Comprehensive Health Planning: Dreams and Realities

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Comprehensive Health Planning legislation was signed into law by President Johnson on November 3, 1966. Since that time frequent attacks have been made on CHP agencies for an alleged lack of significant accomplishment. This article considers such criticisms in the light of the objectives of CHP legislation, the dimensions of the problems involved in effecting change in the American medical care system, and the provisions of the legislation itself. The role which planning for health care is likely to perform in the future is also examined.

On November 3, 1966, President Johnson signed into law PL 89-749—the "Comprehensive Health Planning and Public Health Services Amendments of 1966." Commonly referred to as "Partnership for Health" or "Comprehensive Health Planning," this piece of legislation was accompanied by great hopes for a rationalization of what has recently come to be called the American medical care "non-system." President Johnson heralded the legislation as a notable event in the history of American medical care and Secretary Gardner of the Department of Health, Education, and Welfare expressed the belief that PL 89-749 would be one of the most significant health measures ever passed by Congress. The assumption made by many at that time was that the provisions of this legislation would facilitate a more consumer-oriented medical care industry and that the country would benefit from the application of sophisticated planning technology to problems of the health care sector.

Eight years after the signing of the original CHP legislation and seven years after funds were first appropriated (funds were first made available on July 1, 1967), much criticism has been leveled at an alleged lack of accomplishment on the part of CHP agencies. There has been great dissatisfaction on the part of many with an ostensibly widespread disparity between the theoretical promise of CHP and its actual performance. Although all fifty-six of the states and territories eligible for federal support under the CHP program have received grants and are conducting such programs, re-

proaches such as the "planlessness of the planning movement" and the "futility of exercises in planning to plan" are heard frequently.

The intent of this article is to examine CHP both in terms of the objectives of the original legislation and in terms of the dimensions of the problems which have to be faced in the attainment of those objectives. First a review will be made of the goals of "Partnership for Health" legislation as derived from a brief examination of PL 89-749. Secondly, the contemporary medical care system in the United States will be studied with a view toward assessing the scope and magnitude of the problems faced by those interested in reform. Finally, there will be a discussion of the true possibilities for achieving substantive change under PL 89-749 and a prognosis for the future of the planning movement in the medical care industry.

Goals of Legislation

> . . . to assure comprehensive health care services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts (U. S. Congress, 1966).

As indicated above, the purpose of PL 89-749 is to encourage and help finance the development of comprehensive planning for health services, health manpower, and health facilities, involving every level of government, in voluntary cooperation with the private sector. The legislation has five major provisions:

1. Grants to States for Comprehensive State Health Planning

PL 89-749 stipulated that the largest unit to perform comprehensive health planning should be at the state level. The legislation made available complete federal subsidies (allocated to state units on the basis of population and per capita income) for financing a single agency in each state to administer that state's health-planning function. Each one of these state agencies was required to create a state health-planning council, composed of representatives of public and private agencies concerned with health services. The function of this council is to advise this designated state agency, commonly known as the "A" agency. The duties of the state "A" agency include the formulation and continuous updating of a com-

prehensive state plan for the delivery of health services and the coordination of those planning activities of other publicly and privately financed agencies which relate to health services.

2. Project Grants for Areawide Health Planning

Upon the approval of the state "A" agency, the law also authorized federal funds for the financing of comprehensive regional, metropolitan, or other local area health-planning agencies. These agencies are usually referred to as "B" agencies, or "areawide" agencies. Unlike the "A" agencies, "B" agencies must finance 25 to 50 percent of their budget with local contributions. The functions of the "B" agencies parallel those of the "A" agencies mentioned above, but relate to a more geographically limited "medical catchment" area. Additionally, the "B" agencies are expected to coordinate their local area plans with the state "A" agency, which comments on their work programs before they are sent to Washington for funding. The "B" agencies also are required to have advisory boards, the majority of whose members are to be composed of representatives of consumers of health services in that area.

3. Grants for Training Health Planners

PL 89-749 also authorized Congress to appropriate funds for grants to public or non-profit private agencies "to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation." This provision acknowledged both the key position of planners to the effectiveness of CHP and the shortage of personnel trained in health planning which existed at that time.

