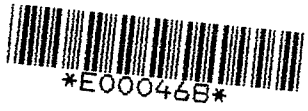
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GOVERNMENT BY NON-PROFIT CORPORATION

A Discussion of H.R. 16204, 93rd Congress

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GOVERNMENT BY NON-PROFIT CORPORATION

by Paul D. Ward

The granting of governmental powers to non-profit corporations is a concept that should astound most students of the democratic process. It is almost impossible to believe that Congress is well down the road toward blanketing the nation with non-profit corporations and intends to place the destiny of the nation's health care system in their hands. Under the guise of "keeping the health care system free from politics" they seem determined to commit the future of health care to corporate boards and staff that have little or no responsibility to the general public. Further, not only do Congress and the Administration seem willing at this point to turn many millions of tax dollars over to these corporations to engage in planning, development and regulation of the system, but they would also give them the power to approve or disapprove each proposed use of federal funds for the support of health services, manpower and facilities in the area they are assigned.

As incredible as this may seem, a bill to do just that may pass before the 93rd Congress adjourns.

The bill is H.R. 16204, the "National Health Policy, Planning and Resources Development Act of 1974." It is slated for vote on the floor of the House of Representatives after election. Too many of us still have a hard time believing such a proposal could have advanced so far in Congress, especially in the House, where the links to the people of this nation are the closest. But it has, and it seems only a drastic awakening of the public will keep it from becoming law. The irony is that this hardly seems the

year for passing legislation that robs the people of any direct or indirect voice at the local level, i.e., the traditional means of public accountability. However, the railroad is in full motion and it may be hard to stop.

It is difficult to explain how this concept developed its current momentum. Basically, it all began in the spring of 1973. As the authorizations for many of the programs in the Public Health Service Act were expiring, leaders in Congress pledged to rewrite most of the programs "to prepare the Nation's health care delivery system to meet the challenges of National Health Insurance." Expiration of authorizations for Comprehensive Health Planning, Facility Construction (Hill-Burton), Regional Medical Programs, several manpower training programs, several direct health service programs (such as Migrant Health, Neighborhood Health Centers, Mental Retardation and Mental Health) and other programs provided Congress with the opportunity to redirect them so as to prepare the system for the greater expectations and demands that National Health Insurance would engender. In late June 1973, the expiring programs were extended for one year (until June 30, 1974) to allow time for rewriting.

Congress undertook this task during immensely trying times. The fuel crisis, Watergate, inflation, impeachment hearings -- all issues of unusual magnitude -- pushed the issue of health care into the background. The rewriting of the Public Health Service Act took place largely at the Congressional staff level and was, in effect, obscured by the flamboyance of the other pervading issues. When the revised parts of the PHS Act began to move in Congress, there was little or no understanding of the actual content of the bills (let alone the many secondary implications) by those involved in the provision of health care, by many members of Congress or by the general public. As we near the date H.R. 16204 will be debated on the floor, the

general public, some members of Congress and a significant portion of the health care industry still do not understand it.

H.R. 16204 proposes to do a number of good things which need to be done, such as developing a national health policy, improving funding for health planning, continuation of the development of our health resources and providing a means by which that development can be rationalized on a sound economic base. But the apparatus which it sets up to accomplish these ends is as faulty as the objectives are sound. Obviously we cannot expect any bill to be all good, but we should at least hope that the positive aspects would outweigh the negative. In H.R. 16204 the opposite is true; the objectives of the bill will be set back two decades because the apparatus proposed for their implementation is designed to create chaos.

Among other things, H.R. 16204 would create a series of non-profit corporations known as Health Systems Agencies (HSAs), which would occupy geographical areas roughly comparable to the CHP b-agencies of today. These corporations would be selected by the Secretary, in consultation with the Governor of the state in which they are located. They would be responsible for long and short term planning, development of services, for approval or disapproval of virtually all federal funds used through grants and contracts for support of health services, manpower and facilities, for certificate of need determination, and for review of existing health care services rendered by facilities to make a determination as to whether they should continue or not. The financing of the HSA would be almost totally federal, with grants to the agency of up to 50 cents times the population of the HSA's area and $1 per capita for development of resources. HSAs would have considerably more power than the current CHP b-agencies, better funding and less responsibility

to the State. Except for their agreement with the Secretary of HEW, they would be free-standing agencies with considerable power.

