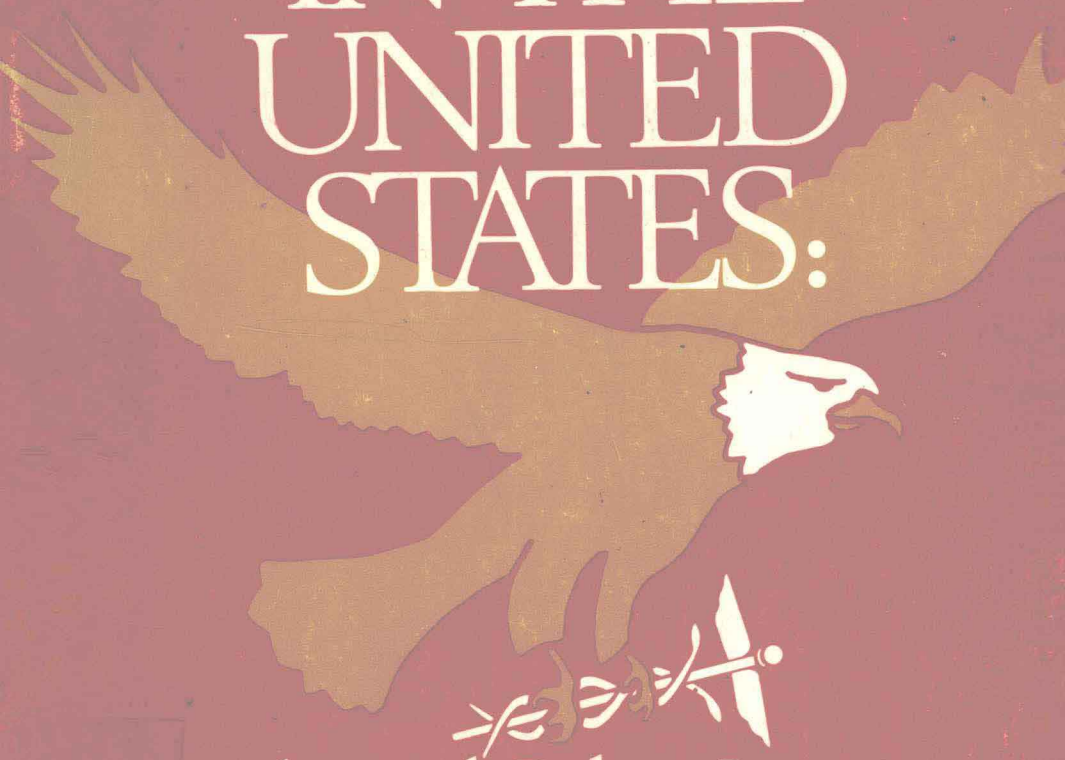
VOLUME TWO

HEALTH PLANNING IN THE UNITED STATES:



Selected Policy Issues

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VOLUME TWO

HEALTH PLANNING IN THE UNITED STATES:

Selected Policy Issues

Committee on Health Planning Goals and Standards

Institute of Medicine

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PREFACE

This volume is composed of the background papers commissioned by a committee of the Institute of Medicine. The committee was formed to study health planning in the United States. A list of the committee's members, including its chairman, Rashi Fein, Ph.D., is provided at the front of this volume. The papers in this volume detail the empirical and theoretical underpinnings of the second year's report, which discusses national, state, and local relationships and consumer participation in health planning. The authors in this volume were encouraged to express their opinions and make their own recommendations. The papers, although reviewed by the Academy, are not submitted to the same review process as committee reports and represent the views of the individual authors, not the committee or the Institute of Medicine. The committee feels that the papers by themselves constitute major contributions to the quality of current debates in health planning and should be disseminated broadly.

Helen Darling
Study Director

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SOME STRUCTURAL ISSUES IN THE HEALTH PLANNING PROGRAM

Lawrence D. Brown

Health Systems Agencies (HSAs) were established by P.L. 93-641 as the mechanism of local health planning. In this paper Brown describes the structure and internal organization of HSAs, their relationships with the organizations with which they must interact, and the political forces with which they must contend. Brown highlights many issues that inhibit the effective working of the HSAs, and concludes with some suggestions for reforms that might improve the contribution of HSAs to the health planning effort.

