from the Federal level, and implemented at state and local levels, all three shifting into novel interrelationships. The ways in which the health planning process was implemented, and the various means of enforcement used are then described.

The total Comprehensive Health Planning experience is evaluated in the last chapter. This evaluation occurs against the backdrop of successor, P.L. 93-641, offering a comparative means to assess progress. In this manner, some indications of future trends, and the government's reaction to them, can be interpolated. Since health is a national priority, and some feel it is a right, the need to understand the nature of comprehensive health planning and the government's role in it will assume increasing proportions in the coming years.

In conclusion, I would like to thank all of the members of the faculty of the Department in Urban Planning, but particularly Dr. Carl Goldschmidt, for his time and effort with the draft, and Dr. Thomas Tenbrunsel of the College of Urban Development, for his help in developing the original topic.

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Camilla J. Kari

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CHAPTER I

HEALTH CARE PLANNING

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."--Disraeli.

Good health is probably the single most valued characteristic that an individual can possess. Ultimately it becomes a matter of life and death. In the interim, it makes the difference between comfort and suffering, self-fulfillment and self-limitation. The presence or absence of health affects not only a man's body but his mental capacities, his disposition, his work, his recreation, his relations with others. It insinuates itself into every sphere of life. When present, good health is taken for granted; when not, almost everything else recedes in importance.

The importance of health on a national level is readily acknowledged. Private citizens, philanthropic organizations and government combine to make health care a multi-billion dollar industry. But for all of these huge expenditures, health care is still not easily obtainable for many Americans. A myriad of problems blocks the

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consumer from attaining the national goal of ". . . promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living."¹

The State of Health Care Today

Although most other social services have moved into the realm of government intervention, health has continued to be mainly a private enterprise system. Aside from general public health measures, which are preventive in nature, federally-sponsored medical research, and limited services to special population groups such as veterans, the health industries have operated virtually undisturbed. This laissez-faire attitude is unique to health and certainly a far cry from the nationalized systems of Great Britain and Sweden. It may also be the reason that the United States is third in terms of international health status instead of being the leader. The quality of American medical practice is not in dispute here. Medical education, research, and innovative techniques are excellent in this country. But excellence in theory does not benefit those who have no entry into the health care system in the first place.

The inadequacies of current health services are based on three major aspects--accessibility, availability, and cost. Accessibility is composed of a variety of factors: geographical location, inadequate facilities, organizational gaps in service and administrative

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restrictions. Inner city residents may have a panoply of prime medical facilities available to them across the city, but cannot gain access because of transportation difficulties or unfamiliarity with administrative complexities. The number of physicians in such localities is small and their caseloads heavy.

Availability is based on the absence of medical facilities or manpower. Rural areas are most often cited as experiencing this problem. However, availability is also encompassed in more subtle terms. There is a dearth of secondary-care alternatives. Care may be available only in terms of lengthy expensive bus rides. The schedules of medical offices and outpatient departments do not usually coincide with the needs of the working poor.

These factors also affect the financing of medical care. Those who cannot afford fee-for-service may be eligible for government subsidies, free or low cost care. However, subsidiary costs in terms of wages lost, transportation and child care may prove a heavy burden to one who lives on the edge of his income.

Medical care, through the combination of the private and government systems, is available. However, these services, because of extraneous factors, are not used until necessary. Studies² show that medical care is income-elastic and that preventive care, on the opposite end of the continuum from emergency treatment, is underutilized, even by those who can afford it.

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Part of the problem lies in proper education of the public. The plethora of recent advertisements for prevention of various diseases is attempting to alleviate this. However, the basic concept of medical care in the past has been disease care, not health care. The basic philosophy has been treatment, not prevention. Aside from the recent phenomenon of health maintenance organizations, medical, hospital and insurance institutions have emphasized illness, not health. A satisfactory state of health cannot be achieved without change in the basic health concept.

What is health? Some would say it is the absence of morbidity, ailments, or defects. Others would call it a state of physical or mental well-being. Certainly the latter positive definition is preferable. It allows room for the broader concept of health, one that is not generally considered at first association. A positive state of well-being results from a benevolent physical and mental environment. H. L. Mencken put it thus, "What is the thing called health? Simply a state in which the individual happens transiently to be perfectly adapted to his environment." In order to achieve the national health goal cited above, health systems must be correlated with those insalubrities that exist in society which create a state of non-health.

These two thrusts, administrative reorganization of the current health system to increase accessibility and efficiency, and the interrelationship of health with

non-health factors are mutually beneficial. An increasingly healthful environment reduces the need for curative medicine and leaves room for preventive medicine. Preventive care, in turn, creates an efficient system for ensuring a healthful environment.

Problem Rationale

An attempt to introduce this broader concept of health into the current system was instituted by the federal government in 1966. P.L. 89-749, Comprehensive Health Planning, was an innovative step designed to perform two functions: to coordinate health services in order to increase efficiency of resource allocation, and to expand the basis of health by coordinating it comprehensively with other social services. Thus, planning was to take place on dual planes, vertical coordination of health organizations and horizontal cooperation with other forms of planning.

In order to arrive at an assessment of this law since it was adopted, several factors had to be considered. To properly appreciate the difficulties facing such an undertaking, the complexities of the health system are outlined in Chapter II. Here, the elements of health are divided into those factors which determine a state of well-being. Aspects which constitute the health care delivery system also comprise a part of the total health picture. Health activity types describe the variety of services which a health system provides. Health resources are the

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basic materials which produce health care. Health goals describe the dual nature of the health system as administrator and producer. The decision makers involved in health make up the audience by whom each program is scrutinized.

Since P.L. 89-749 was an innovation in terms of government entry into the health administrative function, it would be valid to examine the historical trends which led to its development. The importance of the law in legislative history rests on the legal bases of past decisions and an expansion of the concept of the federal role in health. Equally important is an understanding of the Constitutional limitations of government intervention. Such a survey in Chapter III serves to indicate the changing ways of thought that brought us to the present, and points an arrow to future directions.

The actual implementation of P.L. 89-749 is described in Chapter IV. The forms and functions of Comprehensive Health Planning in all of its components are explained, as well as the administrative problems which confronted health planners in attempting to organize such a function. The difference between theory and practice provides significant guidelines for future experiences.

The planning aspect of the law is discussed in Chapter V. With a dearth of specific health planning techniques, the methods and forms of health planning as derived from the Comprehensive Health Planning experience form an

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important foundation for future progress. The ways in which Comprehensive Health Planning performs its horizontal cooperation with other forms of planning is also considered, in order to assess the practicality of such cooperative arrangements.

Chapter VI concludes with recent developments and places P.L. 89-749 in current perspective. An examination of the bill's strengths and weaknesses provides a necessary background for assessing its successor, P.L. 93-641, the National Health Planning and Resources Development Act, which attempts to rectify discovered inadequacies.

The evaluation of Public Law 89-749 was accomplished with a minimum of direct secondary sources. Since the law had been implemented fairly recently, some agencies were still in the organizational stages. Most research disclosed only rhetorical debate on the merits of the Act, while concrete materials were available only from working agencies. Thus, emphasis was placed on primary sources: legal materials, speeches, unpublished guidelines, and working documents. Journal articles were used to supplement these, since texts on health planning are still at a minimum.

Because comprehensive health planning is a discipline as well as a legal mandate, the latter is distinguished from the former by the use of capital letters.

Since the federal programs have unwieldy titles, they are

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¹U.S. Congress, Public Law 89-749: Comprehensive Health Planning and Public Health Services Amendments of 1966. 89th Congress (Washington, D.C.: U.S. Government Printing Office, 1966), p. 1.

²American Medical Association, The Cost of Medical Care (American Medical Association, 1964) and Herbert Klarman, The Economics of Health (New York: Columbia University Press, 1965).

CHAPTER II

ELEMENTS AND PARAMETERS OF
HEALTH PLANNING

The need to define comprehensive health planning arises from the relative novelty of the concept. Although problem-specific planning had previously occurred, it was not seen in a system context. Planning was disease-oriented for the most part, with occasional forays into the delivery of services, i.e., as performed by health and welfare councils. But comprehensive health planning was to encompass problem-specific action, systems administration, accessibility, availability and delivery of services, and is now encouraged to look into alternate payment mechanisms. All the threads of the health network are within the loom of comprehensive health planning and health, in turn, is interwoven throughout the fabric of modern society. Therefore, the scope of chp has a theoretical field of involvement that ranges from housing standards to multiple sclerosis.

Health Determinants

By consensus of the various agencies,¹ the determinants of health were seen to be four: properties of the

environment, properties of the health care delivery system, properties of behavior, and properties of heredity. In order to recognize fully the scope of dealing with such a large problem area, the components of each of these determinants will be briefly listed in Table 1. Properties of the environment have long been included as part of the health problem, particularly in terms of sanitation. Local public health departments have always been concerned with environmental quality on a limited scale. The 1970 Census rated environmental conditions for the first time, an expansion from the assessment of conditions only within the four walls of a structure. General environmental determinants of health are composed of nutrition and food quality, waste systems management and vectors of disease such as insects and rodents. Housing involves structural safety, ventilation and efficiency, while crowding deals not only with unit density, but privacy on a neighborhood scale. Pollutants of land consist of litter and erosion, pollutants of water are composed of effluents and run-off, and emissions and noise pollute the air. Mental health, often environmentally related, is concomitant with physical health in these factors.

Properties of the health care delivery system are based on qualities necessary to the effective functioning of any societal system. Its basic components are accessibility not only in terms of geographic location but transportation and entry into the system through administrative procedure.

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Table 1
Determinants of Health

1 -	Properties of the environment:	2.	Properties of health care delivery system:
	a. nutrition		a. accessibility
	b. sanitation		b. availability
	c. vectors		c. affordability
	d. housing		d. continuity
	e. crowding		e. comprehensiveness
	f. work place		f. quality
	g. education		g. humaneness
	i. pollutants in:	3.	Properties of behavior
	i. land		a. abusive habits
	ii. water		b. personal hygiene
	iii. air		c. use of delivery system
		4.	Properties of heredity
			a. congenital defects
			b. tendencies towards certain diseases

Source: Adapted from "Guide to Plan Document Development," Community Health, Incorporated.

Availability is another component, in terms of medical care for population groups, ethnic or socioeconomic, and in terms of time, since health is a twenty-four hour affair. Cost is measured not only in terms of physician fee or hospital stay, but other peripheral expenses, such as medication. Continuity of care involves follow-up or preventive treatment, and is related to education, accessibility and affordability. There is also a need for comprehensiveness of care, a systems approach not only administratively but medically, since the practice of referral is not practical for all population groups. Quality is an aspect only now concerning consumers, the quality of practitioner standards as well as quality control of medical care; and finally, humaneness, long discussed, little practiced, where the emphasis on technological efficiency can contradict the problem itself, a human being in need of help.

