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The Regionalization of Personal Health Services

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Regionalization of Health Services: Current Legislative Directions in the United States

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The concept of regionalization of personal health services has been advocated for many years to provide a framework for organizing the complex functions inherent in modern medical care. The Dawson Report (1920) in England and the writings of American proponents such as Grant (Seipp, 1963) and Mountin (Mountin et al., 1945) propose the same basic concept as a guide to the planning of health services. The factors that led to a concern with regionalization—greater specialization based on expanding knowledge and accompanied by problems of increased costs and access to services of acceptable quality—have intensified in recent years; yet regionalization remains a concept rather than a reality in American health care. With the imminence of National Health Insurance strengthening the already existing trend toward greater regulation of the health services industry, it is timely to take the measure of regionalization as an active principle guiding national policy. The focus of this paper is on federal legislative intent and the specific legal mechanisms that might be used to implement regionalization, including those previous legislative actions which are the direct antecedents of current legislation.

The realities of specific legislative provisions, legislative history expressing Congressional intent, and experience with the halting efforts of legislative antecedents during the past three decades all

provide clues to the type of environment provided by the American political system for implementing planning strategies such as regionalization. The analysis will show that there is ample reason to be skeptical about any strong commitment to regionalization in current legislation. But such conclusions are speculative. The primary current legislative event, the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), was signed by the President on Jan. 4, 1975. Its future implementation will take place in a climate greatly influenced by the probable passage of some form of national health insurance and a growing array of other regulatory mechanisms at the state and federal levels.

Definition of Regionalization

A definition of regionalization that follows closely the classic concept of Dawson, Grant, and Mountin is used in this paper to provide demanding criteria for the legislative analysis. Regionalization is an explicit plan covering a defined geographic area. The plan sets forth specific responsibilities for providing access by the population to the full array of functions involved in the delivery of modern medical care. Those functions are divided among several levels of care according to the complexity of the services and the frequency of their use among the defined population. Each practitioner and institution is assigned responsibility for particular sets of those functions, usually with a major focus on one level of care. The hierarchical system set forth in the plan has provisions for integration of the component parts, including referral patterns upward through the levels of care and established patterns of consultation (and related education).

A fully implemented policy of regionalization would require constraints on the types of services that could be offered by an individual or institution. Such a policy would also imply specific responsibilities to provide the defined population with each type of care. The policies to carry out such an organized regional system might be referred to in other fields as franchising rather than regionalization.

The Federal Legislative and Program Antecedents of Current Legislation

The National Health Planning and Resources Development Act of 1974 is based on and replaces the legislation authorizing three federal health programs—the Hill-Burton program providing assistance in the construction of health facilities, the Regional Medical Programs, and the Comprehensive Health Planning programs. In addition, the Act removes authority for the experimental health services delivery systems that were created by administrative action using broad research and development authorities. A brief review of these preexisting programs traces the thread of regionalization through previous federal legislative policy.

The Hospital Survey and Construction Act (P.L. 79-725), commonly known as the Hill-Burton Act, was passed by the Congress in 1946. The basic purpose of this legislation was to support state surveys of the need for hospital facilities and to provide matching grants to assist in the construction of hospitals and public health centers. While the primary justification of this legislation was in terms of the need for new hospital construction, especially in rural areas, following the hiatus of construction through the depression and World War II, a review of the legislative history reveals some reference to the concept of regionalization as a basis for hospital planning. During the Senate hearings, Surgeon General Thomas Parran described a regionalized plan (U.S. Senate Committee on Education and Labor, 1945: 59–60). Parran's plan, which seems to be based on the concepts of Joseph Mountin, sets out a four-tiered care system consisting of health centers for primary and emergency care, rural hospitals, district hospitals, and medical centers, or base hospitals. His plan was laid out in some detail. The following exchange during the hearings (p. 60) provides an early indication of the reluctance to make a real commitment to a conceptual plan within the American political system:

> Senator Pepper: That is essentially the pattern which is contemplated in this bill, is it not, Dr. Parran?
>
> Dr. Parran: It is.

Senator Taft: Do you mean to say it is going to be forced on the states, whether or not they want it?