4. Grants for Comprehensive Public Health Services

Prior to PL 89-749, federal funds for medical care projects were granted to the states according to specific categories (e.g., cancer, mental illness, heart disease). The major intent of this provision of the law was to grant the states flexibility in the use of federal funds by removing many of the categorical restrictions which existed prior to that time. As a result of these categorical restrictions, the states had previously been required to construct their programs with an eye on the specific federal monies available, rather than solely on the basis of the particular health requirements of the individual state. Federal funds could not be transferred from

one category to another by the state. It was hoped that the elimination of these categories would reduce the discontinuities which had developed in the patterns of services available and enable states to use federal funds more effectively.

5. Project Grants for Health Services Development

Under this provision, PL 89-749 also made available monies to public or non-profit organizations for providing services to meet health needs, for stimulating and supporting (for an initial period) new programs of health services, and for undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services. It was required that such grant requests be reviewed by both state and regional comprehensive health-planning agencies as well as the federal government.

Many of the objectives of this legislation can be deduced from reading these brief descriptions of the major provisions of PL 89-749. One of the principal goals of the legislation was that the health-planning process be comprehensive. Long before 1966 individual segments of the medical care industry had been planning for their own institutional and professional futures. Hospitals, nursing homes, physicians, and other providers were well versed in the advantages to be gleaned from regular and systematic planning for the future. However, most of this planning took place without the benefit of an over-all appraisal of the future of the medical care system as a whole. Providers were accused of being myopic for not looking beyond their own spheres of interest and for not seeking to broaden their personal perceptions of patient well-being. Comprehensive Health Planning—on the other hand—was given the responsibility of looking at the system as an operating unit. From this viewpoint efficiency requires detailed knowledge of the functions and interrelationships of all elements within the system. Evidence exists which has indicated surprisingly little communication between health providers, even within the same local community. One of the obvious challenges to CHP was to take a more macroscopic view of the health care system.

Closely related to the objective of making medical care planning comprehensive was the desire to involve representatives of consumers in the decision-making process. Prior to PL 89-749, most of the decisions about the allocation of resources within the

medical care industry were made by the various provider groups, without any direct input from consumers. The growth of third-party financing for medical care (i.e., the government and insurance companies) has made financial considerations more remote from the consumer and has probably made the system less responsive to the wishes of the public. The scarcity of medical care resources has further reduced the market power of the consumer. Providers have sometimes been accused of making decisions more in accordance with their own interests than in accordance with the interests of consumers. In order to reduce the power of those with vested interests, CHP legislation required that the majority of the membership of the boards serving as advisers to the planning agencies be composed of representatives of the consumers of health services.

Another clearly apparent objective of the legislation was that the health-planning process be decentralized. As noted above, PL 89-749 stipulated that the largest unit to perform health planning was to be at the state level. Furthermore, the local "B" agencies, active on the "grass-roots" level, were given significant responsibilities in the planning process. The advantages of such decentralization are multifold. Such a system tends to avoid the inertia and lack of responsiveness of a highly centralized system. Furthermore, the benefits to be derived from an intimate knowledge of the local situation can more easily be elicited through regionalized agencies. Coordination of federally funded programs and recommendations attuned to local political realities are accomplished more effectively at the local level.

Another element running throughout the legislation—and sometimes in apparent conflict with the other aspirations of the law—is the desire for minimal interference with the existing medical care system. In the words of the legislation, ". . . without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts." Clearly the intent of the law was not the imposition of a monolithic master plan. CHP legislation did not establish an elaborate regulatory mechanism to control the medical care industry, but rather was designed to accommodate the pluralistic and predominantly private nature of our health care system. The underlying assumption of PL 89-749 was that, although planned change was necessary, evolutionary

change—rather than revolutionary upheaval—had a far greater potential for political acceptance and ultimate success.

In view of the underlying philosophy of PL 89-749, how well equipped were the CHP agencies to become a significant influence in the rationalization of the American medical care industry? Were the various elements of the health-planning movement provided with the power necessary to bring about substantive change? Stated briefly, were they given power commensurate with their responsibilities? Any attempt to answer these questions must begin with an examination of the fundamental characteristics of the medical care industry in the United States at this point in our history.

The Medical Care Industry

The American medical care industry is exceedingly large and complex. Ranking behind only agriculture and construction in magnitude, expenditures for its services constitute approximately 8 percent of the Gross National Product and continue to grow each year. Unfortunately, many of the same characteristics which make this industry unsuitable for the purely competitive system of the marketplace also make it rather unamenable to the planning processes of governmental and quasi-governmental agencies.