The properties of behavior involve both old and new problems. Abusive habits, such as alcohol and tobacco, have been on the scene for years, but the widespread abuse of drugs in this country is relatively recent. Personal hygiene and nutrition habits are still a cause for re-education, since common-sense health seems to have little popular appeal (witness the need for accident prevention commercials). The use of the delivery system is a preventive type of health behavior, which also requires education, since the majority of the population sees health care as

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primarily treatment care. "Get a check-up" advertisements for a plethora of ills are attempting to combat this kind of medical use.

Properties of heredity such as congenital defects and tendencies towards certain diseases are primarily seen in the postnatal context. Here again, preventive measures are emphasized since the only other alternative is extensive research and treatment. Public education and fund-raising is a major function of voluntary groups.

Health Activity Types

The properties which determine the relative health of a population are spread over a broad spectrum. Health activity types, while not so far-ranging, are also involved in a variety of areas as shown in Table 2.

The first type, preventive medicine, apart from quarantine measures, is a fairly recent phenomenon, and ranges from vaccinations, environmental controls and family planning to televised warnings about the dangers of high blood pressure.

Diagnostic activities are those traditionally conceived of as health care. Treatment can be divided into those which occur by place: at home, ambulatory locations or in-patient facilities. Treatment can also be divided by specialty--medical, dental and psychological, and further subdivided by level of specialization--primary, secondary

Table 2

Health Activity Types

1. Preventive activities	3. Rehabilitation activities:
a. environmental control and services	a. by specialty:
b. education, communication	i. physical therapy
c. counselling	ii. occupational therapy
d. prophylactic procedures	b. by place (see 2a)
2. Diagnostic and treatment activities:	4. Custodial activities:
a. by place:	a. home care
i. home	b. domiciliary care
ii. ambulatory locations	c. nursing homes
iii. in-patient facilities	5. Transportation activities (getting patients to services):
b. by specialty:	a. emergency
i. medical	b. public
ii. dental	6. Communication activities:
iii. psychological	a. between patient and system
c. by level of specialization	b. between components of system
i. primary	7. Quality improvement:
ii. secondary	a. licensing of manpower, facilities
iii. tertiary	b. continuing education
d. by intensity of care:	
i. emergency	
ii. acute	
iii. chronic	

Source: Adapted from "Guide to Plan Document Development," Community Health, Incorporated.

and tertiary. Related to the level of care is intensity: emergency, acute, chronic, and ambulatory.

Rehabilitation is often a forgotten part of medicine. Not only are the physically handicapped included here, but the mentally ill and those recuperating from addiction to abusive substances. Rehabilitation in a criminal/medical sense is also involved in the psychiatric treatment of prisoners.

Custodial care usually engenders visions of a state mental hospital, but also includes care of the physically and mentally handicapped, and the aged.

Transportation is a neglected part of health. Although ambulances traditionally brought the patient to trained care, the paramedic concept is bringing emergency care to the patient. Non-emergency transportation is being initiated for the elderly and some experiments are being made to provide such service to low-income groups.

Communication may seem odd as a health activity, but it warranted a special television program on the difficulties patients have in talking to and understanding medical staff. As well as educating the consumer into the health system, communication activities involve components between the system and constitute the mainspring of health planning.

Quality control has been a health activity type practiced by professionals. Now this activity, like others, is moving into the consumer participation arena. Besides the initial licensing of manpower and facilities, continuing

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Health Resources

One of the elements of health that most closely affects planning is health resources, since one of the major functions of any planning is resource allocation. Table 3 shows the contents that health resources are composed of. Knowledge, research and data are all paramount resources. These can be divided into areas of expertise. Manpower, in the varying degrees of skill and specialty that the health field requires is of continual concern, since the supply does not always match the need.

Facilities of all degrees, from specialized hospitals to neighborhood drug centers all contribute to the health system directory. Equipment is often expensive to purchase, staff and operate but plays an increasingly large role in modern medical care. This element must also be kept in balance; its lack or overduplication detracts from an efficient health system. Funding is a resource that is derived from a variety of sources.

Health Goals

To further complicate matters, health planning, in line with different approaches, also has different goals. Health status goals are medical in nature, dealing with morbidity and mortality rates, infant and maternal deaths,

Table 3

Health Resources

1. Knowledge/technology:	4. Equipment:
a. environment	a. radiation
b. education	b. laboratory
c. physical health	c. surgical
d. mental health	d. pollution control devices
e. genetics	e. ambulances, buses
2. Manpower	f. communication systems
a. environmentalists by specialty	5. Money: (Sources of)
b. educators	a. individual payer
c. dentists	b. third-party payers
d. physicians by specialty	i. private
e. nurses	ii. government
f. pharmacists	c. philanthropy
g. veterinarians	d. grants
h. paramedicals by type	
3. Facilities:	
a. schools by type	
b. pollution control plants by type	
c. in-patient facilities by level of care types	
d. out-patient facilities	
e. sheltered workshops	
f. rehabilitation centers	

Source: Adapted from a "Guide to Plan Document Development," Community Health, Incorporated.

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and other disease-specific statistics. These aspirational goals represent the ultimate aims of health planning, the elimination of morbidity-creating factors and achievement of a satisfactory national health status. These broad statements consist of stable policies, a desired end, which operate in a very long time frame. The emphasis is on the future state, not necessarily feasible in the present. These goals can be very philosophical in nature, i.e., a physical and social environment conducive to safe and healthful living; or unattainable due to present technological or system inadequacies, i.e., elimination of all incidences of glaucoma.

Health system goals are administrative in nature, dealing with functional and organizational services. Philosophy is incorporated here in a more specific manner, dealing with the agency's approach to planning and its implementation of plans. Organizational goals are also fairly stable, but remain in the realm of the foreseeable future. Therefore, they are flexible and subject to change as situations progress. Health system goals are specific statements describing the agency's role in the community health system, i.e., its establishment as the primary contact for provision of health problem and resources information in the area; or the changes it hopes to implement by playing this role; i.e., the resolution of health system conflicts and issues by public discussion and coordinated action.

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The Participants

Another of the factors that makes health planning such a complex endeavor involves the broad range of population called into play during its various phases. Participants are basically made up of consumers, providers, and government officials. Consumers are composed of the entire population represented by a selected number of citizen participators, who may represent specific interests. Providers include hospital representatives and other health facilities, private practitioners and third-party payers, who contract for services. Straddling between providers and government officials are public health officials, who perform both provision and regulation of services. Health planning staffs are funded by government money and generally work within its administrative network. The legislature is called upon to enact supportive legal devices and various elected and appointed public officials have the responsibility of carrying out these directives. Moreover, each of these actors in the health planning scene has his counterpart on the local, state and national levels. With a wide spectrum of participants and a complex hierarchy, merely organizing a comprehensive health planning schema is a difficult task, not to mention its smooth and continuous operation.

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Health Planning in Context

Yet another aspect in the multi-faceted reality that confronts health planning is fitting it into the larger picture. Since health does not exist in a vacuum, health planning must be compatible with other forms of planning that involve a variety of social dimensions. Rein goes so far as to state that the traditional functional allocation of resources within a single social sector is inefficient and suggests investment in non-health programs to maximize health.² Roemer concurs, "For the very essence of planning is to analyze the total landscape of health needs in populations, and this cannot be done along the parochial channels of particular diseases . . . persons, or . . . agencies. Planning requires rather the viewpoint of 'community' . . ."³

This interrelationship is reiterated by Kissicks's rhetorical viewpoint.

Health planners must consider the social activities related to . . . the various health programs, for no planning can be effective out of context. Health is a social concern, closely related to a variety of social concerns, and we return to parochialism if we consider it as a separate entity.⁴

There are two major reasons besides fear of parochialism for considering health in a larger context. One is that in order for planning to fulfill its dual purpose of resource allocation and coordination, it must work with areas of activity which affect health, such as industrial sanitation, safety, air pollution control and care of the mentally ill, which present problems of funding,

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quality of service, establishment of standards and multiple agency interests. Simultaneously, many agencies other than health become involved in services with health implications and various skills from other agencies may approach the same problems differently. With appropriate interagency planning, these duplications can be ironed out to a significant degree.⁵

Another reason for encouraging interdisciplinary cooperation involves implementation of health plans. As Elling states,

. . . to assess the power budget available to the health planner, one must realize how the bases of power have come to be distributed through complex changes, internal and external, to the health system. These have entailed fluidity in power relations, a more prominent place for health concerns generally in society . . .⁶

Not only must society be related to health in the status quo, but health concerns change with the times, reflecting social changes. According to Engel, changes in society "have a specific and dominating influence on the philosophy of health planning . . . there is hardly any manifestation of modern social and economic life without influence in this aspect. Planning for health must therefore always be integrated with socioeconomic development planning."⁷ Some of the modern social concerns that affect physical and mental health can be traced to urbanization, affluence, social services trends, education, ecology, synthetic environmental factors (toxics), and aging.

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Cooperative efforts between specifically urban planning, which is comprehensive in touching upon all social aspects, and health planning, have been largely neglected. There is a dual cause for a partnership between these two fields. Urban planning's experience with goal formulation, invention and testing of alternatives, implementation and evaluation methods has high potential applicability to health planning. Moreover, health planning concerns have come to overlap those of urban planning. An article in one planning journal states, "Understanding and projecting the urban context is basic to anticipating future health needs. Changes in urban development patterns, population distribution and transportation systems influence local health needs and affect decisions regarding health programs and facility sites."⁸

Until now, little correlation has existed between the two disciplines. The American Institute of Planners cites two reasons for this. For one thing, the health planning movement has come to be recognized as a forceful element only recently. The planning that did take place operated in a fragmented manner, offering no central clearinghouse for urban planners to make contact. There has also been a hostile atmosphere between the two groups; health administrators often felt that health was a specialized field outside the scope of generalists, and urban planners rejected entry into health because of narrow, land-use definitions of planning. Limited resources, lack

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of knowledge and the discrepancy between urban and health planning regions all contributed to a spirit of alienation.⁹

With the introduction of a formalized mechanism for comprehensive health planning, some of these barriers to cooperation have been removed. The urban planning agency can now be represented on health councils, share data on health facilities and services, use such data in community plans, coordinate zoning variances with need, and maintain formal working relationships with its health planning counterparts.

With the emphasis placed by theorists on health as part of the total environment, the failure of chp and urban planning to optimize collaboration negates the basic purpose inherent in both forms of planning, that of being truly comprehensive. Now that health planning has an acknowledged place in the government structure, its acceptance by cohorts should follow swiftly.