Dr. Parran: By no means, Senator Taft.

The only reference one can find in the original Hill-Burton Act implying that regionalization would be a guiding principle is amended language (Section 622A) introduced by Senator Taft calling for the state plans to include

> . . . the number of general hospital beds required to provide adequate hospital services to the people residing in the state and the general method or methods by which such beds shall be distributed among base areas, intermediate areas, and rural areas.

On this thin reed of legislative purpose and history was based the hope that the Hill-Burton state plans might become an instrument for regionalization of health services. While the state plans did not contain a designation of base, district and rural hospitals, most observers would agree that the Hill-Burton Program did little to influence the kind of functional integration required for a regionalized system.

Recognizing the limitations of a state plan and construction grants as mechanism for implementing health facilities planning, amendments to the Hill-Burton Act in 1964 provided grants for areawide health facility planning agencies. These planning agencies, established outside the framework of state or local government, were based on the voluntary health facility planning agencies already carrying out facility planning in some communities. Given no regulatory power, these areawide agencies attempted to influence the course of facility planning through persuasion, the publication of planning studies indicating needs, and the stimulation of better institutional planning.

In spite of these attempts to emphasize planning, it seems clear that the political strength of the Hill-Burton program was based on construction or modernization of health facilities, not on the creation of an integrated regional system of care, the former being a purpose more to the liking of our political tradition.

The next major legislative event that bears on regionalization was the passage of the Heart Disease, Cancer and Stroke Amendments of 1965 (P.L. 89-239). This legislation authorized grants for the establishment of Regional Medical Programs (RMPs) to consist of "regional cooperative arrangements" among health care institutions, medical schools, and research institutions to facilitate the wider availability of the benefits of advances in the diagnosis and treatment of heart disease, cancer, and stroke. The law grew out of the report of the President's Commission on Heart Disease, Cancer and Stroke, chaired by Dr. Michael DeBakey. That report recommended the establishment of a national network of regional centers, local diagnostic and treatment stations, and medical complexes. This concept of a regionalized system for each category of disease was fundamentally modified in the final legislation to reflect the objections of private medical practitioners, hospitals, and medical centers to the detailed categorical arrangements proposed by the DeBakey Commission.

The administrative guidelines for RMPs attempted to emphasize regionalization as a theme for the program (U.S. Department of Health, Education, and Welfare, 1968), yet the basic mechanism of the program was voluntary and responded to plans developed by each RMP. Pressures for implementation of an explicit plan for regionalization were not applied, partly because of the strong reaction to the original DeBakey Commission concept. The categorical focus of the program, confusion over shifts in national policy, preoccupation of much of the health care system with the implementation of Medicare and Medicaid, growing concern over the rising costs of medical care and access to primary care, and resistance of health care providers to compliance with more formal plans were all reasons that eroded the potential of RMP to evolve into a broader force for regionalization. Such political commitment as there was to RMP was in terms of specific activities undertaken by each RMP, rather than a commitment to a broader concept of organization of health services.

The next legislative antecedent, the Comprehensive Health Planning program, was authorized by P.L. 89-749 in October 1966. Comprehensive Health Planning (CHP) was deliberately steered

away from the Hill-Burton program's concern with construction of health facilities and the RMP categorical and action-oriented emphasis. The planning mechanisms created at the state and areawide levels were to encompass all factors that relate to health. These planning agencies replaced the areawide health facilities planning agencies created under the Hill-Burton Act. The legislation itself was very general. Review of the legislative history provides few clues to a more specific intent other than an emphasis on the need for coordination of splintered categorical federal programs. While the planning agencies were encouraged to formulate local plans and priorities for action, they were given no power to implement their plans or to enforce constraints on undesirable duplication of services.

Subsequent legislation and policies gave these planning agencies responsibility to review and comment on other federally supported health programs and provided a reemphasis on the planning of health facilities by tying Medicare and Medicaid reimbursement policies to planning agency recommendations concerning the need for facilities. Nowhere in the legislation itself or the legislative history of the program can one find specific indication that comprehensive health planning was to be used as an instrument of regionalization as it is defined in this paper.

