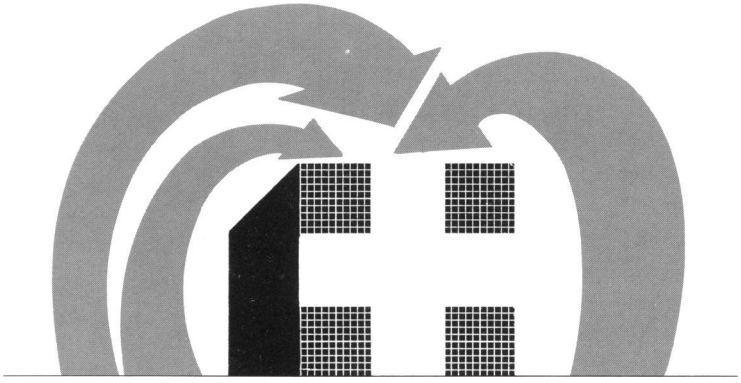
The Right of Public Access to Information Submitted Under the Requirements of the Health Planning Act



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THE RIGHT OF PUBLIC ACCESS to information submitted by private and semi-public health organizations to various bodies is specified in Public Law 93–641, the National Health Planning and Resources Development Act of 1974. This topic would not have been generally discussed just a few short years ago since Public Law 93–641 is, of course, less than 2 years old. On a more basic level, however, two important changes in the Federal legal environment have given this topic a relevancy that did not exist until recently. The first change involves the public's "right to know." The second involves the increasing regulatory power of the Federal Government over private and quasi-public health institutions.

The very concept of a public right to information kept by the U.S. Government is only as recent as 1966. Before that year, Federal agencies were allowed by statutory language to withhold information on the basis of "public interest" and "good cause," and records were required to be available only to "persons properly and directly concerned." Government agencies could withhold almost anything, and it was often impossible for the public to gain access to information.

Congress, in 1966, decided to rectify this situation by passing the Freedom of Information Act (FOIA). This act makes all records not within nine specific exceptions available to "any person." The FOIA does not speak merely of information gathered by Government employees, but speaks of all records. The materials submitted by individual persons or institutions to the Government, that thus become a governmental record, may be subject to public disclosure under the act. In 1974, overriding a Presidential veto, Congress passed amendments to the FOIA. One of the most interesting, now codified at 5 U.S.C. Section 552(a) (4) (F), requires the Civil Service Commission to initiate a proceeding to determine whether disciplinary action is war-

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ranted against Government personnel if a court issues a finding that the withholding of information raises questions whether agency personnel have acted arbitrarily and capriciously in the withholding. The public's right to know is now a cornerstone of Federal administrative law.

The requirement that private health care organizations submit information about their organization and operation to Federal agencies, or bodies created by Federal law, is also, for the most part, recent. Before the passage of Medicare and Medicaid in the mid 1960s, and the subsequent health planning, utilization, and expense control legislation of the early 1970s, only organizations voluntarily submitting themselves to governmental scrutiny for a grant or for some other favor were required to submit information to the Government. The explosion of health legislation in the last few years, especially the Health Planning Act and amendments to the Social Security Act, has forced many private health organizations, for the first time, to submit substantial internal information to governmental and quasi-governmental bodies. While the public's access to Government records is being vastly expanded, the requirements that health organizations supply information for those records are also being expanded.

The health-related agencies are not the only private organizations required to increase reporting to the Government. The Pension Reform Act, for example, requires a variety of organizations and individual persons to provide information to Government bodies. Congress, noting the increase in information requested, some of it rather personal, passed the Privacy Act of 1974. The act permits an individual to determine what personally identifiable information is being kept concerning him and prevents other than limited, enumerated disclosure of that information without his consent. It should be stressed that this act applies only to persons acting in their individual capacities, and not to corporations and proprietorships.

Both the Freedom of Information and the Privacy Acts exemplify congressional concern about the public availability of governmental information gathered from private sources. On one hand, there is a feeling that an open and free society should have access to governmental information. On the other hand, there is a concern that individual rights of privacy must be protected. It is not difficult to see the inherent conflict in these two philosophies. Where does the public's right to access end and the right of confidentiality of the individual or organization begin?

There is no complete answer. The interface between public access and personal and organizational privacy differs from program to program since each agency and program develops its own protocols, procedures, and regulations. Congress itself will sometimes set this balance in the enabling legislation for a program. For example, in Section 1532(b)(10) of the National Health Planning and Resources Development Act of 1974, Congress minced no words:

> (b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) at least the following: . . .
>
> (10) Access by the general public to all applications reviewed by the agency and State Agency and to all other written materials pertinent to any agency or State Agency review.