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CHAPTER III

THE HISTORICAL BACKGROUND OF HEALTH LEGISLATION

The span of two hundred years that encompasses the history of the American states saw technological and social changes that became reflected in novel needs, concepts and values. Changing ways of life brought new health problems or sharply focused on old insoluble ones. Groping toward a solution was an evolutionary process, as each century brought about an expansion of the concepts of health problems and the government's role in dealing with them. The history of health legislation parallels the dawning political and social consciousness of the nation. A brief synopsis is sufficient to indicate the depth of change that health legislation has passed through, from rudimentary survival measures to sophisticated programming techniques.

The great bulk of precautionary health measures in the fledgling United States arose as a response to the successive waves of epidemiological diseases that were rife at that time. These measures were locally produced and enforced, reflecting the particular medical type and scope of problem afflicting an area. The original regulations

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were also disease-specific, coping not with general health maintenance, but aimed only at containing an epidemic once it had begun. Moreover, this type of law was temporary, in effect only until the crisis passed.

As a point of fact, the first medical-related legislation within the American Colonies occurred in Virginia in 1639. The Assembly ruled that a physician could not refuse treatment of patients who lacked the ability to pay his fee. Most of the other colonies also regulated "chirurgeons and physicians."¹ However, records indicate that most early medical legislation dealt with quarantine against contagious diseases.

Local Quarantine Activities

With the tremendous amount of exploration, immigration and merchant shipping occurring during the seventeenth and eighteenth centuries, isolated populations were especially susceptible to the infectious diseases that were carried aboard sailing vessels. Diseases with high mortality rates, such as smallpox, cholera, and yellow fever were especially feared. Therefore, quarantine regulations were established in Boston as early as 1647 when the Massachusetts General Court ordered a quarantine of all ships coming from the West Indies. By 1790, rudimentary regulations existed in almost all American ports.²

In order to enforce these quarantine regulations, local boards of health were instituted. Petersburg,

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Virginia, set up what was probably the first board of health in 1780, and by the turn of the century, New York, Boston, Baltimore, and New Orleans followed suit. The effectiveness of these agencies varied with the scope of the problem. New Orleans, hardest hit with wave after wave of yellow fever, enforced rigorous standards. New York responded in kind as a result of a particularly virulent epidemic in 1819-22. However, changing medical opinion regarding the efficacy of quarantine exerted political pressure to weaken the authority of the health boards. By the second decade of the nineteenth century the great majority of physicians were anticontagionist and antiquarantine. In 1820, an anticontagionist president on the Philadelphia Board of Health applied "localist principles" and virtually ignored the quarantine laws still on the books. Around the same time, the Boston Board of Health, under attack for its quarantine procedures, was abolished by a new city government, which promptly relaxed quarantine regulations.³

However ineffectual, the concept lingered, and by 1873 there was some form of health board in 124 cities in the United States. This local action preceded state-wide programs. Public health measures were instituted only to meet local situations. State authorities took cognizance of health problems only when pressured by a large number of localities or a major city. The type of problem which precipitated action was still the yellow fever epidemic rife in New Orleans, which resulted in the first state board of

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health in Louisiana in 1855. From then until 1872, only Massachusetts (1869), the District of Columbia (1870), California (1871), and Virginia (1871) had established state boards of health.⁴ After this, state boards of health were included as part of the regular state administrative organization.

Federal Intervention

On a federal level, the first federal health law was in the form of a request from George Washington to Congress on April 3, 1794, for passage of a measure which would allow the Chief Executive to convene the Congress outside the capital if epidemic disease should threaten its members.⁵

Two years later, the question of central government versus states' rights arose in a federal proposal. The debate concluded that the states' right to preserve health and life was inalienable. "The law that finally passed assigned quarantine authority to the states and placed the central government in a permissive supporting role."⁶

Public health services had their beginnings in 1798, when John Adams signed an act on July 16, establishing the Marine Hospital Service for the relief of sick and disabled seamen. Hospitals were erected in port cities and twenty cents a month was deducted from the sailors' wages toward their upkeep. This constituted what is

probably the first prepaid medical plan in the United States.

Other population groups under the direct jurisdiction of the federal government also benefited from medical services. From a post-Revolutionary roster of one surgeon and four surgeon's mates for the Army of 700 men, the War Department by 1812 had a delineated corps of army medical officers. Eventually, there successively evolved the national medical care of Indians, of territorials and of federal employees.⁷

Another attempt by the Congress to intercede in health matters occurred with the Act of February 27, 1813, requiring the federal government to guarantee and distribute effective cowpox vaccine to any citizen who requested it. Its repeal nine years later was followed by a ruling by Supreme Court Justice John Marshall in 1824, stating that health matters were not specifically assigned and therefore belonged to the states under the 10th Amendment.⁸ This had long been the contention of the states' righters. "In the establishment of the Constitution of the United States, the individual states did not cede to the Federal government the responsibility and authority for the preservation of health within their respective borders. They . . . retained this function and . . . have theoretically remained responsible for all health activities."⁹

After the yellow fever scare of 1878 resulted in the establishment of a National Board of Health Act of

March 3, 1879, ensuing opposition by the states rendered the agency ineffective and it was allowed to pass out of existence four years later. After yet another impending epidemic in 1892, the Act of February 15, 1893, finally put quarantine authority, which had been bandied about for over a century, firmly into the hands of the federal government.¹⁰

The Twentieth Century

The beginnings of the twentieth century witnessed little progress in health legislation, with the exception of two portent trends. In 1906, the Pure Food and Drug Act was passed. Its sphere was restricted to the proper labeling of containers; not until 1938 was the regulation of advertising and the inclusion of cosmetics brought into its scope. However, this was the first attempt by the government to legislate peripheral medical concerns; heretofore the focus had been on specialized, immediate problems, such as the control of communicable diseases.

Also in 1906, there occurred a portent in terms of health administration. J. P. Norton, professor of economics at Yale, introduced a bill into Congress calling for the establishment of a national department of health having Cabinet status. The bill died without passage in 1912.¹¹

The First Health Grants

From this rag-bag of events, one trend was to become firmly established, the health grant system. In 1918, the

Chamberlain-Kuhn Act authorized the first program of federal health grants, thereby instituting what was to become the major role of the federal government in health concerns--spending money.

The Constitutional basis for national health activity is not found in any specific grant of power but in the federal powers authorized by the courts as connected with the exercise of the enumerated powers. The principal foundation for federal intervention in health lies in its power to regulate interstate and foreign commerce, the power of taxation and the power to spend money raised by taxation for the common defense and public welfare. The reservation by states over health rights and the spending power of the federal government was to form a peculiar detente over ensuing years.

Following the conservation of World War I, the governments from Harding to Hoover showed little interest in health except that of veterans. An exception was the Sheppard-Towner Act, providing grants to states "for the promotion of the welfare and hygiene of maternity and infancy" in 1921.¹²

The modern era in federal-state relations regarding public health began in 1935 with Title VI of the Social Security Act, which authorized \$8 million annually for training and technical assistance to states and local health work. As Chapman states, "Health had become a respectable political topic, and . . . no political party

dared ignore it altogether . . . it was unquestionably a major watershed in the evaluation of federal health policy."¹³

The federal grant system, particularly for physical facilities, sanctioned by the constitutional basis of expending tax monies for the common welfare, continued to be the main means of federal intervention, but it was an increasingly powerful intervention, signaled by the phrase "annual authorization." Smith explains its significance.

The "new federalism" created by the Social Security Act was characterized by the redistribution of responsibilities for programs to the federal and state governments--from what was formerly a state-local responsibility; by the shift of fiscal balance whereby federal grants become more a necessity than a supplement . . .¹⁴

The Hill-Burton Act

In 1946, Congress enacted the Hospital Survey and Construction Act to provide federal aid to states for surveying needs and developing state plans for hospital construction and financially assisting in such construction. Public Law 79-725, or as it is more familiarly known, the Hill-Burton Act, created hospital planning councils whose major task involved statewide identification of bed shortage areas and the equitable distribution of facilities. According to Hilleboe and Barkhus this act was to become significant for future legislation for several reasons. It was the first time that any systematic statewide planning, albeit in a limited aspect, was required for the expenditures

of federal grants. Secondly, the institution of active local planning bodies, with health provider representatives, was to furnish good experience for a more encompassing program. It was this piece of legislation which provided the impetus for a federal-state partnership. For the first time, there was coordination of facilities planning and standards were set up for health facilities construction and distribution. This thrust toward regulative planning was a forerunner of the Community Health Services and Facilities Act of 1961. Since facilities planning is an integral part of general health planning, some excellent patterns of planning were established, especially in the area of community participation.¹⁵

Besides physical facilities, Congress undertook a sustained investment in medical research. Through a series of National Institutes of Health, beginning with cancer in 1938, heart, mental health, arthritis, child health and so forth, a sum in excess of \$14 billion has been spent over the past twenty years.

The third resource of health manpower was geared into federal aid programs by a series of training acts: mental health manpower in 1948, public-health specialists in 1956 and broad subsidies for health professions education in 1963. These were expanded by the Nurse Training Act of 1964, the Health Professions Educational Assistance Amendments of 1965, and the Allied Health Professions Personnel Training Act of 1966.¹⁶

Norton's idea became reality and health was given administrative acknowledgment when it achieved cabinet status in 1953 with the creation of the Department of Health, Education and Welfare. This created better control of the thrust of federal programs but not the unmanageable proliferation of categorical grants.

The 89th Congress

The period of the sixties was a golden age in terms of health legislation. Faced with the knowledge that despite tremendous expenditures of health resources, health care in the United States did not compare favorably to international standards, Congress and the Johnson administration addressed themselves to the organization, delivery and payment of health services. Two major thrusts characterized the health policy of the mid-sixties: efforts to guarantee the consumers' capacity to purchase health care, and institutionalization of health services. To quote Kissick, "Attention to the financing mechanisms and patterns of organization that shape health-care delivery systems was added to the existing responsibilities of the federal government for categorical grants-in-aid and development of resources."¹⁷

The initiating effort to provide payment mechanisms in the United States was P.L. 89-97, the Social Security amendments of 1965. Medicare and Medicaid specified three means of meeting health care costs: compulsory social

insurance, third party coverage and grants to states for public purchase of medical care. It was assumed that private services could assure adequate health care if payment was provided to certain user groups.

However, a series of bills also focused on the patterns of organization and utilization. Community Mental Health Centers, Office of Economic Opportunity Neighborhood Health Centers, Regional Medical Programs and Comprehensive Health Planning, a total of twenty-seven pieces of major health legislation were passed by the 89th Congress, mostly in the first session.

Regional Medical Programs and Comprehensive Health Planning were both planning-oriented programs rather than direct service projects. Public Law 89-239, the Heart Disease, Cancer and Stroke Amendments of 1965 instituted the Regional Medical Programs (RMP) as an attempt to coordinate local research efforts among medical schools, research institutions and hospitals and to disseminate new knowledge in the local health field. Aside from dealing with medical data systems, RMP were awarded planning grants to support surveys of needs and resources, feasibility studies and the organization of planning staffs. However, these tasks were to be accomplished without interference in the patterns and methods of financing patient care or the administration of hospitals, a mandate clearly stated in the opening clauses of the act.