Another federal program intended to improve the organization of the health delivery system on an areawide basis was the Experimental Health Services Delivery Systems program, initiated in 1971 by administrative action and funded through the National Center for Health Services Research and Development. This program had as its intent the establishment of community management structures intended to improve the organization of the health delivery system, in order to improve access to care and moderate the increase of costs while maintaining or improving the quality of care. The programs were also intended to achieve greater integration and coordination of the federal health funds being provided to the selected communities. This program was plagued from its beginning by lack of clear policy objectives, by administrative reorganizations at the federal level, and by a temporary funding commitment. The lack of specific legislative authority as well as the

administrative difficulties indicate that this short-lived program cannot be considered as any further evidence of political commitment to the implementation of regionalization.

The Political and Legislative Context for the New Legislation

An unusual legislative climate was the breeding ground for the new legislation replacing all the programs just described. Strong conflict between the executive and legislative branches of the federal government led to legislative battles over authorizing legislation and appropriations. The President desired in early 1973 to eliminate many federal programs, including Regional Medical Programs and Hill-Burton, and to reduce funds for others. The resulting confrontation led to a determination by the Congress to seize the initiative in rewriting federal health legislation, rather than reacting to executive branch proposals—the primary pattern of legislative initiative in recent years. The Congressional committees were sensitive to rising pressures for resolution of problems of health care costs and the distribution of services. The committees seemed determined to make the new legislation focus specifically on defined problems of the health care system. In formulating sharper objectives, they wished to resolve the confusion surrounding the roles of the existing programs. The imminence of national health insurance added to the pressures to create a stronger planning and development mechanism through federal legislation.

Though the new legislation was conceived in an initial atmosphere of legislative-executive conflict, a surprisingly broad area of agreement rapidly emerged. The Administration and the Congress could agree that the existing programs had not been sufficient instruments for improving the effectiveness and efficiency of the health care system. There was agreement to replace the multiple planning structures of the previous programs with a single planning program involving both state and areawide components. There was agreement on the need to sharpen the objectives of the new program and establish clearer criteria for accomplishment. In spite

of the areas of agreement that emerged between the Congressional committee staffs and the staff of the Department of Health, Education, and Welfare, it is still fair to conclude that the basic initiative for this new legislation came from the Congress.

As the intent to draft legislation that looked afresh at the structure for planning, regulation, and development of the health care system proceeded, a number of major policy issues needed to be resolved—issues that had never been clearly settled in previous legislation. These issues included

—the influence of public authority over the predominantly private health care sector;
—the division of responsibilities among the federal, state, and local levels of government;
—the degree to which the major sources of health care financing, both public and private, are subject to the influence of planning agencies;
—the extent of regulation over capital use, rates, and the distribution of manpower;
—the relationship of medical centers, including medical schools, to a structure for the planning of health services; and
—the relationship of the planning structure to other federal health services programs.

The success of any attempt to develop and implement plans for regionalization of health services in this country would seem to be heavily dependent on how these issues are received. However, the pressures of compromise prevented a clear resolution of any of them, except perhaps the strengthening of controls over the availability of capital for the construction of new facilities.

Description of the New Legislation

The National Health Planning and Resources Development Act of 1974 that emerged from this legislative context is a very detailed piece of legislation. Among the reasons for this degree of detail were the perception by the Congress that the executive branch had misused broadly written authorities to achieve purposes not included in the Congressional intent, a Congressional view that the lack of clearly specified objectives and procedures impeded the effectiveness of RMP and CHP, the provision of more detailed procedures because of the regulatory impact of the new legislation, and finally the sheer diversity of issues dealt with in this legislation. The amount of detail makes a brief summary of the law difficult, but the following are the key features of the legislation that have potential significance for its use in implementing regionalization.

The legislation would establish a three-tiered planning structure. At the federal level the Secretary is required to specify national guidelines for health planning, including standards respecting the appropriate supply, distribution, and organization of health resources, and a statement of national health planning goals, stated to the extent practicable in quantitative terms. To guide the Secretary's actions, the Congress has provided a specific list of national health priorities. In developing the national guidelines, the Secretary will be advised by a new National Council on Health Planning and Development.

