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HEALTH PLANNING

A Systematic Approach

SECOND EDITION

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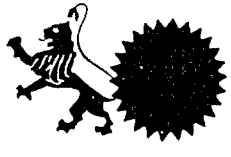

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sanitary reform movement, which remained within the domain of local community government, captured the consciences of the majority of the American public. Although enlightened studies in the field of health care promoted modern concepts of preventive medicine, the institution of such programs met largely with opposition from the centers of power that would have been able to make them realities. The most progressive changes were to evolve in the early decades of the twentieth century. But again, these remained sporadic forays into the realm of modern health care and were thwarted by a public that could not be convinced to support with taxes the kinds of programs that would have been required. The trend toward government intervention in health matters was slowly, but definitely, emerging. Society's inability to control its purse strings and the creation of the federal income tax accelerated the inevitable formalized type of central help.

SIGNIFICANT HEALTH ISSUES: 1920 TO PRESENT

Prior to World War II, health care delivery and efforts to coordinate and plan health services were generally initiated by private (voluntary), nongovernment agencies at the state or local levels. Studies and planning efforts were usually disease oriented, categorical or fragmented in approach, directed toward specific health problems.[19] Efforts were initiated by voluntary health groups such as the National Tuberculosis Association, the American Cancer Society, and the American Public Health Association. In an attempt to coordinate the activities of these voluntary health agencies, the National Health Council was created. The experience of the depression of the 1930s, World War II, the profound rise in medical care costs resulting from the increasing imbalance between supply and demand, and the expanding role of the federal government in providing economic assistance conditioned a steady expansion of government participation in the planning, financing, and delivery of health care. This shift to increased government involvement in meeting health needs is best illustrated by examining the major health issues of the pre- and post-World War II periods and the responses of the private and public sectors to those issues.

Between 1920 and 1965 several major health issues emerged: regionalization of health facilities (provision and coordination of health facilities), alternative methods of health care delivery, financing of health care, the impact of biomedical research, and health personnel. It would appear that the most consolidated effort was initiated by the voluntary and public sectors in response to the need of regionalization of health facilities.

Regionalization of Health Facilities

Population growth, the movement from rural to urban areas, and rising medical costs were instrumental in the regionalization of health facilities as early as 1920. Regionalization was the response to such needs as adequate provision of health care facilities—expressed by many studies in numbers of hospital beds per unit of population—and facility coordination within a region.[20] Prior to 1945, the private sector played the dominant role in initiating efforts to study these needs. Each effort undertaken by a voluntary group focused on a particular locality and generally remained separate from similar efforts undertaken by other voluntary groups. As a result, criteria varied from study to study.

In 1920, the New York Academy of Medicine studied 180 private and municipal hospitals in New York City to determine if there were enough hospital beds to care for the sick. The standard measure of need used by the academy was the Public Health Service estimate that, at any given time, approximately two percent of the population would be sick. Finding that one hospital bed existed for every 200 people, the academy concluded that the health needs of the population were being met. This study marks the first formal recognition of the necessity to plan hospital needs in the United States and was followed by a number of local and regional studies.[21] These studies were obviously categorical in approach; questions of geographical distribution and availability of hospital care to all facets of the population were never studied.

A more comprehensive study of hospital needs, "The Need for More Hospitals in Rurals Areas," by A. B. and P. Mills, was published in 1935.[22] The authors studied the question of population density, the number and training of physicians, and other factors related to determining need. This was the first study concerned with health service centers, facilities of 250 or more beds designed to serve a population within a 50-mile radius of the cities where they were located.[23] Again, the emphasis was on the number of beds available to a population. The important point of this study was the Mills' concern with the question of regional health services.

