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HEALTH PLANNING MEMORANDUM
FROM COMMUNITY HEALTH, INC.

No. 14 March 27, 1970

HSIA-70: The Administration Viewpoint

WASHINGTON MEETING

In an effort to create a climate of better understanding for its Health Service Improvement Act of 1970 (S.3443; H.R.15960), the Administration ran a well-organized briefing session for national agencies and others in Washington on March 13. Dr. Joseph English, HSMHA Administrator, led a wide-ranging discussion of the intent of the Act, again stressing the fact that it does not combine RMP and CHP activities, except within a single Title of Federal law. A summary of the Administration's view of the purposes and effects of the proposed law was distributed, and HPM is reprinting it verbatim along with a budget estimate distributed at the meeting. These items should give those with an interest in this program a clear picture of the Administration's intent.

PURPOSES

The major overall aim of the proposed "Health Services Improvement Act of 1970" is to make it possible for the Federal Government to step up the pace of action, in concert with the States and local public and private agencies, to move away from the present patchwork health care delivery system toward functioning, effective, consumer-oriented health care delivery systems.

The draft of the proposed legislation, together with the related recommendations for administrative action, analysis and evaluation, and policy decisions, reflects the Administration's determination to accomplish the following five purposes:

1. To conserve and protect the gains made toward the goal of improved organization and delivery of health care by the Regional Medical Programs, comprehensive health planning agencies, the National Center for Health Services Research and Development, and the National Center for Health Statistics;

2. to encourage these programs to continue those efforts which show promise of achieving the goal more rapidly and effectively;

3. to bring about improved coordination and cooperation among the four programs at the Federal level, thereby making clear the Federal intention that these programs should complement and support one another as they assist State and local public and private agencies;

4. to designate as leaders in a new thrust to develop more effective health care systems the Regional Medical Programs and the comprehensive health planning agencies; and, finally and most important;

5. to focus limited resources on health care systems building, a purpose which would be accomplished through experiments in selected places in the development of effective, integrated health care delivery systems which can serve as working models for other areas of the nation.

ASSUMPTIONS

The assumptions which underlie these purposes are 10 in number:

1. The Federal Government has emphasized heavily the provision of aid to those who need health care, but has not paid sufficient attention to the matter of the way by which that care is organized and delivered to the consumer. The need to act to create improved systems of health care at the local level is critical, since the present patchwork is clearly inefficient, is pushing costs higher, does not provide care for all who need it, and is not responding fast enough to meet the urgent need for change.

2. The existing Federal programs designed to contribute to improved organization and delivery of health care, the Regional Medical Program, comprehensive health planning, and the National Center for Health Services Research and Development, have not made a coordinated effort among them aimed at the central problem of creation of an integrated, effective, consumer-oriented health care system, largely because they were not originally intended to do so. RMP has focused primarily on cooperative arrangements among providers of care in the areas of heart disease, cancer and stroke. CHP has concentrated primarily on planning, rather than development of health care systems. The National Center has concentrated primarily on research and demonstrations, rather than on system development.

3. If significant changes are to occur in time, before the critical situation grows still worse, new inter-governmental and public-private efforts to create effective, consumer-oriented health care systems are needed. The initiatives needed will not occur of themselves in the private sector, but require that the Federal government, jointly with the States and with local public and private agencies, take the lead under new legislative authority to develop the needed system.

4. There is no single answer or simple solution to the problem of how to bring about improved health care systems, but rather there exist multiple proposals for improving and developing systems. The Federal government is not committed to a single solution, and is prepared to experiment with a number of proposals for the purpose of developing a variety of models for potential use throughout the nation, at the State, regional, and area-wide levels.

5. Since there are agencies--Regional Medical Progams and comprehensive health planning agencies--which are now engaged in important aspects of planning and development, the most sensible use of resources dictates that these agencies should jointly be designated as the lead agencies to conduct experiments in the development of health care systems. The National Center for Health Services Research and Development should provide funds and technical expertise to assist these agencies in Washington and in the field with the experiments. The National Center for Health Statistics should cooperate with the above three agencies and with States and local agencies in the necessary research and development aimed at the design and implementation of a Federal-State-local health information system which would provide comparable health data to all planning and program agencies.

6. Since all four of the agencies affected are within the Health Services and Mental Health Administration, it should play the major role in coordinating the efforts of these four agencies and in the design and conduct of the experiments.

7. The best way to communicate the dual intention both to conserve what has been accomplished to date and to move aggressively to develop and build effective health care delivery systems is to propose legislation which places all the agencies directly concerned with improved methods and procedures for organization and delivery of health care in one title, with a single statement of purpose, a single authorization of purposes, and a single advisory council, all of which should contribute to clearer policy and improved coordination of effort, and therefore to a clearer understanding on the part of Congress and the public as to the nature and purpose of the programs.

8. Since rational decisions about organization and delivery of health care depend on good information about health resources and health status of the population, it is essential to begin construction of a Federal-State-local health information system which provides comparable data. Given that a determination remains to be made as to what data are needed for what purposes, and given that no design is now available for such a system, it is best to begin by performing, through the National Center for Health Statistics with the help of the National Center for Health Services Research and Development, the research and development necessary for the design of such a system and to make proposals at a later date for any needed legislative action and financing.

9. It is important that the gains made to date by the Regional Medical Program and comprehensive health planning agencies in the area of organization and delivery of health care should be conserved, protected, and supported in the future, both because what they have done in many cases is to lay the necessary groundwork for health care system building and

because they have captured the imagination, enthusiasm and cooperation of a widely varying group of providers and consumers all across the country.

10. In order to facilitate cooperation between RMP and CHP agencies at the State, regional, and areawide levels, requirements need to be set forth in the law for review and comment and mutual participation in local advisory councils.

WHAT THE PROPOSAL DOES

The proposal, resting on the above assumptions and designed to accomplish the above purposes, does the following:

1. It places RMP, CHP, and NCHSR&D in one title, Title IX, and gives them a single statement of purpose, a single authorization section, separate appropriation statements, a single council, and requires a single annual report evaluating their accomplishments.

2. It continues both RMP and CHP, decategorizing RMP, strengthening the authority of the CHP agencies, and supporting both levels comparable or somewhat above the FY 1970 levels;

3. It provides that resources and attention be focused on the problem of development of models of the health care systems through joint efforts by RMP and CHP, assisted by NCHRS&D, with policy direction from the Office of the Assistant Secretary for Health and Scientific Affairs, and under the direction of HSMHA:

4. It proposes that half a dozen to a dozen places be selected, through negotiation with local RMP and CHP agencies, for experimentation in the development of health care systems;

5. It proposes that these experiments be designed, conducted, and evaluated by both the participants at the local level and by Federal officials, in a partnership effort, and that a variety of models be tested;

6. It proposes that out of this experience with experiments may well come several models of health care systems appropriate for various kinds and sizes of areas and populations throughout the nation;

7. It proposes that the National Center for Health Services Research and Development should participate in the experiments research support on what models are available for possible testing, through both financial and staff support for the experiments themselves, and through support for cooperative efforts by the NCHSR&D and the National Center for Health Statistics to do the needed research and development for the design of a Federal-State-local health information system;

8. It proposes that the scope of the national health survey be enlarged to include a broader health focus;

9. It proposes a series of administrative, analytical, evaluative, and policy steps which appear to be required if the proposal is to be made to work with greatest efficiency and effectiveness.

HEALTH SERVICES IMPROVEMENT ACT BUDGET ESTIMATES

	FY 1969 Actual 1/	FY 1970 Estimate 2/	FY 1971 Estimate
COMPREHENSIVE HEALTH PLANNING AND SERVICES			
314 (a) State Planning	7,329	10,371	7,675
314 (b) Areawide Planning	6,174	7,700	10,200
314 (c) Health Planning Training	3,186	4,125	4,125
Total Planning	16,689	22,196	22,000
314 (d) Formula Grants	65,642	90,000	90,000
314 (e) Project Grants	75,851	82,782	109,500 3/
Program Direction	1,011 4/	3,185 4/	4,564 4/
Total	159,193	208,163	226,064
HEALTH SERVICES RESEARCH AND DEVELOPMENT			
Grants and Contracts	16,846	37,440	50,867
Direct Operations	7,850	3,850	5,025
Program Direction	1,390	1,212	1,511
Total	26,086	42,502	57,403
NATIONAL HEALTH STATISTICS			
National Vital and Health Statistics	6,860	8,633	9,358
State-Federal Health Statistics System	--	--	--
Program Direction	616	537	560
Total	7,476	9,170	9,918
REGIONAL MEDICAL PROGRAM			
1. Regional Medical Programs:			
a. Grants	72,365	73,500	79,500
b. Direct Operations	896	1,771	1,812
2. Technical Assistance & Disease Control 5/	--	(18,287)	(13,168)
Regionalization Activity of the RMP	2,038	1,795	1,805
3. Program Direction including Chronic Disease Control	--	(3,023)	--
Program Direction for Regional Medical Programs	1,402	1,947	2,022
Total	78,701	79,013	85,139
GRAND TOTAL	269,456	328,848	378,524

1/Does not include budget item "Change in Selected Resources" for any of the programs.
2/Program estimates are as they appear in the President's FY 1971 budget & do not reflect final action on the FY 1970 budget.
3/Includes $30,000,000 transfer of funds and program responsibility for OEO.
4/Total Program Direction of CHS.
5/Includes Chronic Disease Program.

JOB OPPORTUNITIES

03-001

Proj Coor, Joint Hosp Clinic, Large Multi-Spec Clinic, Blue Cross/Blue Shield Proj, Struc & Market Health Prog, Emphasizes Prev & Ambu Care, Salary w/Exp: E Eckland, Adm, Fallon Clinic, 630 Plantation St., Worcester, Mass.

03-001

Staff Planning Consultant, 314B agency, grad.degree, 10M-14M/annum. Contact R.H. Lauterstein, Comprehensive Health Planning Council of W.N.Y., Inc., 300 Genesee Bldg., Bflo, N.Y. 14202. (two positions)

03-001

Assistant Director, MHA or equiv, exp. planning desir., not essential, estab areawide plan. agcy, salary open. Write S.Sieverts, Ex. Dir., Hosp. Planning Ass'n., Chatham Center, Pgh, Pa. 15219

03-002

Coordinator, seven-hosp corp., total 1,790 beds, dev. areawide prog., MHA or equal, salary open, excep. opportunity. Send resume to J.P. Zimmerman, Assoc. Ex. Dir., Hosp. Planning Assn., Chatham Center, Pgh., Pa. 15219

03-003

Research Associate, MPH biostat. or equiv., direct data program for estab. areawide plan. agcy., sal 10,000 up. Write S. Sieverts, Ex. Dir., Hosp. Planning Ass'n., Chatham Center, Pgh., Pa. 15219

COMMUNITY HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

HEALTH PLANNING MEMORANDUM
FROM COMMUNITY HEALTH, INC.

No. 13 March 18, 1970

Law and Health Planning....California State Legislation on CHP....Maryland Franchising....