Perhaps the most fundamental problem in analyzing the medical care industry is the type of "output" with which it deals. This problem has many facets, an important one of which is the fact that—for the most part—medical care "output" consists of services, rather than goods. Service industries are always more difficult for the consumer (and the economist) to deal with because of the intangible nature of the end product. When the service is medical in nature, the problem is compounded several times.

One of the major problems of service industries is the difficulty of assessing the quality of output. Standards and other measures of performance can usually be established and utilized with fairly simple procedures when the end product is a "good" rather than a "service." Sampling techniques, tolerance limits, inspection processes, etc., can readily be established for measuring and/or maintaining performance. When the output is a service, however,

quality assessment can be very difficult. In many cases the perceived quality of the service—over very wide ranges—is largely contingent upon the subjective predispositions of the consumer. This is particularly true when the service is very complex. For example, the level of sophistication required to be a truly knowledgeable consumer of medical services has increased tremendously during the last decade, and the average citizen is well below this level. Even the measures being devised by professionals are relatively crude and the subject of much controversy.

Another aspect of the "output" measurement problem is the fact that many, many factors affect health status, and it is very often difficult to ascertain either the precise cause of a particular problem or the best combination of factors to remedy the situation. Physical environment, housing patterns, dietary habits, heredity, life style, etc., all contribute to health status and variations in these factors make facile comparisons between different countries—or even within one country—grossly unreliable. Furthermore, since many medical problems are either self-limiting or beyond the healing capacity of contemporary medicine, the contribution of modern medicine to better health is very difficult to estimate.

Most of the above considerations are summarized by the economist in the statement that it is exceedingly hard to specify production functions in medical care. Here more than in almost any other industry it is extraordinarily difficult to specify all the various combinations of inputs which will produce a given result, determine the costs of these various options, and then specify the most efficient alternative. One has only to examine the literature concerning the advantages and disadvantages of solo, fee-for-service medicine versus prepaid group practice, or the topic of economies of scale in reference to hospital size, in order to realize that the answers to some very fundamental questions are far from clear. Of late even the previously widely held assertion that there is a serious shortage of physicians in the United States has been opened for debate (Ginzberg, 1969: 100-110).

The traditional institutional structure of medical care in the United States is also inimical to health planning. In large part because of the complex nature of the services rendered and because of the fact that most of these services are considered necessities, certain characteristics have evolved with which the

analyst has great difficulty coping. These properties differentiate the medical care industry from most other American industries, and have placed this sector beyond many of the standard analytical models.

One property which is of constant frustration to the analyst is the not-for-profit nature of perhaps the most visible segment of the industry—the hospital sector. Because the predominant ethic has considered it unjust for institutions to profit on human misery, the vast majority of American hospitals are non-proprietary. This has posed innumerable problems for students of hospital behavior. If hospitals do not operate so as to maximize profits, as do most capitalistic institutions, what is the fundamental motive of operation? If it is to maximize patient well-being, how does this rather vague *modus operandi* determine efficient resource allocation? Who determines what constitutes maximum well-being for the patient, and how it is to be attained in this important sector of the medical care industry? How are cost considerations programed into decisions? Is the decision-making authority in the hands of the medical staff? Or is it vested in the hands of the ever-growing number of professional hospital administrators? Or is it in the hands of the boards of directors of the hospitals?

Another qualitative factor which profoundly affects hospital operation is the relatively high incidence of direct religious affiliation. An immigrant- and strongly church-oriented nation placed reliance on its organized religions for much of its medical care. Today, our much more secular society still continues to witness a close relationship between medicine and religion. To what extent does this influence efficiency? To what extent does the authority over hospital decisions of the local bishop or other religious authorities bode well or ill to the practice of medicine in this country? Religious affiliation is just one more qualitative property contributing in no clearly predictable fashion to an already analytically complex situation.

An additional institutional consideration is the influence of the major professional organization of the most important human input in medical care—the physician. The American Medical Association has without doubt been a major force in shaping the health care industry in the United States. It has profoundly affected the educa-

tion of physicians, the number of physicians, the medical decision-making process—both inside and outside of hospitals, the forms of medical practice (e.g., solo, fee-for-service medicine versus pre-paid group practice), and governmental legislation concerning the industry. Although there is some evidence which indicates that the impact of the AMA on American medicine may be declining, it has been a major force in fashioning the system as it operates today and will continue to be a major political force affecting the direction of change in the future. In view of the length of time and the amount of money invested by physicians in their education and the difficulties of participating in continuing education programs, it is perhaps too much to expect that their professional organization will be particularly open to substantive changes in the way medical care is practiced in this country.

