GOVERNMENT LEGISLATION ON HEALTH PLANNING IN THE UNITED STATES FROM 1935-1984 WITH AN EMPHASIS ON CITIZENS PARTICIPATION IN HEALTH PLANNING

by

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INTRODUCTION: WHY THIS REPORT

The primary objective of this report is to look at the development of health planning and citizens participation and its relationship to government legislation on health care from 1935 to the present. Advances in the health care field have changed how citizens view health care. Health planners are experts who help local communities in health planning. Health care is a state of well being and all Americans would like to achieve this goal. Health as defined by the World Health Organization, is "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

In the last decade, the role that citizens play in the health planning process has made significant progress. The federal and local governments have made it possible for citizens to be involved in human rights, minority rights and health care. Government officials are beginning to understand that a balance of power must take place between health planners and citizens who purchase health care service.

In 1962, President John F. Kennedy proclaimed a "declaration of rights" for all Americans. Under President Lyndon B. Johnson, consumer education programs grew rapidly. He understood that current and adequate information was important in understanding health care and eliminating some of the waste of federal dollars. The President wanted to pay special attention to

minority people and special interest groups including the elderly, low income people and teenagers.

During the 1960's and 1970's, the United States government debated the issue of how to finance and manage it's growing health care system. Methods have been developed to improve the quality of health care services through:

- government legislation on health care;
- involvement of citizens in health planning;
- providing current information on health care;
- creating community health care, and health planning organizations;
- health organizations developed at the neighborhood level; and
- creating citizens health planning boards at the local, state and federal level.

These methods may provide a better quality of service for all involved in health care.

Health planners must develop an adequate health care delivery system because of the rising cost of health services. The high cost of health care is important to rural poor, senior citizens and handicapped people in this country.

Key Issues

Health planners plan hospitals for communities who need the service. The quality of performance in the health care system is sometimes different from one health care organization to another. The reason for the inconsistency is because there is not a universal measurement tool for health care.

Citizens participation is usually a part of health care planning. The opinions and evaluations of citizen groups about health care problems are regarded as questionable by some professionals in the health care field. Health planners need to involve citizens in the development of policies in health planning. Providers and consumers should work together in full partnership to bring out the best possible product.

Physicans play an important role in the health care process. Doctors may have the power to change the goals and objectives in the health care field. Some doctors make it hard for consumer boards to participate in the health care process because of the professional language and procedures. This may recreate problems among consumer boards, because their opinions are not respected. In the last ten years, physicans and consumer boards have worked closer together. This helps to bring about a better delivery of health care services.

There are multiple sources for financing health care. The federal, state and local governments all have money for health care. How do people get money and what are the requirements for the program? The requirements may be different at each level of government. This causes problems for citizens and makes it harder for them to understand the process. Instead of the government providing one funding source for health care, they duplicate services at all three levels. The federal, state or local government should take control of financing health care, so there could be a better quality of service. This would also enable better consumer involvement.

At the local level, community leaders usually speak for the residents in their neighborhood. Health care issues have become very important issues to local neighborhoods. The leaders are concerned with cost and allocation of resources. Some consumer boards have been very active in health care

planning. Examples of such organizations are Citizens Board of Inquiry Into Health Service for Americans, and the Health Policy Advisory Center. The Citizens Board of Inquiry was set up by the universities of North Carolina and California. The basic concept of the board was to study health care from the viewpoint of the consumer, not the professional. These types of organizations bring exposure and creditability to other consumer boards. The American Hospital Association has supported consumer groups in their assessment and evaluation of health care. This group understands that citizens provide valuable input into the planning process.

Government legislation on health care will determine the role that health planners and citizens play in the health care planning process. The federal government didn't get involved in health care until 1935. The Social Security Act was passed during this time. Government legislation was written in 1964 and it was called the Economic Opportunity Act. The act developed the idea of "maximum feasible participation."

Today, the federal government uses block grant money for health care. Money is given to the states on the basis of population. The federal government is giving more control to the states, so they can establish a funding source and objectives for health care. The federal government believes it is spending too much money on health care.

How President Ronald Reagan views health care will also be an issue in the next few years. He believes that the health care system should be competitive and not public. To illustrate this point, some public hospitals have been closed because of the lack of funds. He believes that competition between private companies will reduce the price of health care. If the price of health care is reduced, what happens to the people who still can't afford health care services? Is there a need for public

health care facilities for the poor and disadvantaged people? These issues will be explored in this report. In the future, new approaches will be developed by the federal, state and local levels to insure a better delivery of health care services.

What happens if the federal government decides to let the states take over funding of health care services? State governments would have to increase their staffs to support this kind of program. The government would have to use more state money on the program. At the present time, it would be hard for some states to implement this program. This approach may be used to fight the increasing costs in health care.

The basic goals of health care are the same today as they were when society started to promote the idea of quality health care for individuals in America. The goals are the following:

- To increase the average length of human life.
- To decrease the mortality rate from preventable disease.
- To decrease the mortality rate from specific diseases.
- To increase the physical well-being of the individual.
- To increase the rapidity of adjustment of the individual to his environment.[1]

Methodology and Review of the Literature

This report will analyze government legislation on health care with an emphasis on citizens participation in the health planning process. Educators and students and professionals will find this report helpful in providing them with some information on health care from 1935 to the present time. Some insights about the future of health care will also be presented in this paper.

The majority of the information for this report will come from a review of the literature, including books and government documents on health care legislation. Periodical and journal articles will be used to get information on citizens participation. This report will help planners assess and evaluate government legislation on health care from 1935 to the present.

Outline of Study

The remainder of this paper will outline health care legislation at the federal level with an emphasis on citizens participation. Chapter two deals with early years of government legislation on health care. The concept of "maximum feasible participation" will be discussed.

Chapter three reviews Comprehensive Health Planning and Public Health Service Amendments of 1966 (Partnership For Health). This legislation evolved from the Public Health Service Act of 1944.

Chapter four analyzes the National Health Planning and Resource Development Act of 1974. This act developed a network of local planning agencies called health systems agencies. This program revised Comprehensive Health Planning of 1966, Regional Medical Programs of 1965 and the Hill-Burton Program of 1946.

Chapter five will assess how new federalism looks at health care. This chapter will review some of the health care legislation developed by Congress in 1983 and review health planning in Kansas.

Chapter six will conclude this report. This chapter is a discussion from the author about the issues in health care today and in the future, with consideration of citizens participation in health planning.

CHAPTER II

GOVERNMENT LEGISLATION ON HEALTH PLANNING IN THE EARLY YEARS, 1900-1964

The early 1930's was a period of depression in the United States. Widespread poverty couldn't be dealt with by local government and the private sector. The depression finally brought the federal government into the planning process.

In 1935, the federal government passed the Social Security Act. This legislation represented the first entrance of the federal government into the area of social insurance and financial assistance. At this point in our history, it was important for the federal government to get involved. The money provided by this program would be helpful to all people at every level of government.

The first Social Security Act was a lengthy document and was misunderstood by some people. The act has been amended frequently during the last fifty years. The basic concept of the law has remained the same.

The original legislation created a social insurance and financial assistance system. This process involved a payroll tax from employers and employees, providing unemployment compensation for a specified time while a worker looks for new employment. This act established three

categories of persons entitled to financial assistance. Those categories are the needy, the aged, and dependent children.

In the beginning, the Social Security Act made formula grants available to the states for maternal and child health, child welfare, vocational rehabilitation, and crippled children services.[2] The formula used to determine the size of the grants depended on the population, wealth, and character of the state. Grants were extended to rural areas and ghettos to improve staff competence and promote high priority services.

The Public Health Service Act of 1944 was developed to consolidate and review the laws relating to public health service. This act included Title VI of the Social Security Act. Title VI provided grants to the states and local health services. The money would be used for health care services. The act set forth legislation on organization, staffing, and activities of services as they relate to health planning.

This act would encourage research and investigations relating to physical and mental diseases, and impairments. The public health service will also treat narcotic addicts. Section 314 of the Public Service Act would provide grants and services to states to assist in veneral disease control, tuberculosis control, and the establishment and maintenance of adequate state and local public health services.[3] The allotment of money to the state depended on the population, other health problems, and the financial stability of the state.

There were some amendments to the public Health Service Act. Some of them will be discussed in this paper. Up to this point in the government legislation, the idea of citizen participation wasn't put into law. Throughout

the health planning process, citizens have provided input into the health planning process.

The Hospital Survey and Construction Act of 1946 (Hill-Burton) was very important for the construction of hospitals and public health centers. This act was an amendment to the Public Health Service Act of 1944.

During the Depression and World War II, there was little hospital construction. In 1944, a commission was organized to study the national need for hospital facilities. The Hill-Burton Act became Title VI of the Public Health Service Act and was founded on the philosophy that Government and voluntary groups must work together to maintain and improve the health of American people.

