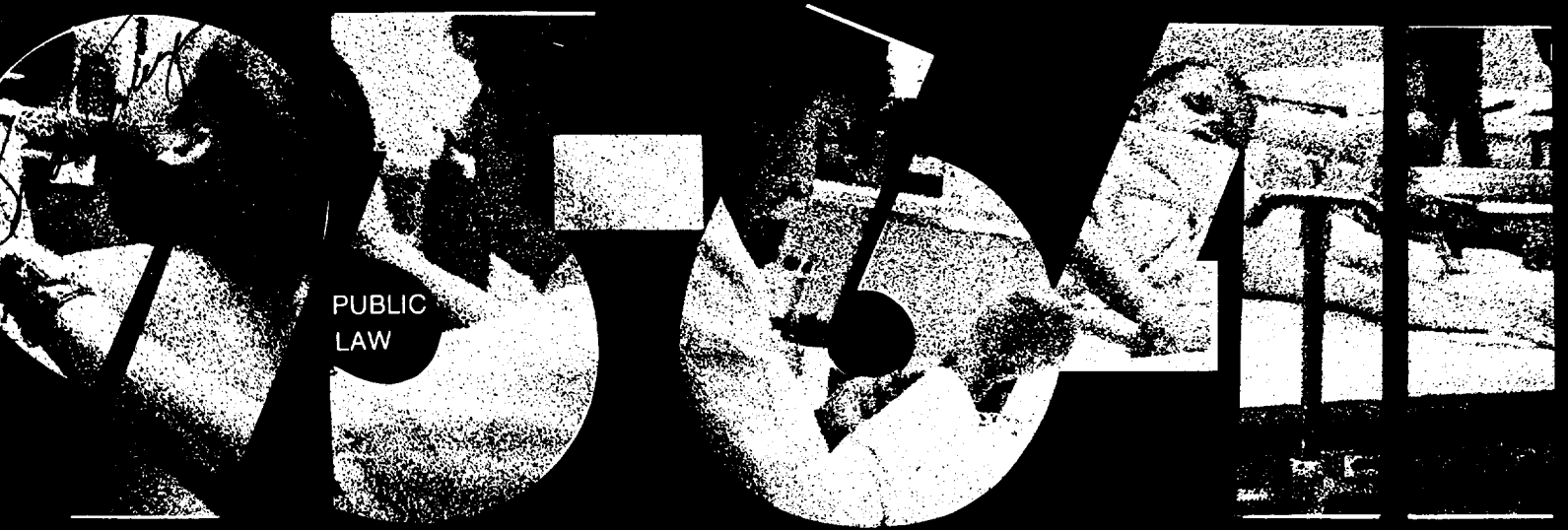


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**HIGHLIGHTS OF THE NATIONAL CONFERENCE FOR HEALTH SERVICE LEADERS  
MAY 5-7, 1975—ATLANTA, GEORGIA**

*Presented by The National Association of Regional Medical Programs*

# 93-641

*David Drazgin*

Public Law 93-641, "The National Health Planning and Resources Development Act of 1974," is to be fully implemented by the U.S. Department of Health, Education and Welfare (HEW) within 18 months after January 4, 1975. Essentially the Law does away with the nation's existing Regional Medical Programs, Comprehensive Health Planning Agencies, Hill-Burton Agencies and Experimental Health Service Delivery Systems. Replacing these national programs and discharging their responsibilities as well as new functions will be a network of approximately 200 Health Systems Agencies (HSAs) within the 50 States, Puerto Rico and the U.S. mandated territories in the Pacific. Each State will have a state Health Coordinating Council and an Advisory Council with a consumer majority, and each of the States' HSAs will operate under a Governing Body with a consumer majority. The Secretary of HEW is named as the federal official responsible for administering the Law, and he in turn will be subject to a National Advisory Council with a consumer majority.

