Health Planning—A New Phase

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THE HEALTH PLANNING AND RESOURCES Development Amendments of 1979, signed by President Jimmy Carter on October 4, revise and extend the nationwide program begun in 1975 under Public Law 93–641. Passage of the 3-year extension, Public Law 96–79, affords an appropriate opportunity to examine the program's accomplishments thus far and to reflect on the possibilities for its future course. The next few years will be crucial in revealing whether the health planning program can succeed in its goals of moderating the currently unacceptable rise in health care costs and improving access to health care.

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Under Public Law 93–641, the National Health Planning and Resources Development Act of 1974, health planning was initiated in a nationwide network of local health systems agencies, State health planning and development agencies, and statewide health coordinating councils. The two-tiered structure receives Federal financial support, guidance, and direction from the Bureau of Health Planning in the Health Resources Administration (Hyattsville, Md.) and personnel in 10 Regional Offices of the Department of Health, Education, and Welfare. Certain facility component aspects of the program are administered by the Bureau of Health Facilities, also in the Health Resources Administration.

The health planning agencies begin their operation under the 1979 amendments with an impressive record of progress toward implementation as mandated in Public Law 93–641. The organizational structure is in place,

State and local plans have been drafted and approved in their respective communities, and results are beginning to be evident. Moreover, there is solid evidence that the actions taken by the health planning agencies are beginning to impact on the way health care is delivered.

Organizational Structure

There are 198 fully designated health systems agencies (HSAs), 4 with conditional designation, and 2 health service areas temporarily without an agency. Local health planning is underway in eight other geographic areas where the State or Territorial agency conducts both local and State health planning.

State health planning and development agencies (SHPDAs) have been established in 57 States and Territories. Thirty-seven of these State agencies are fully designated and 21 hold conditional designation. Statewide health coordinating councils (SHCCs) have been established in 52 States and Territories.

Only when one looks at the developments that were necessary to bring the agencies to their present status is one fully aware of the magnitude of this accomplishment.

All of the fully designated HSAs have drafted long-range health systems plans (HSPs) describing goals for improving the health status of area residents and for bringing about improvements in the health system, including cost containment. They have also prepared annual implementation plans (AIPs). To do this it was necessary for the HSAs to develop a clear understanding of the issues that would influence the accomplishment of their goals, define the changes necessary to produce the needed improvement, produce a community understanding and commitment to the designated change, undertake a defined set of implementation activities and regulatory recommendations to accomplish the required changes, and promote linkages between physical and mental health care systems.

State health planning and development agencies with full designation have adopted a certificate of need program satisfactory to the Department of Health, Education, and Welfare (DHEW) to provide for the review of proposals for new construction, replacement, and modernization of health facilities, purchase of equipment, and elimination of duplicative health services. These State agencies have also developed a preliminary State health plan, which the statewide health coordinating council will review and modify as necessary, in order to establish a State health plan. The State health plan is made up of the health systems plans of the HSAs within the State.

Broad Participation

The preparation and acceptance of health plans by local communities and States required the cooperation and participation of large numbers of citizen volunteers. It has been estimated that more than 50,000 volunteers have directly participated in or been involved with the health planning program at the State and local levels and that they have contributed a million and a half hours of time. More than 9,000 persons currently serve on their local HSA governing bodies as consumer (53 percent) or provider (47 percent) members, and nearly 2,000 others serve on the 52 statewide health coordinating councils. Some 16,000 citizens also serve on subarea councils (over half the HSAs have such councils). Approximately 25,000 others are volunteer members of the special committees (for example, plan development, project review) or task forces (such as mental health, emergency medical services) that every HSA has.

Planning agencies, by and large, have had little problem in finding replacements for members, interested and willing citizens who are "broadly representative" of the areas served by the agencies. Of the consumer members of HSA governing bodies, for example, 38 percent are women and 22 percent are black or other minorities.

Business and industry, labor, and State and local governments are increasingly supportive of health planning. Nearly all HSA governing bodies include local elected officials; indeed they now constitute nearly 20 percent of the consumer membership and about 8 percent of the total membership of these governing bodies.

Most governing bodies also have business and labor leaders serving on them. The director of health planning of the Caterpillar Corporation, Peoria's largest employer, is on the governing body of the Illinois Central HSA and serves as chairman of its council on health systems alternatives. IBM's director of personnel in Tucson serves on the governing body of the HSA of Southeastern Arizona.

The reason for such widespread participation on the part of industry is not hard to find. Donald I. Lowery, a group vice-president of Proctor and Gamble, who is the chairman of the governing body of the CORVA HSA in Cincinnati, noted that Proctor and Gamble has not been faced with an increase in hospital insurance premiums for its employees in 3 years. He attributes that in large measure to the fact that CORVA has been successful in holding down capital expenditures and block-

ing the unnecessary duplication of expensive equipment and services.