In 1946, legislation authorized grant-in-aid to the states that wanted hospital construction. Grants were given to the states to inventory their existing hospitals and health centers and develop programs for the construction of such facilities. Federal funds for surveys and planning facilities were to be allocated on the basis of population. Few states had the standards of man-power to operate and maintain such a complex program. The new facilities used the separate-but-equal doctrine in relationship to race. In order for states to receive funds, they followed this format:

- Designate a single state agency to administer or supervise administration of the program, and establish a state advisory council to consult with the state agency. The council is to include representatives of nongovernmental agencies and state agencies concerned with hospitals, and representatives of the consumer of hospital services.
- Submit a state plan for the construction of facilities based on the statewide survey of need, and conforming to regulations prescribed by the Surgeon General.

- Provide for the designation of a State Advisory Council to consult with the state agency in carrying out the act's purpose.[4]

The basic ideas of Hill-Burton have expanded to include federal assistance for health facility construction and modernization. The idea of grnats-in-aid will continue, but more money will be made available to states through direct loan and loan guarantee programs. State agencies are organizing educational and training programs for health personnel and consumers. In the beginning, Hill-Burton money was used for hospital construction in rural areas. Funds from this program are being used for urban and rural areas today. The Hill-Burton Act has been amended frequently over the years.

The Concept of "Maximum Feasible Participation"

On January 5, 1964, President Johnson declared "war on poverty" in his State of the Union address. President Johnson wanted new legislative proposals to support the war on poverty. This new approach was to provide for a broad attack on the major cause of poverty. This would be made possible with the help of the Youth Employment Act and Domestic Peace Corps proposal, developed under the Kennedy Administration. Johnson asked Sargent Shriver, director of the Peace Corp, to develop strategy for the war on poverty. Shriver was known to have no great respect for the old bureaucrats in government. He was a practical idealist and got things done. In developing this Act, Shriver and his assistants did get input from churches, labor, business and civil rights groups. Shriver didn't use the American poor in developing this act. It goes almost without saying, of course, that it is in no way rare that the poor did not participate in the design of a major administrative proposal.[5]

The Economic Opportunity Act of 1964 was the piece of legislation that Shriver developed. Title I and II were very important to the war on poverty. Title I established three youth programs, two of which were very similar to the Kennedy youth employment opportunities bill which was passed by the Senate. The third youth program was a work-study program for college students. Title II, on the other hand, was a new concept in government. Title II had the name "Urban and Rural Community Action Programs." This idea came from the President's Committee on Juvenile Delinquency. Title II came through the Congress without any problems in 1964. Attorney General Robert Kennedy had this to say about the maximum feasible participation requirement:

> "The institutions which affect the poor-education, welfare, recreation, business, labor-are huge, complex structures, operating far outside their control. They plan programs for the poor, not with them. Part of the sense of helplessness and futility comes from the feeling of powerlessness to affect the operation of these organizations. The community action programs must basically change these organizations by building into the program real representation for the poor. This bill calls for maximum feasible participation of residents. This means the involvements of the poor in planning and implementing programs; giving them a real voice in their institution."[6]

The community action program developed a direct relationship between federal and local levels. Community action encouraged the development of local projects that could change urban ghettos and slum schools. The main objective of Title II was to carry on the idea of "maximum feasible participation" of poor people at the local level. Power had to be given to poor people if the community action program was to work.

Shriver got community action programs through congress without any major problems. Title II reads as follows:

Section 202(a)

The term "community action program" means a program- (1) which mobilizes

and utilizes resources, public or private, of any urban or rural, or combined urban and rural geographical area (referred to in this part as a community), including but not limited to a State, metropolitan area, county, city, town, multi-city unit, or multi-county unit in an attact on poverty;

(2) which provides services, assistance, and other activities of sufficient scope and size to give promise of progress toward elimination of poverty or a cause or causes of poverty through developing employment opportunities, improving human performance, motivation, and productivity or bettering the condition under which people live, learn, and work;

(3) which is developed, conducted, and administered with the maximum feasible participation of residents of the areas and members of the group served;

(4) which is conducted, administered, or coordinated by a public or private nonprofit agency (other than a political party) or a combination thereof...[7]

No one in Washington knew what community action was, so that's why this act went to the Hill in six weeks instead of the usual time of six months. Johnson also understood how to get things done in Washington.

Title II of the Economic Opportunity Act operated on the assumption that the involvement of the poor in policy-making was necessary in order to redistribute power in the cities; without power redistribution, they believed, there would be no great improvement in the lot of the Negro poor. In other words, one of the major problems of the poor is that they are not in a position to influence the policies, procedures, and objectives of the organization responsible for their welfare.[8] The Economic Opportunity Act was the first major government legislation that developed the idea of participation of disadvantaged people.

Major Findings of this Chapter

The federal government passed the Social Security Act in 1935. The legislation involved the federal government in the health care planning process. Funds from this program were used to help people in need. The purpose of this program was to bring about better health care services to individuals.

The Public Health Service Act of 1944 reviewed laws relating to public health services. This program brought delivery and organization of health services to the state and local level. Controlling health diseases was a goal of this program.

The Hill-Burton Act of 1946 organized the construction of hospitals and public health centers. Volunteer organizations were used to help determine the location of new facilities. States used this money to survey existing structures and to make recommendations on where new facilities should be constructed.

The concept of "maximum feasible participation" was developed by Sargent Shriver. He developed the Economic Opportunity Act of 1964. The intent of this idea was to involve the poor in the planning process. The development of health care facilities and of planning health care would involve low income people. The involvement of the poor would redistribute the power at all levels of government. The results of the legislation haven't been determined yet. This act did get some involvement from disadvantaged people.

During the early years of health care planning, the federal government tried different approaches to the problem. The government wants to provide quality health care to individuals at the lowest price. Achieving this goal has and will take sometime. The government and the citizens must work together to achieve this goal.

CHAPTER III

COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICE AMENDMENTS OF 1966. (PARTNERSHIP FOR HEALTH)

Background

In 1965, President Johnson was very concerned about health planning in the United States. He stated on January 7 that "the first concern must be to assure that the advance of medical knowledge leaves none behind. We can--and we must--strive now to assure the availability of and accessibility to the best health care for all Americans, regardless of age or geogrpahy or economic status." He also said, "Our advances, thus far, have been very dramatic in the field of health planning. We are challenged now to give attention to advances in the field of health care."[9]

The first program the President wanted was the Medicare for-the-aged bill. This program would be paid for under the Social Security Program. Other proposals during this period were scholarships for medical centers, grants for staffing for community mental health centers, and a reorganization of vocational programs. All of these programs were old health planning programs brought back to life.

The President also wanted to develop new programs. He wanted to attack heart disease, cancer and stroke at the national level. These diseases were three of the major killers in the United States in 1965. The President wanted to control the use of psychotoxic drugs.

Overview of Legislation

S 3008 authorized comprehensive planning and coordination of public health services on a state area-wide basis. The planning was designed to identify emminent and pressing public health problems and establish priorities for health service.[10] The aim of this legislation was to promote planning of health care at every level of government. This legislation was one of the first attempts to change the organization and delivery of health services.

This bill consolidated various formula grants from the Public Health Service Act that dealt with specific diseases, and substituted a new system of project grants for comprehensive public health. Formula grants take into consideration population, extent of need and state per capita income. Before this program, states didn't have the flexibility to deal with all kinds of health problems. Project grants are grants given to state and local health agencies for a specific project or program.

S 3008 stated that at least 15 percent of state money should be used for state mental health authority. The federal government would share from one to two thirds of the total cost of health service, depending on the per capita income of the state applying for the grant. This program proposed to assure comprehensive health planning for every person, but without detailed consideration of existing patterns of private medicine.

In 1968, this program authorized 62.5 million dollars to public and nonprofit agencies to cover part of the cost of:

- providing services to meet health needs of a limited geographic scope,
- stimulating new health services, and
- undertaking studies or training to improve methods of providing health service.[11]

Section 314a provided states with grants for Comprehensive State Health Planning. The state must provide a plan for comprehensive state health planning. This plan must appoint a state agency to be responsible for state's health planning and also for the development of a state health planning council to advise the agency. This council is to include representatives of state and local agencies, nongovernmental organizations and groups, and consumers of health services; a majority of the membership are to be representatives of consumers.[12]

Comprehensive Health Planning created federal programs to promote health planning at the state and local level. The program was broadened to include health services and manpower development. Before 1966, there was duplication of health services and construction of facilities. Congress wanted this program to stop the duplication of services. The idea involved consumers in the planning process. The local boards consisted of consumers, providers, and representatives of the local government. The local health boards would represent the specific population being served. All of the local boards had a majority of consumers.