The bill did incorporate health care providers into its schema. As one textbook put it, "Local participation, especially of health care providers, in planning is a . . . basic feature of the Regional Medical Programs . . . (another) feature of the RMP is the dual nature of the funding mechanism--namely, a planning phase and an operational phase."¹⁸

The Comprehensive Health Planning and Public Health Service Amendments of 1966 (P.L. 89-749) were also characterized by these features. Although differing in terms of both organization and intent, RMP and CHP have certain similarities which are indicative of practically all health planning efforts. One analysis found that the legislation for both programs requires that (1) a planning agency be advised by a citizen's council, (2) that the agency work toward regionalizing institutions, (3) that grant money be available for planning activities, demonstrations and ongoing projects, and that (4) the agency refrain from interfering with the existing patterns of health delivery. This last point is clearly set forth at the onset of each bill.¹⁹

Although it was not to interfere, CHP was mandated to coordinate private efforts. But even more, CHP was geared toward government. Its intrinsic innovation was a "Partnership for Health" concept, the first time regional, state, and federal agencies would coordinate health planning efforts. A text on health planning puts it so:

. . . the emphasis on the direct federal-regional relationship means that RMP projects have not easily been incorporated into . . . existing federal or state programs. . . . One contribution that (CHP makes) . . . to health planning in the United States . . . is to function as a means for the various federal, state and regional programs to be brought together in a more coordinated health care system.²⁰

The need for this type of coordination did not dawn suddenly in 1966. As far back as 1932, a report on Medical Care for the American People perspicaciously pointed out this need. To quote from this far-seeing document,

Even when each individual hospital is efficiently administered, wastes . . . often exist in the hospital system . . . as a whole. These are largely due to the failure to coordinate institutions and to the lack of any planned development. . . . There should, therefore, be an agency in each community, through which the lay and professional groups . . . could consult, plan and act . . .²¹

The report goes on to state that coordination is needed in metropolitan areas, where inconvenience of location makes medical care inaccessible although there is no lack of facilities in the locality as a whole. It is perceptively pointed out that the major problem is functional, not geographical, so that the sectionalism of institutions simultaneously leaves gaps and duplicates services. The report includes the need for coordination in rural areas, which could be performed by regional planning agencies and supervised by the state. State agencies, the book continues, would need legislative and financial authority and should foster a broad plan, whereas local bodies would work under persuasive auspices, through systematic conferences based on local data. These local agencies would strive for

cooperation between the professional groups that furnish service and the lay groups that receive and finance it.²²

The recommendations of this amazing document were not to be heeded for thirty-four years, when the National Commission on Community Health Services recommended that community health services required greater federal participation and that comprehensive health planning must take place on a continuing basis.²³ After four years of study, P.L. 89-749 was passed in 1966.

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CHAPTER IV

P.L. 89-749: ADMINISTRATION OF THE LAW

The passage of P.L. 89-749, the "Comprehensive Health Planning and Public Health Service Amendments of 1966," was greeted with enthusiastic plaudits from the health fields and the law-makers. Between 1966 and 1967, the bill was almost universally endorsed with great optimism as a progressive innovation. Cavanaugh praised,

The legislation develops a base for a vital step forward in comprehensive health planning, not as an end in itself, or as a new and different program, but as a dynamic process and means for identifying and delineating courses of action. In contrast to many previous health planning efforts, the planning elements of P.L. 89-749 are not limited in time, or to a collection of programs, or to a segment of the population . . .¹

The central concept intrinsic to the legislation was phrased by William H. Stewart, Surgeon General at the time of the bill's passage. "In sum, the comprehensive health planning envisioned in P.L. 89-749 extends laterally across all health activities--those which are strictly medical in nature and those which relate to health in its broadest sense. It seeks to assure that the whole is greater than the sum of its parts."² The bill became colloquially known as the "Partnership for Health"--a vertical form of

"creative federalism," forging a partnership not only between the federal government and its state and local counterparts, but among all health resources, public and private, individual and institutional, all directing their efforts to a common goal. The bill also provided for the first time, for consolidation of nine categorical programs into a single block grant which state authorities could use in accordance with their individual priorities.

The law that inspired such rhetoric was quite simple--both in its language and in its content. Its purpose was to achieve

. . . close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations . . . to support the marshaling 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 . . .³

P.L. 89-749 was an amendment to Section 314 of the omnibus Public Health Service Act. Seven programs were provided with grants in five major sections of the bill. Section 314 (a) provided for state level planning for health services, manpower and facilities. It required the creation of a single state agency, advised by a lay council.

Section 314 (b) authorized project grants for the establishment of areawide health planning agencies within the state. Section (c) involved project grants for training, studies, and demonstrations, while (d) freed the state health agencies from the old system of categorical

grants, allowing greater discretion at the state level regarding expenditure of funds. Sections (e) and (f) provided for project grants for health services development and interchange of personnel with states, respectively. Section 314 (g) amended the authority of the Surgeon General to comply with the preceding sections. The remaining sections authorized the continuation of previous public health grants.

The major thrust of the law is stated in the Declaration of Purpose.

. . . 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 . . .⁴

The grants to states were based on the submission and approval of state plans for comprehensive state health planning. This state plan was required to fulfill several functions. First, it was to designate or establish a "single State agency, which may be an interdepartmental agency, as the sole agency for administering . . . the State's health planning functions . . ."⁵ Secondly, the law called for the establishment of a state health planning council, to include representatives of state and local agencies, private organizations and consumers to advise the state agency. An interesting departure from previous participatory councils, which had emphasized the presence

of health providers, this council was to consist of a majority of consumers of health services.

The state plan was also called to explicate procedures for the expenditure of funds; to encourage cooperation between and among government and private groups and similar agencies in related fields such as education, welfare, and rehabilitation; to provide methods of administration; to report to the Surgeon General; and to review annually the state plan.

Aside from these general mandates, the actual methods and scope of operations were left to the discretion of the individual states. Stewart touted this as the flexibility aspect of the bill. "P.L. 89-749 is a genuine expression of faith in a process of planning to meet different priority needs in different ways. It is an invitation to initiative from states and communities."⁶ The states' reactions over the ensuing years have been predictably varied.

The State Agency

The state Comprehensive Health Planning agency became known as the "a" agency because it was cited in Section 314 (a) to distinguish it from its regional counterpart, which became the "b" agency. According to various Senate committee reports, the "a" agency was to provide the mechanism through which individual specialized planning efforts could be coordinated to each other. It was to

serve as the focal point for relating comprehensive health plans to planning outside the field of health, such as urban development and public housing. It was to provide for the first time, resources to measure the special health needs of each state. And it was to extend horizontally through all health activities from medicine to the environment.⁷

State planning for health had existed previously under the aegis of state health departments, whose functions, described by Mustard, included the study of specific state health problems such as high neo-natal mortality rates or disease vector control (vermin), and planning for their solutions. The state health department also undertook the coordination and technical supervision of local health activities and financial aid to local public health departments. The enactment of regulations which have the force of law in dealing with sanitation, disease and other public health controls was largely the work of the state agencies. Finally, state public health departments had the regulatory function of establishing and enforcing minimum standards of performance.⁸

Although planning per se was not a novel phenomenon to state agencies, the special qualities called for in Comprehensive Health Planning presented a challenge. Roemer relates,

Planning of certain sectors of personal medical care or environmental health service has, of course, been carried out for years. State health departments have devoted a good share of their energies to planning and promoting various preventive programs. . . . The

special feature of the CHP program, however, is its breadth of scope, intended to encompass all aspects of health services, in both public and private sectors . . .⁹

Coping with these new responsibilities placed quite a heavy burden on states unused to such administrative planning. Since relatively little research had been devoted to systems methods of health planning and there was a paucity of experienced professional health planners, states were left to make the rules as they went along. The lack of organizational principles in the law or in any textbook created identity problems as to what the "a" agency should be doing or where it should be located.

Functions

Four points were specified in the act itself. Each state would designate the single health agency, would appoint an advisory council, would complete a state plan, and would coordinate other local planning efforts. Beyond these points, no specification was made for the mechanisms or standards of coordination.

The American Public Health Association then devised a statement, "Guidelines for Organizing State and Areawide Community Health Planning," which suggested objectives such as improving organizational patterns for health services, discouraging unnecessary programs, identifying health needs and improving the quality for health care through better coordination.¹⁰ With such vague rhetoric as their only

guidelines, it is understandable that most states were still in the throes of organizational disarray by 1968. By 1970, enough experience had been gained to sprout more sophisticated theories, as with Colt's discussion of the "levers of influence" which could be used by the "a" agency.

According to Colt, primary function is the completion of a state plan--the articulation of a broad-gauge, long-range public policy of health efforts for the state. This would include the development of generalized goals for the health system and the preparation of guidelines for planning, program administration and evaluation. Secondly, through their review and approval function, the state agency acts as the funnel for government funds, giving it considerable leverage for influencing the decision making process. Thirdly, the function of assembling and analyzing the hard data needed to base decisions on is preeminently the state's role. "Moreover, as the source of reliable data . . . the state . . . agency will also achieve a certain degree of influence over the way this data is used, and thus in the decision making process itself."¹¹ Related to this would be the state's role to supply the traditional health providers, who lack the resources to maintain a continuing planning and evaluation function on their own, with financial and technical assistance. This would create more specific planning at smaller scales, at the same time strengthening the role of the state in the private and public health fields.

Administrative Location

A source of contention was not only the role of the "a" agency, but its location within the administrative framework of the state governmental organization. The establishment or designation of the agency was left up to the states, the law specifying only that it be a single state agency.

The role of state planning in general has been a complex enough debate without the insertion of the delicate web of interrelationships that characterizes health planning. The functions of general state planning are: provision of generalized intelligence to the executive and the legislature; coordination of the planning of departments and agencies; and the development of plans and programs. Close cooperation must exist between the planning staff and those responsible for planning within the individual operating departments. John Dyckman iterates,

This cooperation is at the heart of comprehensive planning. The idea of "comprehensiveness" is hierarchical. Planning, as an activity, becomes more comprehensive as it cuts across or embraces more departments of government and its ability to be truly comprehensive increases as it moves up the ladder of authority.¹²

The same reasoning held true for the location of the "a" agency. Four options were immediately open to the states at the time of the bill's passage. They could designate the state health or health and welfare department as the state Comprehensive Health Planning agency. The "a"

agency could also be established as a unit in the executive office of the governor. The law also allowed the single state agency to be an interdepartmental commission. The final option was the establishment of an independent agency. John Gardner, then Secretary of Health, Education and Welfare, requested each governor to perform the designation, the initial step in the organizational process. The choices that resulted were dependent on parameters such as the previous existence of a state planning agency and the level of fragmentation of the states' health programs. Where a state planning agency existed, the health planning function was generally placed there, whereas the public health department was chosen when it administered the majority of public programs.

