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STATEMENT OF PAUL D. WARD
Executive Director
California Regional Medical Program

RE: S2994: National Health Planning and
Development Act of 1974

Before the Senate Subcommittee on Health:
Tuesday, March 26, 1974

Mr. Chairman and members of the Subcommittee on Health, my name is Paul D. Ward and I am Executive Director of the California Regional Medical Programs. With me are Drs. Thomas A. Nicholas, M.D., who is Executive Director of the Colorado-Wyoming RMP, and John Ingall, M.D., Executive Director of the Lakes Area RMP. It is our intent to attempt to express a summary of the conclusions reached by those active in leadership roles at the regional level in RMP concerning issues addressed in S2994 and other similar measures.

We congratulate the authors on the drafting of a comprehensive yet understandable piece of legislation. We support strongly most of the purposes of bill and the activities which it would create. There is consensus among RMP leaders that planning, implementation and regulation, as functions, are essential to the improvement in the organization, delivery and quality of

health care services, in containing cost increases and in maximizing the efficiency and effectiveness of health care. Our support of the planning function, especially where the end result of the planning clearly defines the health care needs of a community and places priorities on them, is well known. Further, we believe S2994 could do much to improve health care planning, and make it more uniform in quality across the nation, but we believe at least one important change would have to be made in the way S2994 structures and relates the three functions of planning, implementation and regulation if this improvement is to actually occur.

Before making our comments on the structuring and relating of these three functions, however, it should be stated that in lieu of a more precise definition we have assumed that "development" and "health service development fund" refer primarily to the ability to design, arrange, and implement new or improved health care services where the need for them has been demonstrated and so indicated in the area plan, if one exists. This would include developing points of access to care such as outpatient clinics and other means of entering the system, developing specialized and tertiary care

capabilities such as dialysis, coronary care, dosimetry and other similar services, developing means of early detection of disease as well as rehabilitation capabilities, developing quality control systems, and developing the manpower capabilities as needed to implement the services. In this regard, we have assumed that a "definitions section" will be added to the bill since even such common terms as "plan" and "planning" are in serious need of a common definition if we are to gain a uniform high quality health care needs determining system.

Specifically in regard to our major problem with the bill, there is a tendency throughout both Parts A and B to lump all three functions together as if they were compatible activities that could be performed by the same agency, understood by the same board and performed by the same staff. Having observed these functions at the local and state level, at least to the limited degree that they now exist, we cannot help but conclude that this commingling of functions will tend to worsen the present situation rather than improve it.

Based upon the experience of the last seven years since the enactment of P.L. 89-239 (RMP) and P.L. 89-749 (CHP), there are certain conclusions that seem to us inescapable. First, most planning agencies had a

difficult time getting started. Where strong voluntary planning agencies had been created prior to the CHP legislation under Sec. 318, which preceded in time Sections 314A and 314B, the transition from the 318 Planning Agency to the CHP b-agency took time, much patience and energy. The conflicts between the old and the new agencies often took years to finally resolve. Where no agency had existed prior to the formation of a 314b-agency, the inexperience of the community with health planning caused delays. The process of "getting organized" often caused interminable delays. Especially the arguments over how the board of the agency was to be constituted and organized consumed great amounts of staff and board time. These conflicts left little time for developing a plan in the early years. In fact, in some cases so many years went by without a plan that some agencies felt they did not need one.

As the conflicts were resolved, and as the b-agencies acquired more staff, it was assumed by those developing services that the plans would begin to emerge and would indicate each community's needs and which needs had highest priority. But before most b-agencies could develop and refine a quantitative plan more responsibilities were heaped upon them and the plan development

process was further delayed. In areas where they were assigned such tasks as certificate of need determinations and other complicated time-consuming tasks, the development of a plan suffered correspondingly.

The manner in which S2994 assigns the various functions which it proposes is certain to perpetuate if not compound this problem. Part A of S2994 creates a limited staff at the Health Service Planning Agency level, stipulates their expertise along planning lines [Sec. 602 (b)(2)] and then in Sec. 603 and 604 assigns them such a wide variety of tasks involving the functions of implementation and regulation, as well as planning, that it will be nothing short of a miracle if any of the tasks are completed, let alone done well.