The consumer must have a voice in the decision making process relating to health care. During the first few years of the EOA program, mayors of major cities were concerned about the idea of citizens participation in any kind of state or local government planning. Participation of the poor became a political struggle between big-city mayors and militant urban negro poor. The increasing cost of health care in the United States has made this issue a major concern among poor people.

Some people aren't impressed by the development of Comprehensive Health Planning. Health Planning was a political struggle vested between

interest groups rather than efforts to coordinate health care. It was noted in 1978:

> "Ten years ago, local area health planning was a sporadic activity taken seriously by only a few. At the state level, health planning often consisted of routine paper work, a necessary annual precondition for receiving and awarding federal construction grants under the Hill-Burton program. At the national level, health planning consisted of ringing pronouncements in preambles to legislation, supporting by modest appropriations. At best, health planning was viewed as inconsequential, and often it was irrelevant to the development of health care delivery, utilization of services or health care expenditures."[13]

Health planning must involve members in the community in order to develop all the options that might be open to the community. The greatest possible number of persons and viewpoints must be involved in health planning, so that deleterious options do not go unchallenged, nor conceivably desirable alternatives go uninvestigated.[14] Health Planners need to have adequate information in order to make intelligent decisions on health planning.

Comprehensive Health Planning Amendments

The Partnership for Health Amendment of 1967 extended the ideas of Comprehensive health planning and it made some changes which include:

- State plans for comprehensive health planning are to provide for assisting each health institution to develop a program for capitol expenditures consistent with meeting the needs of the state for facilities and services most economically, efficiently, and without duplication.
- Representation of the interest of local government in areawide planning agencies is required.
- Section 314e was revised to transfer authority for studies and demonstrations to another section, and to limit the training provisions.[15]

The Public Health Service Amendment of 1970 extended the program for another three years and some changes were made to include:

- State and areawide planning must include home health services.
- Areawide health planning is to be established to include two representatives of the interest of local government, of the regional medical program, and of consumers of health services. A majority of members of such councils are to be representatives of consumers.[16]

The state health planning council didn't have a handle on what their role was in developing plans for health planning during this time. It wasn't determined at this point how many consumers should be poor minorities, and racial minorities. The legislation simply said the majority of the council members should be consumers. Health planning has always had involvement from citizens. The purpose of this legislation is to involve poor and disadvantaged people in the decision making process. The Comprehensive Health Planning Amendment was one step in developing involvement of minorities in making health decisions for their communities. The National Health Planning and Resource Development Act of 1974 completely changed the comprehensive health planning program. This new program will develop in more detail how state and areawide councils should act in making health planning decisions.

Major Health Planning Programs of 1965

The Heart Disease, Cancer and Stroke Amendments of 1965 became S 596-PL-89-239. The program encouraged localities to establish regional medical programs. These programs would then look at a lot of diseases with an emphasis on heart disease, cancer, and stroke.

This bill was provided to save lives by providing professional care for people in need of special care. The objectives of S 596 were:

- to improve the nation's health manpower by training new specialists in heart, cancer and stroke problems and by providing for continuing education of medical personnel;
- to upgrade heart, cancer and stroke health facilities by encouraging renovations and replacing of obsolete equipment.[17]

This bill was signed into law on October 6, 1965.

The President also endorsed the Community Mental Health Certers Act Amendment of 1965. This Act became public law 89-105. This program provided money to agencies or nonprofit organizations to help cover the cost of professional and technical personnel at community mental health centers. Under this program money would be provided for 51 months to a community health center; after the 51 months, the local community must take over the cost of staffing the facility. This program covered from 75 percent to 30 percent of the staffing costs. This program also included:

- training teachers to teach mentally-retarded and handicapped children;
- improving educational opportunities for these children.

The President approved of this program, so it was extended until 1968.

In 1967, Congress extended the Community Mental Health Program and made some changes. Congress amended the Mental Retardation Facilities and Community Mental Health Center Act of 1963. This program authorized the Secretary of HEW to compensate the professional and technical personnel in community health centers. The Secretary evaluated the health needs of each state before giving them grant money.

The Community Health Service Extension Amendments of 1965 were developed by Congress (S 510-PL-89-109). The bill was signed into law on

August 5, 1965. S 510 extended for three years existing program (PL-87-865). Grants were given to states and local governments to immunize children against polio, diphtheria, whopping cough, and tetenus.

S 510 extended for three years Migratory Workers Health Service (PL-87-692). Grants were given to agencies for health services to domestic migrant workers. This bill included care for migrant worker's families.

The forerunner of the Comprehensive Health Planning Amendment is the Public Health Service Act of 1944. Title 111 and section 314 of this act made federal money available to the states for health planning of specific health diseases. The money came from the federal government in categorical grants. The federal dollars were used for specific purposes. The system of categorical grants had come under a lot of criticism as being too rigid, because it denied state health departments freedom to determine where federal dollars would go to fund public health problems. The Comprehensive Health Planning Amendment represented a departure from the idea of categorical grants. This legislation authorized block grants for public health programs and included provisions for the development of state and local planning for health services.[18]

This amendment involved a complete reorganization of Section 314 of Title 111. This program authorized the Surgeon General to train personnel for state and local health work. This program would provide greater flexibility in tackling health problems.[19] The bill became S 3008-PL-89-749 in 1966. President Johnson asked for this program on March 1, 1966 in a message on health and education.

Major Findings of this Chapter

Comprehensive Health Planning was developed to identify public health problems and to promote health care planning at every level of government. States were given project grants for Comprehensive State Health Planning. This program wanted to stop some of the duplication in facility construction and services.

This program did allow for citizens participation. Some people viewed citizens participation as wrong. Big city mayors wanted to maintain control, but participation by the poor brought about some changes. The poor community developed its own leaders and were allowed to have a voice in the health care planning process.

This program has been amended over the years. States are required to develop a plan for capitol expenditures during the year. The program wants to provide services in the most economical way. State health planning was formed in 1970. The majority of people on the council were consumers.

The major health planning program of 1965 was developed by the President. He wanted to attack heart disease and the use of psychotoxic drugs. The programs developed extended existing programs and encouraged cures for mental retardation. Congress increased the amount of funds available for health care programs in 1965.

Comprehensive Health Planning did provide a new innovative way and a broader planning method for health care. States were allowed to develop their own programs, but coordinating health services was a critical issue during this period.

CHAPTER IV

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Background

In 1974, Congress examined ways to develop a national health insurance program for this country. Much of 1974 was spent on assuring that families would have good medical care once the health insurance program paid the bill. The most important piece of legislation enacted during the year established a network of local groups to improve the distribution of treatment facilities and to curb unneeded development adding to health care costs.[20] Congress also considered a bill to ease doctor shortages in rural and inner-city areas. This particular bill didn't get voted on in 1974.

On February 6, President Nixon unveiled the administration stand on a health insurance proposal. The three part proposal would have required employers to offer their workers insurance plans covering standard health benefits, provided federally subsidized coverage of the poor and restructured the Medicare program for the aged.[21] A family would only have to pay $1,500 a year for medical care under this proposal. President Nixon went on national radio on May 20 to express to the American people the need for a health insurance program, and that the administration would compromise with Congress on a program for health insurance.

The Democrats developed a compromise proposal sponsored by Senator Edward Kennedy and Senator Wilbur Mills. This compromise was somewhat like organized labor's comprehensive plan, but allowed a larger role for private insurers and required patients to share some costs.[22] The Kennedy-Mills plan relied on new payroll taxes. This made participation in the program mandatory. This proposal also required the federal government to administer the program with only a limited participation by the states and private insurers.

The Kennedy-Mills proposal was viewed as a retreat by labor groups. People thought that this approach would leave many basic health needs unmet. Abraham Ribicoff, a former Health Education and Welfare Department Secretary, agreed that a giant new health program ran by the federal government would be a "bureaucratic nightmare."[23] After Nixon resigned on August 8, 1974, there was stronger support for a health insurance bill.

Senator Mills and the Ways and Means Committee staff worked on a compromise bill. This committee couldn't come up with a good bill. The members of the committee couldn't agree on certain aspects of the bill. The committee did approve the bill by a vote of 12-11. On August 21, Mills stated, "I think the members of the committee will agree with me that we've done everything we can to bring about a consensus," he said. "We don't have that consensus." At this point there wasn't much talk about a health insurance program.[24]

Congress believed that poor planning was the cause of the nation's big medical bill. On December 20, 1974, Congress passed the National Health Planning and Resource Development Act of 1974, or S-2994-PL-93-641.

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THIS IS THE BEST IMAGE AVAILABLE.

Overview of Legislation

Legislation S-2994 developed a new national network of local planning agencies. These agencies were called health systems agencies. The major responsibility of these agencies was to establish priorities for development of services and facilites that were needed, and to monitor use of federal health funds in particular areas.[25] The new state planning agencies were asked to develop a plan on state-wide levels also.