## Participants

**The Honorable George Busbee**  
Governor of Georgia

**The Honorable Daniel J. Flood, M.C.**  
Washington

**The Honorable James F. Hastings, M.C.**  
Washington

**The Honorable Ted Stevens**  
United States Senate  
Washington

**Henry E. Simmons, M.D.**  
Deputy Assistant Secretary for Health  
DHEW, Washington

**Paul D. Ward, Executive Director**  
California RMP

**Walter Branch, Ph.D.**  
Assistant Director for  
Intergovernmental Relations  
DHEW Region IV

**Eugene Fowinkle, M.D.**  
President-Elect  
Association of State and  
Territorial Health Officers

**Michael K. Gemell**  
National Association of Counties

**A. R. Jablonowski**  
Assistant Executive Director  
Medical Malpractice  
Medical Association of Georgia

**W. Daniel Barker**  
Board Member  
American Hospital Association

**George Pickett, M.D.**  
Executive Board Member  
American Public Health Association

**Karen I. Shanor, Ph.D.**  
National Center for Community Action

**Edward Mearns, J.D.**  
Professor of Law  
Case Western Reserve University

**Richard Shoemaker**  
Assistant Director  
AFL-CIO Department of Social Security

**Daniel I. Zwick**  
Associate Administrator for Planning  
Evaluation and Legislation  
DHEW, Washington

**Gerald T. Gardell**  
Acting Director  
Division of Regional Medical Programs

**Earl Wright**  
Director of Health Facilities and Planning  
DHEW Region IV

**Robert T. Jones**  
Executive Director  
New Orleans Area Health Planning Council

**Gordon R. Engebretson, Ph.D.**  
Director  
Florida RMP

**George Rosemond, M.D.**  
President  
American Cancer Society

**Elliot Rapaport, M.D.**  
President  
American Heart Association

**Joseph B. Stocklen, M.D.**  
President  
American Lung Association

**Colon R. Wilson Jr., M.D.**  
National Arthritis Foundation

**James C. Hunt, M.D.**  
President  
National Kidney Foundation

## Foreword

On the last day of the second session of the 93rd Congress the Health Planning and Resources Development Act of 1974 was passed in the waning hours. The late December recess in governmental functions followed immediately. Perhaps this is why so little publicity was given to the new Public Law 93-641 from Congressional Offices, from the White House, or from the Department of Health, Education and Welfare.

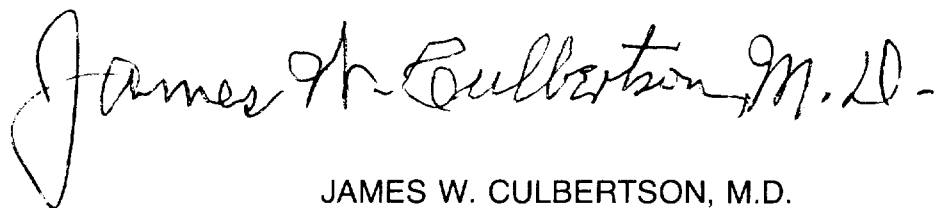
It became obvious during the first quarter of 1975 that there was a widespread lack of knowledge, familiarity, or understanding of the sweeping new health services law among the many health service leaders and administrators who normally should have been the most concerned with its implications for the future delivery of health services and with the requirements for implementation of the statute.

In March it was announced that the Health Resources Administration was planning a series of multi-state informational conferences during the month of April. No similar plans were announced for other governmental agencies or public organizations.

Perceiving the urgent need for early dissemination of pertinent information about the new law, the Program Committee of the National Association of Regional Medical Programs decided on very short notice to change the program for its spring educational meeting to develop a

National Conference for Health Service Leaders and to devote the entire session to a detailed examination of the Health Planning and Resources Development Act of 1974 and potential problems in its implementation. The meeting was designed to be open to the public with all interested leaders and officials in voluntary health agencies invited to attend. Despite a severely limited length of time for national advertising, 350 registrants attended the meeting.

The Program Committee is most sincerely grateful to the program participants and to the various agencies that sponsored and supported their appearance. There was a remarkable and uniform spirit of cooperation among all those involved. Several of the speakers, especially those from the Congress, accepted personal inconveniences in order to contribute to our enlightenment. All of us are indebted to them for their compelling sense of public responsibility.

A handwritten signature in cursive script that reads "James W. Culbertson, M.D." with a horizontal line at the end.

JAMES W. CULBERTSON, M.D.  
Chairman, Program Committee



Health Service leaders from across the Nation gathered in Atlanta in late Spring to weigh the implications of a new law that may have more profound effects on the health of Americans than anything seen in a decade.

It was the first national meeting on the subject of the Health Planning and Resources Development Act of 1974 (Public Law 93-641) since the law was signed by President Ford in January.

Richly varied concerns, praise and skepticism threaded through the talks given by Congressional and Administration leaders, health care providers, planners, governmental officials, professional and voluntary health agency leaders and consumers.

The Atlanta meeting, said John R. F. Ingall, M.D., Chairman of the National Association of Regional Medical Programs, would explore all aspects of the law with the "fundamental objective to make this law work."

"The number one thing we're interested in in the Congress of the United States, as I'm sure you are," said Congressman James L. Hastings (Rep., N.Y.) of the House Subcommittee on Public Health and Environment and a co-sponsor of the bill, "is the development of some sort of a rational national health policy, something this country in my judgment totally lacks."

## The Law's Import

A succinct assessment of the new law from Georgia's Governor George Busbee set the tone for the meeting called by the National Association of Regional Medical Programs:

"I don't know of any act passed by Congress since 1965 that will have more impact on health in this country," he said. Others agreed.

Hastings urged the delegates "to devote the best of your ability to try to make this what I think it really is—probably the most important piece of health legislation that hit the floor of the Congress, and most people don't know it."

The law, said Senator Ted Stevens (Rep., Alaska) of the Senate Subcommittee on Labor and Health, Education and Welfare, "is conceived as a preparatory measure to national health insurance, and establishes an elaborate system of federal standards and regulations covering the state and local health planning agencies and endowing them with strong power to ensure that institutions abide by the planning decisions on the delivery of services."

"While it is too early to tell how 93-641 is going to work," said Daniel J. Flood, (Dem., PA) Chairman of the House Appropriations Subcommittee on Labor—Health, Education and Welfare, "it is not too early to say that we must preserve what good relationships exist in the health community now."