Unquestionably, the major fault with H.R. 16204 is that it does in fact assign governmental powers to non-profit corporations. It attempts to hedge the legal question of "public accountability" (i.e., the legal precept that public policy can be created only by those officials elected by the voters or an appointee of an elected official duly authorized by law to create policy) by having the non-profit corporation enter into an agreement with the Secretary of HEW to perform such functions on the Secretary's behalf. As such, in theory, the corporation would be an agent of the Secretary's office. In fact, however, the corporation is an autonomous unit exercising public powers at the community level, much as any public agency would do, except that its governing board is neither elected nor appointed by an elected official duly authorized by law to do so.

Nor is it possible to deny that these organizations would be creating public policy. Congress has declared health care a right for all citizens, somewhat in the same sense that education is a "right." No one can deny that influencing the delivery of health care through the planning, development and regulatory process would not in fact be an act of creating public policy. Further, the fact that nearly 80% of the funds authorized for these functions are controlled by the HSA's board and staff should be de facto evidence of where the control lies and where the action occurs. It would be difficult to argue with any honesty that an "agreement" with the Secretary of HEW nullifies the de facto powers of an HSA.

If a local citizen or group feels aggrieved by an action of the agency, to whom does he turn for redress: the mayor, city council, board of supervisors, governor, or other officials? No. Since they do not select the board or

staff, they have no responsibility for the actions they take. There is a limited recourse to the courts, and in some cases to the Secretary of HEW as the fund granting agency. About all this assures is abundant court actions during the first years, if this becomes the way health policy is created.

It is not our intent to condemn non-profit corporations. When they are used in a proper way, they usually serve as a sound vehicle for needed accomplishment. They are essentially organizations to provide services for people without involving the profit motive. They were never intended to be public policy creating organizations. Certainly the Health Systems Agencies created under H.R. 16204 are public policy creating organizations that do not possess public accountability in the traditional sense.

A Broad Public Policy Authority

HSAs would have broad public policy authority in terms of designing the local health system, implementing pieces of that system with its developmental funds and, to a limited degree, regulating that system. No one questions the legitimacy of a non-profit corporation developing a health plan for the local community so long as final approval of the plan rests with another public body meeting the test of public accountability. No one questions the validity of a non-profit corporation developing health care services for the community so long as that corporation is obligated to follow a publicly adopted plan and so long as its activities are scrutinized by publicly accountable officials. But one would always question the legality and appropriateness of non-profit corporations engaging in the regulatory process regardless of the situation, since this has been a function in our society that has always been assigned to a public body that is in all respects accountable. But when all of these functions are mixed together and placed in a single non-profit corporation

such as an HSA, and the only link with public accountability is the agreement that exists with the Secretary of HEW, then the historical concept of democratic government based on elected representatives and their appointees is critically strained.

"Agents of the Secretary" vs "Agents of the Community"

Eventually, in order to meet any legal test of public accountability, the HSAs would have to be considered "Agents of the Secretary." This is a dramatic change in philosophy from the current situation. Our current health planning agencies are considered to be agents of the community; that is, an agency belonging to the community and designed to bring providers and the public together at the local level to make decisions about the provision of health care and to develop a plan that is acceptable to the community. This philosophy is completely reversed if the HSA is made an arm of the Secretary extending into the local community. Currently the local planning agency relates to the State A Agency and is considered to be a relatively autonomous part of the overall state planning apparatus. Under H.R. 16204 the relationship is between the HSA and the Secretary with the Secretary consulting the state in an advisory sense only should he decide to seek information from it.