During the first two years of the Partnership for Health, state CHP agencies were designated in all fifty states, the District of Columbia, American Samoa, Guam and Puerto Rico. In twenty-nine of the states and the District of Columbia, governors placed the Comprehensive Health Planning function in their state health departments. In sixteen states, it became a division in the governor's office--generally in the state planning agency, the department of administration or the budget office. In five states, the interdepartmental commission was chosen.

To assist them in their decision making, the Council of State Governments forwarded a letter to the Governors, discussing some of the aspects of agency placement. It was

stated that the organization and location of the Comprehensive Health Planning agency in state government must be conducive to effective operation. At a minimum, this must include representation and inputs from all relevant interests in the health system and the establishment of close relationships to federal and other state agencies and regional organizations. The necessary ingredients for an effective planning process include: prestige and prominence through close alignment with the governor's office; the authority to surmount interdepartmental barriers; planning knowledge and capability; and an inherent mechanism for implementation of recommendations.¹³

The placement of the "a" agency in an operating department such as the state health department, has the obvious advantage of a built-in knowledge of medical affairs. However, a conflict of interest, competing for resources and time, between the planning process and the daily provision of services which an operating department must supply can easily be envisioned. Moreover, the role of CHP involves both public and private spheres of influence. Traditionally, operating departments, such as health have dealt with public affairs, and due to their regulatory function, may have strained relations with the private sector.

An interdepartmental commission, composed of the directors of several departments and divisions, although it

may provide the comprehensive viewpoint, simultaneously lacks the cohesive unity necessary for implementation.

Placement in a state planning agency can narrow the scope of the "a" agency. Although its function is policy planning, contact with the daily problems is essential in policy formulation. Moreover, the large staff needed to provide expertise in all state planning aspects would make it difficult to aggregate that number of skilled specialists.

The placement of the "a" agency in the executive office of the governor has many obvious advantages. Prestige and public interest would result. State monetary budget allocations are made in the executive office, enabling health affairs to be closer to the resource allocation source. Interaction of CHP with other types of planning is made possible by its central location and neutral ties to any particular department. Finally, location in the executive unit enables a close symbiosis to exist between the governor and the "a" agency. The former would have immediately at hand all the pertinent information needed for efficient decision making and the latter would be in a position of power regarding implementation of their policies through the governor's influence with the legislature, executive orders, etc.

As always, there is another side to the coin. Location in the executive office can also be too flexible, too independent. It would be easy for the "a" agency to

virtually ignore the other agencies with which it must work and which are crucial in implementation procedures. Moreover, close ties to the governor can place the CHP agency too much in the political spotlight. Since the chief executive may change every four years, and directors are appointed to represent the views of the governor, the policies and procedure of the "a" agency could lack essential continuity and stability. Finally, the location in the executive office can be too personality-oriented. Dependence on the governor's own interest in health and his relationship to the legislature could mean that the "a" agency would experience some stagnant periods.¹⁴

By 1970, administrative issues had been resolved enough so that all the eligible jurisdictions except Nevada had innovated and begun conducting statewide planning programs. However, the progress from organizational stages to substantive planning did not prevent continuing shifts in the administrative location of the "a" agency. Within two years, the number of planning agencies in health departments had risen from twenty-nine to thirty-five, the number in the governor's office had fallen from sixteen to eleven. Six states located their Comprehensive Health Planning offices in state planning agencies. The original five interdepartmental commissions were reduced to one (Louisiana), and whereas no independent agencies had initially been established, by 1970 Arizona and Michigan had chosen this alternative.¹⁵

One reason for these changes in the administrative location of the state CHP agency is attributable to the new wave in state executive reorganization. Twelve states underwent major or substantial reorganization between 1965 and 1972, due to an expansion of state functions in response to federal-aid programs and the reappraisal of the state role in the "creative federalism."¹⁶ As a result of Michigan's general reorganization limiting the number of total departments or California's superagency groupings or the establishment of new departments in many states for transportation, human resources, environmental quality and other recent concerns, health planning has reflected these changing trends. As Hall so aptly states,

Even more than the health administrator, the planner has sought to insulate himself from the vagaries and hazards of the political process. To minimize interference with his work, he has experimented extensively with the organizational chart to find an administrative location with the utopian combination of proximity to the source of power as well as independence from "politics."¹⁷

In order to resolve the debate of location and to determine the relationship of the quality of planning functions with the location of the health agencies' placements, a survey under the aegis of the Health Services Research Center of the American Rehabilitation Foundation was conducted in 1969. Four variables were analyzed in a chi-square test of association: relative contribution of factors to the goal-setting process; the proposed solutions to health problems which were identified; the factors that

demand the greatest staff time; or the problems it anticipated could be handled by the 314(b) agencies. The same responses were most frequently given, regardless of agency placement. The survey suggested that there appeared to be no association between agency placement, whether health department, governor's office or interdepartmental commission, and the goal-setting processes or health problems identified by the states.¹⁸

As of July 1, 1972, over one-half of the states (26) had placed the "a" agency in the state health department, eighteen were in the governor's office or state planning agency, eight were in health and welfare or human resources departments and four were either independent or interdepartmental. This picture is still changing. Doubtless, agency placement will continue to be flexible in order to best serve the needs of a particular state. This flexibility is the strength envisioned by the law-makers in creating the original document.

The Areawide Agency

The complexities that arose during the organizational phases of the "a" agencies also beset the "b" agencies. There had been previous experiences with local health planning due to health and welfare councils instituted by local social work organizations and due to the administrative type of planning practiced by Hill-Burton advisory councils. However, planning of the broad,

comprehensive scope called for by the bill was outside the expertise of any of these groups. One of the problems facing the "b" agencies was the lack of specification as to what such an agency was. According to the law, "any . . . public or nonprofit private agency or organization" could receive project grants of up to 75 percent of costs. A glimpse through a directory of such agencies shows the great majority of these to be private nonprofit groups. Many of these sprung up in response to the law, although some had existed previously in other guises. Several organizational alternatives were available to qualify for the "b" grants. Health planning could be built into the framework of an existing regional planning agency, a new agency could be established, or the responsibilities of an existing county health department, health planning agency or voluntary organization could be expanded.

Selection

The ramifications of alternate selections were explicated in a health planning manual for local officials. The most widely chosen alternative, the organization of a new agency, has the obvious advantage of being specifically designed to implement Comprehensive Health Planning objectives without additional commitments. Its organization can be geared directly to its regional needs, and its resources devoted to its sole purpose. The equally obvious

disadvantage is the time required to begin establishing such an agency without a previously existing base.

The second alternative is to designate a council of governments, regional planning council or economic development district as the "b" agency, by appointing a section as the health planning division. Such a selection provides an existing organizational foundation, relates CHP to other physical, social, and economic development and provides a quasi-governmental tie to assure funding. However, care must be taken to avoid inhibition of private participation in such a governmentally-oriented program. If the existing agency lacks effectiveness, the CHP function will suffer equally. And the emphasis on its original planning purpose, combined with lack of health planning experience, may belittle the health aspect.

Expansion of existing health departments have the same pros and cons as their state counterparts: experience, personnel, knowledge and coordination versus limited viewpoint, service orientation and a government base.

Use of an existing health planning agency provides the necessary base, but this is often specific and limited in scope, and tends to be regulatory and provider-oriented.

The existing framework of a voluntary agency also provides a base, but one which tends to concentrate on the previous area of expertise.¹⁹

All of these alternatives are bounded by the needs, concerns, and individual situations of a region. The

legislators of P.L. 89-749, realizing that a wide variety of interests and organizational frameworks characterizes this large nation, deliberately inserted the flexibility necessary to fit all these circumstances.

By 1966, the year of the bill's passage, there was a total of 80 agencies around the nation. By 1972, this figure had more than doubled; from 198 areawide agencies, 69 were in the organizational phase and 129 were already at the planning stage. Every major metropolitan area had a "b" agency serving it, and every state except Rhode Island had at least one such agency. More than half the population in the United States lives in an area served by a regional agency. The boundaries circumscribed by an areawide agency range from one county to thirty-two; most are multi-county regions.

Functions

The stated purpose of the "b" agency, according to the law, is ". . . developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and services required for the provision of such services . . ." ²⁰

Like their predecessors, the Hill-Burton councils, areawide CHP agencies have tended to concentrate on the last phrase cited above. Substantive planning seems to have focused on the review and comment responsibilities of the

"b" agency. This refutes the purpose of P.L. 89-749 which was "an attempt to promote positive planning, that is, planning to meet people's needs, rather than to put a check on hospitals' capital decisions."²¹ CHP aimed at creating regional agencies concerned with medical services, prevention, environmental health and manpower as well as construction. Yet, as Stebbins says, "Planning under CHP auspices has tended to focus on facilities . . . 'a' and 'b' agencies have developed standards and guidelines to be used in planning new facilities or renovating or relocating existing facilities."²²

With the original passage of P.L. 89-749, CHP agencies were called upon to comment on proposals for the expenditure of certain federal funds, but this function was not viewed as a major responsibility. However, review and comment activities were expanded with the passage of P.L. 92-603 (October 1972) which requires review of capital expenditures which (1) exceed \$100,000, (2) changes the bed capacity of a facility by such an expenditure, or (3) substantially changes the services offered by a facility by such an expenditure. Thus, the review and comment responsibilities of both "a" and "b" agencies have greatly expanded, often to the detriment of other planning functions. However, in a number of states, the responsibility devolves especially on the areawide agencies, since they have the responsibility for undertaking review and

comment on numerous federal programs as well as review of projects under the above certificate of need legislation.

Federal programs calling for CHP agency review now include alcoholism, communicable disease control, mental health centers (staffing and construction), mental retardation facilities, family planning, health maintenance organizations (HMOs), Hill-Burton projects, migrant health, drug abuse, Regional Medical Programs, student loan forgiveness, venereal disease control, state public and mental health plans and federal health facilities (VA hospitals).²³ The recommendation of the areawide agency is passed on to the state for final approval, but such approval is often routine, since the "b" agency is the most closely involved with the local situation and thus must accept the major portion of responsibility.

Other functions which are included in the compendium of regional agency activities are similar to those of the state, but on an areawide scale. Provision of assistance to institutions, agencies and groups in developing planning mechanisms as individual service providers constitutes the technical assistance aspect. The areawide agency is also responsible for collective planning in relating the health programs within the regional framework.