An administration view came from Henry E. Simmons, M.D., Deputy Assistant Secretary for Health and Director of the Office of Professional Standards Review.

"We now understand, I think, that something more than the fragmented, unemployed efforts of the past will be required if this country is to secure a right to quality health care for all citizens at a price that society can afford."

American Heart Association President Elliot Rapaport, M.D., Chief of Cardiology at San Francisco General Hospital, declared that the AHA "considers that Public Law 93-641 has the potential of profoundly affecting the fate of quality health care throughout the country."

And from American Hospital Association Trustee W. Daniel Barker came this view: "Although it is not the only way to approach planning, it is the law of the land at this time and we have to rededicate our efforts to make sure that it works, that it brings together some pretty difficult functions of the regulator, of the planner, of the provider, all in one agency. This, in itself, is a tremendous Herculean task."

***"The aim really is to avoid waste and duplication."***

**-Stevens**

A highly condensed review of the major priorities in P.L. 93-641 was offered by George Pickett, M.D., Director of Public Health and Welfare for California's San Mateo County and Executive Board Member of the American Public Health Association.

These priorities include 1) making primary care services available to underserved populations; 2) development of comprehensive health systems to include sharing among institutions and facilities, formation of group medical practice as parts of the systems and consolidation of high cost, low-volume services; 3) training and use of more physician assistants; 4) improved quality of care; 5) comparison and containment of health care costs, and 6) more emphasis on disease and cost prevention through nutritional and environmental programs and better education of consumers concerning the appropriate use of available health services.

"There are a number of potential value conflicts inherent in these priorities," Pickett said. "On the whole they point clearly towards the need for a total governmental control of the health industry in the United States. Those goals, if priorities do reflect goals, cannot, I think otherwise be achieved. That may not be what Congressmen voted for and it may not be widely popular. In fact, important goals are rarely achieved without offending someone's values, but the basic American ambivalence towards health and welfare is moving painfully towards some conclusion."

***"I want health systems  
development to forge ahead***

-Flo



Although feeling the need to get on with implementation, many speakers voiced concerns with the new law and with the potential for problems in developing Health Systems Agencies on local levels and State Health Planning and Development Agencies and State Health Coordinating Councils on the higher level.

Boundary designation—establishing the geographic areas for the developing HSAs—drew much comment. The law requires that HSA areas conform as nearly as possible to several existing boundaries.

"I have been through one session in the Professional Standards Review Organization Program in which we had to divide up the United States. Let me tell you something: it can't be done without being crucified in the process. There is no way to satisfy everybody's desire to divide up this country," said Simmons.

"Geographic and population boundaries may be considerably different from those in current use in health Programs. State lines may be crossed and interstate Standard Metropolitan Statistical Areas will be involved," said Walter Branch, Ph.D., DHEW Region IV Assistant Director for Intergovernmental Relations.

"Trying to line up the functional regions of the health care field with geographical regions is a difficult if not an impossible thing to do. We have hundreds of 'regions' in the health care industry," said Daniel I. Zwick, Associate HEW Administrator for Planning, Evaluation and Legislation.

***"Physicians, who really do want the sort of planning needed, were caught napping. Now the frenzy of boundaries and agency control is intense."*** -Pickett

***"It is possible we will have to seek amendments to the law for the sake of clarification"***

***-War***

## Concerns

Simmons listed the area designation process as the first potential pitfall in implementing the law—"How well we carry that on and how intelligently we can meld those areas into area designations for other programs the government has to have. If that should be fouled up it would be terrible because that would make integration so much more difficult and integration is necessary across the Nation."

Simmons listed as other pitfalls to be avoided the possibility that some particular interest group could capture the process of building effective HSAs and health programs, weakened consumer partnerships because of inadequate public involvement, and lack of adequate and pertinent data required to make the tough decisions about costs and services so that "everybody in fact doesn't get everything they want."

Hastings had additional concerns, as did James C. Hunt, M.D., President of the National Kidney Foundation and Chairman of the Department of Medicine at Mayo Medical School.

"A lot of my medical friends differ with me on this, but I think it's disastrous what we're doing in the Federal allocation of Federal resources as they relate to manpower, because in the Manpower Act we seemingly are just going to try to put more money into a system that has not solved the problem—that primary problem that I'm concerned about—of maldistribution, both geographically and in the specialties. We're not addressing that question effectively at all," Hastings said.

Said Hunt: "The thing I guess that concerns me more than anything else is that there is no provision for health manpower training in this legislation. And we are going to build a system in terms of planning and resources without training of health manpower? That is impossible."

Still other concerns were voiced.

"The states should make a strong commitment in terms of political attention, manpower allocation, appropriation of dollars, organizational prominence and so forth, to assure that the law from the State's perspective works and works well," said Eugene W. Fowinkle, M.D., Tennessee Health Commissioner and President-elect of the Association of State and Territorial Health Officers.

