National Policies and Local Planning for Health Services

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The primary reason for health planning in this country is the numerous instances in which the interests of the individual, health-care institution and those of the community may diverge, as in the case of hospital staff appointments for physicians.

From a technical standpoint, it is much more difficult to plan for health services at the local level than nationally. Notwithstanding, health services are mostly provided at the local level, and health planning should be geared to the solution of local problems. In performing health planning, the local area can benefit from outside assistance.

In the past decade, local health planning has been hampered by unstable federal funding. The absence of national policies and guidelines has led to a constant quest for new ideas. In the absence of substantive concerns, requirements for consumer representation have led to a preoccupation with structure and organization.

What is required, in addition to steadier funding, is a fostering of local capabilities for health planning. Health planning organizations will require a good deal of technical assistance in the form of concrete ideas on ways to enhance the flexibility and versatility of health facilities and personnel, monitoring natural experiments and learning their lessons, and elucidating the public policy implications of empirical research findings and even of apposite propositions from theory.

In specified circumstances the federal government is expected to serve as the superseding decision maker.

On an occasion like this, afforded the opportunity to celebrate the contributions of a beloved educator and administrator at the University of Missouri, one is tempted to step back and reflect on developments over the past 25 to 30 years in all of the areas of activity in which Dr. William D. Bryant was involved during his career—medical education, health economics, interdisciplinary research in the health services, health planning, etc. I shall refrain from doing so, however, and turn to a more useful task and concentrate on describing and analyzing selected features of the current and emerging health care scene in the United States. Specifically, I shall discuss the relationship between health policies set at the national level and health planning performed at the local or areawide level. More precisely, I shall emphasize national policy for local health planning.

The year 1975 is a propitious time for such discourse. It is a

healthy sign that the rhetoric of persistent crisis in this country's health services system has quieted down. Of course, there are serious problems pressing for attention, problems that may be new or old, problems that may owe as much to the fact that some of our past undertakings have succeeded very well as that others have failed. This year may be viewed as one of special opportunity for taking stock, in preparation for the major change in health care financing that looms ahead.

To stay within the limits of time and space, it has been necessary to settle for certain exclusions. Other economists have discussed why government intervenes in our type of society (Arrow, 1970; Davis and Kamien, 1970; Steiner, 1969). Tobin (1966) has discussed the various ways in which government intervenes, with planning being only one of them.

The outline of the paper follows. First, as background information, I present some health care expenditures data pertaining to the United States as a whole. Second, I discuss the fairly new problem of the purchase of health services by third parties at wholesale, which has assumed major importance in the past decade. Third, I discuss the extra difficulties of health planning at the local level. Fourth, I discuss how the federal government with its variety of programs has influenced local health planning. Fifth, I offer an agenda for reform and federal technical assistance. Sixth, I offer a few suggestions for self-help by local health planning agencies. Finally, I compare the two hitherto distinct activities of health policy analysis and health planning, and suggest that their similarities outweigh their differences, if any.

Trend in Health Care Financing

In the past decade, starting with the enactment of Medicare and Medicaid in 1965, an appreciable shift in the sources of payment for health care has occurred in this country. At the same time total expenditures for health care have grown substantially. Yet little change has taken place in the organization of health services.

Specifically, for the first time in this nation's history we have reached and passed the figure of $100 billion for annual expenditures on health care. In fiscal year 1974, which ended in June 1974, the officially estimated, preliminary figure is approximately $104 billion (Worthington, 1975); it is safe to venture that in the fall of 1975 we are spending for health care at an annual rate in ex-

cess of $120 billion.

Total expenditures for health care have amounted to 7.7 percent of the Gross National Product (GNP). The corresponding proportion in 1940 was as low as 4.1 percent, and it was but a little over 5 percent (5.2) in 1960. In 1965, before Medicaid and Medicare went into effect, it was below 6 percent (5.9), or almost two percentage points lower than in 1974. It is clear that the percentage of this country's GNP spent on health care is much higher today than formerly. However, it is lower than might have been expected, for the figure of 7.7 percent held constant for four years, 1971–74 (Worthington, 1975). It is my own belief that the stability displayed in recent years is attributable in large part to the high rate of inflation in the economy as a whole, so that the health care expenditures numerator has been pursuing a galloping GNP denominator. Such is my reading of health care expenditures trend data from other countries, notably Japan (Klarman, 1975a). Others, Worthington (1975) among them, suggest that the stable percentage reflects in part the success of the economic stabilization program of the Nixon administration in Phase Three.