HERMAN LEAVING DCHP

Dr. Harold Herman who has been one of the principal architects of the CHP Program since its inception will leave Federal service about April 15. Dr. Herman will join Linton, Mields & Coston, Inc., a consulting firm. No replacement has been selected at this time.

A LEGAL CRISIS?

While most of the health planning fraternity have been turning their attention to whether or not there would be legislation to extend the Partnership for Health, Dr. William J. Curran of Harvard is questioning the legal status of the current concept of areawide CHP. In an article entitled "Health Planning Agencies: A Legal Crisis?" (Am. JI. P.H. Vol.60, No. 2, February, 1970) he notes several serious legal issues surrounding CHP that must be resolved in the 1970's. Citing the legal status of areawides as the most critical problem, he questions whether public accountability can be assured in a predominantly voluntary areawide health planning system. Curran writes, "Comprehensive Health Planning, as it develops, seems to be primarily a new political system for decision making and priority-setting in the health field, public or private." He also cites the CHP Acts' lack of definition of the relationship between State and areawide agencies as a possible source of legal difficulties. Dr. Curran's provocative comments should be "must" reading, particularly since the matter of continuation legislation is an open issue in Congress.

THE CALIFORNIA APPROACH

In view of Dr. Curran's concerns, it is instructive to review a bill signed into law during 1969 by Governor Ronald Reagen of California. This bill represents the furthest any State has gone in developing an extended legal base for voluntary health planning. The basic legislation is Assembly Bill No. 1340, a bill to establish a permanent base for voluntary area planning in the State. The introductory section is quoted in full as follows:

"This act established a permanent basis for voluntary planning to guide communities in developing hospitals and other health facilities of a desirable size and location and commitment to community service purposes. Through continued coordinated development of hospitals and related health facilities and services, including facilities licensed by the Department of Mental Hygiene, the people of the State of California can obtain more effective service and can save substantial sums in capital costs and operating expenses.

"Planning for hospitals and related health facilities and services is complex and includes sensitive relationships between consumers, professional groups, institutions, and governments.

"The purpose of this act is to establish a public policy that each hospital and related health facility, including facilities licensed by the Department of Mental Hygiene, proposed to be constructed, expanded, or altered for the purpose of increasing bed capacity or changing license category shall in good faith review its plans and program with an approved voluntary area health planning agency and obtain its objective reviews and recommendations before proceeding to licensure. It shall also be a purpose of this act that all state and local governmental zoning and planning agencies shall, within the limits of statutory authority, give consideration to, but not be bound by, the actions, of such approved voluntary area health planning agency."

AGENCY CRITERIA

The Act provides that the State shall approve no more than one voluntary area health planning agency for any area of the State, providing the group:

--is an incorporated nonprofit body with a majority of public members on the controlling Board of Directors

--shall develop principles for determination of community need as a guide to institution in acting in the public interest

--shall conduct public meetings.

REVIEW FUNCTION

The agency shall review individual proposals for the construction of new or additional hospital and related health facilities; for the conversion of one type of facility to a different category of licensure or the creation or expansion of new areas of service; and will make decisions as to the need and desirability for the particular proposal in accordance with the principles developed pursuant to (other parts of the bill).

ADMINISTRATIVE PROCEDURES

The law establishes certain procedures that must be followed in review of individual proposals, which include:

(1) A public hearing.

(2) Reasonable notice.

(3) Right to representation by counsel.

(4) Right to present oral and written evidence and confront and cross-examine opposing witnesses.

(5) Availability of transcript at applicant's expense.

(6) Written findings of fact and recommendations to be delivered to applicant and filed with the State Department of Public Health as a public record.

It also provides that the agency may levy filing fees and charges for processing and appeal as a means of financing these procedures.

APPEAL MECHANISM

An appeal mechanism is built into the law *whereby the State* Health Planning Council will designate the consumer members of the Board of a second area health planning agency as the appeals body to hear appeals from a sister agency's area of jurisdiction, but prevents agencies from being designated as appeals bodies for each other. In effect, agency B could be the appeals body for decisions from agency A's area, but A could not be the appeals body for decisions by agency B. The decision on this type of appeal can also be appealed by the applicant directly to the State Health Planning Council. A vote of 1/3 of the Council's members is required to accept the request for a hearing. If the State Council agrees to hear the appeal, the full council must participate in the final decision. A decision thus becomes final only when accepted by the applicant, or when all rights to appeal have been exhausted.

MARYLAND FRANCHISING LAW

A bill was introduced last month in the Maryland legislature to institute a system of franchising hospitals and related institutions in Maryland through the State Comprehensive Health Planning Agency. In the case of the pending Maryland legislation, the purpose reads as follows:

"(A bill to change the existing law by) requiring the State Comprehensive Health Planning Agency to specify the services and facilities required of hospitals and related institutions in this State, providing the procedures and requirements for these services and facilities; requiring the State Comprehensive Health Planning Agency to determine, as a condition precedent to licensure, that a hospital or related institution is rendering effective services at the most reasonable charges to the public and requiring, for the purpose of making such determination, that any and all records of any hospital or related institution be made available to the State Comprehensive Health Planning Agency and to compel their production by subpoena duces tecum, requiring sworn copies to be filed with the State Comprehensive Health

Planning Agency, providing that the appointments to the State Health Planning Council be made by and with the consent of the Senate, providing for the designation and the appointments thereof of sub-areawide comprehensive health planning agencies, and relating generally to hospital licensing and the Comprehensive Health Planning Agency."

ADMINISTRATIVE PROCEDURES

Like California, the law in Maryland provides for quasi-judicial review and appeals mechanisms, and states that "Proceedings, rule-making, contested cases, rules of evidence and judicial review" will be governed by the State Administrative Procedure Act.

STATE DESIGNATION OF AREAWIDES

The proposed Maryland legislation vests in the State Approved Health Planning Agency the authority to "designate all subareawide comprehensive health planning agencies to be organized for the purpose of conducting and coordinating comprehensive health planning for any given area of the State; *and the Governor, with the advice and consent of the Senate, shall appoint the members of the Advisory Council serving such sub-state area-wide comprehensive health planning agencies.*"

COMMENT

These two States have moved to establish a base for operation of health planning agencies that extends beyond the concept of the basic Federal concept embodied in P.L. 89-749. California has elected to call its system *voluntary* area planning, but has built in a quasi-judicial review system and essentially structured an adversary system for decision-making by the "planning" agency. In the Maryland bills, the extent of the State presence at the community level is illustrated in the role of the Governor, with the advice and consent of the Senate, in the appointment of Advisory Council members reviewing an areawide agency. Dr. Curran--in the case of the California legislation--notes that "it sounds more like a court or public regulatory agency than a planning agency." This comment seems even more appropriate to the Maryland bill.

COMMUNITY HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

ROBERT E. SHANK, M.D.
HEAD OF DEPT. OF PREVTVE. MED.
WASHINGTON UNIV.
SCH. OF MEDICINE
4550 SCOTT AVE.
SAINT LOUIS, MO. 63110

HEALTH PLANNING MEMORANDUM
FROM COMMUNITY HEALTH, INC.

No. 12 March 4, 1970

HPM - SOME GOOD NEWS AND SOME BAD NEWS

FIRST, THE BAD...

In September, 1969, HPM was launched as an occasional memorandum to get items of special interest to health planners into the field as quickly as possible. An audience of 200 or so agencies was anticipated for a dozen or so memoranda each year, "geared to developments of interest rather than a fixed schedule". Interest has been much greater than expected. Issue #10 was mailed to more than 1700 individuals and organizations, and was the fifth issue since January 26. In view of both the increased demand and the increased activity, it has become necessary to establish a modest subscription fee schedule to cover the costs of producing and distributing HPM. This schedule will go into effect on April 1, 1970. The schedule includes bulk rates for agencies who wish to distribute HPM to staff or Advisory Board Members, etc. The bulk rates are generally competitive with photocopying costs.

What will you get? A minimum of 12 issues per year, but more likely 20-25 issues of current coverage of topics of interest to health planners, such as HPM coverage of legislation (#6-11), BOB A-95, etc. We hope that this service has been useful, and we will strive to keep it that way.

Rates

Single Subscription (agency or individual)		$10.00 per year
Single Subscription (student)		$ 5.00 per year
Bulk Rates:	2nd to 10th	$ 1.50/yr./copy
	11th to 25th	$ 1.00/yr./copy
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If you wish to receive HPM after April 1, fill out and return the attached subscription blank with your check or money order to:

Circulation Desk - HPM
Community Health, Inc.
1775 Broadway
New York, New York 10019

NOW, THE GOOD...

At the Tulsa Meeting of 314 (a), (b), and (c) agencies, the representatives expressed the need for some sort of information source on job opportunities in the health planning field. CHI agreed to take on the job of serving as a contact point, at least on a trial basis. The following program has been worked out as the most efficient at this time:

-Once a month, a HPM will be published devoted to, or including, a job opportunities summary

-The summary will simply list job opportunities, and will not be able to provide a box number or other exchange functions

-Listings will be limited to opportunities in the health planning field, but may include planning jobs in agencies other than (a), (b), or (c) grantees, i.e., health departments, voluntary agencies, etc.

-Agencies with vacancies who would like them listed in the summary should submit three 75 character lines (on a 3" x 5" card) stating the job title, salary, agency name and address. Other information may be included, within the character limits, as in the following example:

Planning Asso. Bistate 314b dev. grantee seeks recent MPH, int. comm. org. vol. agency exp. desirable. Start $12000 p.a. liberal fringes. Write J. Smith X.Dir., Bistate Health Planning Comm. 185 Front St. Silver Spgs.N.Y. 10000

-All items meeting the criteria for length will be printed for two successive months and then dropped unless the agency requests extension in writing.

-Items from job seekers as opposed to job opportunities cannot be accepted.

-HPM cannot be responsible for the accuracy of the description submitted--caveat emptor!

If you want a job or jobs to be listed in the first summary on March 27, send your card(s) to:

Job Information Desk - HPM
Community Health, Incorporated
1775 Broadway
New York, New York 10019

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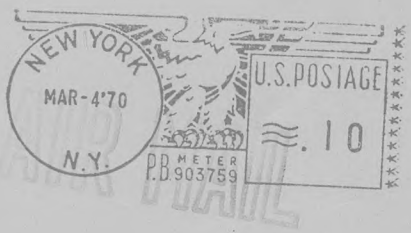

ROBERT E. SHANK, M.D.
HEAD OF DEPT. OF PREVTVE. MED.
WASHINGTON UNIV.
SCH. OF MEDICINE
4550 SCOTT AVE.
SAINT LOUIS, MO. 63110

HEALTH PLANNING MEMORANDUM
FROM COMMUNITY HEALTH, INC.