The health planning system needed some changes before Congress could think about a national health insurance plan. Extra beds in under-used hospitals were costing this country 1 billion dollars just to maintain. Some of the present health planning programs were overlapping on state and local levels and some components of these programs were unenforceable because of political opposition. S 2994 replaced three programs that were supposed to control the development of health care facilities and services.

- The comprehensive health planning program set up in 1966. In 1974, 218 area-wide agencies covering 79 percent of the nation's population were in operation under this program.
- Regional medical programs authorized in 1965 to encourage regional arrangement between medical schools and research and health care institutions to bring to local areas national advances in the treatment of heart disease, cancer, and stroke.
- The Hill-Burton hospital construction program set up in 1946 to provide federal aid to help correct severe shortages of hospital beds in many parts of the country. This program had helped finance the construction of almost 500,000 hospital beds in the mid 1974 months.[26]

The major component of PL-93-641 was new Titles XV and XVI of the Public Health Service Act of 1974. Part A of Title XV was very important to the health care legislation. This act required the Secretary of HEW to provide a national health care plan with goals based on health care priorities. These priorities were required by law at this time. Previously,

health planning has had goal formulation without developing goals. The Secretary also had a National Council on Health Planning and Development to help set goals for health planning. The National Council goals were very vague and powerless.

Part B of Title XV was the whole core of this health care program. Health Systems Agencies (HSAs) were established by governors for their states according to a set of complex guidelines. The HSAs were federally funded and their responsibility was:

- Reflect consideration of the different health planning and developmental needs of metropolitan as opposed to nonmetropolitan areas;
- Not divide Standard Metropolitan Statistical Areas (SMSAs), a stipulation honored mostly in the breach;
- Be coordinated with areas for Professional Standard Review Organization and areas for existing regional and state planning efforts.[27]

Each HSA was to contain at least 500,000 and no more than 3,000,000 people, unless the state population was less, or the population of SMSA more. In each HSAs, there needed to be one place to provide highly technical health care service. HSAs could be public or nonprofit agencies. In some cases the HSAs were quite successful, but in other sectors it still confused the planning process. Under 1513 of PL-93-641, HSAs were charged with:

- gathering and analyzing suitable data
- establishing health systems plans (long-range) and annual implementation plans (short-range), abbreviated as HSPs and AIPs
- providing either technical and/or financial assistance to those seeking to implement provisions of the plans
- coordinating activities with appropriate planning and regulating entities
- reviewing and approving or disapproving applications for federal funds for health programs in the area

- assisting states in the performance of capital expenditures reviews (certification-of-need)
- assisting states in reviewing existing institutional health services with respect to the appropriateness of such services; and annually recommending to states projects for the modernization, construction, and conversion of medical facilities in the area.[28]

The Health Systems Agencies were to help, assist, and coordinate health services for a particular area. Health Systems Agencies had three major tasks:

- improving the health of the residents in the service area,
- increasing the accessibility, acceptability, continuity, and quality of health care services,
- restrain increases in cost and prevent unnecessary duplication of health resources.[29]

PL-93-641 also created two planning bodies that would be represented at the state level. The State Health Planning and Development Agency (SHPDA) was the first agency developed. Their purpose was to use information from Health Systems Agencies to create a statewide health plan. This agency also reviewed institutional services for their particular states.

Statewide Health Coordinating Council (SHCC) was the second planning body. This Council, aided by the SHPDA, would review and coordinate the plans of the Health Systems Agencies. They would also review budget and state applications under the Public Health Service Act, the Community Mental Center Act, and the Alcoholism Control Act of 1970. All of the HSA's would be represented on this council. At least 50% of the members on the council would have to be consumers and one-third should work in the health care profession.

Title XV represented some earlier concepts relating to health planning and it also worked out some new ideas. The SHCCs and HSAs have majority members who must be consumers. The presence of consumers with public

officials brings out the idea of public accountability. This would seem to mean that citizens would have a voice in the decision making process.

Title XVI was named Health Resources Development. This program was developed to provide assistance for up-dating medical centers, construction of inpatient and outpatient facilities in areas that have a lot of growth. This title would also provide provisions for new health care services, and for projects related to the elimination of safety hazards and the avoidance of noncompliance with licenses or accreditation standards.[30] The SHCC would have to approve the state facilities plan in respect to the overall state plan. States would receive money based on population, financial need and the need for a particular medical facility. The federal government can pay up to two thirds of the project depending on the area of the project.

PL-93-641 was a major piece of legislation because it shows the close relationship between the federal government and state health planning agencies. This program was seen as a compromise to the Comprehensive Health Planning idea. If disagreement came about between state agencies (HSAs) the Secretary of DHEW would take care of the problem. The SHCC has the power to prepare, review, and revise state health plans and approve or disapprove state funding under the Public Service Act of 1944. The HSAs from each state had a majority on all SHCC. This means that all policy would in the end be controlled by HSAs and not necessarily by consumers of health care.

Amendments to S 2994 of 1974

On October 4, 1979 the Health Planning and Resources Development Amendments of 1979 became law. This law revised the health care program in the United States. During the 1970's, the United States had spent many finances on health care. A lot of jobs were being created because of health care. From 1970-1977 one out of every seven jobs created was in health care. The United States had spent 200 billion dollars on health care in 1980. Some health planners feel this amount will go up to 758 billion in 1990.

Technological changes in health care may be one of the causes of rising costs. The need for skilled personnel is quite expensive. The government is spending large amounts of money on Medicare and Medicaid. The elderly are increasing their numbers, thus placing an extra burden on the health care system.

The health care system was spending money on health care during the 1970's, but some people were not receiving adequate health service. Poor people, minorities, handicapped, and elderly in rural and urban areas were not getting quality health care services.

By creating a nationwide system of local and state health planning agencies, public law 96-79 would put health planning into the communities and set in motion a process that lets the needs for health facilities and health services be determined by the people who are to be served.[31]

This program was set up in 1974 and it developed three levels of health planning on the state level. The levels were the local Health Systems Agencies, State Health Planning and Development Agencies, and a Statewide Health Coordinating Council. These organizations were made up of volunteers and staff members. The purpose of these organizations was to improve the quality of, and cut the cost of health care without cutting back on services.

The Nation was divided into 204 health service areas. The areas would be served by a Health System Agency. The District of Columbia was a single agency that worked on health planning at the local and state level.

During the 1970's, Congress tried different methods to solve the health care problems in the United States. Comprehensive Health Planning was work, but a more effective program needed to be developed. A brief summary of each proposal is discussed in the following pages.

Seven Major Health Insurance Proposals Pending in Congress in 1974

Comprehensive Health Insurance Act (HR 12684--Nixon-Ford administration bill). This program wanted employers to offer health insurance plans to their employees. The employee didn't have to participate if they didn't want to. Employers would pay 75 percent of the premiums. This same format would be used under the Medicare program. The states would administer all programs but the Medicare program. Private insurers would provide some policies subject to the state approval.

Comprehensive National Health Insurance Act (S 3286, HR 13870--Kennedy-Mills bill). This bill required that employers and employees be a part of the health insurance. This program would be controlled at the federal level with standard benefits for all people. The poor and Medicare participants would be under the same coverage. People on welfare would have money taken out of their monthly payment for this service. Employers would pay 3 percent and employees a 1 percent tax on the first $20,000 made under the law.

Catastrophic Health Insurance and Medical Assistance Reform Act (S 2513, HR 14079--Long-Ribicoff bill). This program was for families with catastrophic health bills. After the 60th day or when a family incurred $2,000 in medical bills, the family would only have to pay $1,000 for

catastrophic care under this program. This program would cover most of the cost for the poor when catastrophic benefits took effect. Health Education and Welfare Department (HEW) would administer this program.

Health Care Insurance Act (S 444, HR 2222--American Medical Association's "Medicredit"bill). This bill was a voluntary program. Families who participated would receive a tax credit to cover premiums for a standard health plan. The credits for this program would depend on income, and the poor people would receive vouchers to cover their premiums. This program would be controlled by the federal government. Money for the program would come from income tax, and the states would cover changes.

Health Security Act (S 3, HR 22--Griffiths-Corman bill supported by organized labor). This program would provide comprehensive benefits to people. A board within HEW would administer this program. Money for this program would come from general revenue at the federal level. Employees would then pay 1 percent of their first $15,000 of income and 3.5 percent of total income. Unearned income would have a 1 percent tax on it.

National Health Care Services Reorganization and Financing Act (HR 1--American Hospital Association bill). Employers would have to provide standard health plans for their employees, but it's a voluntary program. The federal government will provide the money for poor and disadvantaged participants. Employers will pay up to 75 percent of the premiums. The Cabinet-level Department of Health will be the administrators in this program.