Also during the 1930s, a joint committee of the American Public Health Association and the National Health Council studied the provision of full-time local health services in the United States. This study emphasized the provision of services nationwide rather than in specific localities. The Emerson Report, as it came to be called, was not released until the end of World War II.[24] The recommendations in this report concerned traditional issues of public health services: sanitation, communicable disease control, maternal and child health, vital statistics, and public health laboratory services. The report is connected to those previously discussed by its

statement of minimal standards for local health services in terms of the number of health personnel and number of beds per population unit, and per capita expenditure. The study was notable for its new direction, but, by the time of its publication, public health services had so expanded that the standards recommended were inadequate.[25]

Several ambitious efforts were undertaken to coordinate health care delivery during the 1930s. In 1931, the Bingham Associates Fund, a private foundation, established a program based in Pratt Clinic and New England Hospital in Boston to encourage coordination and integration of medical services for residents in rural areas of New England. The program was conducted in conjunction with Tufts Medical School. In 1933, the Committee on the Cost of Medical Care published a report that recommended the coordination of local health services and personnel to provide maximum productivity of the scarce personnel and equipment.[26]

Thus, it can be seen that, prior to 1940, numerous studies of health care services had been undertaken by diverse participants in the private sector. These studies were conducted in response to a growing concern for adequate provision of health facilities for a growing and more transient population and health services coordination to avoid duplication of services and to combat rising medical costs.

Federal response to the issues in the 1920s and 1930s was limited. Traditionally, personal health care was provided by the private sector, primarily in a one patient-one physician situation. Further, domestic unemployment and economic instability and the ensuing World War II absorbed federal efforts and dominated federal concerns. With the conclusion of the war, however, the federal government had more time and money with which to examine those issues raised by the private sector. The passage of the Hospital Survey and Construction Act (Hill-Burton Act, PL 79-725) in 1946 was a major breakthrough in coordinating and providing health care facilities nationwide.

The Hill-Burton Act provided federal aid to states for hospital facilities. To be granted funds, however, a state had to create a hospital planning council responsible for assessing the need for new hospital construction. Because of this condition for funding, states were forced to survey existing facilities (number of beds per unit population) before they could apply for construction grants. The intent of the act was to coordinate new construction with need and with existing facilities.

In 1954, the Hill-Harris Amendments to Hill-Burton revised and expanded the program to include funding exclusively for modernization or replacement of public and nonprofit hospitals. As a result, the number of institutions applying for alterations and additions increased. Emphasis shifted from providing hospital care in rural areas to altering urban facilities. A most significant change wrought by the amendments was a shift in emphasis from construction to planning of health services. Under the Hill-Harris Amendments, state plans had to apply a new formula for assessing bed need, incorporating utilization data, projected population, and occupancy factors.

The Hill-Burton Act and amendments are often criticized as focusing too narrowly on construction, with little stress on organization and distribution of health care facilities. It should be remembered, however, that Hill-Burton not only introduced systematic statewide planning and minimum national standards for assessing hospital need, but also improved the quality of care in rural America.[27] The act and its amendments were limited because the establishment of a formal relationship among hospitals or health agencies was not made mandatory.[28]

With the passage of Hill-Burton and the expenditure of vast funds for hospital construction, the federal government firmly and irreversibly became part of the American health care system. National health planning had been introduced. This fact, coupled with the great rise in medical costs despite federal assistance, led to the formation of a joint committee of the American Hospital Association and the Public Health Service in 1958. The joint committee sponsored four regional conferences to develop guidelines for planning a coordinated community health service system. Three years following the conferences a report was issued. A rationale for areawide health planning had been provided.[29]

The joint committee recommendations were formally recognized and expanded by the public sector in 1963 when the U.S. Public Health Service issued *Procedures for Areawide Health Facility Planning*. While the joint committee studies were being conducted, the American Public Health Association and the National Health Council sponsored an ambitious project to produce a blueprint for a system of preventive and curative medical services and environmental health protection for the next ten years. Whereas the joint committee was a cooperative public and private sector venture, the National Commission on Community Health Services was largely a voluntary venture. The commission was funded by both the private and public sectors through grants from private foundations, the U.S. Public Health Service, and the Vocational Rehabilitation Administration.