***"The problem I had was with the scrapping of everything that had just begun to work."***

**-Stevens**

The State Health Planning and Development Agency, he said, should be an already established agency with strong demonstrated administrative and other skills; the State Health Coordinating Council should have highly committed individuals; enabling state legislation is needed.

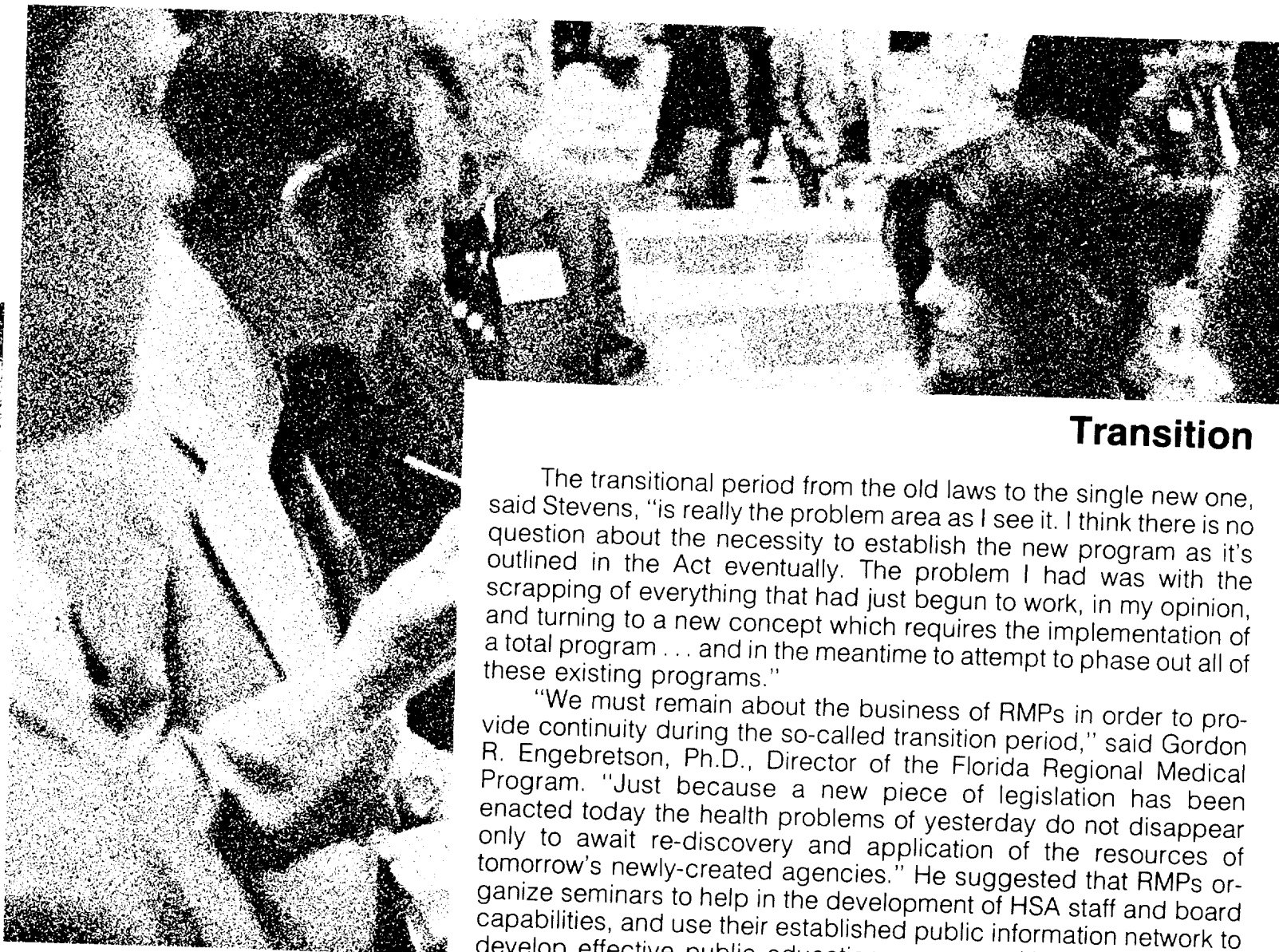
Hunt noted that consumers and providers who have worked together well in voluntary health agencies "are now being pitted against one another in the new legislation, or at least the possibility of that battle for domination of the governing bodies of HSAs certainly exists, so we are going to have to walk a tight rope there . . . There are going to have to be a number of compromises and trade-offs between the private sector and government."

Without strong early involvement of voluntary organizations, said George Rosemond, M.D., President of the American Cancer Society, "no government sponsored or supported health planning program is going to reach its potential. Our political system seems to require a strong committed private constituency to make government programs in professional and public health education meet their objective."

"Regional Medical Programs will be gone soon," said Flood. We're not going to sit down and bawl about it. I am convinced that no greater cadre of health systems development professionals exists than the one right here in this room. Rather than cry, you are going to do something constructive, If I know you. You are going to do your best to make Public Law 93-641 work."