National Health Care Act (S 1100, HR 5200--Health Insurance Association of America bill). This program was also voluntary. Employers would get tax incentives to purchase a standard health insurance plan. The federal government would take care of the poor. A council within the Executive Office of the President would administer this program.[32]

All of these programs were conceived in 1974, but because of the conflicts and struggles on capitol hill, S 2994 was the only agreeable alternative.

Description of Organization

Each Health Systems Agency is made up of volunteers (composed for consumers and providers) and professional people. A Health System Agency would gather information and develop plans to improve it's areas health care problems. Agencies decide on local uses of certain funds, federal health funds, and make recommendations on the need of new institutional health services, major medical equipment and capital expenditures.[33] Most of the money for these agencies comes from the federal government, but they can raise money at the local level.

State Health Planning and Development Agencies work on health planning from the state point of view. This organization reviews the health plans from the local Health Systems Agencies and looks at it's relationship to statewide health plans. The agency then takes all local health care plans and develops a State Health Plan which must be approved by a Statewide Coordinating Council. This agency also conducts and administers certificate-of-need programs.

The Statewide Health Coordinating Council is made up of volunteers appointed by the governor. Some of the members are chosen from the state's Health Systems Agencies. This council will determine the local agencies health plans and help direct the state agency on the performance of it's function. The council works with the state agency to review and coordinate local health plans, and prepares the State Health Plan which becomes official after the governor signs it.[34]

Guidelines for Health Systems Agencies and State Health Planning and Development Agency

A Health Systems Agency operates within one of the 204 health service areas. Agencies provide it's service area with good health planning. The law requires that all agencies meet the following goals:

- improving the health of area residents;
- increasing the accessibility, acceptability, continuity and quality of health service;
- restraining increases in the cost of health care;
- preserving and improving local health care competition.[35]

Each agency must have a decision making body of at least 10 members and not more than 30 members. The members of this agency are all volunteer. The majority of the members must be consumers and the rest providers. If more than 30 members want to be on the agency, an executive committee is set up.

The consumer members of this agency must represent the Health Service Area. People on this organization should represent social, economic, linguistic, handicapped and racial populations of the service area. Consumers must also be major purchasers of health care services. Consumers must have a majority of votes on all subcommittees set up by the governing body or by the executive committee. The consumers on the Health Systems Agency must live in the health service area.

People who work in hospital administration must compromise one-half of the providers membership. A provider is an individual who works in some capacity and provides health care. A person can work anywhere as long as it's in the health care field.

The selection process and replacing board members is simple. This makes it possible for a lot of people to participate in the health planning

process. The law states that at least the board members must be selected by persons other than present board members.

All of the Health System Agencies must provide programs and support for it's members. Special consideration should be given to consumer members. Board members must define objectives of program training and continuing education.

Health Systems Agencies are to involve the general public in all of the following activities:

- gathering and analyzing various data on the area's health status and services;
- developing a Health Systems Plan, a long-range detailed statement of health goals for the area, and an Annual Implementation Plan, a yearly description of action that will be taken to accomplish priority objectives from the Health Systems Plan;
- providing technical assistance to individual and organizations working on projects aimed at achieving Health Systems Plan goals;
- coordinating activities with Professional Standards Review Organizations and other planning and regulatory bodies, including area agencies on aging, mental health planning agencies, and drug and alcohol agencies.
- reviewing proposals for major medical equipment, capitol expenditures and new institutional health services, and making recommendations to the state health planning agency;
- reviewing the appropriateness of existing institutional health services and making recommendations to the state health planning agency.
- collecting, and making available to the public information on the area's 25 most frequently used hospital services, including the average semiprivate and private room rates;
- recommending annually to state projects for modernizing, constructing or converting health facilities in the area; and
- sharing health planning data and cooperating with American Indian tribes and organizations and Alaskan Native villages in their service area.[36]

The law requires that federal funds are used to operate a Health Systems Agency. A particular agency could get more federal money depending on how much local money was collected. Grants are used for the delivery of

Each state must apply to its Department of designation for a State Health Planning and Development Agency. A state must have a Statewide Health Coordinating Council. State agencies are designated for a three year period and this is renewable. State agencies are required to do the following:

- conducting health planning activities of the state and implement those parts of the State Health Plan and the plans of Health Systems Agencies which relate to state government;
- determine statewide health needs after consultation with Statewide Health Coordinating Council, the public and others;
- prepare, review every three years, and revise a preliminary State Health Plan based on Health Systems Plans (the preliminary plan is submitted to the Statewide Health Coordinating Council for completion and then to the governor for signature);
- assist the Statewide Health Coordinating Council in it's duties;
- serve as the designated planning agency in states having capitol expenditures reviews under Section 1122 of the Social Security Act;
- administer a state certificate-of-need program meeting federal regulations and covering proposals for capitol expenditures, acquisition of major medical equipment and the addition of institutional health services;
- conduct a review of the appropriateness of existing institutional and home health services at least every five years and making public findings;
- prepare an inventory of health care facilities along with an evaluation of their physical condition, and,
- provide technical assistance to individuals and organizations in obtaining and completing forms necessary for development of health-related projects and programs.[37]

State agencies get grants to cover 75 percent of their operating budget. This agency makes sure that the state health plan is good for the overall needs of the people in the state.

Comparison of Comprehensive Health Planning To National Health Planning

Comprehensive health planning was established to identify pressing health problems and develop priorities in health planning. The program tried to coordinate health planning at the local and state level. State agencies had problems in developing plans because of political pressure. The agencies found it difficult to persuade some local governments that it wasn't in their best interest to buy an expensive piece of equipment if it were located at a nearby hospital. If state agencies could control the purchasing of expensive equipment, then it would have less problems coordinating health planning.

Comprehensive health planning did establish local planning boards. The boards consisted of a majority of consumers. The goals and objectives of the board weren't easily defined at this particular time. The enactment of the National Health Planning Program of 1974 would define the role local boards would play in the health planning process.

National health planning established a network of local planning agencies. The agencies' goals and objectives were clearly defined. The agencies had the power to approve or disapprove of federal funds for health programs in their area. The local agencies had representation of poor people on the boards. Citizens did have power in the decision making process.

This legislation also authorized two more important organizations at the state level. The State Health Planning and Development Agency was responsible for creating a statewide health plan. This agency got some information from the local health systems agencies. The Statewide Coordinating Council would review the plans of the local health systems agencies. The council would have consumers on them.

National health planning program of 1974 was established to coordinate health planning at all the different levels of government. Comprehensive health planning tried this concept, with some success. National health planning program provided power to the local health system agencies, but comprehensive health planning wasn't developed at this level. The concepts in comprehensive health planning worked during the late 1960's, but new methods were needed during the 1970's. National health planning brought new ideas into health care.

Major Findings of this Chapter

National Health Planning program was developed to prevent unnecessary development and to coordinate health planning at the local levels. Some people saw this program as the first step toward a national health insurance program. This program provided a set of goals and regulations for states and local governments to follow concerning health planning.

This program provided local health systems agencies. Agencies were made up of volunteers and professional people. They made decisions based on the health care needs of the people in their area. Each agency developed an area health plan that was approved by the Statewide Coordinating Council. The intent of this organization was to develop a health care plan using a majority of consumers on the board.

Each state under this program must develop a State Health Planning and Development Agency. This organization conducts health planning activities for the state. The agency would implement the state health plan and coordinate the health services for the state. National Health Planning coordinated health planning at the local, regional and state levels. Organizations were set up to provide health services to people. Local citizens

made policy decisions concerning health planning. The program wanted to increase the amount of health care and construction of facilities without increasing federal or state funds for the program.

CHAPTER V

CURRENT TRENDS IN HEALTH PLANNING

The cost of medical care is rising at a frightening rate. Health planners and city officials are concerned about keeping health cost down. Most people believe that all people have a "right to health care." This value system will reflect government programs on health planning. In the case of medical care as in the case of education, there are strong competing beliefs among large segments of the population that life and health are precious rights that should not be rationed by the marketplace and the ability to pay, but should be distributed on some more equitable basis such as need.[38] The 1980's will be a period of finding the best and quickest way to provide health planning to the Americans who need it most.

The Department of Health and Human Services in 1980 has placed time and energy in promoting health and preventing diseases. One way of reducing the cost of health care is reducing the number of people who need the service. In 1975, 10 percent of the United States population was 65 and older. This 10 percent consumed almost 3/10 of the total health care expenditures. By the year 2000, about 20 percent of the population will be 65 or older. Older people could use 80-90 percent of the available health care money. In 1975 about half of the health care expenditures were paid by the federal government.

Government Legislation on Health Planning in 1983

Summary of HR 2935 (Health Planning Block Grant Act of 1983)

HR 2935 was a major piece of legislation developed in 1983. This bill was introduced by Representatives Shelby, Madigan, and Broyhill. This particular piece of legislation was called "Health Planning Block Grant Act of 1983".