No itemization of the factors which make planning difficult in the medical care industry in America—no matter how brief—should fail to note the importance of the profound ethical decisions which recent technological developments and social changes have thrust onto the medical care scene. Abortion, sterilization, and artificial insemination. Organ transplants, psychosurgery, euthanasia, and renal dialysis. If amendments to the Social Security Act have determined that some of the costs of kidney diseases should be shouldered by a federal insurance mechanism, why not support financially the victims of other similarly serious diseases? What is the value of a human life, and who will determine the priorities between individuals—as well as diseases? Should "extraordinary" methods to support life receive governmental support, and who will determine what is extraordinary?" Should we do all that we are capable of doing, or should technology be the servant rather than the master in medical matters? On a more aggregative level, since we live in a world of limited resources, what portion of them do we want to devote to medical care?

All these ethical decisions are being made today and many more will have to be made in the future. But the question germane to this discussion is how do we "plan" for such decision making? The Supreme Court and the legislative processes operate—perhaps fortunately—on a time-lag basis. One need only witness the recent rulings on abortion. But such a time-lag luxury is not available to

those attempting to plan for the future. How does a governmental or quasi-governmental planning body deal with unsettled moral and legal questions? How does a planning body—whose function is to assist in making rational judgments concerning resource allocation—equip itself to deal with questions involving deeply held human values in a rapidly changing and heterogeneous social system?

This brief review of some of the major characteristics of the American medical care industry serves to illustrate the magnitude of the problems faced by Comprehensive Health Planning. The nature of the services provided by the industry together with its distinctive institutional considerations have contributed to making it an exceedingly difficult industry to approach analytically. It is characterized by quality considerations and subjective judgments. Quantitative information is often not available, and even when it is, it is seldom the decisive factor in decision making. In the words of the economist Victor Fuchs, "The practice of medicine is still more an art than a science. The intimate nature of the relationship between patient and doctor, the vital character of the service rendered, and the heavy responsibilities assumed by medical personnel suggest the dangers inherent in reducing health to matters of balance sheets, or supply and demand curves" (1966: 95). The next section discusses PL 89-749 and the possibilities for achieving significant change under this legislation.

Potential for Change Under PL 89-749

As indicated above, many of the prerequisites for effective planning—in any precise sense of the term—were not present at the time CHP legislation was passed. Furthermore, these conditions could not have been brought into existence by any legislation. Such planning assumes that rational, objective bases for decisions exist. Many substantive decisions in the medical care industry cannot be made on such bases. In a situation where qualitative factors are of pre-eminent importance, and where production-function data are not available and cannot be obtained with any precision, it was clearly overly optimistic to have expected substantial change in the

short-run. The infrastructure necessary for such change was just not present.

Furthermore, health planning was thrust into an environment which could at best be described as unfriendly and—probably more accurately—as openly hostile. Generally speaking, social planning has not been popular in any form in America. In a pluralistic and individualistic culture, this type of planning is seen as contrary to such revered traditions as individual freedom and the free enterprise system. Connoting regulation, coercion, forced interdependence, invasion of personal and institutional privacy, and disruption of the status quo, the concept of planning has always resurrected the typically American fear of excessive governmental intervention. The planning process assumes that those involved are ready to let some supra group decide what is best for them, and such a notion is relatively new to Americans. This is particularly true in an industry which has traditionally attracted people who have a strong desire to be autonomous.

In addition to the numerous analytical, institutional, and philosophical obstacles which CHP faced in 1966, there were other obstacles relating to the legislation itself. Perhaps one of the major deficiencies of PL 89-749 was that it gave no clear definition of what was intended by "planning for health," nor did it detail the processes and procedures by which such planning was to take place. It has been claimed by some that the absence of detailed federal guidelines was deliberate (Strauss and deGroot, 1971: 657) and it is undoubtedly true that the flexibility granted to the individual agencies was in some respects beneficial. However, the absence of specific goals and specific criteria to evaluate progress toward their attainment must be viewed on balance as a deficiency of the legislation. Particularly in view of the fact that health planning at that time was in its infancy stage and that there existed an extreme shortage of personnel educated in this field, more substantive guidelines at the federal level would undoubtedly have been of great value in reducing some of the confusion and wheel spinning which characterized CHP agencies in their early years.