When the individual components of health care expenditures are examined, it turns out that the major factor in the increase has not been population growth, nor an increase in per capita utilization of services, but a rise in price or unit cost, expecially in the case of hospital care (Klarman et al., 1970). The rise in price of unit cost has been variously ascribed by economists to so-called demand-pull inflation, to so-called cost-push inflation, or to cost reimbursement (Davis, 1972); more on this below.

Accompanying the increase in total health care expenditures has been a shift in the sources of payment, expecially in the share of the federal government. For 15 years beginning in 1950, govern ment expenditures for health care ran at approximately one quarter of the total. With the advent of Medicare and Medicaid, the government proportion rose promptly to 37–38 percent. Since then it has slowly and steadily crept upward, so that currently it is almost two-fifths of the total, or 40 percent. [It is to be noted that assignment to the public sector of all expenditures under Workmen's Compensation and of all premiums, including those paid by aged persons, under Part B of Medicare leads to an overstatement of the relative size of the public sector by approximately two percentage points (Klarman, 1969a).]

Under the Great Society of the Johnson administration a series of other health programs were enacted, which pertained to the organization of the health care delivery system, manpower development, and planning, and were but secondarily of a financial nature. Among these programs only manpower development involved sizable expenditures. Many of us hardly think of these programs under their original titles and know them best by their initials: CHP (Comprehensive Health Planning); RMP (Regional Medical Programs); OEO (Office of Economic Opportunity) neighborhood health centers.

These developments in the second half of the decade of the 1960s were superimposed on several major federal programs that began shortly after World War II. Specifically, I refer to the big medical research effort launched under the leadership of the NIH (National Institutes of Health) and to federal assistance for the construction of non-profit and public hospitals under the Hill-Burton Act and of medical facilities under the various medical research programs.

What is worth noting is that if an increase in health care spending of a similar magnitude had taken place 50, 30, or perhaps even 15 years earlier in this country, it is very likely that an attempt would have been made to change the sponsorship of hospitals and the conditions of employment for physicians, as happened in England shortly after World War II. There, once it was decided that public financing of the health services would continue permanently, government assumed ownership of the hospitals, put specialists on salary, and arranged to pay general practitioners with capitation fees. Only 12 years later in Canada, when government hospital insurance was instituted in 1958, the ownership of hospitals was left intact; similarly, physicians were left undisturbed in their medical practice when government medical insurance was instituted in 1968. In the United States, when the new financing programs of the mid-1960s were launched, including Medicare and Medicaid, Congress made clear its intention not to effect any changes in the way that the delivery system was operating. We were not about to change the ownership of hospitals or hire doctors on salary. Rather, we were going to purchase services from existing providers and retain a pluralistic system of organization (Klarman, 1974). A major consideration, apart from the preferences of providers, was a desire to promote a single level of medical care for

all, rich or poor.

Needless to say, when these decisions were made, we were not in a position to foresee all of their consequences, since we had no past experience of comparable magnitude to guide us.

Reimbursement of Providers

It is well to recall that the public discussion preceding the enactment of Medicare focused largely on the anticipated increase in the use of hospital services. There were those who believed that the old people of this country would increase per capita consumption of hospital care by 300–400 percent. It turned out that the increase in utilization was moderate, well within the range of the actuarial projections calculated by the Ways and Means Committee of the House of Representatives (Klarman, 1974).