The basic operating level of this planning system will be a network of health systems agencies with responsibility for health planning and development in geographic areas designated by the governors of the states. These geographic areas are to have a substantial population base and encompass the full range of health services needed to meet the needs of that population. The "health service area" would seem, therefore, to be an appropriate geographic base for regionalization. These health systems agencies are to prepare long-range health systems plans and short-range annual implementation plans that will achieve the goals of increasing accessibility, acceptability, continuity, and quality of health services and restraining increases in the costs of these services. The agencies can also develop specific action plans for particular programs and projects to be carried out within the plan. These agencies can be either nonprofit corporations established for this purpose or public planning agencies that meet the very specific requirements provided in the law. It seems clear from the legislative history that the Congress expects most of these agencies to be nonprofit corporations.

In between the federal and area levels, the legislation establishes state health planning and development agencies, advised by a statewide health coordinating council. This state agency is expected to prepare a state plan based on the area plans, be responsible for a state medical facilities plan, serve as the planning agency for approval of capital facility expansion under Section 1122 of the Social Security Act, and administer a state certificate-of-need program.

The distribution of responsibilities among these three levels would seem to emphasize goal setting and evaluation of the effectiveness of planning agencies at the federal level, the development of specific long-range and implementation plans at the areawide level, and the conduct of regulatory activities at the state level, with substantial reliance in the conduct of those activities on the plans developed by the health systems agencies. In addition, the health systems agencies are given the power to review and approve or disapprove many federal grants and contracts providing for the development, expansion, or support of health resources. The health systems agency and the state health planning and development agency are also authorized to review at least every five years the appropriateness of all institutional health services. However, the agencies are given no specific regulatory power to discontinue any of these services.

The Act authorizes the Secretary to give additional authority to not more than six state planning agencies to carry out a program of rate regulation. This limited number of programs will be used for the purpose of demonstrating the effectiveness of such rate-regulation activities.

Other provisions of the Act provide for assistance in the construction or modernization of medical facilities in accordance with the state health facilities plan and the provision of a small amount of funds to each health systems agency from which it may make grants and contracts to assist in the implementation of its plan.

The law also authorizes the Secretary to provide technical assistance to planning agencies and to support centers for health planning, which will engage in studies to improve planning techniques and provide technical and consulting assistance to the health systems agencies and the state agencies.

The law contains extraordinary detail concerning the structure of the health systems agencies and the state agencies, criteria for their functions, and requirements for coordination with related activities. The law also gives the Secretary very strong responsibilities for reviewing the effectiveness of the agencies and taking action to correct deficiencies.

The provisions of the law and the legislative history were examined for evidence of intent to carry out the concept of regionalization. Nowhere in the Act does the term "regionalization" appear. But the "national health priorities" set forth in the Act do not contain provisions that are supportive of the concept of regionalization. Among the priorities in Section 1502 are the following:

> (2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services). . . .
>
> (5) the development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions. . . .
>
> (7) The development by health services institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

The long-range plans to be developed by the health systems agencies would seem to be the most specific mechanism for laying out a plan of regionalization within the structure of this Act. These plans are to describe "health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable cost for all residents of the area . . ." and the plan shall "take into account and [be] consistent with the National Guidelines for Health Planning Policy issued by the Secretary under Section 1501 respecting supply, distribution and organization of health resources and services . . ." (Section 1513 a 2).

A reading of the legislative history, particularly the reports of the House and Senate committees (U.S. House of Representatives Committee on Interstate and Foreign Commerce, 1974; U.S. Senate

Committee on Labor and Public Welfare, 1974), fails to provide any further specifics concerning the content of the plans. Along with the detailed analysis of experience with the antecedent programs and descriptions of the proposed legislation, the House report (pp. 32–35) does contain a list of seven principles that the House Committee followed in writing the new legislation. Most of these principles concern the processes of planning, and none provide any additional legislative intent concerning regionalization. The justification of the need for better health planning, as revealed by the reports and other legislative history, emphasizes the rising costs of care, the duplication of services, lack of access, and uncoordinated federal programs. The legislation is described as a necessary step to help the health system respond to the additional demands anticipated from national health insurance. In the reports, considerable attention is given to the inversion of financial incentives within the health system that creates a need for planning and regulation to contain the tendency toward excessive use of services and toward superspecialization. But there is generally a lack of attention to specific principles or organizations that would require adherence to a plan.