HR 2935 would reorganize the program being carried out under Title XV of the Public Service Act. The new proposal would be a block grant program authorized by a new part D of Title XIX of the Act. The Secretary of Health and Human Services would have 150 days to develop provisions for this program after the bill has been passed. Also, within 150 days, each state that intends to apply for block grant funds would be required to designate areas for health planning which meet the requirements of S 1962 of the public Health Service Act, designate regional health planning agencies which meet the requirements of S 1963 and 1964, and submit an application for a grant under S 1961.[39]

Under HR 2935 states must revise their certificate-of-need programs. This program will maintain the development of state agencies or health systems agencies. Money will also be used for new equipment.

Part D to Title XIX of the Public Health Service Act authorized $32,000,000 for 1984 and $33,600,000 for 1985. This money would be used for the new block grant program. Funds are given to the states according to their population. States that receive federal money must provide a certificate-of-need program and a state health plan.

Subpart 2 of Part D of Title XIX adds more to the Public Health Service Act. This part of Title XIX would set up the guidelines for the

certificate-of-need requirements. The basic requirements during this part was that the certificate-of-need must review and determine the needs of the following:

- major medical equipment and institutional health services,
- capitol expenditures, and,
- require that a certificate-of-need be issued to the above.[40]

Certificate-of-need is required for all major medical equipment that must be used for in-patient health care. These decisions are made by looking at the state health plan.

Section 1954 of HR 2935 concerns itself with the requirement of the State Health Plan. This section will determine the health services and make sure that all people are getting quality health care service. The State Health Plan will also describe the kind of health services available in the state. The above process will help stop duplication of services and trim some money from the state health budget.

Section 1961 of HR 2935 will provide funds for regional health planning agencies. Regional health planning agencies must apply to the states to get funding. The amount of money given to each agency depends on the population of their service area. A regional planning agency won't receive federal funding unless it can raise 15 percent of it's operating budget.

Section 1964 of HR 2935 shows the guidelines of the regional planning agencies. The function of the agencies are as follows:

- assisting the state agency in the development of state health plans,
- encouraging individuals and public entities in carrying out the plan, and
- carrying out public information programs to inform residents of the area of the provisions of the state health plan which relate to the area.[41]

Each regional agency must make sure it follows all the requirements of the certificate-of-need program. If it doesn't, then funding wouldn't occur. This program would expire on September 30 on the third year after the enactment of the program.

Summary of HR 2934 (Health Planning Amendment of 1983)

HR 2934 was a bill introduced by Representative Waxman on May 9, 1983. This bill was called "Health Planning Amendments of 1983". This bill was developed to amend the Public Health Service Act.

Section 2 of this bill would amend Section 1512 (b), (2), (A), and (B) of the Public Health Service Act. This section would reduce the Health Systems Agency staff to one per hundred thousand residents of a service area, or one per three hundred thousand residents of the area. This section is under a Continuing Resolution for 1983.

Section 3 of the bill would provide something special for Health Systems Agencies. They shall develop a plan to review and make recommendation on certificate-of-need. This process is already provided by state agencies.

Section 4 would look at the designation of Health Systems Agencies:

- Amends paragraph (b) (2) to remove the 36 month limit on the period during which Health Systems Agencies may be designated.
- Revises paragraph (b) (3) and subparagraph (c) (1) (B) regarding the termination of conditionally designated Health Systems Agencies to require the same procedures as are currently required for the termination of fully designated agencies.
- Amends subparagraph (c) (3) (B) to remove the 12 month limit on the period during which Health System Agencies have previously been fully designated may be conditionally designated.
- Amends subsection (d) to permit the same entity to be redesignated as an Health System Agency. Current law only allows the designation of another entity.[42]

Section 6 formulates the ideas for State Health Planning and Development Agencies:

- It deletes the provisions of subparagraph (b) (2) (B) which requires conditionally designated State agencies to progressively increase their function.
- It revises subparagraphs (2) (C) and (3) (B) of subsection (b) regarding the termination of conditionally designated State agencies to require the same procedures that are currently required for termination of fully designated agencies.
- It amends subparagraph (b) (4) (B) to remove the 12 month limit on the period during which state agencies, which have previously been fully designated, may be conditionally designated.
- It amends subparagraph (b) (2) (B) and deletes subsection (d) to extend the period that state agencies may be conditionally designated until October 1, 1986.
- It provides that states shall not be required to have a fully designated agency or be subject to the penalty of a loss of funds under the Public Health Service Act until October 1, 1986.[43]

Section 8 of HR 2934 increased the value of projects which state certificate-of-need programs must review. Capitol expenditures were increased from $600,000 to $1,000,000, operating budget from $250,000 to $500,000, and medical equipment from $400,000 to $500,000. Changes were made in this section because of the increasing cost of material and equipment for health care.

Section 10 authorized funds to support HR 2934. In 1983, $42,000,000 was authorized for Health Systems Agencies, $21,400,000 for states, and $1,500,000 for grants to health centers for health planning. This funding could be increased or decreased in fiscal 1984 and 1985.

Summary of S 1778 (Health Planning Block Grant of 1983)

This bill was introduced on August 4, 1983. Senator Quayle developed

this bill for the purpose of distributing block grant money to states to support health planning. This bill was called, "Health Planning Block Grant Act of 1983."

This Act would add Title XIX to the Public Health Service Act. This new legislation would authorize $40,000,000 to states for fiscal 1984, 1985 and 1986.

States would receive funding based on total appropriation for health planning as the population of the state bears to the total population. If a state wanted funding through S 1778, they would receive at least $100,000. The 1980 census was the tool used to determine the level of funding. States could carry over funds from one year to the next year.

S 1778 authorized funds to the states for the following purposes:

- The conduction of studies to analyze and collect data by a state, local, regional, or private agency designated by the state to fund and deliver health care to the state;
- each state agency must develop a plan for the allocation of health services and resources;
- private or public entities must be developed for the allocation of health services;
- activities carried out by a state agency to review and determine, to the extent determined appropriate by the state, the need for (a) capitol expenditures by health care providers, (b) the acquisition of major medical equipment by health care providers, and (c) major expansions in the provision of institutional health care services;
- the participation of local, regional, public, and private entities designated by the state in the review authorized by the above;
- experiments designed to demonstrate nonregulatory strategies to promote competition in the financing and delivery of health care; and
- experiments designed to demonstrate altermative regulatory strategies to limit the expenditures and services.[44]

Under S 1778, states must do the following to receive funds:

- Submit an application to the Secretary of Health and Human Services;
- after the expiration of the first fiscal year the state receives funds, and the state legislature must hold hearings on the proposed use and distribution of funds;
- the chief executive offices of the state must certify that the state will use the funds in accordance with the act, will designate a state agency to administer funds, agree to cooperate with federal investigations, and certify that the federal money will be used to supplement and increase the level of state, local, and other non-federal funds available for the programs and activities authorized under the act, and
- the chief executive of the state is also to furnish a description of how funds are to be used and assurances that the description has been made public in a way that facilitates comment during its development.[45]

This bill was developed to stop all the waste of funds in health planning. If health planners can stop the waste of funds, then more people can be helped. S 1778 would expire on October 1, 1985.

President Reagan's Views on Health Care

The health care for the poor and disadvantaged people is worse than it is for white people in America. From 1970 to 1975, the cancer death rate for whites increased only 4 percent, but for nonwhites, the increase was 20 percent. The death rate for children is the highest among black children.

In many cities, resources for health services in the public sector and for municipal hospitals are grossly inadequate, and funds for these programs, in real terms, are diminishing in many areas.[46] Public hospitals are closing in cities like St. Louis and Philadelphia. Without public hospitals, poor people will be hard-pressed to get adequate health care service.

In 1980 Reagan didn't do anything to change the health care system. The public hospitals were being closed and poor people weren't being helped at all. Mr. Reagan has attempted to destroy public services in favor of private services, to reduce public entitlements, and to remove regulations that helped to prevent illness and had maintained barely adequate standards for nursing homes and other facilities.[47]

The President has attacked health care in the public sector by attempting to combine twenty-six federal categorical health programs into two block grants for the states. One block grant would be used for health services and the other for disease prevention. The block grant proposal called for a 25 percent reduction in total funds. This reduction could be made up at the administrative level of the state. States would spend more money on block grant health programs than on categorical health programs. States would have to use some of their own funds to run the health care industry.

In 1981, the Omnibus Budget Reconciliation Act was passed by Congress. This Act created four block grant programs instead of two. This bill also limited the amount of funding for programs. This program had $427 million available for fiscal 1981. In 1982, the program would be on a continuing resolution with $348 million available to use. The federal government will put less money in this program for fiscal 1983. The burden then will be shifted to the states to provide funding. The states won't have the manpower or the funds to provide quality health care for all people. So, the final result will have less public health facilities and more private health facilities.