No. 11 February 19, 1970

THE HEALTH SERVICES IMPROVEMENT ACT OF 1970 (S. 3443)

ADMINISTRATION UNVEILS ITS RMP/CHP BILL

The long awaited HEW proposal for extension of RMP, CHP, and related programs was unveiled before a large group of invited representatives of local, State, and national agencies on February 16. The proposal, titled the Health Services Improvement Act of 1970, was discussed by an HEW team headed by Dr. Jesse Steinfeld, Deputy Assistant Secretary for Health and Scientific Affairs and Dr. Joseph English, Administrator of HSMHA. In listing the major points of the bill, Dr. Steinfeld noted that the proposal had grown out of studies of a number of related HEW health programs with "similar goals". He stressed that the proposal requires no forced merging of the programs covered, but rather enables and encourages them to work together. In amplifying this point, Dr. English cited the proposal as an attempt to deal with the problems of health care delivery, and particularly with the "capacity" of the system. The legislative proposal, English continued, is a response to numerous requests from the field that HEW "use the levers available to begin to respond to the health services delivery problem." Strong emphasis was laid on the proposals "permitting flexibility" in development of new systems of health services delivery, systems that may involve some degree of combination of RMP and CHP activities in the future.

BILL INTRODUCED SAME DAY

Later in the day, Sen. Jacob Javits (R-NY) and several colleagues* jointly introduced the bill in the Senate, where it was assigned the number S.3443, and referred to the Committee on Labor and Public Welfare. The bill would amend the Public Health Service Act, creating a new Title IX, replacing the current Title IX as well as Sections 304 and 314 of Title III, and adding to Section 305 of Title III.

MAJOR FOCUS

In remarks in the Senate at the time of introduction, Sen. Javits noted that "It is the purpose of this bill to assist us in our efforts to improve the systems through which health care is provided in our Nation. In keeping with the developing health strategy of the DHEW, existing resources and programs

*Sens. Prouty (R-Vt); Murphy (R-Cal); Dominick (R-Colo); Scott (R-Pa); Saxbe (R-Okla); Brooke (R-Mass); Goodell (R-NY); and Schweiker (R-Pa).

would be focused more intensively on the building of functioning, effective, consumer-oriented health care systems." (The Senator's full remarks appear in the Congressional Record for February 16, 1970, p. S1726.) This language also appears in the introductory portion of the bill itself.

PURPOSES

(Section 900) The declaration of general purpose is similar to that that appeared as the preamble to P.L. 89-749 but stresses the support and encouragement of evolving, innovative patterns and forms of providing preventive, diagnostic, therapeutic, and rehabilitative services. In addition, this section describes specific purposes for RMP and CHP not unlike their present mandates. An additional purpose of the Act is "to provide support for experiments and demonstrations in the integration and coordination of the programs authorized by this title, and appropriate related programs, leading to the development of improved health systems extending high quality care to all, improving efficiency in the use of resources, and promoting the effective interrelationship of assistance provided by Federal health programs."

NATIONAL ADVISORY COUNCIL

(Section 901) The proposal would authorize the Secretary of HEW to appoint a National Advisory Council on the Planning, Organization, and Delivery of Health Services to advise and assist him in the administration of the program. The Council would consist of 25 individuals, including a Chairman and 24 members. The bill states that the membership of the Council would be drawn from fields such as: the fundamental sciences, the medical sciences, those knowledgeable in the organization, delivery, and financing of health care, State or local officials, persons active in consumer affairs or public or community affairs or who are representatives of minority groups. It would advise the Secretary on regulations or policies arising in relation to the Act, or under the Social Security Act and other Federal and Federally-assisted health programs, with particular attention to relationships between the organization and delivery of health services and financing of such services. It will review the grant programs annually, but is not a review committee for individual grants.

APPROPRIATIONS

(Section 902) The bill authorizes three appropriation lines--one each for RMP, CHP, and the remainder of the Title--for three fiscal years. The authorization sought is for "such sums as might be necessary" for the programs in each of the three years. Among the activities to be supported with the funds are cooperative planning and experimentation related to organizing and developing health care systems--including planning for the manpower, services, and facilities necessary--consultation and technical assistance, research, development, training, and demonstrations. The funds may be used to promote effective combinations of methods for delivery of health services, including integration of RMP and CHP activities.

REGIONAL MEDICAL PROGRAMS
(PART A)

Definitions

(Section 911) As defined in S.3443, RMP means a cooperative arrangement among a group of public or nonprofit private institutions or agencies engaged in some combination of the following activities: planning, research, development, training, and demonstration of patient care, including preventive, diagnostic, therapeutic, and rehabilitative measures, and methods of patient care (no categorization) relating to one or more diseases of man as may be permitted in regulations, which is located in an appropriate geographical area; includes one or more of each of the following: medical center, clinical research center, hospital; and has in effect adequate cooperative arrangements. "Medical center" means a medical school or other institution engaged in post-graduate medical training and one or more affiliated hospitals. "Clinical research center" means an institution with primary function of research, specialized training, and demonstration of high-quality services for outpatients and inpatients.

Planning Grants

(Section 912) Planning grants are made available to public or private nonprofit universities, medical schools, research institutions, and other public or private nonprofit institutions or agencies and combinations thereof for planning the development of Regional Medical Programs. Applications for such grants must show that the applicant has an advisory group including practicing physicians; medical center officials; hospital administrators; medical society representatives; State or local public or non-profit private agency representatives; representatives of area-wide health planning agencies; and representatives of consumers of health services (including the poor and minority groups) familiar with the community's needs with respect to services provided under the program. Planning grant applications must be submitted to the State and areawide comprehensive health planning agencies for review and comment prior to approval.

Operational Grants

(Section 913) Operational grants are authorized to similar agencies for establishment and operation of RMP's, including construction and equipping of needed facilities. Such grants must be approved by the Advisory Group and be referred for review and comment to State and Areawide CHP's or, if there is no Federally funded areawide, to another agency which carries out similar functions. The applicant must also seek other sources of funding for such projects after an appropriate period of Federal support.

List of Facilities

(Section 915) S.3443 authorizes the Secretary directly or through contract to establish and maintain a list of facilities equipped to provide advanced methods and techniques in the prevention, diagnosis, treatment, and rehabilitation of disease.

Cooperative Studies	(Section 916) The Secretary is authorized to make grants for services needed by, or of substantial use to, two or more regional medical programs and to contract for the conduct of cooperative clinical and field studies and demonstrations.
COMPREHENSIVE HEALTH PLANNING (PART B)	
Statewide CHP	(Section 921) As reported earlier (HPM #7), the current 314 (a) program is only slightly modified. The requirement for creation of a State Health Advisory Council is modified to require at least one RMP representative and to require representation of the poor and minority groups in appropriate numbers. The appropriate number is to be determined in regulations by the Secretary. Section 314 (a)(2)(I), requiring the State Agency to provide assistance to each health care facility in the State for capital expenditure planning is modified to require the State CHP Agency to "consult with" the areawide agency reviewing the area where the facility is located, or where there is no such agency, another agency with similar planning functions as determined in regulations by the Secretary.
Areawide CHP	(Section 922) The proposed legislation would permit granting of funds to State Health Planning Agencies to assist in development of plans for areas not served by an areawide planning agency. In the case of agencies applying for grants to conduct areawide health planning, the approval of the State Agency is required. The applicant must make provision for establishment of an advisory council, including representatives of public, voluntary, and nonprofit private institutions, agencies, and organizations concerned with health including representatives of the interests of local government, of the RMP(s), and of consumers of health services. At least one member must represent RMP, and a majority of the membership of the council shall consist of consumer representatives, including representatives of the poor and minority groups in appropriate numbers as determined by the Secretary in regulations.
Training, Studies, and Demonstrations	(Section 923) In addition to the grant authority for training programs, studies, and demonstrations in CHP, the Secretary could enter into contracts for these purposes under this section.
Block Grants For Health Services	(Section 924) The block grant program to State health and mental health authorities would be continued. In order to receive their allotment, the State must submit a State plan along the lines of that already required under Section 314 (d).

New language would require that these plans show their relationship to the total health plans of the State, including health activities which are responsibilities of State agencies other than the State health and mental health authorities and including programs concerned with the financing of medical care. In addition, although State Health Planning Agency approval would be required, the Secretary would prescribe by regulation methods for certification by the Governor of the readiness of the Planning Agency to review and approve such plans. Other requirements of the present 314 (d) would be retained.

Project Grants For Health Services Development

(Section 925) The Secretary would be authorized to make grants to any public or private nonprofit institution or organization to cover part of the cost of (1) providing health services to meet needs of specialized national significance or limited regional scope or (2) developing and supporting for an initial period new programs of health services. Such grants can be made only if such proposals have been referred for review and comment to the appropriate areawide health planning agency or agencies, or if there is no such agency in the area, to such other public or nonprofit private agency or organization (if any) which performs similar functions, as determined in accordance with regulations. Reasonable assurances will be required from applicants that they will seek future funding from other non-Federal grant programs or from Federal sources providing reimbursement for medical care costs to eligible beneficiaries.

HEALTH FACILITIES AND SERVICES RESEARCH AND DEMONSTRATION (PART C)

Health Services Research And Development

(Section 931) S.3443 would authorize the Secretary to make grants and contracts to support research, experiments, development, demonstrations, and training related to the organization, financing, and delivery of health services, and of facilities related to such services. Eligible projects would include such things as:

--construction of facilities involving experimental architectural design

--testing of new equipment or systems for delivery of health services

--projects for research and demonstration in new careers in health manpower and new ways of educating and utilizing health manpower.

MISCELLANEOUS

Annual Report

(Section 945) The bill would require the Secretary to report on or before January 1 each year on activities carried out during the preceding fiscal year, along with an evaluation of the effectiveness of the programs; a statement of the relationship between Federal and other financing of the activities including efforts by grantees to develop alternative sources of financing after an initial period of support; and recommendations with respect to modifications of the Title.

Regulations

(Section 947) S.3443 would authorize the Secretary, after consultation with the Council, to prescribe regulations covering the terms and conditions for approving grants under this title and relating to methods for the coordination of programs assisted under this title with other Federal or Federally-assisted health programs.

Withholding of Payments

(Section 926) The Secretary, after reasonable notice and opportunity for hearings, can withhold formula grant payments to the States under Section 921 and 924 if there is evidence of failure to comply with the law, the regulations promulgated under the law, or the State plans submitted as a requirement for funding.

HEALTH INFORMATION SYSTEM DEVELOPMENT

S.3443 would amend Section 305 of the PHS Act (The National Health Surveys and Studies) to add "health care resources", environmental and social health hazards", and "family formation, growth, and dissolution" to the list of areas to be examined by the National Center for Health Statistics. In addition, the bill would authorize the Secretary to undertake directly, or by grant or contract, research, development, demonstration, and evaluation relating to the design and implementation of a cooperative health information and statistics system which provides comparable health data at the Federal, State, and local levels. It would also insert language maintaining confidentiality of information obtained in such surveys.

HEARINGS ON S.3443

Since the Administration bill was introduced late on February 16, and since it dealt with extension of RMP along with the other provisions, Assistant Secretary for Health and Scientific Affairs, Dr. Roger O. Egeberg was able to base his already-scheduled testimony on a previous bill to extend RMP (S.3355) on the new proposal. On the morning of February 17, he appeared before Sen. Ralph Yarborough's Committee on Labor and Public Welfare and testified in support of S.3443.