***"It is going to be a rather startling revelation when we discover that the machinery for improvement and development has been dismantled." -Ward***





## Transition

The transitional period from the old laws to the single new one, said Stevens, "is really the problem area as I see it. I think there is no question about the necessity to establish the new program as it's outlined in the Act eventually. The problem I had was with the scrapping of everything that had just begun to work, in my opinion, and turning to a new concept which requires the implementation of a total program . . . and in the meantime to attempt to phase out all of these existing programs."

"We must remain about the business of RMPs in order to provide continuity during the so-called transition period," said Gordon R. Engebretson, Ph.D., Director of the Florida Regional Medical Program. "Just because a new piece of legislation has been enacted today the health problems of yesterday do not disappear only to await re-discovery and application of the resources of tomorrow's newly-created agencies." He suggested that RMPs organize seminars to help in the development of HSA staff and board capabilities, and use their established public information network to develop effective public education programs. He also urged that

Comprehensive Health Planning (b) agencies be assured necessary interim support to allow them to continue health planning activities. "RMPs, like CHPs, are storehouses of information, data, reports, recommendations, findings, plans and so on. These should not become lost to the planners and resource developers of the future," said Engebretson.

"We really want to make this program work," said Paul D. Ward, Executive Director of the California Regional Medical Program. "It is the law of the land; it is going to need amendments, but I hope that we advance amendments and changes on the basis of improving the situation . . . I don't believe that any of us want to see a further deterioration of the health field. I think, too, that we've got to convey our hope for an orderly uninterrupted transition."

"This law will not work by itself," said Stevens. "Its success or failure will rest on those people administering and implementing it." He urged the delegates to "help meet the objectives of the new law, in spite of my questioning of it. Then, perhaps, the Congressional oversight committees will be able to conclude that the medical needs of all our citizens are being met in a most effective and efficient manner, and we will stop this biennial amendment, change and consolidation of national legislation in the health field and let some continuity seep into the planning and the program of our health care delivery systems. I don't think that's an unattainable goal, but I do think it will take everyone working together to make it achievable. I would hope that all of you will be prepared to critically appraise the efforts that can be made under this new law and to advise us what changes you feel are necessary to achieve this goal."

"If there is danger that the transition period will run much longer than 93-641 contemplates," said Flood, "then the Congress will surely be pressed for some legislative relief . . . It would be bad judgment, unmitigated stupidity to stop health resources development in this country just because our administrative restructuring is moving slowly."

***"We don't want to see advancements made under the old system go down the drain in the transition period." -Hastings***

## Funding

Accompanying the concerns about the transition period were equally serious comments about funding support.

"Everybody has this idea that there's a windfall of money," said Earl Wright, DHEW Region IV Director of Health Facilities and Planning. "But if we conceive of full coverage of our 50 states with the HSAs and everybody gets 50 cents per capita, you can easily see that \$60 million doesn't stretch where 105 or 110 is needed. One of our problems might be some retrenchment in certain areas unless more funds are made available."

"We could well end up with less funding under the new legislation than we have now," said Robert T. Jones, Executive Director of the New Orleans Area Health Planning Council. "And perhaps, although I sincerely hope not, we may see repeated the inequities in the funding of CHP over the past few years."

Stevens reminded the conferees that six years ago the Defense Department share of the budget was 48% and that of DHEW 28%; these figures are now almost reversed, with Defense 27% and DHEW 47%. "There is very little room for any more reordering of priorities on a significant scale as we have done in the past six years," he said.

"I think we have to be patient with the obvious fact that we're at the low end of the roller coaster right now," said Ward. Inflation has hurt all health programs, "but inflation won't be with us forever, and we've got to be ready—if we really care for the development of a fine health service in America—to run like heck once the question of inflation resolves itself. When the chance comes to really get the push back, then we've got to be prepared to move. And I think that's what we ought to set as our goal in the future."

## Control

The Health Planning and Resources Development Act require that HSA governing boards be made up of a majority of consumers—a fact that drew thoughtful and provocative comment from many speakers.

"We (the New Orleans CHP agency) supported the legislation we believe it to be good legislation," said Jones. "It places major responsibilities at the local area and that's where we believe it should be. It maintains the provision for consumer majority in the decision making process, and that's as we believe it should be."

But how consumerism can best contribute to effective health planning obviously troubled many. Consumers, Engebretson notes, have to be representative of the ethnic, linguistic and racial minorities, the sexual population and special groups such as retired persons, requiring "judicious selection of governing body members." It may be difficult to recruit a seasonal farm worker to serve on a HSA governing body who would lose pay and may possibly move from location to location with the harvest. Rather the task should be one of selecting someone who would effectively represent the interests of this population group."

"Many people may say that we've had consumer input in the past and it just hasn't worked. You're right, it hasn't worked, but why hasn't it worked?" asked Karen I. Shanor, Ph.D., of the National Center for Community Action. "Governing boards of local agencies which by law have consumer majorities, all too often fail to reflect the interests of the public. The General Accounting Office has found professionals such as retired physicians, administrators at homes for the aged and directors of social services programs listed as consumers."