> "We designed it backwards."--Official in the U.S. Department of Health and Human Services.

That planning is inseparable from politics is a truism. The corollary--that planning is therefore also inseparable from political structure--is less familiar.[1] Political "structures"--the explicit distribution of roles and powers among official participants in a public program and the informal distribution that both official and unofficial participants invent to supplement these explicit arrangements--do much to define the rules of the policy game and the balance of power among interests.

A new federal program raises three central structural questions: first, How will the program be organized internally? ("organizational" questions); second, How will it fit with existing programs in its immediate (usually state or local) environment? ("environmental" questions); and third, What requirements, regulations, and informal understandings will bind it to its federal creators and

administrators? ("federal" questions). These questions are especially important when the federal government tries to meet its objectives by creating and working through a new organization--for example, the Health Systems Agencies (HSAs) with which this paper deals. An organization-building effort is not content to alter existing organizational and intergovernmental arrangements at the margin, as by means of new requirements and incentives attached to grants-in-aid. Instead it injects a new organizational presence--a new structure--into the existing set of programs. Building a new organization is more complicated than deciding what conditions to attach to grants-in-aid. Fitting a new organization into the universe of state and local organizations is more complex than trying to alter the behavior of some member of that universe in delimited respects. Trying to decide how the trade-off between federal control and local autonomy affects the capacities of a new organization is more difficult than attempting to assert "the influence of federal grants"[2] incrementally over time in established programs.

These structural questions are highly pertinent in the health planning field, where organization-building has been central to the federal government's strategy.[3] In 1974, convinced that the nation needed a network of area and state-based health planning bodies, but that the Comprehensive Health Planning (CHP) agencies created in 1966 had proved to be too weak, the federal government set out to strengthen the CHP model. The health planning bodies established in the Health Planning and Resources Development Act of 1974 (P.L. 93-641) were to be known as Health Systems Agencies. In each state one or more HSAs would assume responsibility for drawing up long-term "health systems plans" (HSPs) and "annual implementation plans" (AIPs) that considered the needs of their jurisdiction and the degree to which present and projected resources and resource development patterns were adequate, excessive, or insufficient. The agency itself would be run by a governing board, the structure of which was set forth in considerable detail. It was to be composed of representatives of consumers, providers, local organizations, and special income, racial, linguistic, and other groups. Consumers were required to constitute a majority of the board. As of November 1979, there were 202 HSAs, 16 of which crossed state lines and 12 of which covered an entire state.[4]

The law also prescribed new intergovernmental arrangements. To assure coordination and planning on the proper scale, it required that the work of the HSAs be coordinated by a single state agency, the so-called State Health Planning and Development Agency (SHPDA), which would synthesize HSA plans into a statewide plan subject in turn to the approval of a Statewide Health Coordinating Council (SHCC), a majority of whose members would come from HSAs within the state. The plans would be considered by federal grant-giving agencies in the review of applications for funds (so-called "proposed use of federal funds" or PUFF reviews) and by the states in their reviews of applications by health care institutions for "certificates of need" (CON). These state and local bodies are themselves subject to regulations and guidelines issued by the Department of Health and Human Services (DHHS) (until recently called the Department of Health, Education, and Welfare), advised by a National Council on Health Planning and Resources Development.

Thus, the federal government has chosen to strengthen health planning in the United States by establishing new local--and state and federal--organizations and by conferring on them significant planning responsibilities and regulatory powers. These powers, located along the hazy line between review and comment and review and sign-off, are rather weak regulatory weapons. Yet the powers, and still more the presence, of the HSAs, SHPDAs, and SHCCs are of considerable political importance. The official expression of a federally created "voice of the people" on health planning questions can legitimatize or impugn professional, institutional, and "grassroots" initiatives and can thereby help shape the nature of health care debates and perhaps even tip the balance of power in state and local health politics decisively to one or another side.