There are many compelling reasons why planning, health service development and regulation should not be assigned to the same agency. Each of these functions requires staffs possessing different skills and boards made of different constituencies. This is not to say that health service development should not have to conform to the needs and priorities set in the plan, nor is it to say that regulation should not be based on input from the plan where

appropriate. But it is to say that planning agencies and staffs should not attempt to become regulators or health services developers, nor should regulators become planners or service developers, nor should service developers attempt either planning or regulation. All three functions require different skills, different attitudes and approaches and a different involvement of people. To the degree that one attempts to do the other's job, it will further compound our problems.

The function of planning requires an agency board that knows the community it serves and the problems that community faces. It should know how its citizens will react to certain stimuli and have an appreciation for the priorities its citizens intuitively place on needs. The function of planning requires staff leadership imbued with imagination, a deep regard for human problems and an optimism that human needs can be described and a reasonable assurance that there will be an appropriate response to try to meet the need.

The function of regulation requires another approach and another set of interests by its board or commission members. It requires staff leadership and a trained staff possessing much different skills and interests.

Regulation requires more of the skills and interests of the economist, the manager and the fiscal expert - an orientation not usually found in today's health planner. Nor do we normally find persons skilled in the art of regulation that make enthusiastic and imaginative planners. Based on our recent experience in certificate of need, planning staffs should not manage the regulatory process nor should the regulatory staff and board manage planning.

The function of health services development requires yet another set of skills and interests on the part of the staff and its board. It requires staff leadership that has been involved in the administration and delivery of health care, a staff that knows how care is or should be delivered at the patient level, a staff that knows how to create secondary and tertiary referral patterns, how to make quality judgements and how to lead a patient from the front door of an institution or facility to the care he needs. Today's planner looks at the broad health care needs of a given community and tries to match those needs against resources. If the resources in terms of care delivery units are not in existence, then they have to be created. Neither today's planners or regulators have the skills to design, arrange or implement a new

service. Also the governing board of a health care development organization, if it is to perform its functions successfully, has to possess a wide technical knowledge of delivery and has to be able to influence the health care industry sufficiently to obtain its cooperation in providing resources to meet the indicated needs. That board should be composed of representatives of the various disciplines, i.e., nursing, hospital administration, physicians, public health, medical education, and others from professional and voluntary associations who have the respect of their peers and can influence their conduct in relation to the described needs. This type of organization can and has created new services where they were needed by drawing on its strengths with the various state professional associations to gain support for the programs involved. Such support could not have been gained through the planning agencies as described in this bill and other current legislative proposals.

We believe that the most effective organizations for the development of services are statewide. This would constitute another major reason for separating the functions. This allows the board to be composed of representatives of the statewide professional and voluntary associations associated

with the health field. It is one of the few instances when representatives of the important health forces within a state are drawn together for constructive purposes. We recognize that a very few exceptions do exist where it is traditional to separate a state or to combine two or more, but we believe practice has shown that the statewide structure functions best. We would recommend that language be added to S2994 which would establish a statewide non-profit corporation as a development agency, with latitude being provided the Secretary to deviate from state boundaries in rare instances, and that it be the purpose of this agency to develop services to meet the highest priority needs of the state. We do not believe the legal question of public accountability is as grave in the development of health services as it is in the functions of planning and regulation, but if it is we are recommending that the Health Services Development Board be appointed by the Governor upon recommendation by the various statewide professional and voluntary organizations.

We would make the additional suggestion that if proposals are being made to consolidate programs it would seem more logical to consolidate certain features of Hill-Burton and RMP than it does to combine regulation, planning

and development. The most pressing needs of hospitals today seem to be to improve the ambulatory care capabilities and for renovation. This is especially true of certain large core city facilities. If the services development were to become a major part of Hill-Burton, it should be combined with the development function.

We have heard arguments to the effect that we should place a moratorium on the development of new services. The argument states that each new service requires health care support dollars and by putting a lid on new services we thereby slow the increasing number of dollars going into health care. Experience has shown time and again however that to delay the orderly creation of new services simply means that they will be far more expensive to create at a later date. Organized points of access to care in many urban core cities and rural areas are in great demand. The 100 to 125 million authorization in S2994 for development appears to be on the low side when compared to the need now existing plus the probable advent of National Health Insurance and a current annual expenditure of 94.6 billion for health care. The provisions in S2994 are far superior to the unrealistic limitation of $25,000 placed on developmental

projects in other measures.

Again, we would urge that the functions of planning, development and regulation be clearly separated in the bill. We would agree that regulation and development must be based on the plan and its priorities. But we see little hope for avoiding the mistakes and frustrations of the past if planning agencies and their staffs are overwhelmed with tasks they are ill equipped to manage.

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