Substantive planning involves the formulation of goals and policies for improving the existing system in providing physical, mental, and environmental health

services and designing programs on varying time scales to attain these objectives.

The provision of liason and informational services to the public and appropriate interest parties includes advising on legal and research topics. Periodic evaluations are another mandate of the law. Assistance in the local implementation of state programs comprise yet another responsibility. Aside from state-coordinated data systems, "b" agencies must conduct special studies of particular health problems in the area, and determine by surveys, factors peculiar to the region in terms of environmental hazards, socioeconomic characteristics, financial, organizational and jurisdictional impediments to effective resource use. The number and nature of health services, facilities and manpower available in the area, as well as potential sharing with adjacent regions is also the responsibility of the regional agency.

The areawide agency is also mandated to involve public and voluntary health related organizations through consensus and mutual communication. This communication extends to its governmental counterparts.

For the first time, there is a direct relationship not only to the state but to the federal government. Formerly such a relationship existed only with the state as intermediary. The direct interaction is symbiotic--the federal government is relieved of the onerous review tasks involving its multiplicity of programs, while simultaneously

ensuring that regional federal programs are consistent with the health needs of the locality. The "b" agency, in turn, receives its financial support from Washington.

The relationship of the areawide agency to its state counterpart is less succinct. Its foundation lies in voluntary cooperation, with the state allowing room for the "b" agency voice in its schema, and the areawide agency making the effort to become involved in the larger picture. Activities particularly ripe for cooperative efforts include health legislation development. Here the "b" agency is best suited to judge the influence of state legislation on the total picture. In turn, the "a" agency has the responsibility for keeping their local counterparts advised of legal trends, in order that the latter can make pertinent decisions.

Recruitment and training programs also provide opportunities for cooperative endeavors, since manpower can be trained and facilities shared to provide for the needs of both state and regional agencies. Collection and use of data is another obvious area for mutual cooperation. Similar data types collected on a broad geographical basis create a uniform information foundation, from which particular statistical requirements can be derived. With the state directing the type, scope and depth of data needed, and the areawide agencies performing the actual compilation, the former difficulties of mismatched data bases on incompatible scales can be overcome.

The Advisory Council

Advisory councils play an important role in both the state and areawide Comprehensive Health Planning agencies.

P.L. 89-749 calls for the "a" agency to

provide for the establishment of a State health planning council, which shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, to advise such State agency in carrying out its functions . . . and a majority of the membership of such council shall consist of representatives of consumers of health services.²⁴

The actual composition of membership is left to the discretion of the state, but a typical roster might include commissioners of public health, mental health, labor, economics, public education and other related fields. Physicians, dentists, nurses, pharmacists, hospital administrators, and medical educators would also be appropriately placed on the board. Representatives of local health agencies, voluntary organizations and manpower training would be included. Consumers could be divided by sphere of interest in health services to labor, schools, welfare recipients, mentally retarded, or by type of activity, such as mental health and environmental hazards. The remainder needed to fulfill the majority seating could be appointed at large. Such appointments are generally named by the state's chief executive for a term of office. Members of the state CHP council serve without pay and meet at regular intervals during the year.

The council makes its tasks manageable by dividing into committees and task forces. Functional areas generally include health facilities, manpower, services, finance and environment.

The Advisory Council of an areawide agency operates in much the same manner. Council membership consists of similar categories of representation from government and consumer interests. However, in addition to functional representation, regional councils must also reflect representation by population distribution. Executive committees maintain the consumer majority; task forces, subcommittees and technical advisory committees need not.²⁵

The problem facing both state and areawide advisory councils is the task of recruiting interested, aware and knowledgeable representatives. Because health is largely a technical field and consumers must work with experienced health professionals, they may often feel at a disadvantage regarding expertise. Having majority standing is not effective if consumers feel inhibited in exercising their voice. For this reason, some states have initiated orientation programs for consumer members, introducing them to vocabulary, rules and processes of health planning. This may somewhat alleviate the handicap burdening novice consumer representatives.

Still another detriment to efficient operation involves the time commitment needed by representatives. Glances at several areawide council rosters shows that a

majority of consumer representatives are non-working women, while most health providers are men. While this may not be representative of areawide councils at large, it seem safe to surmise that scheduling creates an imbalance. Holding meetings outside of working hours should alleviate this condition.

Combining a population representative with the necessary functional requirements can also pose difficulties for an areawide council. Care must be taken to create a council large enough to absorb both representatives by functional category and at-large consumers to represent geographical areas.

A review of the literature suggests that the Comprehensive Health Planning Councils which consist of an organized body of intelligent citizens, laymen, and professionals, have far-reaching effects on health in their area. Although the health planning councils are not regulatory or funding agencies, but are advisory in the real sense, the inherent power of a properly constituted and functioning group is in little doubt. The intent of the law dictates that the judgement of the councils is a valued input into the decision making process. The state council's responsibility lies in designing the overall health plan for the state. The regional council's duty is to fit the pieces for its region into the state plan. The cooperative endeavor called for by CHP must also exist here.

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CHAPTER V

THE HEALTH PLANNING PROCESS

It would probably be a fair assessment to say that many of the health planning techniques used now were formulated as a result of the passage of P.L. 89-749. Because of the mandate for comprehensive health planning, there opened a ready market for competent professional health planners, and schools of public health took up the challenge of filling the educational void. Previously, those involved in health planning were largely public health professionals, whose viewpoint was rather specialized, and a sprinkling of public administrators and planners who extrapolated the general planning process into the health field. With the advent of comprehensive health planning legislation and the necessity for its rapid implementation, researchers went to work to devise some principles that would aid those involved in such a complex endeavor.

The few health planning textbooks that exist have maintained the general planning process phases: identification of health needs (study design), inventory of health resources (data collection), consideration of alternative

courses of action (analysis), development of recommended priorities (goal formulation), implementation and evaluation.

The Planning Process

The on-going, cyclical aspect of planning has always been emphasized in theory. Cavanaugh succinctly states, ". . . it is not with decision making itself that Comprehensive Health Planning is concerned, but rather with the process of decision making."¹ In A Manual for Health Planning, it is defined as "a dynamic process, a means to an end, which is concerned with identifying problems, considering alternatives, and making decisions about future actions . . ."² Kissick considers this realization to be of great significance.

. . . perhaps the most valuable lesson we have learned is that it is the planning process that is of paramount importance. . . . A rigid, inflexible, "perfect" planning system, or a master plan is not what we want in health . . .³

Reinke presents a schematic framework of the planning process by placing "mission" at the top of the chart, then proceeds downward to goals, objectives, functions, targets, programs and procedures and instruments, each being the offshoot of the phase above it. He explains this verbally.

Planning initially requires the identification of health problems as major deviations from broad goals and of the causal and contributing factors associated with the problems. Second, alternative plans of action are specified in the light of imposed

constraints. Particular courses of action are selected from among the alternatives on as rational a basis as possible. Objectives are then assigned to appropriate points in the plan of action along with the activities (procedures) and resources (instruments) required . . .⁴

Facets of this health planning process are hardly original to Comprehensive Health Planning. Planning elements have been included in health activities for many years. Program development planning has been a significant function of public and private operating agencies. However, program planning is typically a linear process rather than cyclical, and has resulted in limited evaluatory feedback. Resource allocation decisions have traditionally been made based on budgetary considerations and categorical programming. Baker cites the advent of the planning-programming-budgeting concept as permitting a new rationality for allocating resources based on broad, defined and consistent public policies. Program evaluation, assessed against health objectives, has long been a part of traditional health planning. This evaluation has been on a one-to-one basis and technical in nature. Only, recently have cost-benefit analysis and other techniques enabled a more sophisticated approach.⁵

Anderson identifies other principal features of previous planning programs as promotion and education of health principles, action-planning on a problem-by-problem basis, coordination and technical advice, including data collection.⁶ These tasks are still inherent in

Comprehensive Health Planning. However, there has come to be a redefinition of terms. Coordination is now emphasized, including citizen participation. Program planning has shifted to policy planning. Resource allocation continues, but on a broader, more sophisticated level. These three elements of CHP will be examined separately.

Coordination

Coordination involves the distribution of resources among a fixed vertical system, national, state, and local strata. Within each of these is a horizontally organized system, which operates by function (health, education, housing) or by clientele served (age, problem, income). These complex components are also interrelated, with overlapping workloads and a conglomerate of activities relevant to the solution of a single problem. The purpose of coordination is to bring these services into better harmony without reducing autonomy. Thus, the triple thrust of coordination is to reduce the duplication of agency activities which perform similar tasks, to enhance inter-agency communication and to create a central repository of information.⁷

Federal guidelines for coordinative activities of the CHP agencies specify the identification of health related organizations and planning bodies and the establishment of cooperative relationships. A strategy for planning coordination in the state is encouraged, focusing on

eliminating duplication of planning effort and filling gaps in existing activity. The respective roles and responsibilities of the state and areawide health planning agencies are included in the delineated strategy. Organizational links and regular channels of communication and mutual input are major elements in coordinative planning. Recognition of conflicts of interest in both public and private spheres and reconciliation of these are equally important. Coordination within and between subsystems works in two ways, by agreements and joint planning. Coordination by agreement, according to Anderson, can accomplish only a limited degree of change, usually by instituting something that did not exist before. Since it is based on establishing consensus among its participants, who are often providers, the influence of such cooperative planning is limited to what can be accomplished through persuasion and project funds. Such measures are insufficient to enact the removal or change of obsolete or inefficient programs and facilities. The major advantages of this type of planning lie in its emphasis on encouraging grass roots action on cooperative endeavors toward a common goal undertaken by those who provide services. Disadvantages exist in terms of its piecemeal approach and its assumption that existing programs can be maintained without major alteration.⁸

This lack of power to enforce recommendations which are opposed by affected members can also distort joint

planning, which operates similarly on the governmental level. Mary Arnold poses this as a system malfunction.

Coordinative planning . . . implies that there should be coordination of the action of two or more organizations . . . so as to increase availability of scarce resources or to enhance the impact of several organizations' actions. Thus there is an implied larger system consisting of the input and output constituencies of the particular set of organizations concerned with coordination. In this case, however, the larger system is merely the general arena in which a particular set of organizations operate and not the total social environment. This type of planning generally falls into an information exchange and mutual adjustment process. The autonomy of each subunit of these sets of organizations is not questioned. . . . Public Law 89-749, the Partnership for Health Program, is an attempt to develop coordinated community, local and state plans for allocating resources to meet the health needs of each area, but there is no plan for the larger system planning that is tied directly to this.⁹

The conclusion to be drawn seems to point to the fact that coordinative planning, per se, is not a sufficient means of implementing or enforcing effective action.

Relying on common agreement to induce change may result in nothing more than a harmonious maintenance of the status quo.