Labor leaders have similar reasons for supporting health planning efforts. Higher costs for health benefits take away earnings that might otherwise go into higher salaries. Labor participation in health planning includes the AFL–CIO State director for education, who is a governing body member of the Southwest Washington HSA, and the president of the local bricklayers union, who is on the governing body of the Southern New Jersey HSA.

The support of business and labor goes beyond mere membership, however, as illustrated by the actions of the Washington Business Group on Health (an offshoot of the Business Roundtable created in 1974 as a response to national health insurance proposals), which has repeatedly indicated its strong support for health planning and industry participation in all phases of health planning. As Willis Goldbeck, its director observed, "If business is serious . . . that they indeed would like to see a private sector health system in the United States, then we best make this planning system work."

Occasionally support for health planning takes more concrete forms. A spin-off of the activities of the Cleveland HSA, the Metropolitan Health Planning Council, has been the establishment of the Greater Cleveland Coalition on Health Care Cost Effectiveness. Its membership includes top industry and health officials in the area. Concerned about the escalating costs of health care—since 1971 hospital costs in Cleveland, Akron, and Canton have risen 99.6 percent—the coalition has adopted long-range goals which include better use of available health care services, elimination of overbedding, and control of unnecessary hospital stays.

Health insurers, both the nonprofit Blues and commercial carriers such as Aetna, Connecticut General, and Mutual of Omaha, have been especially supportive of the health planning program. For example, Aetna Life and Casualty, one of the largest health insurance companies in the country, recently ran full-page ads in 15 national magazines (Newsweek, People) and large metropolitan newspapers (New York Times, Washington Post) encouraging the public to support their local health systems agencies and indicating that Aetna strongly believes HSAs are worthy of such support. The cost of this advertising campaign to Aetna was $485,000.

Blue Cross-Blue Shield has also been supportive. Last spring the Vice President for Health Economics of the Indiana office wrote each of the three HSAs in that State expressing strong support for health care cost containment and asking the HSAs and others to cooperate in every way possible to assure the maximum return for every health care dollar spent. He urged that they "refrain from approving any *major* projects until a community-wide hospital plan has been developed . . ."

Editorial comments, often a barometer of public opinion, have also been supportive of health planning. An editorial in the Portland, Ind., Commercial-Review of April 5, 1979, offered general support for HSAs, saying that the local agency had been getting unfair criticism as it scrutinized a hospital's proposal for a new building. The San Francisco Examiner, in an article of May 7, 1979, said ". . . Something must be going right with a Federal law designed to bring better planning to the Nation's health care delivery system. . . . In numerous cases nationwide, unnecessary, duplicative or costly services have been prevented or redirected where they were more needed and cost effective. . . . All of this has been accomplished, not by fiat from governments, but by persuasion and compromise brought about by the community-based planning boards."

In Battle Creek, Mich., the local HSA undertook the task of deciding how to cut out 175 hospital beds in 5 years. The Enquirer and News wrote on December 26, 1978, "For the most part, it appears that a good atmosphere for weighing difficult decisions has been created, and methods for arriving at a fair program put forth. For this, the agency (HSA) is to be commended."

Straight news reports as well as editorials have appeared about health planning, and these reports have increased as the program has become better known. In the main, this news coverage has been supportive, but in some cases where the agencies did not take a strong position, editorials have urged them to move more aggressively and to take a tougher stance.

Focus on Structure and Process

It seems evident, looking at the health planning program as it has operated thus far, that the emphasis has been on process, on getting the organizational structure in place, in developing health plans and getting them accepted in the community, and in preparing for a regulatory process on which review decisions can be based. Such preparations have been perfectly appropriate. The very concept of health planning is relatively new, and efforts to gain the support of community leaders, health care providers, and governmental officials have taken some time. It has been necessary, for example, for most States to pass State certificate-of-need laws that meet DHEW standards. But the agencies are now on the cut-

ting line, and they have to begin to implement their plans and achieve the goals stated in them. It is time we moved from process to product.

The kinds of actions the health planning agencies will be taking as they implement their plans can be seen by examining the plans themselves. The following examples of plan goals and activities have been identified through Bureau surveys and analyses.

Plan Contents

Cost containment. Nearly all, 96 percent, of the first year plans of the fully designated HSAs have cost-containment goals and objectives. These goals include the shifting of third-party reimbursement towards less costly health care alternatives, the development of multi-institutional arrangements for sharing services, regionalization of services, and reduction of excess system capacity. For example, the Akron, Ohio HSA's plan calls for encouragement of third-party payors to cover additional outpatient services as a means of containing costs by reducing inpatient stays, especially for substance abuse, mental illness, and rehabilitation.