The Reagan administration believes that by creating competition in health care, it will then reduce the price of health care. David Stockman,

director of the White House Office of Management and Budget, states there are five basic issues concerning health planning. Mr. Stockman introduced a bill in 1980 that states the following concerning health planning:

- offers consumers economic choices for health care;
- provides any reimbursements for medical care in the form of fixed monetary subsidies that are "inherently controllable," as opposed to the "open-ended contract" that characterizes Medicare, Medicaid, and income-tax allowances;
- places at financial risk to those who purchase new technology and construct medical facilities;
- structures competition among medical-care providers and the marketing of medical care "on a retail basis";
- bases the system "on the laissez-faire notion" of a completely self-organizing system. In other words, this kind of system would do the following:
- substitute market competition for government regulations;
- provide consumers an incentive to be cost-conscious;
- provide consumers an incentive to choose among health insurance plans;
- dismantle regulatory structures;
- place the burden of risk on providers.[48]

Some experts say the rich will benefit from competition in a health care system. They will pay less for health insurance, but this lower cost will still be too high for poor people. The Reagan administration must provide funding for community hospitals to help insurance provide adequate health care for poor and disadvantaged people.

The Reagan administration wants to encourage private health care facilities. The President will reduce the federal government responsibility and expenditures in health care. The states will have to take over the health care programs. Most states won't spend the same amount of money on health care as was allocated to them by the federal government.

The administration has endorsed a market strategy for slowing all health cost increases, not simply to control public spending, but to better align cost with benefits in the health care sector.[49] This strategy would mean tax reforms and other measures to increase the amount of information to consumers about the prices in health insurance. The administration believes that this approach will help promote a better use and delivery of health care services.

The failure to address Medicare cost will add to the pressure to make further cuts in health service grant programs and to reduce federal contributions to Medicaid.[50] The taxpayer in the 1980's will spend a lot of money on health care if the federal government keeps reducing funds used for health planning.

President Reagan made a speech to the American Medical Association on June 23, 1983 concerning his views on health planning. He said, "We have the best health care in the world, because it has remained private."[51] The administration will always promote private health care instead of public health care.

Health care planners must fight against budget cuts and the transfer of programs to the states without adequate funding. Planners should question the administration on the closing of public hospitals and the idea of competition in health care.

Kansas Report on Health Planning 1984

Chapter 248 was enacted by the Kansas legislators in 1983. A Commission was set up to study the future of health planning in Kansas. This

eleven-member Commission would report their findings to the Governor at the 1984 Legislature. The Commission was created to evaluate the role of health planning in Kansas, the effectiveness of health care, and the quality of health planning. The Commission would also develop goals and objectives for state health planning. The members of the committee were called the Health Planning Review Commission. This Commission had 42 conferees to discuss health planning in Kansas.

Evaluation of Health Planning by Kansas Commission in 1984

The Commission was in support of functions carried out by the Statewide Health Coordinating Council. This council is made up of consumers and providers of health services. The State Health Plan is a document that is produced by the Statewide Health Coordinating Council. The commission supports this documentation and believes it is an important function for the state.

Testimony given to the commission on the role played by the Health Systems Agencies was mixed. The Health Systems Agencies did a good job of providing local input into the total health planning process. The Commission was concerned about health systems agencies on the continued role of the certificate-of-need process and the present form of the Health System Agencies. Many people noted that local planning efforts should be continued in some form and stated that staffing and consumers, as well as provider representation, should be components of health planning.[52]

In general, the testimony given to the commission was in support on health planning systems for the state of Kansas. Some people believe that consumers should be brought into the full partnership with providers in

developing health planning policies. The health planning structure at the local and state level should get more exposure, so more people will understand health planning.

Conclusions by the Kansas Commission on Health Planning

The Commission concludes that there is a need for a strong health planning function at the local and state level. The Commission sees many positive things resulting in health planning since the 1970's, including: the development of a data base that did not exist prior to the creation of the current planning structure, the development of resources that allow increased citizen participation in decisions about the health care delivery system, improved decision making based on developed criteria, and the positive implementation of some of the recommendations arising from the health planning process.[53] The new health care system must provide for citizen participation in the planning process.

The health planning for the state has not been effectively coordinated with other governmental functions. The state agency should improve their coordination process and data sharing techniques. The structure of the state's health planning process is very important.

The Commission concluded that local input is important to the health planning process if consensus on the direction of health initiatives to take should be developed, policies are to be identified, and recommendations are to be implemented.[54] Money will be a problem for local health systems agencies to function. If the federal government stops sending money to the states, the local agencies will have to work on a volunteer basis.

The role of the local health systems agencies is very important in the

1980's. Their role should be a legitimate power of the local government. If the health systems agencies are seen in an adversary role, this will hurt the effectiveness of the organization.

Recommendations by Kansas Commission on Health Planning

The Commission recommends that the health planning process and the certificate-of-need program be extended through July 1, 1987. The Commission also noted that changes will occur in the health planning field and a system should be developed to monitor those changes.

The Commission has two recommendations to bring about better coordination of health care with other state governmental functions. The Commission would like to see the Governor appoint a secretary from his office to the Statewide Health Coordinating Council. The second recommendation relating to coordination and visibility is a strong idea to the Governor to convene cabinet level meetings to discuss health planning, health policy, and the recommendations of the Statewide Health Coordinating Council as set out in the State Health Plan.[55]

The Commission recommends that the certificate-of-need process be deleted from the local health systems agencies. The Department of Health and Environment would take over this responsibility. The local health systems agencies would have some input into the certificate-of-need process, but they would not have the final vote.

Findings by the Kansas Commission on Health Planning

The Reagan administration is moving toward the privatization of the health care system. The government is using deregulation in increase the

decision making process of individuals on health care. Community hospitals have closed because of the lack of federal funds. The government is decreasing the amount of medical care providers. Reagan is using "new federalism" to destroy health planning programs. States have been given programs without adequate funding from the federal government. The states don't have the resources or the administrative staff to support the programs or to create new programs because of a demand. The government believes that the level of health care services for local government should be left up to local governments.

The government spends more money on death than it does to support prohealth activities. 330 million dollars were spent by the government to eliminate smallpox; the same government will spend more money per day on arms. If the federal government used one-tenth of the proposed 1.5 trillion dollars for defense from 1981-86 for health care and planning, the citizens of the United States would have the best health care in the World.

Major cities have had to close their community hospitals, because of the cuts in the federal health care budget. Without federal dollar funding, community hospital babies are dying, who could be saved, adults and older people are left in misery because they aren't receiving adequate health care. There should not be any health problems in America, because this country is one of the richest in the world. The federal, state, and local governments are killing people and will do so until they change their policy on health planning.

The Reagan administration wants to provide competition in the health care field in order to reduce cost. The poor and elderly will pay more of their money for health care than others. How would competition force the private market competitors to take on these customers? People who work in the private market want to be paid for their services. People who are poor

can not pay because they have no money or insurance.

Competition will provide a better quality of health care service. But, the cost of the services will also be high. The private health care market will provide services to those people who can pay the price. So, competition in health care doesn't drive the price down, it increases the price. So in the end, the only people that benefit from competition in health care are the rich. The rich will pay less for health care for the poor, and providers will provide services for those who can pay and leave the real health problems to an inadequate public health sector.

Report of the Health Planning Review Commission

The Commission supported the idea of local health systems agencies working in their present form. The agencies provide data and then develop short and long term plans to improve the area's health care problem. This organization is made up of consumers and providers. In the 1980's, the cost of providing health care services will increase at an alarming rate, so low-income citizens must provide input into this process. People must feel like they are making a contribution to their community. If not, the people get angry and upset.

The report stated that health systems agencies may have been influenced by their role in the certificate-of-need process. Some people would like this phase taken from the health systems agencies. The agencies should continue to give input or health care, and help with the certificate-of-need process.

The Commission noted that if federal grants are discontinued, the health systems agencies will have to depend on voluntary efforts. The federal government must continue funding for this process. If volunteers

are used for health planning, the quality of the final product will decrease. The communities being served by the health systems agencies could use their local funds to support the agencies. But usually, they don't have enough money for their own governments. Health care will be a major problem in the 1980's. That's why it's imperative that the health systems agencies maintain a funding level, so they can determine the health needs for their areas.

The report stated that the State Health Planning and Development Agency should continue, and is functioning in a professional manner. This agency had developed a high quality of data for health planning and an adequate health planning staff. The functions carried on by the agency should always be reviewed to make sure goals and objectives are being met.