Policy Versus Program Planning

There has not been a great controversy over the question of whether Comprehensive Health Planning should be problem or long-range planning, policy or program-oriented. It is generally accepted that its proper role lies in the sphere of the continuous and broad, leaving concrete specifics to the operating agencies. Moreover, it has

generally been agreed that the initiation of such policy belongs in the hands of the public. As Baker states, "A citizen participatory planning process is essential to assist the development of unified policy."¹⁰ An assessment of societal values and needs serves as the guide to acceptable statewide policy for both public and private sectors. Arnold presents this, not only as a question of efficacy, but of ethics. ". . . the problem of the appropriateness of goals or objectives is an ethical or value problem, which is not amenable to rational analysis. Therefore, the choice of goals and objectives is left to the political process of obtaining consensus . . ."¹¹

Once policy goals have been formulated, methodologies for problem-solving in a policy-planning context must be devised. If the emphasis is away from short-term crisis conditions, there is danger that a policy would be so aloof as to be unresponsive to the concrete realities of chronic problems, or immediate priority needs. The Work Program, FY 1973, of the Michigan "a" agency reflects this concern.

Comprehensive health planning has been viewed as a dynamic process resulting in a series of problem specific analyses as opposed to static plan document. We clearly recognize, however, that the ultimate success of these efforts is heavily dependent upon the extent to which . . . crises are addressed within a rational, overall framework.¹²

Baker affirms, "If the planning cycle is to . . . respond to the complexity of our social planning challenge, it must also accomodate both long and short-range planning efforts

. . . it must be convertible to both program level and policy level planning activities."¹³

Criticism has been leveled at CHP agencies for dealing with areas which theorists feel are out of bounds. With the confusion over the definition of CHP, the pressure for immediate results and public scrutiny, agency directors have found it easier and more dramatic to neglect long-range interests for responsive planning. Such activities are proper only when carried within recognized parameters and an acknowledged direction, as the Michigan agency realized.

The type of planning which deals with policy versus operational planning has been termed managerial planning. In her study of the "a" agencies, Anderson cites management information systems, priority setting, budgeting processes and resource distribution as the major functions of this form of planning. The authority in this type of organization is derived from close ties to policy makers and elected officials, to whom the planning agencies make recommendations. Using administrative and budget tools such as information systems, planning-programming-budgeting techniques and cost effectiveness analysis, management planning can deal with longer range problems and consider policy issues on a broader base than can coordinative planning.

Since managerial planning places more emphasis on a health systems approach, it attempts to consolidate

resource and production units, reducing duplication of services and covering gaps, particularly in areas where it exerts funding approval authority.¹⁴

Resource Allocation

According to the Encyclopedia of the Social Sciences, allocation is the division of limited resources among competing claimants. It involves a policy choice of the same resources among welfare goods, i.e., health, education, housing. The question of allocation within a single social sector, such as health has traditionally been dealt with by functional domain, that is, health has been the concern only of health programs, and health programs have dealt only with medical factors.¹⁵

According to Baker, the process of planning-programming-budgeting has been a major cause for change in health planning.

Resource allocation decisions, particularly within the governmental sector, have historically been based on a line item budget defining categorical programming needs and expectations . . . the advent of a planning-programming-budgeting concept . . . has had a significant impact on the health care system . . .¹⁶

This radical concept is true not only for planning within the domain of P.L. 89-749, but for the passage of the bill itself. Rethinking the traditional categorical and project grants resulted in the flexible block grant that enables each state to use its own PPB formula. The point of major importance is not only the efficient allocation of

resources within the health planning sector, although this is a primary function of CHP. However, the integration of CHP with other state plans and the efficient use of resources on a state-wide, multi-function basis is another, often neglected aspect. Without such consideration, difficult as it may be to implement in the bureaucracy of state government, there is no possibility for fulfillment of the term "comprehensive" or Arnold's total environment. The Program Policy Guidelines for FY 1975-76 for Michigan indicated this realization.

A review of the current situation in Michigan indicates that virtually every public and private agency concerned with health performs health planning . . . utilizing different data sources, different resource allocation procedures, and self-maximizing objectives . . . many of these agencies have conflicting priorities or are competing for limited resources. The resulting dilemma is . . . that there are no universally acknowledged criteria for determining the best resource allocation . . .¹⁷

The supposedly rational process of planning, without such criteria, can devolve into a strategy of relative values and self-aggrandizement. One of the major pitfalls has been the lack of a common data base. Since decisions are based on information, it is obvious that different facts will lead to different decisions. Information can be distorted by being outdated, by a non-cohesive geographical or population base or by non-consistent variables. Areawide agencies have had to begin from scratch to create a compendium of health statistics based on their own unique geographical region. It is obvious that resource allocation

decisions will become more coherent when supported by a firm foundation of knowledge, the collection of which has become the function of CHP.

Another means for controlling resource allocation decisions is to put certain decisions directly into the hands of the agencies. The original passage of the bill called for a minimum review and comment role, but subsequent amendments have greatly expanded it. The most recent expansion of this activity came with P.L. 92-603, 1972, which requires review of capital expenditures. Both state and areawide agencies are called upon to accord approval or rejection for a wide variety of other state and federal projects.¹⁸

The major way in which CHP agencies effect their resource allocation is regulatory planning through review and comment. This type of regulatory planning offers an administrative mechanism for accomplishing planning controls with veto power over the constituents. By placing a boundary on performance standards to ensure minimal competence or coordination, regulatory planning opts for a negative role instead of creative input. The type of planning also fails to include all but a certain segment of the private health sector. With such a limited scope and limited participation, regulatory planning should only be a partial function of the total CHP picture. Moreover, it can prove a heavy burden to the limited resources of the agencies themselves, draining time and manpower away from

corallary planning activities. CHP should be more than a clearinghouse for health facility construction and grant applications.

With a diversity of roles open to them, state and areawide agencies have been able to opt for any combination. In practice, the ARF survey showed that such a combination of coordinative, managerial and regulative planning actually did occur. The organization and planning of the agency seemed to be the primary accomplishment, especially in terms of deriving a philosophic process for comprehensive health planning. Establishing a working relationship with public and private agencies, citizens and professional groups was also a widespread achievement. The creation of task forces, preparation of legislation, public education and information about CHP, staff training, review and comment were other functions which were seen to be vital functions by the agencies.

These tasks were able to be realized because of P.L. 89-749. In the next chapter, those shortcomings of the law which inhibited progress will be explored.

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¹⁸For a list of review and comment projects, see Chapter IV.

CHAPTER VI

POSTSCRIPT

The purpose behind the preceding chapters was to place comprehensive health planning in a setting, to state briefly its purpose and need, to place it in historical perspective, to list its contents and methods, to explicate its process and techniques and to describe the workings of P.L. 89-749, the first Comprehensive Health Planning legislation in the United States. The purpose of this chapter is to provide a critical assessment of CHP as it is currently practiced.

The purpose of a critical assessment is not to belittle the accomplishments of a law that had no precedent, no previous expertise and no organizational base. That P.L. 89-749 was ever passed is in itself no mean feat. Such a passage reflected well on the insight of the legislators and others responsible for its conceptions. Such insight could not be all encompassing, however, and P.L. 89-749, faced with high expectations, could not have hoped to fulfill them.

The final phase of the planning process is evaluation. The bill itself provides for annual self-review by

the agencies. The federal government is undertaking an assessment of CHP organizations.¹ Such evaluation is particularly necessary for planning programs, where time-frames are long and results may be nebulous. Accomplishments may not be concrete or dramatic, thus hard to assess. But the future is built on the past, and progress uses steps carved out of corrected errors. In retrospect, the entire Comprehensive Health Planning experience offers invaluable lessons in the study of government in health.

Assessment of P.L. 89-749

The previous description of the organization and methods of Comprehensive Health Planning has revealed some of the anomalies and weaknesses inherent in its current structure and practice. Some of these were due to the bill itself; others resulted in the way the law was applied.

One of the structural paradoxes of P.L. 89-749 that became evident was contained in the opening phrases of the act. The mandate to coalesce both private and public health services was immediately contradicted by the non-interference proviso. Not only was CHP to refrain from effective action in the private sphere, it was to coordinate federal, state, and local public activities without an administrative structure in which to operate. Although federal review responsibilities later became expanded, there was no central clearinghouse or guidelines for implementing such coordination. Many health-impacting

federal and state programs contained no requirements for CHP review. Therefore, all of the "comprehensive" coordination that was to be exercised by CHP depended solely on voluntary cooperation. Without political authority or enforcement clout, worked into the law itself, the coordinative mandate of CHP has remained relatively ineffectual. Ironically, an example of such an impediment to CHP is its predecessor, Regional Medical Programs. Because it is not state-based but regional, it is not responsible to state executive offices, including CHP. Nor is such responsibility legally mandated. With greater funds at its disposal, and with the corollary power, RMP's independence from Comprehensive Health Planning restraints poses a threat to the latter's effective functioning.

Other weaknesses contained within P.L. 89-749 itself involve lack of definition. Nowhere did the bill specify what "comprehensive" meant. Nowhere was "planning" defined. "Health" was considered self-explanatory. As was discussed in Chapter II, each word of the term "comprehensive health planning" involves different parameters and policies. Indeed, according to the present system, the terms "comprehensive" and "health" are mutually exclusive; health means medical affairs and comprehensive involves everything else. Without a redefinition of the term "health," the traditional boundaries of medicine remain the paramount concern.

Further confusion arose due to the ambiguity of "comprehensive." Although the law contained the words "environment," "education, welfare and rehabilitation," planners understood these to be examples of, and not restrictions to health-impacting social functions. But where did it stop? Interpretations could range from traffic pollution to physical fitness programs. Without parameters to guide them, planners were innundated by a mass of potential applications of the term "comprehensive," all of them needed, all of them feasibly the concern of chp. Before substantive planning could even begin, valuable time was spent deciding what the substance of the planning should include.

"Planning" also posed a problem. The Hill-Burton and RMP programs had federal planning guidelines delineated; moreover, their content was defined and limited. Comprehensive Health Planning was not so fortunate, creating further confusion and time lost to devising a sphere of operations, methods, and techniques.