The Illinois Central HSA wants the number of its area hospitals with established multi-institutional sharing or contracting arrangements for administrative services to be increased from 3 (15 percent) to 20 (100 percent).

Goals related to the regionalization of services were more tentative or preliminary in the first year plans. The Southwest Washington HSA's plan calls for a regionally stratified and integrated system of care for the delivery of highly specialized hospital services. The system links the hospitals providing only basic services with those of increasing complexity, thus minimizing costs and enhancing the quality of care provided.

Reduction in excess system capacity was linked with desirable levels of utilization or population-based targets. The goal of the Maine HSA is to have, by 1982, occupancy levels in medical-surgical units at or above the following acceptable standards:

Less than 50 beds	70 percent
51–100 beds	75 percent
More than 100 beds	85 percent

Access to primary care. Three-quarters of the HSAs have included health systems plan goals calling for an increase in the accessibility and availability of primary care for underserved populations or areas. The goals included the development of programs in rural areas or for economically deprived populations and increasing the availability of primary care manpower.

More than 1,000 National Health Service Corps personnel have been placed with the help of the HSAs over the past 3½ years. HSAs have also been facilitating the development of manpower residency programs and are working to assure the availability of rural health facilities and services. Further, HSAs have undertaken initiatives to increase the availability of primary care services to special populations or to insure that services continue to be available in medically underserved areas.

HMO development. One-third of the HSPs contain goals and objectives relating to the development of HMOs and other types of prepaid group practices. They are found chiefly in the plans of HSAs serving major metropolitan areas or those areas with sizable urban-suburban populations or centers such as Charlotte, N.C., or San Antonio, Tex.

HSAs and, in a few instances State agencies, are taking actions that promote the development of HMOs. Some actions had the effect of fostering the spread and strengthening of HMOs. Others stimulated and assisted with HMO development.

Care for the elderly. Eighty-eight percent of the first year plans of fully designated HSAs include a broad spectrum of goals related to the care of the elderly. Long-term care, home health services, and other alternatives to institutional care, and expanded housing, transportation, and other services are among the broad areas addressed by HSA plan goals and objectives.

Responding to the lack of long-term care facilities in their communities, agencies are undertaking initiatives to promote the development and funding of alternatives to institutional care and fostering the development of primary care services, adult day care services, and congregate living programs for the elderly.

Health promotion and prevention. Ninety-six percent of the HSAs address the issue of disease prevention and health promotion in their plans. The goals and objectives touch on almost every aspect of life from improving water quality to eliminating safety hazards in workplaces. Plans advocate wider use of screening and immunization programs, dental disease prevention initiatives, and the promotion of healthier life styles and safe environments.

HSAs have been supporting actions to increase immunization levels and sponsoring health fairs designed to provide education about and screening for potential health problems. They have also fostered the development of dental disease prevention programs, air pollution awareness programs, and programs promoting health through the reduction of self-imposed risks, for example, obesity, smoking, and others. Some HSAs are working with industry and other major employers to improve occupational safety levels or promote the health of employees.

Maternal and child health. Nearly all (96 percent) of the HSPs contain goals and objectives which focus on such priority areas as reducing infant mortality, improving both perinatal and pediatric services, and providing education regarding all aspects of natality.

Many HSAs have undertaken initiatives to attack the high infant mortality rates of their communities. Other HSAs are supporting the development of services for adolescents and other high-risk childbirth populations and the development of services to support and care for pregnant women. While most HSAs have addressed themselves to rationalizing the supply of acute care inpatient services, other agencies have tackled the problem of assuring care for the disabled child.

Mental health. Ninety-eight percent of the first year plans of fully designated HSAs address mental health needs. These plan goals and objectives relate to many priorities within the mental health field, including comprehensiveness of care, deinstitutionalization, integration of mental health into the mainstream of health care delivery, and public and professional education.

Some SHPDAs and HSAs are undertaking joint initiatives to shift resources toward community-based care programs while, in other areas, the HSAs are working to assure the availability of acute care psychiatric services in their communities. HSAs are also fostering the development of comprehensive mental health care centers and facilitating the development of service delivery plans that rationalize the provision of mental health care or have the potential of increasing the quality of that care.

Impact

Information gathered through surveys and analyses of the actions of the health planning agencies suggest that they are establishing themselves as central forces in the health care industry and that their actions are impacting on the cost of health care as well as its availability and accessibility.

A survey by the American Health Planning Association early in 1979 showed that in the 24-month period ending August 1978 health planning agencies reviewed $12 billion in capital investment proposals and disapproved or otherwise turned aside $3.4 billion. The survey covered 81 percent of the health systems agencies and 53 percent of the State health planning and development agencies. In the hospital sector, 16,000 new beds were proposed, of which 7,900 will not be built as a result of the review process. For skilled nursing facilities and intermediate care facilities, 114,000 new beds were proposed and 49,000 of these were not approved.