Sections 1512(b)(3)(B)(vii)(III) and 1522(b)(6)(C) both require that the governing bodies of health systems agencies and State agencies, respectively, make their "records and data available, upon request, to the public." Any doubt about the unlimited public access to this information is dispelled on page 68 of the Conference Report to the act:

> The House amendment contains a provision, not included in the Senate bill, which requires that a health systems agency in making its records and data available to the public conform to confidentiality requirements prescribed by the Secretary to protect the confidentiality of matter comparable to matter described in 5 U.S.C. 552(b) [The Freedom of Information Act]. A similar requirement is applicable to State Agencies (sections 1412(b)(3)(B) and 1432(b)(9)).
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> The conference substitute conforms to the Senate bill.

By adopting the Senate bill without the FOIA exemptions, Congress showed its intention that these exceptions not protect information submitted under Public Law 93–641.

Regulations entitled "Health Service Agencies" and published March 26, 1976, in the Federal Register follow the congressional intent. Section 122.114 requires that "Each agency shall adopt a policy for making its records and data available to the public for inspection and copying in accordance with Section 1512(b)(3)(B) of the Act. . ." In response to comments requesting that financial and personal data submitted should be held confidential, page 12822 of these regulations states: "It would be impermissible, therefore, in light of the all-inclusive statutory language and its legislative history, for the Secretary so to delimit the statutory provision."

An interesting sidelight concerns PSRO data submitted to planning bodies. Page 12819 of the March 26 regulations contains

a reply to a comment on the confidentiality of such information. The reply makes clear that the agreements between PSROs and planning bodies must require "... only that the PSRO provide such data as may be consistent with the confidentiality restraints in section 1166 of the Social Security Act."

It is clear that everything given to a State health planning and development agency (SHPDA) or a health systems agency (HSA) becomes a part of the public record available for unlimited access. What then does the health professional or attorney for an organization submitting information to a SHPDA or an HSA do to protect confidential information? It seems to me that the first step is to accept that everything submitted to the agency will be available to the public. A sensitivity to this point is most important so that none of the parties involved has unrealistic expectations of confidentiality.

A second step is to realize that the only way to keep information confidential is for the health planning bodies not to request it in the first place. The health planning staffs and representatives of private organizations should work together to design application and reporting requirements that ask only for information necessary for the planning agency to do its job. A strong effort should be made not to request information that would invade personal privacy or create a competitive disadvantage to the submitting organization if released to the public. If such information is needed by the agency, every effort should be made to ask for it in a form that minimizes the invasion of privacy or competitive harm.

This approach is not as impractical as it may seem. There is a tendency for regulators to ask for as much information as they can, often much more than they ever use. It should be the responsibility of all concerned with implementing the Health Planning Act, especially representatives of organizations that will be submitting information, to be sure that only essential information is requested. The organizations being regulated should also assure that the regulators are sensitive to the possible harms of collecting and disseminating certain sensitive information.

I offer two theoretical examples of how information requirements in regulatory activities might be tailored to avoid harmful violations of privacy or the revelation of commercially confidential data. In reviewing a hospital's capital expenditure, an agency might wish to know the number of unnecessary surgical procedures performed in the facility. There may therefore be a temptation to request the minutes of the tissue committee's meetings. The minutes, however, may embarrass individual physicians, especially in a small hospital where only a limited number of physicians practice and identities are easy to decipher. The agency could request, instead, an aggregation of the tissue committee's findings. The planning body would have the information that it needs, and individual providers would not be put in a poor light before the public.

My second example concerns the protection of health maintenance organizations from competitive harm. Applicants for Federal HMO funds must submit information on their proposed marketing plans to show financial viability. Since the HMO will be competing with health insurers for subscribers, access by competing plans to its detailed marketing plans, which include the names of target groups and selling strategies, could put the applying organization at a disadvantage. If the HSAs and SHPDAs request only a description of the potential HMO's overall marketing strategies, with only a small sample of the targeted groups included for verification purposes, competitive disadvantage to the applying organization will be greatly reduced, and the regulatory body will be able to assess the financial viability of the health plan.

These examples should be viewed only as illustrative of the latitude that is possible under the Health Planning Act. Although some may take issue with the specifics cited, I am sure that most policy makers would agree with the general proposition that Government agencies (including HSAs and SHPDAs) should ask only for pertinent information and data and that their staffs should design forms and systems that eliminate some of the problems of freedom of information versus privacy. There is no doubt that the HSAs, SHPDAs, and other bodies involved in planning will need a substantial amount of information on a variety of matters from organizations seeking determinations. Government and the private sector must cooperate to assure that all necessary information is available, but that competitive harm or personal embarrassment is kept at a minimum. If this cooperation occurs, public access to information as required by Congress under Public Law 93–641 will be a service to the country, the health planning organizations will be able to perform their tasks fully, and harm to individuals and organizations submitting information will be minimal.