"Conflicts of interest abound," she said, and consumers are often intimidated by the sophistication of providers. She offered suggestions for improvement under P.L. 93-641: seek consumer representatives through community-based organizations; train them, as well as providers ("because it works both ways"); develop



a solid community participation process; hold public meetings in community-based locations to encourage real participation; enlist consumers to help collect needed data; develop sub-area councils; assure that consumers will be nominated for the state health coordinating council; use consumer input in quality care criteria and at all levels of planning and implementation.

Richard Shoemaker, Assistant Director of the AFL-CIO Department of Social Security, added further to the consumerism debate.

Most health planning agencies, he said, "are afraid of consumers, effective consumer representation. Oh yeah, they like to have them on the boards because they are convenient window dressing but in terms of developing effective consumer participation into the planning process I would say it's been a dismal failure. Generally in planning bodies a majority of consumer representatives is like having six lambs and four tigers. You know how that's going to turn out.

"Now I don't want to be completely one-sided; I recognize that the consumer has many handicaps. For the consumer to effectively participate in the planning process takes a great deal of effort away from his normal activities."

The training of consumers, he said, "is a matter of some urgency. It's completely unrealistic to think that the providers of health care, any more than any other group, will willingly acquiesce to wrenching change. They won't willingly offer to have their services eliminated or curtailed or even modified if they are no longer needed or if these services can be performed better at less costs by other methods, individuals or institutions. Neither will they recognize these facts because they have not generally understood the needs of consumers."

Shoemaker recommended that consumers be provided with their own technical staff, a practice that was adopted in the War Labor Board days of World War II.

But if consumer representatives at the NARMP Atlanta meeting had concerns about the shape of things to come with P.L. 93-641 so too did providers.

***"Further control will be necessary, possibly involving training, licensing and reimbursement mechanisms." -Pickett***





## Provider Concerns

"I don't believe that the physicians in this state or around the country are very happy about the way the law was finally written, passed and signed by the President," said Adam Jablonowski, Assistant Executive Director of the Medical Association of Georgia and a representative of the American Medical Association.

"There is a great deal of concern being expressed by our physician members for the kinds of controls that are envisioned in the law, certainly for construction and expansion of hospitals," he said.

"Another fear of physicians is the kind of service controls that the law envisions. It's probably the one area which has the most emotional impact on physicians. They are very concerned that some bureaucrat is going to tell physicians and their hospitals whether or not certain services can be performed in a particular institution. This obviously has a very negative kind of connotation as far as HSA is concerned for physicians. Another concern is the availability of funds for the development of changes in the health care delivery system.

"Without individual physicians who are in the active practice of medicine participating on the board of directors, I don't believe the HSA will be able to succeed."

***"I still have a lot of problems in my mind visualizing how the planner who is an innovator . . . can also be a developer, a practical administrator, a practicing physician, and at the same time be a regulator."***

**-Barker**



"The initial review responsibility will be assigned to the HSA. This provides a major opportunity for local providers to help state government and community leadership to shape a more effective health care delivery system," said the Hospital Association's Barker.

"Regulations are just not going to fade away as costs continue to escalate, as the demand on our services continues to multiply and the expectations of our citizens continue to expand.

"The main issue is really how all these things that are required by the law are going to fit. Whether we are going to have a non-profit association or governmental mechanism. What does it do with the doctor's office practice, with the institutional services—all these things are still kind of up in the air.

"What for example, will happen when a new hospital is needed and one of the requirements is that at least every five years that institution is reviewed to see if it still needs to be in existence? How can you arrange to borrow money when there is no assurance that in five years that institution is going to be needed or even be there?" he asked.

"There are large problems ahead of us unless we work together to find alternative uses for structures and for institutions as needs change."

"The National Kidney Foundation," said Hunt, "is worried—we are concerned. We are particularly concerned with the concentration of the enormous amount of power in the Secretary of HEW." He recalled that regulations for the end-stage renal disease program authorized by the 1972 Social Security Amendments are still not in final form.

"But that's 2-1/2 years since the law was passed and these regulations still aren't out, and if you're worried about regulations being out for 93-641 then I think you should be.

"I'm concerned," Hunt continued. "Will history repeat itself? RMP, CHP and Hill-Burton legislation is terminated. It's too bad because these programs, particularly in the last several years, have become extremely effective. The RMP, I think, has served more than anything else to bring the private sector together. The voluntary health agencies have helped bring volunteers together. It's too bad that they didn't put together our expertise earlier."

***"And we're going to build a system in terms of planning and resources without training of health manpower. That is impossible." -Hunt***



## Federal Role

"I would hope that we had not gotten away from the concept of regional planning," Stevens said, "instead of mandating immediately the concept of national planning . . . Whether or not we can truly improve the situation with the authority contained in this new Act to me remains to be seen. The areawide, statewide and nationwide agencies could become a bureaucratic nightmare or they could become the vehicle for developing a comprehensive health care services program through the cooperation of the consumers, the providers and the government officials."

"There is no doubt," said Simmons, "that the Federal government must assume a larger role in the development of health resources and in making certain that those resources effectively respond to the health needs of the American people. With the adoption of national health insurance even under an essentially private insurance system, the involvement of the Federal government will be still greater than it is today."