The per capita amount of proposed capital investment reviewed by the reporting agencies for the 2 years was $78.50. The amount denied was $26.45. The total amount invested in health planning per capita for the 2 years was $1.69. It would appear, therefore, that the nation's investment in health planning is paying off.

Other evidence that the planning agencies are earning their way is contained in an analysis prepared by the Bureau of Health Planning. It projects that the growth of capital construction will amount to approximately $4.8 billion in 1979 compared to about $5.5 billion in 1978. We believe the health planning program is at least partly responsible for this projected decline.

Despite this evidence of overall progress in the program, there have been problems. The effectiveness of the health planning agencies varies widely. The majority of them are forceful and courageous agents for change in their communities, but others have been less than effective. In a few cases the Department has had to withhold further funding of the agency because of inadequate performance. In 1979 renewal of designation agreements was withheld from four health systems agencies, causing the Department to seek replacement agencies.

Health systems plans and annual implementation plans of some agencies were seriously inadequate. As a general rule they tended to be too long, and many were cumbersome, hard to read, filled with jargon, and lacking in proper analyses. Health planning is a new concept to many of its participants, and the agencies often lacked the technical knowledge to develop good plans and obtain their acceptance in the community. Assembling staff with the proper training was often difficult. The Bureau is currently providing technical assistance to the agencies in an effort to help them improve their

plans. The effort, concentrated primarily in the four Centers for Health Planning, is aimed at narrowing the focus of the plans and expressing the goals and expectations more clearly.

Another problem that the agencies face is the level and commitment of citizen participation. Some volunteers have left early because of disappointment in what the agencies were accomplishing. Participation in health planning as a member of the governing body of a health systems agency requires the expenditure of enormous time and energy, and some board members have been disappointed that their commitment did not yield more positive results. At least in the short run, project review activities have sometimes overshadowed efforts to improve the system of health care delivery through improving access. The shift to a 3-year planning cycle may correct these differences by allowing the agencies to devote more time to implementation and thereby concentrate on what is perceived as the more positive aspects of the program.

The Future

The results of health planning thus far, while impressive, are nevertheless preliminary and tenative. Whether or not the progress to date can be sustained and the promise of health planning realized depends on our ability to accomplish several things.

One of the things we must do is to define better reasonable expectations for the program. Increasingly, health planning is seen as being all things to all people. We need to do a better job of defining objectives on which the program will be measured and articulating those so that the community, the State and Federal Governments, and other participants in the program know what we expect to happen as a result of it. If we do not do that, we are likely to see this planning program go the route of its predecessors. Unless our expectations for ourselves are well defined, we risk disappointing others who often come to planning with a different perspective.

Second, we have to articulate those expectations with a focus on product or impact rather than on process. The health systems plans, annual implementation plans, and State health plans must be used as springboards for community action and a foundation for certificate of need decisions that change the course of health care delivery, if that is what is needed.

The third factor is our need to communicate to all sectors—Federal, State, and local—what the program is all about, what the goals and aspirations are, and what is being achieved. There is still a substantial number of people who say, "I know there's a health planning program out there, but I'm not sure what it's all about." It is essential that at all levels we do a better job of informing the public. It is essential because it is through knowledge and support of health planning that we recruit volunteers, and volunteers are the backbone of the health planning effort. Articulation of health planning goals and achievements is the best way to make sure we are drawing fully on this pool of talent.

Clear communication of our goals and mission is also a key to our being able to hold our ground with the decisionmakers. The community's reaction to any particular action by the health planning agency depends to a great extent on the public support that the agency is able to generate and the public's understanding of the reasons behind the decisions.

Summary

The basic elements necessary for an effective and successful health planning program were assembled and refined under the National Health Planning and Resources Development Act, Public Law 93-641. The 1979 Amendments to that law provide the opportunity and authority to build on this foundation to achieve our goals of better access to health care and more appropriate utilization of health resources with reasonable costs as an overriding concern. A detailed summary of the amendments appears on pages 183–188 of this issue of *Public Health Reports.*

To reach these goals, the limited and tentative accomplishments of the health planning agencies thus far will need to be expanded and solidified. The emphasis on structure and process which we have seen in these formative years will need to give way to implementation of the health plans that the agencies have worked to establish. Specifically, the agencies will need to take advantage of the 3-year planning cycle to begin to realize goals such as easier access to primary care, development of more health maintenance organizations, improved care of the elderly, more emphasis on health promotion and prevention, greater attention to maternal and child health care, and the enhancement of appropriate mental health care services.

The position of the health planning agencies as a community and State force for healthful change will need to be strengthened, and recruitment of volunteers, the backbone of the program, encouraged through broader public knowledge and a better understanding of the aims and purpose of the health planning program.