H.R. 16204 distorts the health regulatory process of the past, which traditionally has been at the state level and it revises the philosophy of the development of health resources by making it subject essentially to federal approval. Although there has been much talk in recent years about the decentralization of government, this bill, when its implications are taken into full consideration, could be the most power-centralizing at the federal level that has been developed in recent times.

Devices for Policy Endorsement

Not only does H.R. 16204 grant HSAs the ability to create public policy in regard to the formation of the local health system, but it also creates the devices for enforcing that policy. Again, it must be emphasized that these powers are being given to a self-perpetuating board of directors and staff of a non-profit corporation that has not been elected by the public or appointed by a public official, and has no direct responsibility to the electorate except remotely through the Secretary of HEW. This is a self-perpetuating board which is self-selected in the beginning and is in a position to be as contemptuous of public opinion as it desires. The first of these several powers is found in the $75,000 grants that HSAs can make to local entities for the development of services. These grants cannot be considered sufficient in size to develop most of the kinds of health care services that need to be developed, but they can be used to manipulate the system by buying support for HSA positions. This is not to say that every Health System Agency would use its granting ability to bribe local providers into complying with the HSA's policy. But it is to say that the Congress and the Administration are at fault in attempting to create a system that would allow for and in fact encourage this type of bribery. It takes little or no imagination to understand that if an institution or a facility applied for this aid it might be obligated to comply with other demands of the HSA, be they right or wrong, if urged upon them. The statement, "Either you do what we say or you don't get your development money," is certainly implied and could only lead to the distortion of the planning activity if it were to be motivated and enforced by this process. Admittedly, much of our activity is already conditioned by this kind of bargaining, but why give a sledgehammer to an organization that has little if any responsibility to

the electorate. These might be beneficial powers if the electorate were able to respond by removing the board, or the official responsible for their appointment, when or if the board acted inappropriately, but no such recourse is available.

Another dangerous power given to the HSA is approval or disapproval authority over all funds applied for that are authorized and appropriated through the Public Health Service Act. As has been pointed out in several trade journals in the health field, this approval and disapproval power can be interpreted as applying to all grant and contract funds for research, facilities, manpower, mental health, mental retardation, family planning, etc., where health services are involved. In fact, it could be read as inclusion of all funds appropriated through the Public Health Service Act if the Secretary so decided. On the surface this approval and disapproval may appear innocent; however, the fault lies in the fact that the government is creating a situation wherein the local agency could withhold its approval of funds solely for the purpose of gaining compliance with other parts of its self-approved plan. It is obvious that anyone seeking approval for funding could be compelled to comply with other unrelated desires of the agency in order to gain that approval. Again, many agencies would not use these techniques, but the fault lies in the fact that an apparatus is being created which encourages it and there is little or no recourse for settling grievances except for appealing to the Secretary, which might be less than satisfying since the report on the bill indicates that the Secretary should not insert himself in these decisions except on rare occasions. Who is to say how rare is rare?

The Pressures on the Governor

Another major fault with H.R. 16204 is the process by which local health service areas are created and in turn the HSAs approved to run these areas. The proposed law would have the governors recommend, within certain confines, the geographical boundaries of the area and the non-profit agencies that should be designated as the HSAs. If this legislation is passed and when it is understood by the providers, a strenuous scramble will result among certain of the strong providers in an effort to provide favorable people for the board of any non-profit corporation selected as the Health Systems Agency. Since the agency must make findings for certificate of need and then continuously review all services rendered by institutions to recommend either continuation or termination, naturally the bigger and more aggressive institutions, facilities and providers will want to protect their interests in the services being rendered. The governors are going to receive tremendous pressures, especially from urban areas, concerning the designation of areas and agencies. A tremendous amount of strife will develop during the first year while these designations are being made. For any agency that has these powers vested in its board, and any board that is self-perpetuating after its establishment in that it selects and elects its new members in perpetuity, it is obviously advantageous to obtain favorable board representatives (whether they be public or provider) at the time of agency designation. Later, many institutions, facilities and providers will find themselves without representation and perhaps will feel the need to continually rebel against the decisions made by the agency. Not only will the governor be besieged at the outset, but the courts will be besieged later on the question of public accountability when decisions are made that are not to the liking of those not represented on the board.