"All of us, in government and out, must guard against the tendency for necessary and proper involvement to become unnecessary encroachment on the practice of medicine and the whole health care delivery system. Clearly there are things that government can do best in the health field . . . but individual decisions involving the care of individual patients are best kept out of bureaucratic hands whenever possible. It would be tragically unwise for any of us to assume that policy, good or bad, can be or should be framed by government alone."

"RMP," Simmons said, "did do a good deal of work and it did do a lot of network creating, and it did have innovation, and it had some remarkable effects. Now, I believe that the scope of the problems in the government will require every bit of talent that RMP has left over."

***"We are particularly concerned with the concentration of the enormous amount of power in the Secretary of HEW."***

-Hunt

***"Government involvement and regulation in the health care industry will continue to grow."***

-Barker

***"When government makes a mistake, the whole of society suffers, and every individual and institution in it."***

-Simmons

The costs of medical and health care, a basic consideration in the new law, caused a great deal of discussion in Atlanta, along with public accountability.

"Health planning in this country needs public accountability," declared Michael K. Gemell, legislative representative for the National Association of Counties. In following the legislation as it developed in Congress, he said, "we wanted to stress that governors should be given the option to designate private, non-profit corporations, regional councils of government or a single unit of general purpose government to do the health planning and be designated the HSA." The concept won, Gemell said, but there remain differences in interpretation between Congress and DHEW as to what the law intends.

"Who will appoint the governing bodies in the HSAs?" he asked. "That's a question not answered in the law. We maintain that local elected officials are the ones best to appoint. Nobody seems to understand that public accountability can only rest, we think, with the local elected officials."

Edward Mearns, Professor of Law at Case Western Reserve University, and a legal advocacy representative, offered these comments:

"When I say my reasonable expectations are assured access to adequate care on a more equitable basis, I think I recognize that this has to be achieved even at the expense of perhaps offending some of the ideologues who would maintain a present balance of the private and public roles in health care delivery.

"At some point the consumers, the non-professionals, the rest of us have to say something about developing the instruments to achieve public accountability. We've got a terrible struggle to get the consumer aware. I think the consumer is only moved to perceive inadequacies from the actual delivery of care, and is not concerned with patiently observing experiments in decision-making or in procedure."

***"We can no longer afford the luxury of 'in name only' governing body members"***  
-Jones

***"Who will appoint the governing bodies in the HSAs?"*** -Gemell



## Value Conflicts

***“Taken together, our new national priorities are in conflict with one another.”***

-Pickett

When it comes to making choices on costs, said APHA's Pickett, "the provider has a ready and expensive answer: the consumer really has the responsibility and he will pay for that answer whoever makes it. To deal with such problems effectively we will have to learn about negotiating quality rather than assuming it simply a constant. We'll have to chance shifting control from providers to consumers."

The priorities in the new Act, he continued, are "laudable and acceptable...but are in conflict with one another. Better, more equal access and higher quality simply cannot be obtained realistically at a lower cost, even at the same cost. Something has to give, some value.

"To make any real progress in achieving the goals enumerated by Congress, a substantial expansion and change in control would be necessary. It's not clear that this would ultimately mean a government-managed national health insurance but it is clear that, if all the priorities were to be attained, control of the industry would have to be wrested from the providers and transferred to the consumers, who would hopefully combine democratic humanism with managerial rationalism. If this really happened, it is hoped that government will broker the transfer and not assume unto itself the arrogance of control. We may not like the results."



## Timetable

The timetable in Public Law 93-641, which has legislative authority extending through June 30, 1977, begins with the area boundary designation, a process likely to be largely completed in late Summer, followed by HSA formation.

"It will be possible," said Gerald T. Gardell, Acting Director of the Division of Regional Medical Programs, "to establish many health systems agencies by January, principally in homogeneous rural areas such as the upper peninsula of Michigan and in those states which will have a statewide HSA, and in those areas where an existing agency—CHP(b) or RMP—transfers itself into the HSA.

"Formation of HSAs by January 1 is unlikely in those areas where there are likely to be competing applicants, where there have been major metropolitan areas such as New York, San Francisco, Boston, Chicago and Detroit."

Once HSAs are in place they are expected to contribute substantially to an effective national health insurance and to the Nation's developing health policy.

Flood, listing his own personal priorities, chose first a mechanism for resources development —“filling gaps, seeing that patients get service where it doesn't exist now”—followed by the national priorities set forth in the new law and national health insurance.

“Congress knows that we need national health insurance. I think it is a plus for the lawmakers, however, that they have debated over several years how to provide that insurance. It is complicated. The infusion of gobs of new money into our health care delivery system could have catastrophic price results.

“The real answer, of course, is prevention,” he said, adding that he hoped the Public Health Service Commissioned Corps could be put “back at work at prevention of disease.”

National health insurance, said Hastings, “will come next year in some form.” But he, too, expressed concern about cost. Everyone seems to want in it access to everything available, he said. “My friends we'd better understand one thing once we start writing national health insurance: there is not enough money in the whole world to make those kinds of promises and then deliver.”