There was little discussion in the literature in 1964–65 or earlier on how providers were to be paid. My own informal contacts with staff members of the Department of Health, Education, and Welfare in 1965 indicated that reimbursement was viewed essentially as an administrative problem, which could be handled by employing established, presumably experienced, insurance plans as fiscal intermediaries. I am unable to recall from my conversations in 1965 any expression of concern that the price or unit cost of covered health services might increase substantially. Nor do I recall any discussion of a possible link between reimbursement method and price or unit cost. Specifically, I am not aware that any consideration was given to the possible consequences of a wholesale adoption of reimbursement at cost in the case of hospitals and reimbursement on the basis of a newfangled formula (customary and usual fees, subject to a prevailing fee cut-off) in the case of physicians.

In the event, it was unit cost or price that soon became the major object of public concern. This occurred even before the rise in cost became the subject of research by economists. As previously indicated, three principal alternative explanations are in contention. One is associated with, and derives from, Martin Feldstein of Harvard University (1971a and 1971b); it states, essentially, that health insurance and other third-party payments introduce a dual price system. At the time of illness the patient pays a low net (out-of-pocket) price, and consequently uses a larger quantity or more sophisticated services than he would if he were faced with the true,

or gross, price. A second theory focuses on labor cost, including extension at the time of the minimum wage law to hospitals and the effects of unionization of hospital employees or the threat of unionization. Among economists the third theory, which emphasizes the importance of the reimbursement methods employed by third parties, is mostly associated with my own writings (Klarman, 1970 and 1974). It is fair to say that today there is still no consensus among economists on an explanation for the persistent, high rate of increase in unit cost or price of health care after 1965. It is only fair to acknowledge, as Somers and Somers (1967) do, that the method of paying hospitals adopted in 1965 was perhaps inevitable for institutional and political reasons. The important point today is to recognize the adverse effects of the reimbursement scheme that was adopted and to embark on corrective action.

Both of the two new national health insurance bills introduced in 1974 in the Congress—the Kennedy-Mills bill and the Mills bill on behalf of the Nixon administration—incorporate provisions for provider reimbursement, but say little of a substantive nature. Rather, both bills turn the reimbursement problem over to the states. I believe that the states will need guidance. It will be necessary for them to create mechanisms for bringing together all major sources of third-party payment, as long as there is more than one, in order to exert an unambiguous, single influence on the provider. Ideally the method and amount of payment to the individual institution should reward efficient performance; in practice, they should at least not stimulate additional expenditures.

Extra Difficulties of Local Planning

Although the problem of reimbursement is relatively new, we have already learned a good deal about it. At least we know what we must refrain from continuing to do. By contrast, a much older, perennial problem has received little attention, so that its implications have neither been spelled out nor realized. I refer to the fact that health services have been, and will continue to be, delivered in a local area.

Health care organizations that serve large markets like the Mayo Clinic or Massachusetts General Hospital are the exception.

The medical care market is predominantly local, with the provider attracting the bulk of customers from the local area and with the large majority of consumers obtaining care from local providers. Unlike the provision of manufactured products, which can be transported, the rendering of a personal service requires that the provider and consumer come together. By its very nature the health services market is circumscribed, limited by distance and travel time. In general—without attempting here a precise delineation—the size of the medical care market is on the small side.

This fact has serious implications for health planning, which, broadly, aims to assure a population of access to an adequate supply of health care resources—manpower and facilities—and the provision of services of acceptable quality at the lowest cost that is compatible with the criteria of adequacy and acceptability. (The matter of quality is not pursued in this paper, but the matter of quantity is elaborated below.) In my opinion, the major reason for departing from reliance on market forces and for undertaking health planning is that in many instances the interests of individual institutions and professionals diverge from those of the public at large (Klarman, 1971).

Projections of Population and Utilization

In any study of a particular health care problem, preliminary to preparing a plan for dealing with it in the future, the first task facing the planning agency is to develop a set of demographic projections. With respect to estimates of total population, the record of the experts has not been so good for the nation as a whole (Dewhurst and Associates, 1947). The accuracy of projections is bound to be poorer for a small area, because migration to and from it plays a larger role.

When the projection goes beyond total population to the composition of population—by age, sex, or ethnic status—the conventional data on net migration no longer suffice. Data are needed on in- and out-migration by the specified characteristics, which are seldom available.