This paper, which summarizes impressions drawn from the author's research in progress on the implementation of health planning and regulatory efforts in Maryland, Washington, Michigan, and New York states, addresses the question whether the structural arrangements adopted by the federal government for health planning are adequate to the ambitious goals set for the planning process. In evaluating the structure of such a program, level of detail is not a sure indicator of level of sophistication. Program designers may address structural questions in minute detail and still miss the most important ones.

Details may stem from a realistic and dispassionate understanding of institutional patterns "out there," or they may reflect the designers' ideologies, certain intuitively or widely held prejudices about "how things work," or the need to smooth rough legislative edges to win the support or assuage the opposition of important groups.

As Raab's paper in this volume demonstrates,[5] the structure of the planning system strongly reflected the values and world view of its designers, especially of the congressional staffs who developed the legislation in detail. This outlook took a dim view of the contribution of state and local politicians and administrators to health planning: their parochialism, susceptibility to interest group influence, and general inefficiencies, it was thought, made it highly desirable to limit their planning roles.[6] Thus, in most cases, the HSAs were to be not public but private, nonprofit agencies. But if the designers disdained conventional politics, they valued pluralism highly. They recognized that providers, consumers, and other community interests must be involved in plan development and viewed the HSA as a suitable forum for working out their differences precisely *because* it was a new and self-contained organization, at arms length from the "pols" and civil servants. Even so the "partisan mutual adjustment"[7] of interest group interaction was not what the designers had in mind: the planning process was to be rigorous, technocratic, and rational.[8] Presumably these qualities were thought to follow from the emphasis the designers placed on "checks and balances," on fashioning a structure that would withstand the dominance of politician, bureaucrat, and professional alike, and indeed of any single special interest. Agencies endowed with the countervailing power of a consumer majority and an admixture of various community "factions" would arrive at a reasonable and efficient understanding of the community's true interest and then embody it in plans.

There is room for disagreement over whether this blend of antipolitical animus, pluralism, technocracy, and countervailing power was a coup of theoretical ingenuity or a fatuously inplausible construct. It is beyond doubt, however, that the cohesion of this precarious assemblage of values and processes depends heavily on the structure of the HSA and its related institutions. If for some reason the HSA organizations fail to work as intended,

the premises of the program cannot be maintained and the expected conclusions do not follow. It is useful therefore to turn to the three structural questions mentioned at the start of this paper--organizational, environmental, and federal--and examine the realism of the designers' work.

THE HSA AS AN ORGANIZATION

Examination of the organizational structure of the HSAs usually, and properly, begins with analysis of the HSA board. In 1977, for example, Bruce Vladeck persuasively argued that the HSA strategy and structure are in many ways at odds. Assembling around a table representatives of a wide range of local interests is not likely to produce the dispassionate and rational planning modeled in the texts. Instead it creates a highly politicized body in which the surest road to consensus is the splitting of particularistic and parochial differences by means of bargaining, logrolling, and pork barreling.[9]

HSA's behavior cannot be entirely predicted from the composition of their governing boards, however, for these boards are but the tip of an organizational iceberg. The boards consist of part-time "volunteers" meeting intermittently to consider proposals developed in other settings. These other settings--the work units of the organization--deserve attention in their own right. First, however, it is necessary to consider the nature of the HSA's work.

The HSA's mandated mission is broad, complex, and ambiguous. According to one account, "The agency's primary responsibility is the provision of effective health planning for its area and the promotion of the development (within the area) of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies and implement the health plans of the agency."[10] This definition emphasizes "planning" and "promotion." Yet the same account implies that the heart of the HSA's mission may be mainly research. For example: "The Plans must . . . describe and characterize the status of the entire health system, noting the effects that changes in one part of the system may have on other parts. . . ." They must emphasize "a systemwide approach with specified, quantified goals, and the addition of information on costs and financing

(and the effects of proposed goals on cost containment goals). . . . Moreover, "the agency must consider the array of influences on health. In developing their plans . . . agencies are expected to identify all relevant health factors and problems . . . and where possible isolate those conditions which can be addressed by the delivery system. . . ."[11]

In practice, however, it appears that a fourth mission may be most important: cost containment by means of regulation of capital investment. A recent study of health planning in New England found that most of the agencies studied "accept regulation as their first priority. . . ."[12] And Basil Mott writes that "cost containment is the driving force behind P.L. 93-641."[13]