PL 89-749 also did little in the way of granting CHP agencies the power necessary to bring about change in the medical care industry. In fact, as noted above, the act clearly specified that CHP

agencies were to conduct themselves in a manner so as not to interfere "with existing patterns of private professional practice of medicine, dentistry and related healing arts." The only real power that the agencies were given was the power to comment and make recommendations upon requests which involved federal funding (for example, the Hill-Burton program). Given the capacity of the private sector to generate its own funds, this power to influence federal financing can only be described as inadequate. Beyond this review and comment responsibility, CHP's power depended on the influence they were able to muster in the local community. Their only real source of leverage was whatever ability they had to influence the allocation of other public and philanthropic funds for capital programs. Beyond that, they were given no positive measures to effect more efficient performance. The lack of power granted to CHP agencies by PL 89-749 has been decried by Cyril Roseman: (1972: 17) "Philosophically, CHP lacks any mission but continuing consultation about what might be wrong with health care delivery . . . . no mechanisms for action have ever been provided."

Another clear and debilitating weakness of PL 89-749 is to be found in the provisions it established for the financing of "B" agencies. As mentioned above, "B" agency activities are to be financed with federal "matching" monies which are contingent upon very substantial contributions from local sources. The effective financial constraint on the "B" agency lies, therefore, in the amount of money it can raise from local sources.

In a world where the competition for private donations to public causes is intense, to expect that a new and unproved agency would be able to attract a large volume of "untied" donations was expecting a great deal. Many more traditional and widely accepted causes preceded the creation of CHP. The accomplishments of a planning agency—by their very nature—cannot be widely advertised. Much of their work involved arbitration between contending institutions where public knowledge would be a detriment to progress. Highly visible attainments are the exception rather than the rule, and this fact handicaps the "B" agency in its ability to raise local contributions.

The difficulty of raising funds works many hardships on "B" agencies. Financial viability becomes a concern all out of propor-

tion and causes the planning effort to suffer. Inordinate amounts of both staff and board energies are devoted to fund raising. Many long-term programs cannot be wisely undertaken for fear that the funds for completion will not be available. Given a situation where gradual and long-term progress is perhaps the best that can be anticipated, funding uncertainties inhibit action.

Similarly, these funding arrangements profoundly influence staff effectiveness. If—as is currently the case—the majority of non-federal funds are derived from local medical care institutions, there is a danger that the staff will not always operate in a completely objective manner. It is also clear that in some cases the inability to attain a proper funding level has caused the size of the professional staff to be below optimum. Furthermore, when tremendous uncertainty exists concerning the viability of the organization, staff members are inclined to devote much of their time to maintaining their mobility into other areas of the medical care industry. It is unlikely that these factors will contribute to the effectiveness and objectivity of CHP agencies.

The provisions of the legislation designed to assure strong consumer participation on the boards of CHP agencies also did not warrant the great expectations which many held for them. Although the legislation required that consumers were to constitute a majority of these boards, their influence has not been proportional to their numbers. Perhaps the nature of the medical care industry predetermined that this would be so, but weaknesses in the legislation certainly contributed.

From the very beginning, the assumption that consumers on the board would function as a strong interest group was hardly justified. This is particularly true because the legislation enunciated neither a clear definition concerning what constituted being a "consumer" nor any requirements for proportional representation from the different ethnic-social-economic classes. Neither did the legislation provide any mechanism by which consumers would be held responsible to their constituencies. As a result many of the consumers on these boards—although not directly engaged in providing medical services—are affiliated with the provision of medical care in one way or another, such as through board membership on hospitals in the region. As one might expect, the views of these consumers are on many issues more in sympathy with the

providers on the board rather than with other consumers. Because proportional representation from different social classes was not required, many segments of the population are either poorly represented or not represented at all. With no formal mechanism for accountability, consumer members are free either not to participate in board activities at all (which is very common), or to participate only when a topic which is of particular concern to them is on the agenda.

In reality, there is little motivation for a truly disinterested consumer to participate in the planning process via board membership. Since health-planning agencies are relatively new and very controversial, they could hardly have been expected to attract a sufficient number of civic leaders who already had many more traditional and widely esteemed outlets for their energies. A good medical care system does create many positive externalities, but—since civic leaders usually have easy access to good health care in any case—it is unlikely that these externalities alone would be enough to justify the amount of contention and controversy which truly effective participation requires.