To the extent that random forces are operative, the size of error is larger for small numbers (or areas) than for large numbers

(or areas). That is to say, smaller numbers are inherently less stable and therefore more uncertain.

Usually the next step is to apply to the estimates of population projections of per capita utilization of services. In the health services the latter are subject to a degree of chance variation. Again, the band of variation is relatively wider for small numbers than for large numbers.

The crux of my argument is that if a certain number of forecasts for small areas are made, an appreciable proportion of them will be wide of the mark. In practice many health planning agencies avoid the problem, either by refraining from making population forecasts, as in the State Hill-Burton plans, or by making forecasts for short periods like five or 10 years. Since the expected life of a hospital building, even in this country, is at least 40 years, it can be said that neither solution faces the real problems of forecasting for small areas.

In planning for the future it is also necessary to make projections of the supply of health manpower and facilities. Even for so closely observed a category of manpower as physicians, our record of projecting supply at the national level has been dismal (Hansen, 1970). At the local level the problem is complicated by geographic migration, a shift in the location of practice from the office to the hospital, the maintenance of dual offices by some practitioners, moonlighting by hospital house staffs, etc. The greatest complication in making local projections is posed, however, by weaknesses in the current inventory, aggravated by lack of reliable data on historical trends. From my observation of the situation in New York City, I doubt that the types of manpower and facility counts that were estimated for the late 1950s (Klarman, 1963) could be made today. As data collection has been rationalized, access to data by analysts and health planners has diminished.

It goes without saying that to the extent that supply is affected by changes in productivity, such changes should be taken into account (Klarman, 1969b).

Geographic Boundaries

The implicit assumption so far is that the area for health planning is known and self-contained. An important practical problem in planning for a small area—in entirety or in part—is to delineate its boundaries. Local service boundaries differ from national boun-

daries in that they are more permeable, far from unique, and subject to change.

What is meant here by the permeability of boundaries is that appreciable numbers of patients flow across them. It is therefore necessary to decide whether one is trying to plan for the residents of an area only or for all persons who request services locally, allowing for the in-migration of some patients and for the out-migration of others. The point assumes additional importance when a facility is located near the periphery of a delineated service area.

The boundaries of a local service are not unique, in that they vary with the type of service under consideration. If the sickness conditions and required services occur with a high rate of frequency in a population, they can be accommodated within a smaller service area than if the conditions and services occur at a low rate. This is one of the essential distinctions between primary care and tertiary care, distinctions that are often encountered in the literature on regionalization (Altshuler, 1969: 144–188; White, 1973).

The boundaries of the appropriate service area may shift as changes take place in ease of access, cost of transportation, and recourse to different means of communication. In practice, health planning agencies have found when they attempt to delineate areas on a permanent basis that such areas are more useful as modules for compiling statistical data than as units for planning. It turns out that almost every study of a specific problem requires anew the delineation of a special set of boundaries, after preliminary exploration of primary areas, secondary areas, and possibly tertiary areas. Close to the time of the study's completion a tertiary area may be discarded or added to a secondary area; in turn, a tentatively designated secondary area may become part of the primary area (Klarman, 1964).

Beyond such technical considerations lies a related substantive issue. Many experts in medical care favor the observance of geographic boundaries as catchment areas (White, 1973). In a formal sense, this refers to the proposition that the residents of a defined geographic area will receive all of their health care within it. Whether the strict observance of such a rule is really tenable in a free society is an important question. Enforcing strict compliance with catchment area boundaries is probably not practicable in large urban centers with their multiple providers with respect to persons

who are willing to pay something extra out-of-pocket for exercising free choice. To the extent that strict observance of the catchment area is lacking, however, the presumed benefits of precise planning for defined populations are vitiated. Alternatively—and this is a paradox—to the extent that compliance is achieved, the patient is exposed to the ministrations of a single provider or a small number of local providers, who enjoy disproportionate power in the health care market relative to consumers. Freedom of choice by patients, particularly if exercised more or less routinely, may be an important source of signals between patients and providers and of countervailing power for the former (Freidson, 1970).