The weakness of P.L. 89-749 was compounded by attitudinal difficulties arising from the lack of definition. First of all, the spate of enthusiasm which greeted CHP was not yet tempered by the difficulties of implementation. The optimism engendered by the act created high expectations of reorganizing public-private health service relations. Another hope was that of effecting a new rationale, not only in administration, but of delivery of

health services. Without enforcement authority, without a firm foundation of experience and knowledge, without a settled administrative structure, and without the ability to delve into the private sphere, an ambience of disillusionment set in. Anderson makes this quite clear when she cites "the 31 percent turnover of 314(a) agency directors since the program's inception . . . (and) the transition in titles (of articles) . . . from 'potentials of comprehensive health planning' to 'problems of comprehensive health planning.'"²

Another weakness confronting CHP involved the type of planning that was generally opted for. In Chapter V, it was reported that the American Rehabilitation Foundation identified three types of planning--managerial, regulatory and cooperative, with the last most widely practiced. The ARF report concluded,

It is unrealistic to expect providers of health services to volunteer to close up an unworkable shop, to give over responsibilities they have long regarded as their own . . . or to phase out a program in order that another may initiate it. . . . In summary, (chp) based on the "cooperative planning" model offers insufficient assurance that it can effect coordination, protect consumer interests, be broadly representative of all health concerns, or directly involve the government policy makers.³

Yet a further problem resulted from the consumer participation requirement. Laudable though such participation may be, those handicaps cited in Chapter IV remain valid--consumers disadvantaged by lack of technical expertise, time for meetings and assessing reams of data,

balance of consumer representatives by geography, area of interest and population group, and the difficulty of removing the traditional preconceptions about health care. These barriers could be removed with education, but the need for such an orientation was not taken into account in the law.

Recent Developments

Legislative action on comprehensive health planning has not stood still since the passage of P.L. 89-749 in 1966. Awareness of some of the discrepancies in the law led to an attempt to rectify these by "The Comprehensive Health Planning and Service Act of 1970" (H.R. 18110). The Report of the Committee on Interstate and Foreign Commerce, the House body assigned to health matters, stated that the principal purposes of the proposed bill were to extend and expand the original authorizations for grants. The bill also provided the initial authority for the development of a cooperative federal, state, and local statistics and information system to produce comparable and uniform health data throughout the nation. The bill further required representation of Regional Medical Programs on the state health planning advisory council. The legislators commented,

The committee is aware that the question of the proper relationship of Comprehensive Health Planning and other programs is of concern to all persons engaged in health programs in the States. As the program of (CHP) achieves greater strength in the

States, it is intended that closer coordination of programs will result. For that reason, the committee will consider, as future legislation, in the field of health activities . . . the proper role of CHP in the direction of the new legislation.⁴

The report continued that the existing law did not specify that state CHP plans provide for environmental health, "although this was clearly contemplated by the original legislation." Furthermore, although the state plan for provision of public health services was required under Section 314(d) to be in accord with the state CHP plan, H.R. 18110 would add that the state plan be compatible with the total health program of the state. The movement toward a more specific, more powerful comprehensive coordination was on the way.

This movement was assisted by a series of bills expanding the basis for the review and comment function of CHP. P.L. 90-174 created an amendment for state CHP, requiring the state plan to make provisions for assisting each health care facility to develop a program for capital expenditures for replacement, modernization and expansion consistent with an overall state level. These review and comment responsibilities did expand the base of comprehensive health planning authority, although only in a negative sense, through veto powers. Further attention was awarded the CHP program with P.L. 92-585 (1972) which mandated the review and comment by CHP agencies, of Public Health facilities utilization. Although the progress involved in this law was minimal, the overt recognition by Congress of

CHP's role in monitoring health affairs strengthened its position with related agencies. Another expansion of this function occurred in 1972, with P.L. 92-603, which provided for review of facilities requesting a certificate of need. Subjecting applications to a scrutiny in the light of regional needs meant that duplication of services and over-provision of bed spaces was avoided when a health facility decided to modernize, expand or rebuild.

The realization that expansion of review and veto powers was not sufficient to correct the deficiencies of P.L. 89-749 was evidenced early. An attempt to patch up the existing law without drastic change was accomplished by amendment. The modifications made through Public Law 91-515, "The Heart Disease, Cancer, Stroke and Kidney Disease Amendments of 1970," were disappointingly mild. It called for a systems analysis of national health care plans and cost-benefit studies for national health insurance, and did implement the uniform health information survey for all levels of government. However, in terms of extending grant authorizations for CHP, P.L. 91-515 amended only representation on the state council and inserted the phrase "and including environmental considerations as they relate to public health." The changes in representation did rectify two anomalies that had occurred in P.L. 89-749. Section 220(b) called for representation of federal agencies, as well as state and local, including a representative of a Veterans' Administration hospital. Furthermore, a

representative of RMP was specified to serve along with "organizations concerned with health." Both of these amendments were designed to answer charges that the federal government refused to cooperate in coordinative planning.

Section 316 of the same act called for the establishment of a National Advisory Council of Comprehensive Health Planning Programs. Members were to consist of leaders in the fields of science, medicine, organizational health care, officials in CHP agencies, state and local officials in government or health and consumer representatives. The duties of the Council were to

assist . . . in the preparation of general regulations for, and as to policy matters arising with respect to, the administration of Section 314 . . . with increased emphasis on cooperation in the coordination of programs . . . with the . . . Regional Medical Programs, with particular attention to the relationship between the improved organization and delivery of health services and the financing of such services . . .⁵

The recognition of the need for (1) a central federal clearinghouse, (2) unified general regulations and policy clarification, (3) cooperation with RMP and (4) emphasis on the delivery of health services all indicated that Washington was aware of the lapses of the previous law. The means of change occurred with the passage of Public Law 93-641 on January 4, 1975. Cited as "The National Health Planning and Resource Development Act of 1974" this law set, for the first time, national guidelines for health planning, changed "a" and "b" agencies to

"health systems agencies," set up a program for state health planning and encouraged health resources development.

The purpose of this new law was a far cry from the rhetoric of "assuring the highest level of health." P.L. 93-641 corrected the vagaries of P.L. 89-749 in a reasonably substantive manner. It stated that the achievement of equal access to quality health care at a reasonable cost was a federal priority, that the massive infusion of funds into the existing system had failed its purpose, and that previous responses to the problem had not resulted in a comprehensive approach to the lack of delivery, maldistribution and excessive cost of health care. It cited overuse of hospitals, warned providers to become involved in policy development, and recognized the public lack of knowledge regarding personal health care and system utilization. Each of the weaknesses of the current system that were pointed out in preceding chapters were acknowledged by P.L. 93-641.

This amazing document went even further. It called for national standards for the supply, distribution and organization of resources, as well as a statement of national health planning goals to be expressed in quantitative terms. Detailed guidelines replaced obscure assurances. Ten priorities listed areas to be of prime concern, including the development of group practices and health maintenance organizations, stress on prevention and general health education. The mandate of noninterference was

nowhere in evidence. The National Council no longer specified consumers, but emphasized multi-level government participation, including the Department of Defense.

The organization of the planning bodies which were to act on these concerns was spelled out point by point. Part B of the law--Health Systems agencies, defined health service areas in detail. The legal structure of such agencies was formulated and staff size, expertise and duties were specified. The establishment of an agency's governing body was spelled out and its responsibilities and functions listed in detail. Other agencies that it must coordinate with were designated, as well as review responsibilities. Several pages were devoted to the designation of such an agency, whereas the previous bill had devoted one paragraph to the entire establishment and organization of the "b" agency.

Part C, dealing with state health planning and development, called for a state agency to administer a state program. Two interesting departures from the previous pattern required the state agency to conduct its business meetings in public and required "providers of health care doing business in the State to make statistical and other reports . . . to the State agency."

The function of the state agency changed from creating an overall state health plan to preparation of a state plan "which shall be made up of the HSP's (health systems plans) of the health systems within the state."

The state could make the revisions necessary to achieve appropriate coordination or to deal more effectively with statewide health needs.

Further functions included administration of a certificate of need program, which involved not only services and facilities, but new organizations as well. The state was also to review periodically all institutional health services being offered in the state.

The new "Statewide Health Coordinating Council" still had a majority of consumers on its board. However, each of the regional agencies was now to be represented. This council was still to act in a review and advisory capacity.

Part D, General Provisions, detailed procedures and criteria for reviews of proposed health system changes. Technical assistance to state and regional agencies was to be provided by the Secretary of HEW, and would include planning approaches, methodologies, policies and standards, guidelines for the organization and operation of the agencies and establishment of a national health planning information center to provide uniform systems for cost accounting and other statistical derivations. Other centers for health planning would give technical methodological assistance for multi-disciplinary health development. Federal review of all health systems agencies would occur at least every three years. The remainder of the law dealt with financial aspects of implementation.⁶

It is evident that the problems facing P.L. 89-749 were made known to legislators and were of a sufficiently serious nature to warrant prompt alteration. Only nine years after P.L. 89-749 was passed, only a part of which involved substantive planning, it was superseded by P.L. 93-641, which amended, point by point, the inherent flaccidity of its predecessor.

Summary

This ready rectification of the law augurs well for the future progress of health planning. More of the parameters of health organization and delivery, environment and prevention are gaining recognition and acceptance and therefore broadening the scope of health planning to what it should be. The history of social change in terms of health legislation reveals a steady advance to fuller understanding of the inadequacies of the health system. From an era of laissez-faire, the sixties created an era of government intervention. It is heartening to see this has not waned, but seems to be a continuing trend. With the strictures which bound Comprehensive Health Planning removed, National Health Planning has sufficient scope to implement the planning process methods which exist to date, and to develop further skills.

Whether P.L. 93-641 will face the same pitfalls as its predecessor remains to be seen. Although its scope is widened and the noninterference clause removed, its

structure remains a supplement to the current delivery system; it does not supplant it. It may be that, although the trend is away from a policy of protection of the health industry to a philosophy of accountability, law and medicine is "metaphysical misalliance."⁷ The health laws express themselves through government agencies. Much of health care remains in the private sphere. Springer queries,

Can the legal system bring about a planned comprehensive health care program that meets the currently felt and specifically articulated needs for access, reasonable costs and quality? The answer . . . is probably not. Our system and our philosophy cannot tolerate such an intrusion. Moreover, the division of powers is too complex . . . among executive agencies and legislative bodies . . . the law can point to change, but it alone is rarely capable of transforming entrenched institutions, systems and mythologies that act as operational hypotheses for action.⁸

Two alternatives remain open. Legal restraints can increase and government intervention expand. Many see this as feasible; witness the present debate about a nationalized health system. Or the private sector can move to rectify present inefficiencies. Group practices and health maintenance organizations, either for profit or not, are already burgeoning. Many see this as a practical application of free enterprise, whereby affordable preventive medicine will be the attractive, viable alternative. This has much to be said for it. The public and the medical establishment could effectively block nationalization for a long time. Moreover, the American people would be

reluctant to endorse a closed government system. An efficient delivery system watchdogged by the government would be an acceptable compromise and in full keeping with past parallel situations. It is quickly becoming an American tradition that the free enterprise system should be protected, while at the same time, the government is expected to protect the people from it. It seems likely that government intervention will take the stance of standardizing, regulating and supporting private health care. That this will continue to be the trend is forecasted by the mandate in the new bill to foster alternate health care mechanisms. In the uniquely American spirit of partnership between government and big business, the health, happiness, and power of the nation is being advanced.

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