Briefly then, the obstacles to effective consumer participation on CHP boards are very great. Civic leaders are not likely to be attracted in sufficient numbers. Other truly disinterested and well-motivated consumers frequently feel themselves at a tremendous disadvantage because of the technical jargon and highly educated background of the provider representatives. Whereas providers have well-specified and professionally important objectives to be accomplished by their participation, the reward for the considerable amount of work and controversy necessary to become a well-informed consumer representative is relatively meager. Few people in today's society have either the leisure or the motivation to fulfill such an important role in a truly adequate fashion.

The consequences which may result from these obstacles to effective consumer participation are relatively clear. Well-motivated and highly articulate providers can have an influence in the control of planning agencies which is far greater than their numbers would indicate. Consumers are likely to feel the frustrations of being ill-equipped to handle their roles effectively. Except when issues which are of special importance to them come on the agenda, consumers are likely either to not attend the board meetings at all

or to fail to participate in the discussions when they do attend. The same forces apply to attendance and participation at board committee meetings, where most of the issues of substance are determined.

The Future of Planning for Health Services

To many, particularly those in the planning profession, the tenor of this article undoubtedly seems excessively bleak as far as the contribution of planning as a mechanism for improving the status of health care in the United States is concerned. The output of the medical care industry is a very complex service, where quality considerations—always difficult to measure—are of paramount importance, and knowledge of production-function relationships is meager. Furthermore, the institutional characteristics which have evolved around the practice of medicine in this country and the prevalent attitudes toward social planning have added further dimensions of difficulty to an already Herculean task.

The reason for this rather extensive enumeration of the difficulties of planning in the health care arena and the inadequacies of PL 89-749 has been to illustrate the size of the problems faced by CHP agencies since 1967. In view of these analytical and institutional difficulties and the rather schizoid nature of legislation designed to accomplish substantive change "without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts," much of the criticism which has been leveled at CHP is unwarranted. To blame comprehensive health planning agencies for not eradicating in eight years the faults which have been accumulating for decades is "to seek scapegoats rather than solutions" (Strauss and deGroot, 1971:657).

In spite of some current dissatisfaction with CHP, it is highly probable that the future will involve much more health planning than does the present. The need for health planning will guarantee its continued existence. The American people and their representatives are increasingly vocal in their dissatisfaction with access to medical care and the cost and quality of the medical care which they do receive. Since America is among the top nations of the

world in the percentage of GNP devoted to medical care, its people are disturbed when they read of the rankings of the United States in the various measures used to indicate international health status. Furthermore, they hold the medical care industry responsible for these rankings, even though such statistics are of dubious value as a measure of the impact of a health care system. Americans in general are increasingly dissatisfied with both the absolute and relative status of the health care delivery system in the United States.

Accompanying this dissatisfaction with the performance of the medical care industry are more and more legislative proposals for various degrees of increased governmental involvement in the industry. Immediate problems are so critical, and have been so well publicized—see, for example, Kennedy (1972)—that the electorate is apparently willing to sanction a much larger governmental role, particularly at the federal level. The government is currently the single largest bill payer in this industry, and taxpayers are looking to it for an increased level of leadership and accountability. In their role as bill payers, governmental agencies are being charged with the functions of a countervailing power and consumer advocate, functions which private health insurance companies have been accused of not performing with any degree of enthusiasm or success in the past. It is likely that some form of national health insurance will be adopted in this country in the near future. Furthermore, it is highly improbable that the strongly inflationary effects of Medicare and Medicaid, where the government assumed financing responsibilities without making significant efforts to increase the availability of medical services, will be permitted to occur again. As the government continues to increase its role relative to the market, planning will serve as an increasingly important tool in the allocation of scarce resources in the health care industry.

Currently, actions at both the state and federal level seem to be highlighting the importance of Comprehensive Health Planning. State "Certificate of Need" legislation, which has become more and more common in recent years, frequently utilizes the "review and comment" processes of CHP. Recent "HR 1" legislation (PL 92-603) also increases the authority and responsibilities of these agencies. The Regional Medical Program, often considered in some respects a competitor of CHP, was recommended for a gradual phase-out by the Nixon administration. In general, there appears to

be a change in emphasis at the federal level away from medical research and the actual production of health services by the government and toward improving a predominantly private—but regulated—delivery system. With this new emphasis, the government will undoubtedly use planning as an important ingredient in its attempts to improve efficiency and effectiveness.

A question which is more difficult to answer than whether or not health planning will exist in the future is the question of the form in which it will exist. Since for the foreseeable future aspirations for better health care are likely to exceed the resources available to satisfy these aspirations, how will health planning be utilized as a device for bridging these shortages? What are the functions which health-planning agencies will be expected to perform, and what are the mechanisms they will employ to accomplish their objectives?