There appear, then, to be at least four distinct components to the HSA mission: research, planning, regulation, and advocacy (promotion). Unfortunately, organizational arrangements suitable for one of these tasks may not be suitable for others. For example, the very systematic and ambitious research described above will require the skills of highly trained academic experts and will take years. Planning presupposes an adequate research base to support the plans, but requires a rather different mix of skills: not the ability to do research but rather the capacity to understand it and to apply it intelligently and flexibly to the specifics of a local situation. Regulation calls for a high degree of legal and political skill for it entails the application of a plan to institutions and the defense of those applications against the laments (and suits) of aggrieved interests. Advocacy, finally, requires a talent for reducing complex matters to readily understandable terms, the rhetorical power to stir the blood, and the organizational ability to mobilize some community interests for and against others. It is difficult to picture one agency performing well all four tasks simultaneously.

Given the breadth, diversity, and complexity of the HSA missions, it is not surprising that participants sometimes express uncertainty over the nature of the enterprise on which they have embarked. As the executive director of an HSA in Washington State put it in an interview: "A basic underlying problem is, it's sort of like building a ship. It's a big enterprise. You have to put all the parts together. But it's not been decided what kind of ship it's going to be, or even if it's going to be a ship, or what it's evolving toward." Some even appear to

doubt whether the HSAs are principally health agencies at all. Thus, Checkoway cites one director who describes the HSA as a "social planning agency focusing on health" and another who views it as "an agency for social change."[14]

A rationally designed program would presumably begin by deciding the "outputs" it wishes to achieve, would then prescribe "processes" (activities) that conduce toward those ends, and would finally define the "inputs" (personnel and other resources) needed to sustain those processes. The intended outputs of the planning process may be interpreted to be anything from cost containment to social change, with many ambiguous possibilities in between. The prescribed processes encompass research, planning, regulation, and advocacy. And it is questionable that the participatory, corporative structure of the HSAs is well suited to support any, let alone all, of these processes.

Because each of the various ends and activities has influential proponents, HSAs must attempt in practice to honor all of them. In essence, the HSA mission is to assemble a representative and committee subset of community volunteers and then bring these members together to canvass rigorously and scientifically virtually the entire range of health needs and resources in the community, "compare" (in some sense) needs with resources, devise a long-range plan that rationally relates needs to resources, and then rework the long-term plan into a short-term plan of sufficient clarity and specificity that it may serve as a defensible basis for making detailed decisions about resources and services in the area in the present and future. It need hardly be said that these are not easy tasks. No one knows how to make these judgments "in general." Although various planning methodologies may be culled from the literature, none is self-evidently correct, and partisans dispute hotly about the merits of different approaches.[15] The problem is aggravated by the HSA structure, which transforms the agency's environment into organizational participants. HSA board members meet collectively only on occasion and many may be only casually interested in a matter at hand. But that matter may be of intense and immediate concern to a subset of board members or to well-connected executives of local health care organizations. Therefore, if the HSA is to go beyond the formulation of bland and nonspecific plans, it must be prepared to fight--within its own ranks and in the community--for the stand it takes.

The central organizational problem of the HSAs is how to make their herculean tasks--"near impossible" of attainment[16]--more nearly manageable. Their response is the age-old expedient of division of labor; that is, they divide their members and staff into subgroups and ask them to specialize in portions of the tasks at hand. Division of labor in HSAs takes three main forms: committees, staff, and subarea councils (SACs). The heart of HSA decision-making is to be found in these three subunits. But these subunits, vital as they are to the organization's workings, also act as centrifugal forces, pulling control away from the center (the executive director and the board) and fragmenting the agency's identity and unity of viewpoint. HSA management is therefore a constant and sometimes hopeless struggle to reconcile the virtues of comprehensive planning with the virtues of decentralized work groups.