The Statewide Health Coordinating Council prepares the State Health Plan each year. This body is made up of volunteers appointed by the governor. The Council does serve a function for the state. The Commission stated that the Council should work on being more visible to the public. The general public isn't aware of the Council's studies and recommendations. The Statewide Health Coordinating Council should set up meetings with the local Health Systems Agencies to explain their role in developing health care plans for the citizens of the state. The major setback for the Council is the lack of funding. Money should be provided for the Council, because they provide a service that is critical for states concerned about health planning.

Major Findings of this Chapter

Public hospitals are closing in major cities because of the lack of federal and state funds. The President has reduced the federal government responsibility in providing funds for public health facilities. He believes that private funds should help provide quality health care. The administration hopes that by creating competition it will reduce the price of health care to the consumer. The results of this theory haven't been determined yet.

The Omnibus Budget Reconciliation Act was passed by Congress in 1982. This act limited the amount of money the federal government would spend on health care in fiscal 1983. The states would then take responsibility to fund some health care programs. Some states may not have the funds or the staff to handle this program. The long-term effects of this program should be discussed in a later report.

The Kansas Report on Health Planning had some interesting ideas on health planning. The Commission supports the idea of local health agencies. These agencies provide an outlet for citizen's participation in the health care planning process. The Commission understood the function of the Statewide Health Coordinating Council and believed it provided a valuable service to people.

The report concluded that local health systems agencies provided an adequate function for the community. There was some concern about their involvement in the certificate-of-need process. Better delivery of services is still the main goal for health planners and the federal government in the 1980's.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS CONCERNING HEALTH PLANNING

If Reagan is elected for another four years, he will continue to promote the concept of private health care facilities. He believes the private sector should help in the construction and operation of health facilities. If the private sector does not provide enough centers to take care of the demand, what happens to the disadvantaged people? Their health care needs will go unattended. Does the government have a responsibility to provide adequate health care to all Americans? If a person cannot afford the service, the government should provide the service to them. The cost of health care will continue to increase, and that is why the government should be involved in the funding and planning process for health planning.

The Reagan administration would also like to reduce the federal government responsibility in funding health care. The states would be responsible for the administration and most of the funding for health care. The states do not have the resources or the manpower to adequately take over this program. The states have moved from categorical grants to block grants. Most states can't replace federal funds dollar for dollar at this point. States have tried to shift funds from one program to another. They are trying to make funds available for health care planning and other

program cuts by the federal government. Some health care programs will be low priority to the states. Public opinion, in some respect, determines how state funds will be used. Programs dealing with medical services will have more of a chance to be funded than programs oriented towards the poor. Mental health programs are more acceptable than substance abuse programs. The political pressure determines what gets funded and what doesn't. In the long run, some people won't be helped at all.

The federal government must provide funding and control for health planning. It would take the states twenty years to develop the plans to administrate such a program. The new health care legislation being considered by Congress reflects the views of the President. HR 2935 was called "Health Planning Block Grant Act of 1983." States must develop a state health plan and certificate-of-need program under this program. The program outlines the certificate-of-need process. The Act was established to stop the waste of funds in health planning. This program has developed regional planning agencies. The objectives of the agency are also defined in the act. The agencies are required to raise 15% of their operating budget or they won't receive federal funds. What happens if an agency can't raise 15% of its budget? This could be an area in need of services. These agencies provide a helpful service to the people in the area. If the service was to stop, the residents would suffer.

The Kansas Report on Health Planning made some interesting observations about local health systems agencies. This report states that the agencies provide input into the total state health plan, but maybe it shouldn't be

involved in the certificate-of-need process. The report didn't state what changes should occur. The health systems agencies provide:

- information on health status and service;
- review proposals for major medical equipment; and
- provide technical assistance to organizations working on health problems.

These are just a few of the services provided by the agencies. If the certificate-of-need process was taken away from the agencies, it would hurt the effectiveness of the agencies. It would continue to provide professional assistance to the residents in its service area.

The report also stated that funding would be a problem for local agencies in the future. If funding was stopped, the organization would have to develop a volunteer network. This would cause some problems for the agencies. The quality and competence of the leaders in the agency would suffer if it was volunteer. The members of the organization may not feel their contributions are appreciated. Overall, the quality of service from the agency wouldn't be adequate. People being served by this organization deserve the best service available, but in a volunteer system they wouldn't get it. The federal government should realize that the local health systems agencies provide an important function to the local citizens. It's imperative that these agencies keep their funding levels. They may need to start raising some local funds to help support the program.

The Commission did agree with the role played by the Statewide Health Coordinating Council. This organization does provide a service to residents of the state. The organization coordinates the plans of health systems agencies and helps develop the state health plan. If the local agencies don't do their job, the final product of the council wouldn't

be up to par. Each clog in the wheel must function properly in order to get a finished product. The council must have 50% consumers on the boards. This allows for participation of residents in the planning process. This organization should remain the same. The certificate-of-need process, if taken from the local agencies, should be given to the council. The local agencies would still have some power in making decisions.

The Commission did make one recommendation that should have been made long ago. The governor should hold meetings to discuss health planning and policy issues as they relate to the state. This process would coordinate all the relevant information needed for health planning. The governor would then receive a report detailing the needs and the amount of funds needed for health planning. The goals and objectives of health planning change from month to month. A view of the policy on a monthly basis is important to the overall planning and implementation of health care.

The governor should also place a representative from his office on the Statewide Health Coordinating Council. The person could report back to the governor on the issues and problems facing the local health systems agencies. These functions would increase the awareness of the governor to the important issues in health planning. These concepts will bring about a better delivery of service to people.

Future Issues in Health Planning

The next twenty years will be critical in the development of an adequate health care system. Senator Ted Kennedy has proposed a national health insurance plan with no results. Without new innovative ideas in health planning, the jobs of health planners will become increasingly difficult.

What will President Reagan do if elected for another four years to the federal governments responsibility to health care? What effect will this have on the poor and disadvantaged people in America? What role will the state governments play in health planning? Does the Reagan administration make quality health care a luxury of the rich?

The local Health Systems Agencies are the major voice of the people. Will these organizations continue in their present form, or will it become a volunteer organization? If it does change to a volunteer group, will the quality of leadership and service increase or decrease? How will these agencies function if the federal government stops funding them? These issues should be considered in the future.

Two problems that must be considered by researchers that were not discussed in this paper are the concepts of Medicare and Medicaid. Will these services decrease under the Reagan administration? What happens to the people being served by the program? Will the states take over the administration of these programs?

This paper has outlined the history of health legislation in the United States and provides some input on why citizens participation is important to the health planning process. All the issues weren't covered in this paper. Further research is needed on health planning. Whether the federal or state government takes over the lead in health planning, the rising cost of health care will promote concern among private and public citizens throughout the 1980's.

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GOVERNMENT LEGISLATION ON HEALTH PLANNING IN THE UNITED STATES FROM 1935-1984 WITH AN EMPHASIS ON CITIZENS PARTICIPATION IN HEALTH PLANNING

by

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AN ABSTRACT OF A MASTER'S REPORT

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ABSTRACT

The major goal of this study was to develop the relationship between health planning and citizens' participation as it relates to government legislation from 1935 to the present. Government legislation on health planning determined how citizens participate in the health planning process. This study showed how citizen participation has evolved in health planning in the United States.

Chapter one of this report introduced the key issues in health planning today. President Reagan's views on health planning reflected government legislation on health planning. The basic goals of health care were discussed in this chapter.

Chapter two discussed early government legislation on health planning from 1900-1964. In 1935, the federal government passed the Social Security Act. This legislation represented the first entrance of the federal government into the area of social insurance and financial assistance. The Hill-Burton Act and the concept of "maximum feasible participation" were also reviewed in this chapter.

Chapter three looked at the Comprehensive Health Planning and Public Health Service amendments of 1966. This legislation authorized comprehensive planning and coordination of public health services on a state areawide basis. The goal of this program was to promote health planning

at every level of government. This bill was the first attempt by the federal government to change the organization and delivery of health services. The major health planning programs of 1965 were also discussed in this chapter.

Chapter four reviewed the concept of the National Health Planning and Resource Development Act of 1974. This act developed a new network of local planning agencies. This program established priorities for the development of services and facilities as they were needed. The goals of Health Systems Agencies, State Health Planning and Development Agency and Statewide Health Coordinating Council were also discussed in this chapter. The seven major health insurance proposals pending in Congress in 1974 were also reviewed.

Chapter five discussed current trends in health planning. Three major health planning bills of 1983 were discussed in this chapter. President Reagan believed that by creating competition in health care, this would reduce the price of health care. A Kansas Commission on health planning was created in 1983 to evaluate the role of health planning in Kansas. The findings of this report were also reviewed.

Chapter six discussed the author's findings and recommendations on citizen participation in health planning. This chapter also discussed President Reagan's views on health planning, government legislation on health planning and the future issues effecting health care in the United States. The major finding in this study is that citizen participation at the local level is needed in health planning. The federal government has a responsibility to provide adequate health care to all Americans.