One must conclude that any further specificity concerning regionalization as an intent of this program must be provided in the Secretary's guidelines or be developed by a health systems agency at its own initiative.

The Prognosis for Regionalization under This Legislation

The previous section points out that the potential to use this legislation as an instrument toward regionalization is consistent with both the structure and the priorities established in the legislation. However, it has also been pointed out that evidence of intent to use the legislation for this purpose is not explicit. Both the history of the antecedent legislation and general knowledge of the American political system's efforts to make substantial changes in major social systems indicate that an explicit political commitment is needed to

make real any expression of intent. Administrative action by the Secretary through regulations and guidelines is unlikely to be sufficient.

Even if that intent and commitment were clear, unresolved policy issues can quickly begin the erosion of the administrative will and energy necessary to bring about major changes. As has been pointed out, a number of these major policy issues were raised in the course of considering this legislation. Compromises emerged on each controversy. It is clear that the influence of public authority over the predominantly private health care sector remains limited, and the responsiveness of the private sector to more specific mandates of responsibility under a health services plan is therefore questionable.

The division of responsibilities among the federal, state, and local levels of government remains ambiguous, as it has always been with health legislation. In this new legislation, the Secretary retains considerable responsibility for establishing objectives and monitoring the planning and development structure, establishing a clear federal role. Yet the health systems agencies seem likely to bypass local government in most instances, and the relationship between the state agencies and the health systems agencies contains the seeds of considerable conflict. The relationship of medical schools, medical centers, and other health manpower training activities to the planning framework seems absent, yet any meaningful concept of regionalization must include concern with manpower distribution. Beginning efforts are made to relate the planning structure to the sources of health care financing, particularly with regard to capital financing and a modest step toward rate regulation. Yet the impact of the financing mechanisms, especially with the imminence of national health insurance, on many other aspects of health services organization are profound, and the ultimate linkage between planning and financing is not yet established. The legislation does take a major step in resolving confusion among federal programs and in relating other federal health services programs to the health systems plans.

If intent, commitment, and resolution of major policy issues are all present, does sufficient authority exist within the legislation to

overcome the resistance of independent providers and the tendency of the political system to respond to particulars rather than general schemes? The Dawson Report (1920: 7) refers to the need to relate intermediate steps to the ultimate design: "To construct any part well and to avoid mistakes in local effort, the whole design must be before the mind."

The regulatory authority provided in the new legislation is focused on capital expansion and federal grant programs. Such authorities would seem to be useful in shaping the direction of new activities but not very effective in influencing the organization of existing institutions and programs. The achievement of a regionalized system through authority over new activities would probably take many years. Primary reliance in achieving regionalization would still be based on assembling and disseminating data, publicizing plans and recommendations, and the persuasive capacities of the health systems agency. Details of structure and process should not be mistaken for real authority, even when a political commitment to change exists.

It is reasonable to conclude that this legislation has potential significance in achieving progress toward regionalization but that the legislation itself is not sufficient for that purpose. What is needed first is a concept of regionalization that contains modifications more appropriate for the probable directions of the American health care system. This concept will have to provide for some real consumer choice among multiple delivery systems developed within an overall regional plan. The concept will also have to deal more explicitly with the legal and political realities of a private health care system and the federal structure of government in the United States. More explicit political commitment for such a concept will have to be sought from both the executive and the legislative branches. Finally, the national health insurance program adopted will have to reinforce the commitment. Perhaps the intent to regionalize the treatment of end-stage chronic renal disease to be financed under the Medicare Amendments of 1972 (P.L. 92-603) will provide a test case for that commitment. The Department of Health, Education, and Welfare published guidelines for that regionalization in April 1974, but specific regulations had not yet been issued at the time this paper was prepared.

This analysis is not intended to denigrate the significance of the National Health Planning and Resources Development Act of 1974. In the author's view, that Act represents progress over preceding legislation. However, realism with regard to objectives and implementing mechanisms is essential for effective actions. So must it be for any progress toward regionalization through the current legislation.

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