The study was conducted in three parts and required four years. Part I, the National Task Forces projects, consisted of numerous autonomous studies; consequently, the recommendations of each task force were disjointed and published individually. Part II, the Community Act Studies, studied 21 individual communities throughout the United States. The findings of each of these task groups provided the basis for recommendations

to be presented during the third part of the project—the Communications project. This part of the project tested public reaction to the recommendations at four different regional conferences. The commission's report, published in 1966, made the following major recommendations:

1. Community health services need greater federal participation.
2. Comprehensive health planning must be undertaken on a continuing basis.
3. Regional or areawide planning bodies must be established to correspond to problem health areas.
4. A single system must be established to provide personal health services that eventually will combine all parts of public and private health care.[30]

Concurrent with these efforts by the voluntary and public sectors to coordinate health services, the Commission on Heart Disease, Cancer, and Stroke was formed by President Johnson in 1963 to recommend steps to reduce the incidence of these illnesses through new knowledge and more complete utilization of existing medical knowledge. The recommendations of this commission were enacted into law as the Heart Disease, Cancer and Stroke Amendments of 1965 (PL 89-239). Even though the initial study was categorical in approach, the establishment of the Regional Medical Programs (RMPs) was a comprehensive response. Cooperative regional arrangements were to be organized from existing medical centers, clinical research centers, and hospitals. Fifty-six health regions were established and charged with evaluating the overall health needs within each region. Initially, the act covered only heart disease, stroke, and cancer, but the 1970 amendments expanded the program. Two important aspects of the act distinguished it from previous legislation and voluntary group emphasis on the coordination and provision of health services. First, the act provided for local participation in planning. This approach departed significantly from purely state and federal planning of facilities that were provided for in the Hill-Burton Act. Second, funding of projects was provided for both planning and operating.

Once regions were awarded planning grants, they became eligible to apply for funds to cover operating expenses of all projects in their jurisdiction. Initially, funding was devoted to continuing education and training, but this emphasis has shifted to organization and delivery of patient services, and improvement of personnel productivity and distribution.[31] Unfortunately, the RMPs were not incorporated into existing federal and state programs, causing both duplication and gaps in delivery of services, personnel training, and research.

The passage of the RMP legislation, together with the recommendations of the National Commission and the guidelines published by the joint committee, culminated in a regional comprehensive philosophy of health planning as opposed to the emphasis on facilities that had dominated voluntary concerns during the 1920s and into the 1940s. This new philosophy became law with the passage of the Partnership for Health Act of 1966.

Health Care Delivery and Financing of Health Care

The regionalization of health care is only one such issue to emerge between 1920 and 1980. The rising cost of medical services resulted in a move to coordinate and regionalize facilities in order to make more efficient use of the health care system and to avoid duplication of services. Rising costs also produced new trends in the delivery of health care and the financing of health services.

In 1933, after a three-year study of the existing system of personal health services in the United States, the Committee on the Cost of Medical Care published a report that illustrated the inability of a large portion of the population to obtain high-quality medical care, owing to rising costs. The most significant recommendation from this committee was the concept of "pre-paid medical groups." The report states that:

> medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses and pharmacists and other associated personnel. Such groups should be organized around a hospital for rendering complete home, office and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.[32]

According to the committee, this system of health care services offered the community the maximum potential for productivity of scarce professional personnel and expensive equipment.

The concept of prepayment and group practice expressed in 1933 was incorporated into the pattern of health service delivery. In 1965, a survey conducted by the Department of Health, Education, and Welfare (HEW) of 582 group plans showed that the plans fell into five categories, depending on sponsor or consumer orientation.[33] The community-consumer plans are nonprofit plans designed to serve the general community or a particular group. These plans incorporate prepaid medical services on a private basis, not a group practice basis. The Health Insurance Program (HIP) of Greater New York and the Kaiser Plan are well-known examples of