From Convener to Adversary

H.R. 16204 also completely reverses the philosophy that the local planning agency's role is to draw the local resources and providers together and develop a consensus on what the plan should be. H.R. 16204 places the planning agency in an adversary role with the individual provider at the community level. The agency, at least to a minor degree, regulates as a superior party in the relationship; it cajoles and entices with its $75,000 grants and it acts as the sole creator of the long-term and short-term plans. It replaces the convening body role with the dominant figure role in the relationship.

Hopeless Combination of Functions

But perhaps the fatal flaw the bill possesses it that it attempts to combine three incompatible functions. 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 staff possessing different skills and boards composed of different constituencies. This is not to say that health service development should not be required 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 service developers, and service developers should not 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 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 who 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 must 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 create 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 cannot be gained through the planning agencies as described in this bill.

The Response

Supporters of H.R. 16204 respond to these criticisms by stating that the bill provides authorization for only three years and any faults can be corrected when and if it is extended. They point out that nearly two years' staff work has been devoted to the bill and that this effort should not be wasted.

Unfortunately, it is this kind of thinking that has plagued the health field for the past decade. Relatively few of the Public Health Service Act programs have had any stability over this period because they do come up for renewal every three years. Both Congress and the Administration have a tendency to think in terms of tearing each of the programs asunder every three years and instituting new programs in their place, instead of making adjustments in ongoing efforts and building on the strengths of the past. It takes three years or more to build a good staff, educate the public on the

purposes and utilization of the program, and gain the support of the community and its resources. If, at the end of each three-year period, the participants in the programs have to face the turmoil of indecision, possible abrupt change in purpose and procedure, reorganization and general confusion, we cannot expect much to be accomplished. The effect on paid staff is obvious, but the public participants become disenchanted also, because by the time they become active in and knowledgeable about the program it is changed and much of their effort has been wasted. Most public participants who volunteer their time are too discouraged to try it the second time around.

H.R. 16204 would be a disaster in terms of the turmoil and disillusionment it would create. It purports to be the amalgamation of Comprehensive Health Planning, Experimental Health Systems, Regional Medical Programs, Hill-Burton and the various approval or regulatory processes like those required under Sec. 1122, State Certificate of Need and Recertification. But in fact, it will prove to be an entirely new ball game. In most cases the conflict will not be between the programs and their staffs that are slated for amalgamation. It will be among the concerned groups in the health field that want recognition on the HSA board. It will take place when the governor of each state is asked to recommend to the Secretary of HEW the area boundaries for each health service area and which non-profit corporation with its specified board members should be selected to serve as the HSA. Although some b-agencies have been told that their selection is pro forma, when the witching hour arrives they are apt to be in for a surprise. The proposed language is clear: most of the existing b-agency boards would have to undergo substantial change, if not complete change, and undoubtedly many area boundaries would be subject to change.

With the change in the boards, board members and area boundaries will come changes in the staff that has been engaged in the planning. This always raises the question of how much of the plans, planning data and related efforts of the former agency the new agency will find relevant. In this event the work of the past years may be lost and the total process begun over again, committing many of the same errors, suffering the same learning pains and once again re-inventing the wheel. Add to this the new functions that have been assigned the agency and it is almost certain to be bogged down in its own confusion for months -- if not years -- to come. This is history repeating itself for we went through this, except on a lesser scale, when the b-agencies took over from the voluntary health planning agencies six to eight years ago.

At this point, the greatest benefit that could accrue to health care in our nation is for H.R. 16204 to fail to become law. This would permit a new bill to be written after the first of the year that would preserve the best of the planning, development and regulatory efforts that have emerged since 1965 when the 89th Congress and certain states put most of these efforts in motion. Our efforts in these areas can be and should be improved, but that is quite a different proposition from that presented in H.R. 16204, which would discard the accomplishments and lessons of the past only to repeat the same problems, create innumerable new problems, and set back several years the chance to prepare the system for National Health Insurance.