Summarizing the provisions of the act, Dr. Egeberg said, "We view this proposal as an essential initiative to improve the coordination of the Department's health programs and to help meet the need for improved health care for the Nation." Commenting on the substantial accomplishments and progress of CHP and RMP to date, he said, "We expect to capitalize on these achievements as we focus more intensively on the development of better systems for the organization and delivery of health services." He cited several specific examples of RMP-CHP cooperation already under way, and noted that "It is this sort of cooperation which gives us confidence that we can put these existing programs to the larger task of developing effective comprehensive health care systems. Our proposal is a first careful step toward that broad goal."

While stressing that "we have no single model in mind now, nor do we expect to develop a single model in the future", Egeberg listed some of the approaches to experimentation in combination being considered by HEW staffers:

> "In relatively small or similar situations, multiple functions could be served by a single RMP-CHP staff, by two staffs and a single board, or by one staff and two boards."
>
> "Under a more complicated and dynamic approach an area-wide CHP agency could be given community responsibility for structuring the local health care system, including considerable influence over programs and capital funding decisions. The RMP would provide specialized regional aid, including technical assistance on the development of primary care, training, continuing education, specialized regional services and professional supervision of quality control."
>
> "Another model would provide for the assumption of geographic responsibility by community hospitals, extending across all levels of care and concerning the efficiency of the total system rather than the efficiency of acute care only."
>
> "Yet another model might experiment with competitive prepaid group practices with various options including the ownership of a hospital."
>
> "Another experiment might focus on relationships along a continuum of care--prevention, diagnosis, treatment, and rehabilitation--attempting to distribute responsibility among community institutions for each of these functions and to create the relationships necessary to make it possible for consumers to know how, where, and when they could and should go for various types of treatment and what that treatment will cost."

Since the hearings at which this presentation was made had been scheduled as hearings on S.3355, the RMP extension sponsored by Sen. Yarborough, the public witnesses who had signed up to testify were groups who were interested in RMP. No public witnesses from the comprehensive health planning field were scheduled, and it appears that there will be no further opportunity for open hearings on S.3443 in the Senate. Agencies which want to comment on the legislation and the strategy it includes may submit written statements to the Committee for inclusion in the record through February 25. Any of HPM's readers who wish to comment can direct their comments to Sen. Ralph Yarborough, Chairman, Health Subcommittee, Committee on Labor and Public Welfare, United States Senate, Washington, D.C. 20501, Attn. Mr. James Babin.

WHAT'S NEXT?

The Administration bill will probably be introduced in the House of Representatives within days. On the House side, it will most likely be considered in hearings along with the Rogers bills (See HPM #10) sometime within the next few weeks. There is more lead time in this case for groups interested in the legislation to ask to testify or to submit written statements on the various proposals. Groups who wish to be considered for testimony in the House hearings should communicate with Mr. W.E. Williamson, Clerk, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Room 2125 Rayburn Building, Washington, D.C. 20515.

COMMUNITY HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

HEALTH PLANNING MEMORANDUM
FROM COMMUNITY HEALTH, INC.

— New File

No. 10 February 17, 1970

ROGERS INTRODUCES CHP EXTENSION

On February 16, Cong. Paul G. Rogers (D.-Fla.) introduced legislation that would extend the comprehensive health planning program in essentially its present form through Fiscal Year 1973 (to June 30, 1973). The Rogers' proposal, H.R. 15895, retains the present independent appropriation authorizations for the various portions of Section 314, but raises the ceilings as follows:

	FY 1971*	FY 1972*	FY 1973*
314 (a)	$17.5	$22.5	$25.0
314 (b)	15.0	25.0	40.0
314 (c)	10.0	12.0	15.0
314 (d)	125.0	140.0	160.0
314 (e)	70.0	60.0	50.0

*Dollars in millions.

SUBSTANTIVE CHANGES

The Rogers' bill would require representation from RMPs on the advisory councils of areawide health planning agencies, a fait accompli in most areas of the country at present. It would also insure the areawide agency a role in review and comment on project grants under 314 (e) which arise in its area, but retains a requirement that 314 (e) projects be consistent with overall State planning as well. It will require the areawide agency to assist health care facilities in its area to develop a program for capital expenditures.

COMPANION TO HIS RMP EXTENSION

H.R. 15895 thus becomes a companion bill to Cong. Rogers proposed extension of the RMP program, introduced on October 23, 1969. In that bill (H.R. 14486), the RMP program would be extended through FY 1973 with a budget authorization of $120 million for FY 1970; $150 million for FY 1971; $200 million for FY 1972; and $250 million for FY 1973.

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RMP-CHP RELATIONSHIPS

The earlier Rogers' bill would require that RMPs--which would have their scope broadened to include heart disease, cancer and stroke and other major diseases--include representatives of voluntary and State and local health and health planning agencies on their advisory groups. H.R. 14486 would also require that grants under the RMP be considered by any areawide health planning agency which has developed a plan covering an area in which the RMP will be located.

EFFECT OF THE BILLS

The effect of the two bills introduced by Cong. Rogers would be to continue both the CHP and RMP programs in their present form for another three years, while requiring more interchange between the two in terms of overlapping boards and project review. The latter points would continue a trend that has already begun in several States and communities within the framework of the present legislation.

COMMUNITY
HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

HEALTH PLANNING MEMORANDUM
FROM COMMUNITY HEALTH, INC.

No. 6 January 26, 1970

IS THIS THE FUTURE?

THE LID LIFTS

A complete, and reportedly authoritative, summary of the long-rumored DHEW proposal for continuation of CHP appeared in the January 7 edition of Drug Research Reports (Volume 13, Number 1), a drug industry-oriented Washington Newsletter. According to DRR the bill--first important health legislation from the Nixon Administration--was largely developed by the Office of the Assistant Secretary for Planning, with minimal input from the health staff. HPM has been unable to find any State or areawide health planners with whom the proposal draft has been discussed, although the DRR projects a "late January" date for introduction in Congress. The major features of the present draft as as follows:

COMBINATION OF INGREDIENTS

CHP, RMP, and activities of the National Center for Health Services Research and Development would be combined under a single statement of purpose and authorization for funds, but in most areas would retain separate identity for program activities.

DEMONSTRATIONS

Several States and cities would be selected as demonstration areas for integration of RMP's and State or areawide CHP agencies in "experiments in developing health care systems," according to DRR.

NATIONAL ADVISORY COUNCIL

A National Advisory Council "on the Organization and Delivery of Health Services consisting of 24 members and a chairman" would be established. The breakdown would include at least three practicing physicians, three involved in research, three knowledgeable in health care financing, three State or local health officials, and a minimum of eight representatives of the interests of consumers. The NAC would function in preparation of regulations for administration of the program, as well as recommending approval of grants under all three components.

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REPORTING REQUIREMENTS

The Administration would be required to report annually on progress in the Partnership Program, including "an evaluation of the effectiveness of programs and attempts by grantees to develop sources of support other than the Federal government."

BOUNDARIES

The DRR article reports "controversy" as to mandating or encouraging common geographic boundaries for CHP and RMP, which was resolved against such a mandate because "any compulsory moves attract attention to a matter of secondary importance."

STATE CHP AGENCIES

The summary in DRR refers to State agencies in only two regards. First, representation from RMP's would be required on State advisory councils. Second, DRR reports "grant veto powers (?-ed.) for State CHP's were also dropped because....staff felt that the CHP's have not yet demonstrated sufficient competence."

COMMENT

Although this is relatively little to go on, HPM felt that the groups most directly affected by the legislation should have it as a starting point for discussion. Whether or not this is the final HEW proposal that will be introduced, the time factor is still a key. Where before we have been counting down in weeks, it is now 110 working days until the June 30th expiration of the existing legislation. It would seem that any alternative to simple extension of existing legislation requires a more adequate public airing than the time remaining could possibly permit. The reported draft raises many questions--the final bill will undoubtedly raise more. Is there time to answer them adequately between now and June 30th?

COMMUNITY HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

AIR MAIL

ROBERT E. SHANK, M.D.
HEAD OF DEPT. OF PREVTVE. MED.
WASHINGTON UNIV.
SCH. OF MEDICINE
4550 SCOTT AVE.
SAINT LOUIS, MO. 63110

HEALTH PLANNING
ISSUE PAPER
FROM COMMUNITY HEALTH, INC.

Issue Paper #3 May, 1970

Areawide Health Planning Agencies: Can They Remain Voluntary?

The Partnership for Health Act authorized a program of grants to "any public or private nonprofit agency" to conduct a program of comprehensive health planning for a substate or interstate area. Community health planning in the United States prior to enactment of this legislation had been largely non-prescriptive in nature, limited to restricted segments of health problems or special population groups, and dealt selectively with individual elements of the system. It was vested for the most part in non-governmental health planning groups. The majority of these were "voluntary" associations of interested organizations and individuals. Examples would include the facilities planning activities of Federally-funded hospital planning councils, the health planning activities of health and welfare councils and one-shot health planning studies by ad hoc citizen groups. Historically, the voluntary planning agencies carried out their functions without any formal regulatory authority over facilities and without control over government funds. A notable exception was New York's franchising law, which vested area hospital review and planning councils with a strong legal review function over facilities.

In the two and one half years since activation of the comprehensive health planning program, a number of these pre-existing voluntary agencies have been recognized or have applied for recognition as the comprehensive health planning agency for their area; in other areas, new autonomous voluntary planning groups have been established and recognized; in still other areas, governmental units have been recognized as the comprehensive health planning agency. (It is usually not recognized that many of the "governmental" health planning agencies are themselves essentially within the voluntary model. Regional Councils of Government (COGS) are in fact private nonprofit associations of representatives of local governments.) The majority of the funded areawide health planning agencies are non-governmental, though the interests of local government are represented as required by law. Theoretically, the determination of the most suitable agency for comprehensive health planning has been based on general agreement within a community that a particular organization is appropriate to conduct the activity.

Comprehensive health planning agencies have been organized on the "voluntary", non-authoritarian model rather than the governmental model for a variety of reasons. Historical precedent was one important reason. Congress, in a report accompanying the Partnership for Health Legislation in 1966, noted the areawide comprehensive health planning program would "extend and expand the successful areawide facilities planning experience" of the Hill-Burton program which was largely a voluntary approach. In most areas, however, a more compelling logic lay behind the creation of voluntary rather than governmental health planning agencies. The health "system" is composed of sectors fragmented in terms of vested interest, ideological concepts, expertise and functions. This complex structure was believed to make it impossible for planning technicians to plan unilaterally for health, and a governmental

authoritarian approach was rejected. A voluntary non-authoritarian model emphasizing participation and partnership was believed more appropriate in order to relate the multiple sectors; to promote expansion and major alteration of systems; to achieve reallocation of resources; and to stimulate entrepreneurial response to health needs.

Many organizers, participants, and communities assumed that these new agencies would continue to operate through cooperation and advice without any particular coercive powers or regulatory functions. Other participants, however, have felt increasingly impotent in this kind of role. They have advocated greater planning agency control over health expenditures in its area. The latter view has been strengthened by a number of other factors--including the increasing Federal financial investment in health as well as the emergence of health-related industry as an attractive investment for private capital. This has led to a call for some sort of planned response to assure that investments are optimal, do not conflict with one another and are consistent with the long term development of the health system. In response to these pressures, a number of developments have occurrred recently at the Federal and state levels in the direction of vesting increased authority in areawide health planning agencies. These portend extensive changes in the method of operation of health planning agencies, and their implications must be explored more fully by the participants.