It would be a waste of effort to deliberate at length over the precise structures which will characterize health planning in the future. PL 89-749 was not the first attempt which this nation has made to utilize planning in order to improve the health care system, and further legislative efforts are to be expected in the future. Structures and processes will continue to evolve building upon experiences of the past and developments in the technology of planning. However, certain major characteristics of the planning mechanism can be foreseen and certain crucial problem areas anticipated.

It is most likely that health planning will continue to pursue its so-called "forum" function. Particularly at the "B" agency level, CHP will go on serving as a common meeting ground where individuals and institutions with their own vested interests can be exposed to the proposals and rationales of other groups within the community. As the pace of change in the delivery of medical care accelerates, cross-fertilization of ideas and information will be essential in order to coordinate the thinking and planning of all those who are concerned with the delivery system. By performing this function CHP has the potential to both identify possible areas of cooperation and to clarify specific areas of disagreement. This forum, with free and open debate, can serve as a potent power base for bringing beneficial change to the health care system. With both provider and consumer representation, many issues become public

knowledge and the system can utilize the political power of non-health participants as well as that of providers. In contentious situations merely getting the actors together is beneficial, and the presence of other participants can only serve to increase the potential catalytic effect of the planning agency.

Closely related to the forum function of health planning is its educational function. This function must be performed in such a way that all segments of the community are informed of both the issues and the alternatives involved in particular decision-making situations. Health care providers will have to be more responsive to changes in the value systems of the public they serve. Consumers must be made more aware of the decisions being made which profoundly affect the quality and quantity of medical services available to them. Particular effort will have to be given toward educating board members so that they can successfully meet their responsibilities. By serving on the councils of other agencies, as well as CHP, these board members can be of great value as conveyors of information to other segments of the community. The benefits of well-executed forum and education functions will be an improved environment for decision making—one in which informed judgments can be made by a wider spectrum of the concerned parties within the community.

However, a health-planning agency must serve as more than a forum for discussion and an educator of the community in health-related matters. It must also serve as the source of expertise and information to all those interested in issues relating to health care in the community. Not only must it collect and make available its own statistics, but it must also be knowledgeable concerning other sources of health data. Not only should it conduct its own research program into health-related problems, but it must also serve as the coordinator of research being conducted by others on these problems. It must serve as the authority in the technology of health planning and work with providers from the earliest stages of their planning in order to help them meet more successfully the needs of the community. Likewise it should serve as the authority on governmental regulations relating to health care. It is difficult, even for providers of medical care, to keep abreast of the details of regulations which appear to be always in a state of flux. These functions will profoundly increase the value of CHP to the local community.

The credibility of the health-planning movement depends to a great extent on its ability to transmit relevant information to local decision-making bodies.

In spite of the variety of legitimate functions health-planning agencies can perform for their communities, many problems will exist in their future. Some of these problem areas have been mentioned above. How can the prevalent American biases against social planning be overcome? How can a sufficient volume of funds be made available for the planning movement without sacrifice of objectivity or preoccupation with the mechanisms of fund raising? How can the multifold advantages of effective consumer participation be attained and the dangers of provider dominance minimized?

Other problematic issues will also have to be faced. One essential question concerns the amount of power which is necessary for CHP to contribute effectively to the reform of the health care system, yet not sufficient for it to be excessively authoritarian. The role of a health-planning agency in the area of regulation is one aspect of this problem. Although the power of CHP agencies would undoubtedly be increased if they were given regulatory authority, would not this type of power be inimical to their planning role? Additionally, regulatory agencies in the United States have sometimes been accused of being excessively sympathetic to the interests of those whom they are supposedly regulating. Would there be a danger then that, with regulatory responsibilities, CHP might serve more as a vehicle for maintaining the status quo than as an instrument for rationalizing the health care industry? For a discussion of the topic of regulation in the health field, see Somers (1969).

Another central question concerns the relationship between the staff and the boards of health-planning councils. Although the board is to be responsible for the actions of the council, there are obvious difficulties involved in successfully meeting these responsibilities. Both providers and consumers are limited in the time which they can devote to their health-planning activities. Unless they are personally familiar with the case under consideration (as is quite often the situation with providers), they are normally dependent upon the staff for information and data on the relevant issues. This gives the staff a relatively large degree of latitude and the power to influence decisions, either deliberately or inadvertently. Care must be taken that the board members do not

become a mere rubber stamp for decisions made by the professional staff of the council. Clearly, it is quite possible that in some cases there may be a substantial difference between the wishes of the staff and the wishes of the community.