“Once we do have a national health insurance program,” said Jablonowski, “and all the elements are successfully functioning there obviously will have to be some kind of formulation of national health policy, and I believe that physicians should carve out for themselves a role in the formulation of this national health policy. They must have a strong voice in the development of such policy and its implementation. This obviously means participation on all levels in the development of HSAs, of both providers and consumers, and I think they can work together.”



## National Health Insurance



***“What will the shortage of primary care physicians be like when some 25 million additional persons are given protection?” -Simmons***

***“What will we pay for medical protection against a rare accident? Most communities lack the experience to identify that question let alone answer it.” -Pickett***

***“We do too little in preventive health care.” -Hastings***





## Health Policy

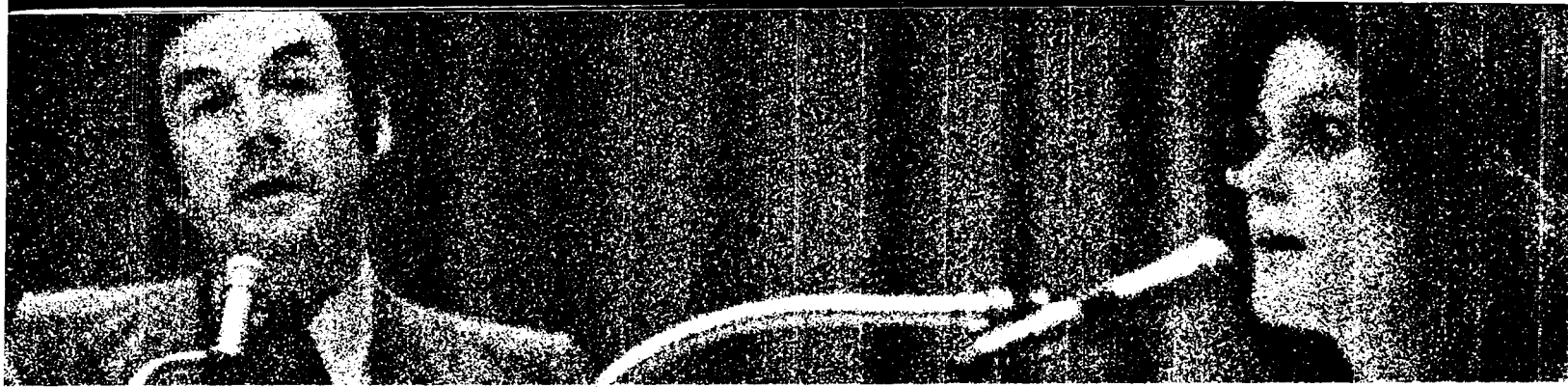
"There is no final oracle on national health policy, no highest office or court of last resort," said Simmons. "We in the United States have not given that distinction to anyone or any institution. And frankly I hope we never do."

"We have taken a simplistic attitude toward national health policy in the last two decades. We assumed that isolated, fragmented programs at the Federal level would somehow solve a multitude of problems."

"It didn't work. Now we feel a sense of urgency. Not only have past efforts proven unequal to the hopes we pinned on them, but even more to the point national health insurance, when it comes, is sure to impose a strain on the health care system the likes of which we have never before experienced."

National health insurance, said Mearns, "is going to come with planning that's pretty primitive. The big fear for me is that it comes when we are not ready, that we will do again what we do so often in this country—produce the expectation in those dwellers in the inner cities, the expectation of those rural areas where services have been inadequate or non-existent. I do not view with great calm the creating once again of high hopes which are not met, when the services are not there."

"It's time to put behind debate on issues raised in the development of Public Law 93-641," said Jones. "This may be and quite likely is the last opportunity we have for local decision-making about allocation of our health resources in this country. The continuation of negative rhetoric will not serve our purposes and will not serve the health care consumers of the Nation. It could, however, well serve a strategy which will lead to the complete Federal domination of health planning in this Nation."



"We can coordinate, we can put lay and professional volunteers together, we can do studies, we can define means, particularly in terms of facilities and so on," said Hunt. "Especially we should get back and work together with you, the professionals in administration who have capabilities that we don't have, particularly in this interim period. We *must* make this legislation work because it probably is the last chance the private sectors are going to have not to be totally controlled by the government."

"Unless we want doctors' strikes, staff revolts or hospital administrators becoming as transient as college presidents," said Flood, "then we'd better not pose radical changes in our health system."

"I believe in a patient being allowed to choose his doctor. I believe that for the demonstrably ill as well as for the worried well it is essential that a doctor know the whole patient and that the patient have confidence in his doctor. Those are essential parts of the cure, you know."

"America has generally avoided the excess of the right and the left, the over-regimentation some countries have perpetrated. I want her to avoid excessive change in medicine as well. We are experimenting slowly with Health Maintenance Organizations and other systems. This is an era of world-wide over-rapid and often mis-directed change. If we watch our priorities, attend to highly visible resource development needs, and rebuild our disease prevention army then I think we will be able to afford national health insurance and we'll live to see our medical care system become as good as the best anywhere."

***"I do not view with great calm the creating once again of high hopes which are not met when the services are not there." -Mearns***



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