In our opinion, several very significant issues are raised by some of these recent proposals. Institution of any or all the approaches suggested in the three instances cited below will surely affect the nature and function of areawide health planning agencies in the future. The questions raised, then, concern the desirability and feasibility of combining planning and regulatory (authoritarian) functions in a single agency; the legitimacy of vesting regulatory responsibilities in a non-public agency; and the viability of the voluntary planning concept in an increasingly regulatory environment.

The three most significant items that highlight these issues have been discussed in detail in Health Planning Memorandum. The community trustee concept (October 10, 1969); the California Legislation (March 18, 1970); and the cost effectiveness amendments (April 27, 1970) are the cases in point. Each of the three have elements that represent major departures from the comprehensive health planning concept as it has developed to date in most areas of the country.

The community trustee for health was the name given to the function of the areawide health planning agency in a working paper prepared in HSMHA in early 1969. Under this concept, the areawide agency would have fundamental responsibility for coordinating the many HSMHA programs that impact on the community it serves. Its functions would include those of convenor of agencies and consumers; broker between consumer concerns and institutional response; monitor of the health care system; stimulator of appropriate management responsibilities for elements of the health care system, including possible development of nonprofit management corporations for health activities; and packager assisting the community in effectively utilizing Federal support to meet community needs. These functions--although not involving direct regulatory or decision-making authority--would vest the agency with a much stronger management orientation than is presently the case. Although this approach

was strictly for discussion and not policy, the concept surfaced again as a part of Dr. Roger Egeberg's testimony in support of the Health Services Improvement Act of 1970, where it was included as one of five examples of how CHP and RMP would be restructured for closer cooperation. It would appear that the general concept embodied in "the community trustee" is the best available insight to current HSMHA, and perhaps HEW, philosophy on the role of CHP.

The State of California has enacted legislation vesting voluntary areawide health planning agencies with decision-making authority on all applications to construct, expand, or alter health facilities for the purpose of increasing bed capacity or changing licensure category. The State designates an agency to serve each area. The legislation lays out the organizational pattern and procedural framework in which the agencies will operate, requiring a public hearing, reasonable notice, right to representation by counsel, right to present evidence and cross-examine opposing witnesses, and written findings of fact and recommendations as a public record. This legislation has been activated and guidelines prepared for its implementation. These guidelines are of sufficient interest to those involved in health planning that they are included in their entirety as an appendix to this Issue Paper.

The Cost-Effectiveness Amendments would vest the health planning agencies with an approval role over capital expenditures of health care facilities receiving reimbursement under Social Security Act programs. Institutions would be required to file plans for both general operating expenditures and capital expenditures with the health planning agency annually. In the case of specific capital outlays, reimbursement by HEW would be tied to a determination of consistency of such outlays with overall community and State health planning.

These proposals--if widely implemented--would markedly increase the management and decision-making load on the areawide health planning agency. If there is no increase in agency support, these functions are bound to interfere with the agency's planning mission through competition for available staff time and resources. Even if there is a fee schedule for review as in California, or a cost-reimbursement program as in the Cost Effectiveness Amendments, it would seem that the quasi-judicial nature of this new agency activity would affect its structure and function.

These are ultimately matters of public policy. Planning is concerned basically with the transition from present realities to future possibilities. In a pluralistic setting, will this transition be accomplished best through regulation/control or through persuasion/influence? The experience of the past with both approaches needs to be intensively reviewed as a base for the public policy decision. Are the franchising of health facilities and the distribution of the dollars purely governmental responsibility or can they be delegated to a non-governmental agency? Dr. William Curran of Harvard has called attention to the potential problem of an agency that is not publically-accountable acting in a public decision-making role.

These are questions that should be taken up early by those active both as staff and as board members in health planning agencies. At this point, it is difficult to generalize on where agencies stand on these issues. A reading is badly needed. We would welcome your comments.

INITIAL GUIDELINES FOR IMPLEMENTATION OF A.B. 1340

Introduction

Several years of experience in voluntary health planning have been augmented by recently enacted Federal and State legislation. The purpose of the legislation is to enhance, encourage and support the voluntary action of consumers and health professionals in the health planning process.

Most recently the State of California through A.B. 1340, now Chapter 1451, of the 1969 Statute, has expressed a need for leadership and coordination in order that capital expenditures, operating funds and manpower utilization for health facilities will be made primarily in the best interest of the community. Under the new law, the State Health Planning Council has the responsibility of establishing guiding principles to assist voluntary area and local health planning agencies in the performance of their responsibilities for health facility planning.

These responsibilities of voluntary area and local health planning agencies are required to assist in the coordinated development of hospitals and other health facilities to guide communities in developing facilities of desirable size, location and commitment to community service purpose. A.B. 1340 establishes a basis for these health planning agencies to review all health facility applications to construct, expand or alter for the purpose of increasing bed capacity or changing licensure category. A basis for hearings and for appeals is provided in the law.

In October, 1969, the functions of the former Advisory Hospital Council were transferred to the State health Planning Council as part of the Governor's program to consolidate boards and commissions. These new responsibilities of the State Health Planning Council involve advising the State Department of Public Health on administration of the Hill-Harris, Facilities for the Mentally Retarded, Community Mental Health Centers Construction, Grant-in-Aid Programs, and the State Construction Loan Insurance Program for Health Facilities. This involves establishing policies for the State Plans for these programs which are revised annually, and recommending an allocation of Federal grant funds annually to projects on the basis of relative need for additional facilities in various parts of the State. Voluntary area and local health planning agencies will continue to review and comment upon applications for health facility construction to assist in the administration of these programs.

Under Public Law 89-749 and State legislation, the State Health Planning Council is responsible for advising the State Department of Public Health in developing the California State Program for Comprehensive Health Planning.

In carrying out its responsibilities under Public Law 89-749 the State Health Planning Council has designated nine Comprehensive Health Planning areas throughout the State and already has designated an official health planning agency for eight of the areas. The three health planning functions established for A.B. 1340, Hill-Harris and State Construction Loan Insurance Program, and Comprehensive Health Planning are to be carried out by the same health planning bodies--State, area, and local. The three purposes involve higher inter-related health planning, but each of the three purposes

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is separate and must be carried out legally and appropriately within the intent of the law which established it.

In establishing clearly the basis for separate action in each of the three programs it is important also to emphasize that all three programs should be consistent to the extent permissible by law. All three should enhance rather than diminish professional goals and organizational drive for growth and diversification. Good planning is a developmental process to assure that growth is rational, supportable and can be justified to the public at large. The planning should encourage and enhance innovative and creative developments. The process requires full involvement and cooperation by the public, by health facilities, and by health professionals.

The purpose of health planning agencies is to serve the total community. Their work involves data collection, research, education, and consultation in order to determine need for health care services, and to establish relative priorities. They also have the role of advising and consulting with the health care facilities in their programs and in long-range capital planning. This approach seems to combine highly useful methods for assuring that developments in health care services are both technically sound and of potential benefit to the community.

It is in the interest of each community, and the State as a whole, to assure that developments in the health care delivery system are economically sound, answer a discernable need and represent improvements in the total system of health care. Involved is attention to the quality of care rendered in an institution, the economic efficiency of the organization, and the effectiveness with which care is delivered.

In their effort to achieve a more coordinated system of care, providers of health care, partly through the mechanism of voluntary health planning, should work toward a greater degree of responsiveness to the public and its needs. Planning is a function of the organization itself, and the action of planning agencies is not a substitute for administrative direction and control.

Growth in terms of the best interests of the community is the objective of A.B. 1340 and of these initial guidelines. Procedures to be followed in carrying out the intent of the law, should be flexible enough to assure that the best thinking of any period can be incorporated and that there will be no attempt to find simple formula substitutes for intelligent, informed, responsible judgment.

As a part of its responsibilities, the State Health Council will prepare an annual report to the public on the effectiveness of A.B. 1340, including review of Guidelines adopted by the State Health Planning Council and those approved for the area and local planning agencies.

Criteria for Approving Voluntary Area Health Planning Agencies

In evaluating a voluntary area health planning agency for approval for a designated area of the State, the State Health Planning Council must be satisfied that the agency under consideration is capable to fulfill the following criteria provided by statute:

"437.7. In order to assure availability of objective and impartial review by planning groups (referred to as voluntary area health planning agencies) of hospitals and related facilities, including facilities licensed by the Department of Mental Hygiene, or proposed projects for new, additional or revised hospital and related health facility projects, including facilities licensed by the Department of Mental Hygiene, the Health Planning Council, from time to time, shall approve no more than one voluntary area health planning agency for any designated area of the state, provided such group shall meet the following criteria:

"(a) Shall be incorporated as a nonprofit corporation and be controlled by a board of directors consisting of a majority representing the public and local government as consumers of health services with the balance being broadly representative of the providers of health services and the health professions.

"(b) Shall review information on utilization of hospitals and related health facilities.

"(c) Shall develop principles for the determination of community need and desirability to guide hospitals and related health facilities in acting in the public interest. Such principles shall be consistent with the general guidelines developed by the health planning council in accordance with Section 437.8.

"(d) Shall conduct public meetings in which members of the health professions and consumers will be encouraged to participate.

"(e) Shall review individual proposals for the construction of new or additional hospital and related health facilities, the conversion of one type of facility to a different category of licensure or the creation or expansion of new areas of service, and make decisions as to the need and desirability for the particular proposal in accordance with the principles developed pursuant to subdivision (c).

"(f) Individual proposal reviews shall be in accordance with administrative procedures established by the Health Planning Council, which shall include, but need not be limited to:

(1) A public hearing.

(2) Reasonable notice.

(3) Right to representation by counsel.

(4) Right to present oral and written evidence and confront and cross-examine opposing witnesses.

(5) Availability of transcript at applicant's expense.

(6) Written findings of fact and recommendations to be delivered to applicant and filed with the State Department of Public Health as a public record.

"(g) Shall have a plan to finance the procedure which shall include, but not necesarily be limited to, filing fees and charges for processing and appeal."

Administrative Procedures for Voluntary Area Health Planning Agencies in Discharging the Responsibilities of Health Facilities Planning

Section 437.7, subdivision (f), of the Health and Safety Code provides that "Individual proposal reviews shall be in accordance with administrative procedures established by the Health Planning Council, which shall include, but need not be limited to:

"(1) A public hearing."

A public hearing on an application to construct, expand or alter for the purpose of increasing bed capacity or changing licensing category of a health facility shall be held by the board of directors of the voluntary area or local health planning agency, or by a committee of such board, or by a committee designated by such board.

"(2) Reasonable notice."

A public notice at least 15 days in advance of all hearing and public meetings shall be provided by certified mail to applicants and be published in a newspaper of general circulation in the area involved.

"(3) Right to representation by counsel."

The applicant, the planning agency and persons so requesting have the right to representation by counsel.