Cost of Information

Another difficulty facing the local health planner pertains to certain technical problems. In getting data for planning, this country has moved away from complete counts, as in the United States Census, toward sample surveys. It so happens that the appropriate size of a sample is a number, not a percentage of the population in question, as is widely believed. That is why so many surveys report on 1,500 persons, properly selected, who tell us what the whole country thinks about a subject. If the appropriate size of sample to achieve a specified level of reliability is a number, then the same number of respondents is required for a small area or population as for a large one; and the per capita cost of obtaining a given item of information is much higher for a local area than for the nation.

It follows that health planners are less likely to acquire and use complete information at the local level than at the national level. The technical problem of sampling and unit cost of information tends to be aggravated by the lesser ability at the local level to attract competent professional staff. In this country, unlike Canada, I am informed, jobs in local and state governments do not rank so high in prestige as jobs in the federal government.

Isolation of Health Planning

Technical problems are exacerbated by still another factor, namely, the traditional insulation of health planning from other kinds of city or urban planning. In my opinion, city planners have been reluctant to touch health planning for two reasons (Klarman, 1967). One is the mystique of medicine, the complexity of health care organization and its impenetrability to the intelligent lay per-

son. The second reason is that city planners are accustomed to dealing with publicly owned and operated facilities. Most elementary and high schools are owned by government; even more is this true of police stations, fire stations, etc. By contrast, hospitals may be sponsored and operated by non-sectarian voluntary groups, churches, private owners, and several levels of government; and their sources of financing are multiple.

As a result, health planning in this country began under medical auspices, such as the New York Academy of Medicine. Even when the board of directors of the Hospital Council of Greater New York—the first local agency established in this country devoted to hospital planning from the community standpoint—consisted of lay persons, the professional staff was always led by a physician. In turn this has had consequences for the nature and criteria of health planning.

Rooting health planning in this country in the medical tradition, according to the criterion of need, is a major source of rigidity in outlook. To plan on the basis of need is to take essentially a technological or engineering view of planning, which, while abstracting from individual financial ability to pay, also abstracts from a community's ability and willingness to pay for health care. The criterion of need, as applied to health planning, is geared to the capability of medical science at a given time to deal with a population's illnesses, whether or not these are known to its members. No consideration is given to the question whether the services offered will be used. By employing fixed input coefficients for staffing, consideration is not given to possible alternative ways of providing a given service. And no consideration is given to differences in preferences, especially differences in the importance attached to a more equal distribution of health services or even to improvement in health status (Klarman, 1965: 14, 97).

Single Concerns

It may be, too, that there is inherently a greater rigidity in viewpoint held at the local level (Navarro, 1970). Local interest groups are more likely to be organized around a single concern than are interest groups at the national level. If so, the former have less room for maneuvering and negotiation with other interest groups who also possess single concerns. If each group has a fixed set of priorities, there is little, if any, leeway for mutual accommodation

in the absence of a surfeit of resources to satisfy everybody's high priorities.

At the national level the concerns of interest groups tend to be broader; if so, possibilities for trading among them are greater. Moreover, resources are often more ample there. My point is that it may be more difficult at the local level than at the national level to arrive at a mutually satisfactory or tolerable consensus when several affected interest groups participate in reaching a decision.

The tendency for local interest groups to focus on a particular priority is reinforced by another factor, the inflow to the local jurisdiction of earmarked funds as grants-in-aid from higher levels of government. Frequently the argument is made that the cost of a program to the locality is substantially less than stated, because another level of government is paying one-half of it or three-quarters. In this type of arithmetic a dollar of local benefits is valued at a dollar, while a dollar of total costs entails a local cost of only 50 or 25 cents. The disparity in valuation is most striking when the grant requires local matching funds. To expect that such programs will be evaluated objectively at the local level is to ask for indulgence in a luxury that can scarcely be afforded.