Conclusion

The evolution of Comprehensive Health Planning which we have witnessed since 1966 has not been without disappointment to many of those interested in the rationalization of the American medical care system. However, much of this disappointment is unwarranted in view of the magnitude of the problem and the provisions of the legislation. The unrealistic objectives of legislative euphoria have led to unattainable expectations, disappointment, and disillusionment.

Some accomplishments, however, have been attained. Progress has been made throughout the country in the essential areas of data collection and research. CHP can also cite successes in such areas as consolidation of underutilized hospital facilities and regionalized programs of cancer therapy, renal dialysis, and family planning. Additionally, by working together with the providers of medical care, CHP has helped to reduce the construction of unnecessary medical care facilities. Organizationally, the experimentation of the earlier years with various forms of committee and board structure has served as the basis for more effective operating systems. Also, health-planning agencies have increased their visibility over this period, and this has improved their ability to attract qualified staff and board membership.

However, perhaps the most beneficial product of this evolution of CHP has been the growing awareness which has developed concerning the true capabilities of health-planning agencies at this juncture in our history. Much of the disappointment with CHP has been caused by a certain naiveté concerning the potential of the technology of planning in effecting beneficial change. The nature of medical care services is such that efforts made to change the system can very seldom be defended on purely objective bases which are acceptable to all parties concerned. Statistical data and quantitative analysis are absolutely necessary and fundamental to

the planning process. However, few areas of controversy can be resolved solely on the conclusions of this type of analysis. (Indeed, there is a danger that since certain aspects of problems can be quantified, that these aspects will be assigned a weighting by health planners which is beyond their true importance.)

With this awareness that few of the important issues concerning medical care can be settled on purely quantitative grounds, the role of politics in health planning has become more apparent. It is not surprising that many health planners have recoiled at the thought of "politicking" as one of their primary functions. The connotation of the word "politics" has seldom been salutary in America. However, in a fundamentally private (albeit regulated) industry—where planning agencies have very limited power—political skill is a very important ingredient in bringing about change. Persuasion, negotiation, and compromise are all essential ingredients in both arriving at and implementing decisions. It can be regarded as a mark of maturity that many of the protagonists in the health-planning movement are now willing to accept the role of politics without apology (Mott, 1969).

However, the essential ingredient, if health planning is to be a significant contributor to beneficial change in the future, an ingredient which has been sadly lacking over the last eight years, is real commitment to the planning process. This commitment must be made by the community in general, by the various levels of government, and—perhaps most importantly—by the providers of medical care. Without this commitment by providers—as evidenced by a willingness to work with planning agencies in the early stages of organizational planning, a willingness to negotiate with other parties affected by proposed changes, a willingness to actively participate in the CHP process even on topics which are not directly related to their own self-interest, and (under current legislation) a willingness to contribute financially to the support of CHP—planning activities will continue to be on an *ad hoc* basis and fundamentally defensive in nature. It is apparent that many providers have not been convinced that CHP is "here to stay" and have been withholding their commitment for this reason.

It is not difficult to understand why health providers have been reluctant to make a true commitment to the planning process. Undeniably this process makes decision making considerably more

difficult and tedious. Comprehensive planning opens decision making to many more actors, representing many more sets of interests, and with many different sets of values. Conflicts are unavoidable and action is much more difficult to initiate. In the words of Dr. Basil Mott (1973:11), formerly of the Harvard School of Public Health, "what we are really seeking is a new distribution of power."

Nevertheless, it has become increasingly apparent that it is in the best interests of the various providers of medical care to make this commitment. Failure to do so is likely to result in the creation of an environment in which it will be much more difficult for them to function. The problems which CHP legislation was designed to alleviate are still very much with us. Poor access, high cost, duplication of expensive facilities, etc., still characterize medical care in the United States. And the American public has definitely not shown any increase in its tolerance for the current situation. CHP, with its emphasis on strong provider participation in a local, decentralized decision-making process, is very likely to be superior to the alternatives which may replace it in the future should it prove to be ineffective. In this sense, providers have a great degree of common interest in seeing to it that CHP is a success. Voluntary planning cannot be successful without their cooperation, and the American public is likely to suffer from a much less responsive medical care system if providers continue to withhold this cooperation.

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