"(4) Right to present oral and written evidence and confront and cross-examine opposing witnesses."

All persons so requesting shall be permitted to present written statements and, within the reasonable discretion of the hearing body, may present oral statements. Right to cross-examination shall be restricted to the applicant and the area health planning agency, or to their representatives.

"(5) Availability of transcript at applicant's expense."

Minutes and verbatim recording of each hearing must be maintained and provision made for transcript of hearing at applicant's expense.

"(6) Written findings of fact and recommendations to be delivered to applicant and filed with the State Department of Public Health as a public record."

All interested parties shall be entitled to prompt notice of and full access to the findings, recommendations, and decisions of hearing bodies and planning agencies. Reasonable means shall be used to accomplish the public notification of the findings, recommendations, and decisions of bodies participating in the health facilities planning process."

(7) The specific language of Section 437.7, subdivision (f), implies the necessity for additional procedures:

(a) A public hearing must be held by a minimum of five persons, a majority of whom shall be consumers;

(b) The findings of fact and recommendations of the hearing body must be made by concurrence of a minimum of five persons, who were present at the hearing, a majority of whom shall be consumers;

(c) Subsequent to the filing of the findings of fact and recommendations, any person who presented an oral or written statement at the hearing may present to the planning agency written objections to such findings and recommendations.

(d) A decision of an area agency or a recommendation of a local agency must be made at a public meeting. One-half of the directors, a majority of whom shall be consumers, shall constitute a quorum. Decisions or recommendations must be concurred in by a majority of the directors present; tie vote is a denial of the application.

(e) Any director or committee member shall be disqualified to participate in any consideration and for the purposes of a quorum if there exists a demonstrated or potential conflict of interest. Potential conflicts of interest shall include, but are not limited to:

1) Any person having the following relationship to the applicant:

a) Ownership

b) Directors, trustees, or officers of the applicant's facility

c) Providers of professional services to or in the applicant's facility

d) Parents, spouse, children, brothers or sisters of a), b) and c) above

e) Employees

2) Any person with a relationship described in (e)1)a) through d) to any competitive health facility in the area served by the applicant.

(f) The Agency and committee shall keep written minutes recording the time, place, members present and all official actions taken.

Section 437.7 (g) provides that agencies "Shall have a plan to finance the procedures, which shall include, but not necessarily be limited to, filing fees and charges for processing and appeal."

(1) The filing fee shall be based upon demonstrated costs according to a schedule acceptable to the State Department of Public Health. The fee shall not exceed $2,000.00.

Section 437.7 provides that "Voluntary area health planning agencies may divide their areas into local areas for purposes of more efficient health facility planning, with the approval of the Health Planning Council..."

(1) The State Health Planning Council may not approve the designation of an area which creates a local agency serving less than one complete county unless the population to be served by a proposed local agency is at least 1,000,000 persons. In no event, however, shall the population within the remainder of such a county be less than 1,000,000 persons.

General Principles for Voluntary Area Health Planning Agencies in Discharging the Responsibilities of Health Facilities Planning

Section 437.8 of the Health and Safety Code provides:

"The Health Planning Council shall develop general principles to guide voluntary area and local area health planning agencies in the performance of their responsibilities under Section 437.7. These principles shall provide for consideration of the following factors and may provide other guidelines not inconsistent herewith."

Guidelines for the consistent consideration of each of the five factors, (a) through (e) specified in Section 437.8 are set forth below.

"(a) The need for health care services in the area and the requirements of the population to be served by the applicant;"

1. In determining the need for health care services in the area, the health planning agency shall afford an opportunity for the public, including representatives of both providers and consumers of health care to present their views for consideration by the health planning agency. Such representation may include providers, health insurers, prepaid hospital and medical care plans, government agencies that contract for health care for their employees or beneficiaries, labor and fraternal organizations, cooperatives and other groups of users of health care facilities and services.

2. In assessing the need for health care services in an area, community requirements shall be considered, including those met by governmental and by nongovernmental facilities. The intent of these guidelines is to promote flexibility and relevance to local needs and requirements. Such community needs shall encompass medical, surgical, maternity, pediatric, psychiatric, diagnostic, emergency, rehabilitative and preventive health care, home care and other services recognized to be medically beneficial.

3. The requirements of the population to be served by an applicant shall comply with a rational community plan which will encourage developments in the interest of improving effectiveness, convenience or comprehensiveness of services or quality of care.

4. In considering the needs of the population, innovation in the organization and provision of health care and the making available of alternative methods of delivering health services shall be considered by the health planning agency.

5. The "requirements of the population to be served by the applicant" shall include (a) quality, (b) effectiveness, (c) efficiency and (d) value of the health care services and facilities to be provided. Voluntary area and local area health planning agencies, in considering the "requirements of the population to be served", shall consider whether, presently or prospectively, the applicant:

   A. Is fully accredited, if eligible for accreditation by recognized impartial nongovernmental accreditation organizations, or demonstrates the probability of achieving accreditation by such organizations when eligible therefor.

   B. Utilizes professional, subprofessional and ancillary personnel so as to maximize their most skilled capacities; similarly employs labor-saving equipment and designs when economically justified; utilizes modern diagnostic and treatment devices to enhance the accuracy and reliability of diagnoses and treatment and to diminish the time required to perform them.

   C. Encourages both ambulatory care in outpatient facilities and preventive health care so as to eliminate or reduce significantly the inappropriate use of acute inpatient services among the population it serves.

"(b) The availability and adequacy of health care services in the area's existing facilities which currently conform to Federal and State Standards."

1. The health planning agency shall maintain records which show the current status of State Department of Public Health determinations regarding which of the area's health care facilities and related services do not conform to Federal and State standards applicable to construction and equipment which are requirements for state licensure and for certification for participation in Medicare. In determining the needs of the area's population for health care facilities and services, the health planning agency shall be cognizant of such

nonconforming facilities and services.

2. A nonconforming facility shall present as part of its application a satisfactory plan for attaining conformity at the same time as its modification or expansion.

"(c) The availability and adequacy of other services in the area such as pre-admission, ambulatory or home care services which may serve as alternatives or substitutes for the whole or any part of the services to be provided by the proposed facility;"

1. It shall be the policy of the health planning agency to encourage diagnostic and treatment services of high quality, using the resource of greatest value to the patient and the community. To this end, the development of preventive, diagnostic and treatment services not requiring inpatient admission shall be furthered, preferably as part of a coordinated comprehensive health care program. Encouraging the desired coordination of such outpatient facilities and services also shall be a function of the health planning agency.

"(d) The possible economies and improvement in service that may be derived from operation of joint, co-operative, or shared health care resources;"

1. To the extent that certain functions of a health care facility can be made more efficient, reliable, or less costly, through joint, cooperative, pooling or sharing arrangements, such relationships shall be considered by the health planning agency when appraising an application.

2. Innovative measures taken or proposed by the applicant, directed towards promotion of economy, efficiency or reliability, shall be encouraged by the health planning agency, especially when they are part of a local, area or national system for utilizing pooled, joint cooperative or shared health resources.

"(e) The development of comprehensive services for the community to be served. Such services may be either direct or indirect through formal affiliation with other health programs in the area, and include preventive, diagnostic, treatment and rehabilitation services. Preference shall be given to health facilities which will provide the most comprehensive health services and include outpatient and other integrated services useful and convenient to the operation of the facility and the community."

1. In determining priorities among applicants, the health planning agency shall give preference to the applicant which, in its own facilities, in facilities under its control or under a common management, or through formal agreements of cooperation, can provide comprehensive health services in an area. In addition to inpatient care, such services may include outpatient diagnosis, treatment and preventive health care; emergency treatment; psychiatric care; rehabilitation services; and home health care.

Procedures for Administering Processes of Appeal Provided by Statute

Section 438.1 of the Health and Safety Code states in part,--"The Health Planning Council, on a periodic basis, shall designate the voluntary area health planning agency or agencies, the consumer members of which shall be the appeals body or bodies for another voluntary area health planning agency, provided that such agencies shall not be the appeals body or bodies for each other."

Grounds for Appeal

1. Failure of the voluntary health planning agency to comply with procedures required by the Health Planning Council or its own procedures in considering the application so as to deny the applicant due process and a fair hearing.

2. Findings of fact and recommendations not sustained by substantial evidence.

3. Action taken arbitrarily, capriciously or with prejudice.

4. Action taken was not in accordance with principles for planning adopted by the Health Planning Council and the voluntary health planning agency.

5. Allegation of grounds for disqualificaiton of a director or committee member discovered after the decision was reached by the area planning agency.

An appeal may be initiated within 30 days of the announcement of the decision of the planning agency, by a written notice of appeal sent by registered or certified mail to the Voluntary Area Health Planning Council which shall be responsible for forwarding the appeal to the designated appeals body.

Such notice of appeal shall include the following:

a. Designation of the proceeding being appealed

b. A brief statement of grounds for appeal

c. A request for the completion of a transcript within 30 days, if desired

d. A list of exhibits, written arguments and other evidence to be transmitted by the agency to the appeals body

e. A statement as to the nature and basis for any additional evidence desired to be submitted

f. Payment of the filing fee for the appeal and the estimated cost of any transcript requested by the appellant and reproduction of documents

On receipt of the notice of appeal the appeals body shall review:

a. The application for appeal

b. Affidavits and written statements or documents in support of application and appeal

c. The original application and all modifications or supplements thereto

d. The written evidence and written arguments submitted

e. The minutes of the hearing and the transcript if supplied

f. Any affidavits or statements submitted in relation to the appeal

g. Any written statements filed by parties in interest

Based upon such review the appeal body shall initially determine whether its review shall be based solely upon the record of a-g above or shall take additional written and/or oral testimony and designate the areas or points to be covered by the additional testimony.

Upon such determination, hearing or meeting date shall be scheduled. A quorum at such hearing or meeting shall be one-third of the members of the appeals body. All actions by the appeals body shall require the concurrency of the majority of the members present, but in no event less than five members.

The appeals body, upon the completion of its proceedings, shall:

a) Affirm the original action; or

b) Reverse the orginal; or

c) Modify in part the original decision if it believes such action to be required in the public interest.

Failure of the appeals body to act within 90 days of the receipt of the request for appeal shall constitute affirmation of the prior decision.

A party in interest may request notice of an appeal and such notice shall be given by the Voluntary Health Planning Agency. Parties in interest on an appeal who may be represented by Counsel, are:

a) The applicant

b) The Voluntary Area or Local Health Planning Agency

c) Any party who submitted an oral or written statement at the original hearing

d) Representatives of local government

The appeals body shall select its own chairman. At the discretion of the appeals body it may be advised by legal counsel who shall not be permitted to vote on any action taken by the body.

HEALTH PLANNING ISSUE PAPER
FROM COMMUNITY HEALTH, INC.

Issue Paper #4 May, 1970

Ecology and Administration

The ecological perspective toward man and his world has taught us that there are literally thousands of finely articulated subsystems in an all-encompassing ecosystem. Man's actions as a manipulative species cause changes in this environment whose effects may be proximate or distant, anticipated or unanticipated. In the current environmental crisis, we are harvesting the fruits of centuries of lack of concern or lack of appreciation of the ecologic consequences of human activity. The cumulative insult to the environment has risen continuously, while the response in society has been highly incremental and oriented toward single problems.