Committees

Like other organizations facing complex tasks, the HSA's first and basic response to complexity is to break up and farm it out. Thus, an HSA usually divides its board members into a half-dozen or more subject-matter committees, each comprised of roughly 5 to 10 members, roughly half consumer and half provider.[17] Committees tend to be of four general types: (1) administration--personnel, budget, and so on, of which no further account will be taken here; (2) "need assessment"--primary care, mental health, prevention, and the like (these committees concentrate on documenting and advancing neglected needs and services); (3) regulatory--especially facilities and grant review; and (4) plan development--drawing up the long- and short-term plans on which HSA decisions are expected to rest, or at any rate, with which they are supposed to be consistent. The committees institutionalize within the agency a split personality. Need assessment committees make it their business to act as spokesmen for more and new services. Regulatory committees are asked to make constraining decisions that require trimming fat and arguing for "less." There is no logical reason why the two tasks must conflict, why denying new acute care beds to a hospital must complicate assessment of the need for a new outpatient clinic. In many cases complications do

arise, however. One reason is that meeting needs may require new grant funds or new facilities. Another is that hospitals themselves may suggest such compromises as expansion of outpatient services in exchange for a favorable HSA recommendation on a bed expansion, modernization project, or new piece of equipment. In these cases, relations between the need assessment and regulatory committees can become confused or conflictual, and the plan development committees, expected to produce a document that both saves money and does justice to the community's real (including its "unmet") needs, may get caught in the cross fire.

Aggregating committee positions into a united agency stand is further complicated by the need for plan development committees to assume a holistic, "systemwide" perspective, while the need assessment and regulatory committees adopt what might be termed an "institutional" orientation. Their decisions turn on such questions as whether institution *X* is doing all it could for (say) the cause of health education, whether it has demonstrated that the community needs its proposed construction or modernization project, and so forth.

Staff

Because their members are part-time volunteers and their tasks are very broad and complex, HSAs depend heavily on full-time staff. Yet, staff recruitment is often more difficult than recruiting members of the board. HSAs are new bodies, with uncertain futures, sometimes in fairly remote locations, therefore offering uncertain career prospects, and relatively low salaries. None of this necessarily bothers board members who have volunteered their interest in health planning, call their communities their home, participate "on the side," and do not get paid. All of it, however, may trouble staffers who wish to advance their careers, may be compelled to relocate families, will work for the HSA full-time, and must make a decent living. For these reasons, an HSA staff position is likely to be attractive mainly to young men and women with master's degrees in health planning or administration (or related fields), often hesitating between a personal or ideological commitment to planning and public service, and the practical advantages of a university doctoral program, a job in the private sector, or a civil service career. Staff, then, are

"plan-oriented"; they are offered an HSA job because they are thought to command the "how to do it" methodological skills of which planning is thought to consist, and they accept such an offer because they are eager to practice their planning skills in the public interest (at least for a time).[18]

Staff are indispensable, but integrating a corps of planning experts into a multifactional, lay-dominated HSA poses problems. First, suitable staff are difficult to recruit and retain. For several reasons--clashes with the agency's director, isolated location of the agency, low salaries, and heavy workloads, for example[19]--high staff turnover has been a problem for many HSAs. Turnover means not only the loss of manpower, but also in many cases the loss of the one or few persons who truly understood (or claimed to understand) the arcane assumptions and quantitative methods that support the plan. When the staffer who patiently and at length managed to persuade the members of the facilities review committee and then the HSA board as a whole that the "Walsh-Bicknell" approach is the one true method of evaluating certificate of need applications departs and is replaced by a colleague with severe reservations about Walsh-Bicknell but full confidence in a rival method, the ensuing "reorienting and training and a new approach to the planning process"[20] may leave consumers and providers alike glassy-eyed and disgusted.

Even if staff tenure is long, however, the danger that the laymen will feel taken in or otherwise ill-served by staff remains. Staff tend to make an odd mix with local consumers and medical professionals on the board and in committees, most of whom know a lot about their communities and institutions and little about the formalities of planning. Whereas board and committee members are apt to emphasize the particular needs, roles, and failings of particular institutions, staff tend to concentrate on the proper role of one institution in the context of others, that is, in the overall plan. Volunteers may then consider the staff to be unduly rigid and may fear that they are being pushed or backed by staff into positions they do not really want to endorse. In the words of the Consumer Coalition for Health:[21]

> Many participants in the planning process, consumer and provider alike, complain about staff control of information, deadlines, etc. Staff *rarely* are