Influence Over Implementation

Another feature of health planning at the local level is that the ability to implement certain plans is considerably smaller than that to implement others. For example, a community is often more successful in carrying out a decision to establish or expand a hospital than to attract physicians or dentists to the area. One result has been a tendency for local health planning agencies to devote most of their resources to institutional planning. Put simply, one reason that so much of health planning has been planning for hospital care is that organizations like to obtain and display tangible evidence of effectiveness.

One outcome of a feeling of powerlessness, not so obvious, is the tendency to adopt the nearest available solution, however untested or drastic it may be. Such a solution sometimes turns out to be costly; an example is the huge rise in annual expenditures over a period of 15 years under the affiliation agreements for medical staffing between the municipal hospitals in New York City and several leading voluntary hospitals. If the proposed solution offers the prospect of prompt initiation of activity, it becomes permissible for

the gestation period to be long. It takes 10 years and longer between the decision to establish a medical school in an area and the realization that a good number of its graduates will settle elsewhere. Meanwhile, discontent on the part of rational persons is dormant, and modest solutions continue to be held in abeyance.

Diverse Agendas

Finally, if only because populations hold different views of the relative importance of certain health services, it is essential that local health planners focus on their own particular sets of problems, starting from where they are now. (There are other reasons for starting with the existing base line, among which the most prominent is the important part played by the available supply of certain services in the demand for them; see below.) Local areas will probably differ in their selection of problems to work on, because surrounding conditions and available resources vary and because the preferences of populations vary.

If so, the value of transferring approaches and solutions found to be effective in one area to another may be low. Yet the cost of devising such approaches and solutions may be too high for a single local area to undertake the task. There may be enough transfer value, however, to justify sponsorship of the task at a higher level of government.

There may be room for a national health planning policy after all.

Federal Influence on Health Planning

For several reasons, then, health planning at the local level is fraught with greater difficulty than at the national level. It follows that local planners could use help. Any policies or external influences that divert them from recognizing the true nature of the task constitute hindrances to health planning.

In my opinion local health planning in this country has been hindered by the federal government in several ways. One is obvious, namely, the unreliability and instability of funding for health planning that is inherent in the project grant mechanism. The latter causes the health planning agency to concentrate on raising money and makes for discontinuity in its substantive activities. Too, there has been an ebb and flow in the total amount of

federal funds—sometimes they are on the rise, sometimes they follow a declining trend, and sometimes they are being redeployed. One effect has been to displace existing agencies with accumulated experience, before the new planning agencies have taken hold and matured. Experience, which often is the accumulation of knowledge on what *not* to do, is thus wasted.

There are also more subtle factors at work. A serious adverse factor in health planning is the global nature of the mandate that permeates the comprehensive health planning activity in this country. Local health planning agencies are expected to take account of everything in sight. If they missed this message in the original act, they were bound to notice the subsequent amendment that brought the entire environment within their purview. What we have here implicitly is a long laundry list of all possible items to be considered; at best, such a list can serve as a convenient checklist for avoiding unintended gaps in attention. What is needed, of course, is an approach toward coping with the actual health or health care problems that face a given community. In trying to look at everything, one is likely to see nothing in particular. Yet it is particulars that are the very stuff of health services problems and of their potential solutions.

Still another negative factor has been the deliberate posture adopted by the federal government of refraining from formulating a national health planning policy or anything that might resemble one and from furnishing guidelines to local health planners. This position was announced most clearly by the leadership of the Regional Medical Program (RMP), which refused to provide any substantive guidance to the locally constituted ad hoc agencies. Rather, the latter were instructed to be innovative in devising cooperative arrangements. Thus, the 1960s did witness the emergence of a host of new ideas, institutions, and arrangements to be fostered, promoted, or developed: neighborhood health centers, community mental health centers, television diagnosis, computer diagnosis, coronary care units, incentive reimbursement experiments, etc.

Yet, to this observer, most problems facing a community and the bulk of their health services requirements do not change from day to day or from year to year. There is some persistence to the problems, as there must be to the indicated solutions.

In fact, however, fads have succeeded one another, and all

health care problems are placed under a new, all-encompassing umbrella, such as RMP, CHP, HMO (Health Maintenance Organization), or PSRO (Professional Service Review Organization).