One result of this incremental, uncoordinated approach to societal programming for the environment has been the development of a multitude of administrative subdivisions in government that deal with one subsystem or another without efforts to achieve integration. Environmental control programs have grown out of concerns as diverse as preservation of wildlife, management of natural resources, protection against communicable disease and increasing agricultural production. In addition, there are many other governmental programs that are related to environmental problems, either as part of the cause or part of the solution. As a result, we find programs of considerable environmental impact distributed widely within government--in departments of commerce, health, housing, conservation, urban affairs, agriculture, and transportation to cite a few. Such subdivisions seldom share goals or information and many operate in direct competition. There is obvious need for better coordinating the programs dealing with the environment, the causes of its deterioration, and the means for its enhancement.

As government at every level strives to respond to the ecological crisis, the solution emerging tends--more frequently than not--to be an attempt to create some type of "ecological superagency". Such agencies--according to their proponents--will unite the fragmented environmental programs that have grown in number in recent years, and create combinations which will be what the Governor of New York calls "an ecological whole". In our view, creation of such agencies represents an approach that is neither logical nor ecological. There is a real danger that--while appearing to "do something" to improve environmental programming--such agencies will merely perpetuate fragmentation at a time when a coordinated response is essential.

In exploring the ecological aspect of our concern, it is necessary to distinguish between environment and ecology. Environment has traditionally been used to designate the physical world--outside of man and his social systems--in which man operates as an autonomous manipulator. Ecology refers to the study of the totality of patterns of relations between organisms and their environment. The environment's response and adaptation to man sets up new relationships which in turn operate to influence new adjustments in man. Heretofore to a large degree we have considered man's relationship to the environment in a very simplistic fashion: Man as the actor and some element of the environment--air, water, land, wildlife--the material to be acted upon. The real significance of the emergence of ecology--both as a label and as an approach--is the attention it draws to the reciprocal nature of the relationship of man and

environment. Drawing from this, we can hypothesize that an "ecological" approach to administering government programs must focus on a mechanism capable of integrating not only those programs dealing with control of pollutants of the natural environment--air, land, and water--but also those governmental programs that contribute to the environmental problem and those programs that deal broadly with the effects of the environment on man and other living organisms.

If the logic behind proposals for recombining environmentally-related programs into superagencies is presented as ecological, there are some very real problems. First, where should the line be drawn for inclusion and exclusion of programs? To do less than pulling all environmentally related programs together destroys the logic of recombination. This appears a practical and political impossibility, and none of the realignments proposed or accomplished even begins to approach this magnitude of change. It is more common to take conservation programs, water quality, air pollution and solid waste under the "ecology" banner and ignore ecologically-equal activities in other fields. In reality, the problems of the environment are so pervasive that virtually every agency of government has some responsibility. Would it not be more efficacious to concentrate on seeing that everyone fulfills their respective responsibilities?

Administratively recombination itself is not a panacea for environmental problems. Organizational proximity does not necessarily enhance coordination of cooperation. Administrative reshuffling does not approach the root problem of equally fragmented legislative authorities, nor does it change the established attitudes and approaches of the career employees within the administrative units. In any event, many decisions pertaining to environmental improvement and protection will involve major reallocation of resources, shifting of priorities and new government-wide policies. These are essentially political choices.

An example from the recent past may clarify the existing situation. The Army Corps of Engineers has for many years conducted a continuous program for removing debris from the waters of New York Harbor. This includes a heavy volume of wood from decaying piers, sunken vessels, and so forth. The method of disposal of this bulky but combustable material has been to fill barges with the waste, and when it is sufficiently dry, to burn it. These barges were anchored off the New Jersey shore near the Statue of Liberty. The burning was clearly in violation of local and State legislation, and in conflict with Federal air quality guidelines. The Corps' response to complaints over the burning was quite simple--they had a Congressional mandate to keep the harbor open to navigation, and the open burning was the only feasible way to dispose of the material until such time as the Congress made funds available for a planned incinerator. Here were a number of agencies with environmental missions acting to carry out their legislative mandates. Two matters of public interest--clear navigation and air quality--were in conflict. "Combination therapy" would not have changed the mandates or mitigated the conflict.

We have raised some questions about a currently popular political response to the "ecological crisis". Is there a means of approaching the problem of ecological programming that can begin to give us the advantages of common goals and less competition, and also leave room for important interest groups to be heard? The analytical framework of ecology suggests a possible solution. In dealing with the

ecosystem, we recognize that there are many subsystems that interact continuously. In the present administrative situation, there are also many subsystems, but they do not interact in any coordinated fashion. Recognizing the limited ability of executive councils to effectively channel the efforts of administrative agencies which have a high degree of independence, we suggest consideration be given to creation of a Legislative Council on the Environment.

This Council would be established by and be responsible to the legislative body, and would be staffed with technical personnel from the various disciplines involved in governmental environmental programming. Its functions would include:

(1) Analysis of legislative proposals in clearly environmental areas and in other fields where legislation might have environmental consequences, and preparation of reports for use by legislative committees, administrative agencies, and the public.

(2) Consultation with, and assistance to, legislators who are preparing environmental legislation, to clarify any deficiencies or potential conflicts with an overall ecologic plan.

(3) Research on environmental questions for legislators and legislative committees.

(4) Continuous review and evaluation of operating programs in the environmental field in the several agencies to identify actual or potential conflicts, both among such activities, and with a general ecologic perspective, and to suggest legislation to remedy such situations.

(5) Institution and monitoring of a government-wide, legislatively-directed program planning and budgeting system for all environmentally-directed program activities.

This approach--perhaps without precedent--is suggested because the situation we face is also unprecedented. Fragmented response has helped bring the nation to the brink of a major ecologic crisis. Only the chief executive and the legislature have a sufficiently broad viewpoint and authority to provide the needed unity of purpose. Since effective coordination of a sufficiently broad scope seems an impossibility on the administrative side, the legislature--theoretically more responsible to the electorate and with its pre-eminent fiscal role--seems more likely to be able to provide the leadership and coordination essential to success, and survival.

COMMUNITY
HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

NEW YORK
MAY28'70
N.Y.
U.S.POSTAGE
.06
PB METER
P.B.903759

ROBERT E. SHANK, M.D.
HEAD OF DEPT. OF PREVTVE. MED.
WASHINGTON UNIV.
SCH. OF MEDICINE
4550 SCOTT AVE.
SAINT LOUIS, MO. 63110

HEALTH PLANNING ISSUE PAPER
FROM COMMUNITY HEALTH, INC.

Issue Paper #2 April, 1970

Planning the Healthy Environment

When the Congress enacted Public Law 89-749 in November, 1966, it clearly indicated that planning for the health aspects of the environment was a function appropriate to the new comprehensive health planning agencies. Three years later--though the environment is one of the hottest public policy issues of the day--relatively little progress has been made in incorporating environmental concerns into the comprehensive health planning activity at any level. Indeed, those whose traditional concern has been for environmental aspects of public health programs are rumbling about the need for separate environmental health planning legislation. The issue--which will certainly peak in the near future--is whether or not planning for health aspects of the environment is logically encompassed in the comprehensive health planning approach. This seems of particular importance in view of HEW's emphasis on comprehensive health planning as a tool for restructuring the health care system, while virtually ignoring the environmental aspects of health planning in policy, program, testimony, and legislation. It is also timely as many States and the Federal government consider shifting many traditional health department environmental activities into non-health agencies. This Issue Paper represents an attempt to spell out reasons for a comprehensive health planning agency to become involved in environmental planning, and suggests some approaches to such involvement.

Note that we do not say the comprehensive health planning agency should be concerned with planning for environmental health programs, but rather with planning for health aspects of the environment. The concepts are quite different. Some understanding of the difference is required in order to logically approach the problem of the kind and amount of involvement a comprehensive health planning agency should have with environmental concerns. This requires exploration of the currently fashionable ecological approach as well as more traditional concepts of environmental health.

Man's relationship to his environment has always been an ambivalent one. The environment that provided food, raw materials, recreation, etc. has also produced major threats to the individual and his societies. In prehistory and early recorded history, the threats came from the natural environment in the form of flood, drought, famine, storm and predators. As man developed the means to control some of these threats, the natural environment became less hostile. The very protective devices that man adopted to offset natural disaster have, however, become even more of a problem than nature itself. Cities--which have protective as well as economic advantages--have become a hostile environment. Chemical aides to agriculture--for decreasing the famine threat--have set the stage for new diseases and deformities. Actions that have seemed consistent with a "better life" have instead resulted in unplanned and unforeseen consequences that have adversely affected the quality of life. Until recently, the earth had the capacity to deal with the worst that mankind could inflict upon it. Natural processes were able to handle the solid waste, the simple chemical compounds, the particulate pollutants, and so on. The dual factors of population growth and its concentration, coupled with rapid technological advance has overwhelmed nature's ability to deal with these insults and suddenly we have an ecological crisis. The ecologists, who have been warning us for years of the adverse effect of man's polluting the environment and of the polluted environment on man, has been thrust to stage center, occupying the spot recently vacated by the urban sociologist. While we are engaged in a national passion for looking at the problems of the environment "ecologically", the existing means for dealing with these problems is the antithesis of an ecologic approach. Like the ecosystem, the structure for managing the environment has many components. Unlike the ecosystem,

these components are isolated from one another by bureaucratic lines and professional traditions. The result is a fragmentation of activity that far exceeds that so often decried in the personal health services area. Futher, as the prospects for mobilizing public and political support for the environment brighten, the various components of the structure are pushing to expand their interest and constituency rather than forge bonds with other groups whose legitimate environmental interest falls into a different activity category. Expansionism in the private sector ("fight solid waste--join the National Wildlife Federation") and the drive toward monolithic organization patterns in the public sector ("Departments of the Environment" attempting to encompass conservation, natural resource management, environmental sanitation, etc.) will surely cause further alienation among the interest groups and professions at a time when greater cooperation would represent a more "ecological" response.

The present "crisis" clearly calls for reexamination of relationships among public and private groups with concerns for environmental problems. The comprehensive health planning agency has a clear advantage over the established environmental interest groups and governmental programs. It has an opportunity--because of its lack of established precedent and of any sense of program "territory"--to develop a posture of cooperation and assistance that could serve as an example to the rest of the environmental field--health and nonhealth. Yet the agencies have little to draw on in terms of experience except traditional environmental sanitation.

In the not too distant past, environmental health--or environmental sanitation as it is often called--encompassed a rather clearly defined set of activities carried on under the auspices of a public health department. Indeed, most of the greatest success stories of public health--if success is measured in terms of decreased morbidity and mortality--have been environmental health program efforts. As recently as 1965, a textbook of environmental health listed the following types of activities as the purview of environmental sanitation: water supply, waste disposal, insect control, rodent control, food sanitation, plumbing, air pollution control, heating, ventilation, and air conditioning, lighting, housing, institutional sanitation, occupational health work, swimming pool sanitation, nuisance control, radiological protection, accident prevention. The tools for attaining and maintaining some acceptable level of health protection for a community in these various areas have been largely regulation, inspection, and enforcement.

In attempting to delimit environmental health for the purposes of designing a role for the comprehensive health planning agency, this type of list is probably inadequate. Not only does it leave out significant aspects of environmental planning which have health implications--transportation, land use planning, parks and recreation--to name a few, but it also ignores the reality that many of the listed programs are no longer--if indeed they ever were--primarily health agency responsibilities. Any number of other environmental interests are now into these fields, including conservationists, nature lovers, housing departments, developmental planners and so on. It is imperative that an areawide comprehensive health planning agency attempting to define its role in relationship to the environment look further than the traditional environmental sanitation activities.

Thus an areawide comprehensive health planning agency when faced with the challenge--what are you doing for the environment?--finds it difficult to frame an answer. It seems the easier course to cite the reasons that one cannot plan for these largely control-oriented, governmentally-based programs than to tackle the larger question of their relationship to the total problem of improving the health status of the nation. Indeed, the comprehensive health planning agency cannot "plan" for the environmental agencies anymore than it can "plan" where the individual providers of health services. The comprehensive health planning agency can, however, do several things that might contribute significantly to strengthening the health aspects of

COMMUNITY
HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

ROBERT E. SHANK, M.D.
HEAD OF DEPT. OF PREVTVE. MED.
WASHINGTON UNIV.
SCH. OF MEDICINE
4550 SCOTT AVE.
SAINT LOUIS, MO. 63110

HEALTH PLANNING ISSUE PAPER
FROM COMMUNITY HEALTH, INC.

Issue Paper #1 March, 1970

LEGISLATION - NEW PROGRAMS, NEW PHILOSOPHIES

1. Introduction

Every agency which depends on either the Comprehensive Health Planning Act or the Regional Medical Program Act for a portion of its financial support should examine carefully all the provisions of the various proposals now before the Congress for extension and/or modification of those programs. It is foolhardy, indeed, to look only at the specific portion of any bill that affects one's own operating program to the exclusion of the legislative and administrative environment in which it is offered. In this, the first of a series of issue papers dealing in some depth with matters of interest to health planners, we would like to examine the Administration's Health Services Improvement Act of 1970 (S.3443; H.R.15960). This bill is of particular interest because it, and the various statements from HEW in its support, reflect the evolving policy of the Administration, a policy that will affect the future course of these Federally-supported programs whether or not the proposed bill becomes law.

In studying this bill, there are two aspects that should receive attention from concerned agencies--the substantive program and the philosophical base. This discussion will be developed within the framework of these considerations.

2. Substantive Program Changes

There are really very few changes in the operating programs of a RMP, a State CHP, or an areawide CHP agency incorporated in HSIA-70. For the most part, the differences that do appear simply codify situations that are already widely prevalent. For example, decategorization of the RMP's has already been under way as the definition of the term "related diseases" has expanded. The interchange of advisory committee members between RMP and CHP programs is widespread. The advisory council for the areawide CHP that appears here was already a matter of policy and a requirement for approval. Other changes "enable" the Secretary to carry out and study coordinative activities that are already possible under existing authorities--for example, the studies in combination of RMP and CHP programs, or the review and comment by areawide agencies on RMP or health services development project grants. There are several new concepts incorporated into HSIA-70, however, that deserve recognition, wide consideration, and support of planners at all levels.

National Advisory Council - Many groups have felt that a NAC for Comprehensive Health Planning should have been built into P.L. 89-749, and that the presence of such a forum for policy review and advice to the program's Federal administrators would have headed off many problems that have arisen in the past 2½ years. A Council, properly constituted, could provide an opportunity for consumer and provider input that has been lacking since the program's inception. Whether or not HSIA-70 is the final legislation enacted, some provision for a national level advisory group seems badly needed.

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Project Grants for Multiprogram Services - The provision in HSIA-70 [Section 916(a)] that authorizes use of appropriated funds for grants to agencies for services needed by two or more RMP's has great potential. Indeed, it is so logical that one wonders whether or not the same concept should be extended to cover services needed by two or more areawide health planning agencies. There are a number of highly technical types of services that could reasonably be considered useful at various levels, even the national, and which should probably not be duplicated in every regional or areawide activity. Indeed, one can envision services of use to both RMP's and CHP's in a State or region that might be brought under this provision.

Recognition and Assistance for Unfunded Areawides - The HSIA-70 has several provisions extending assistance and review-comment functions to community agencies which--although not receiving Federal funds for areawide planning--perform similar functions. This makes it possible for locally-funded health planning agencies to play a role in Federal funding programs. In addition, the new provision for State CHP agencies to receive funds from the areawide planning allocation to assist areas in their State not otherwise covered is a significant step. In view of the stringent restrictions on funds for areawide planning in the 1971 budget, however, it seems unlikely that much would be available for the latter program.

Joint Funding - The HSIA-70 [Section 943] provides a significant improvement in the administration of projects receiving funds from more than one HEW source. This long-overdue reform permits the Secretary to provide regulations whereby a project receiving funds from several HEW sources can be administered by one of the funding agencies. The designated managing program's regulations, policies, and procedures would be followed by all, simplifying the problems of the recipient agency, which now must serve many masters in the joint funding situation.

Cooperative Information System - The HSIA-70 modifies the authority of the National Center for Health Statistics to permit research and demonstration projects relating to the design of a system for producing comparable and uniform health data at the Federal, State, and local levels. The NCHS has built a very effective cooperative network with States for collection of uniform vital statistics. Under the authority in this section, NCHS would refine and extend the data system to include other types of health data. Uniformity of data is so vital to successful planning at each level that this may be the most important single provision of HSIA-70 as written. This proposed authority would allow the NCHS to provide leadership in a critical period in data system development. Without some form of coordination, the many approaches to data being undertaken by various agencies may lead to fragmented approaches that compromise the usefulness of the data. Again, this seems so valid a provision as to be included, whatever the final bill may be.

3. Philosophical Changes

It appears from study of the legislation in light of various statements by officials of HEW both before and since this bill was introduced, that the RMP and CHP programs are seen in a rather different light than was the case at their inception. This is hardly surprising in light of the passage of time, the accumulation of some experience with the programs, and the change of Administration.

In 1965, the RMP program was launched from the base provided by the report of the President's Commission on Heart Disease, Cancer, and Stroke, though the program as approved by Congress differs in many respects from the Commission's recommendations. Directed toward establishment of cooperative relationships between research centers and community institutions and practitioners, RMP's developed as highly autonomous units with considerable variation in scope and type of activities supported from program to program. The Federal administrators and the Advisory Council carefully fostered a program concept that maintained accountability from the individual RMP to Washington with little or no formal relationship to established governmental or non-governmental planning or administrative agencies at any level.

The CHP programs, not really started until 1967, were more formally tied to the existing hierarchy of health agencies at the local and State levels. A great deal of stress was laid on the development of State and areawide planning agencies which would be responsible for studying health problems of local significance and for establishment of local priorities for health action. There was no overt attempt to impose any overriding Federal priorities on these agencies.

One suspects that if participants in either program were asked whether their purpose was promotion of "efforts aimed at the organization and development of improved systems for the delivery of health care and services" to all, they would have rejected the notion. The flexibility and emphasis on local initiative in selection of priorities for program activities was a prime attraction to participants in both programs, though their goals were quite different.

In the intervening years, both programs began organizing to carry out their assigned (or assumed) functions. Not surprisingly, there was considerable variation from area to area across the country when it came to relationships between the two efforts. The conflicts and potential conflicts attracted considerable attention; the cooperative efforts did not. While these activities were attacking the often complex problems of getting organized, a number of changes were taking place in the health world which were of vital importance. The rate of cost escalation, spurred by medicare and medicaid, increased. The medically as well as the socially disadvantaged became more aware of unavailability of adequate health services. The political climate--unfavorable to universal health insurance in the mid-1960's --shifted, and UHI in some form looms on the immediate horizon.

HEW's planners, recognizing that the present care system is not up to the job of responding to a UHI-inspired load, have turned attention to exploration of alternative approaches that might provide more adequate services for more people. The hot political issue vis-a-vis health in 1970 is personal health care services, not mortality from heart disease, cancer, and stroke. It is supply and distribution of physicians, not their competence in treating specific diseases. And it is responding to the short-term demands on the care system, not the long-range dangers of environmental threats to health.

Thus the emphasis on development of systems for health care services in the preamble to the HSIA-70 is hardly surprising. It represents a pragmatic response to the most troublesome political problem facing the Administration in the health field. It represents an interest that is likely to guide the regulations and policies of HEW in the immediate future whether HSIA-70 becomes law, or whether the Congress decides to extend the separate authorizations for RMP and CHP, awaiting results from the experiments in health care systems cited by Dr. Egeberg in his testimony on HSIA-70 before enabling amalgamation. Regardless of the fate of HSIA-70, RMP's and CHP's are clearly on notice that the Federal agency responsible for administering their programs see them as serving the same broad purpose. Hopefully, recognition of this fact will spur closer cooperative efforts between the programs whether they are special demonstration areas or not.

Given the Administration's resolve to bring these programs closer together, both legislatively and operationally, a legitimate concern arises for the ability of the agencies to retain the local or State initiative aspects of their programs. To what extent may the overriding health services systems development mission conflict with the types of programs being developed under RMP and CHP which are now considered to be responsive to local needs? There is no answer to this question in the wording of the legislation or the various supporting statements. To the extent that environmental health concerns have been incorporated into CHP, the virtual ignoring of environmental health in Dr. Egeberg's testimony might give some pause. This may be clarified in testimony on the House version, or later in regulations and policies written in support of the law, if enacted. The same is true of the degree to which this legislation might be used to move an areawide health planning agency into the role of a "community trustee"--with management responsibilities for the local health care "system". Assumption of this role would mark a major departure from the non-directive planning concept developed in the first 2½ years of the Partnership for Health. Among the examples of approaches to experimental combination of RMP/CHP activities cited in the Senate testimony, this concept of the areawide agency as "community trustee" is clearly stated as one alternative approach. There are many similar examples reflecting a degree of uncertainty about the structure of other aspects of CHP and RMP in the future.

The single greatest danger to community-based health planning and programming that arises in relation to the HSIA-70 really has little to do with HEW policy and plans, however. As we enter a period of experimentation in new combinations, the greatest danger seems to lie in the existing agencies' "holding back"--both in furthering their current activities and in exploring cooperative relationships--while they wait for the demonstrations to be completed. If one accepts HEW's contention that "We have no single model in mind now, nor do we expect to have a single model in the future", it would be sad indeed to lose valuable time waiting for HEW to call the shots.

COMMUNITY HEALTH, INC.
1775 BROADWAY, NEW YORK, N.Y. 10019

AIR MAIL

ROBERT E. SHANK, M.D.
HEAD OF DEPT. OF PREVTVE. MED.
WASHINGTON UNIV.
SCH. OF MEDICINE
4550 SCOTT AVE.
SAINT LOUIS, MO. 63110