The absence of federal guidance on health planning policy, when coupled with the requirement introduced in the 1960s for consumer participation, has tended to turn the health planning enterprise into a struggle for control over an agency that eventually, though not too soon, may assert major influence on substantive decisions and actions in the health field. The mechanism of planning has become the central preoccupation of all participants, to the neglect of substantive concerns. In New York City the travail is not yet over, ten years after the enactment of the CHP legislation (Alford, 1975: 109).

Finally, it is fair to observe in this context that many project grants pay for demonstrations, the effectiveness of which is supposed to be evaluated. Usually they are not evaluated, because the project entrepreneur points out, properly, that he or she is a busy person, operating a program that is providing essential services, and has no time to do research. When systematic evaluation is undertaken, as it is occasionally, the question arises, What can be learned of a generalizable nature from a project that is infused with so much creative energy by a charismatic leader? If the answer is "not much," then doubt is cast on the whole strategy of project funding of local health planning by a central source.

To summarize, local health planning is extra difficult. Yet a number of federal policies and practices have tended to hinder it.

Agenda for Federal Assistance

What then is to be done?

Although the agenda of proposed federal technical assistance to health planning that follows is sizable, it can be put under three broad headings: (1) the federal government will cease to do some of the things it has been doing; (2) it will undertake a variety of specific measures of an affirmative nature; and (3) it can play a limited role of decision maker at a higher level of authority.

Abandon Certain Policies and Practices

The cessation of certain policies and practices will at least serve to neutralize the adverse federal influence on health planning. The

most prominent of the existing negative practices, in my opinion, is the mechanism of project grant funding for local health planning agencies. Such funding deters stability and continuity in the performance of health planning functions. Continuity of effort is desirable for maintaining an institutional memory. Fostering an institutional capability is even more useful.

Promoting these functions of a planning agency is to be sharply distinguished, however, from the quest for perfect organizational structure, which, in my judgment, is bound to be evanescent. A structure of governance that is perfect today is not going to be perfect tomorrow, and will be even less perfect a year hence. (I have seen an organization like the United States Public Health Service reorganized virtually to the point of extinction.) My basic assumption is that qualified and industrious people, working together and employing open processes systematically, will arrive at better judgments than will unqualified people employing a closed process and proceeding on an ad hoc basis.

A more technical suggestion is that consideration be given to reinstituting certain full counts in the United States Census, not in order to serve the national interest, but a wide variety of local interests. In this instance the national interest is, at a minimum, the sum of the local interests.

Another suggestion is to descend from abstract objectives and try to deal with problems and programs in a concrete fashion. If this were done at the national level, I hope it might serve to convince local planning agencies by example that it is a respectable piece of work to try to deal with real health service problems, however humdrum, routine, and repetitive they may appear to be.

Affirmative Steps

The above suggestions are intended to correct past mistakes. Steps of an affirmative nature can also be taken.

Flexibility and versatility. The most important one, in my judgment, given the high probability that some forecasts of population and of services utilization for small areas will prove to be erroneous, is for the federal government to develop an idea bank with concrete approaches toward greater flexibility and versatility on the part of health facilities and health personnel. By flexibility I mean the ability to operate a facility at a constant cost over a wide range of outputs. Versatility is the ready ability to convert resour-

ces to alternative uses.

One can think of a number of flexibility devices; for example, installing large numbers of small pieces of capital equipment in a hospital, rather than one big piece; purchasing supplies or services from the outside, in order to capture whatever economies of scale may accrue in the production process, rather than producing them internally (Flagle, 1973); rotating some personnel among nursing units in accordance with variation in patient mix; or the converse, providing for the use of a given facility by two or more categories of patients (Long, 1964); etc. Other flexibility devices have occurred to architects, administrators, and consultants (Weeks and Best, 1970).

In order to enhance versatility it is necessary to broaden the initial training of health personnel. It is difficult to shift a person from one function to another if he or she has received narrow, highly specialized training. Another example of versatility is building facilities in such a way that they can readily be converted to another use, such as from a hospital to a nursing home, or perhaps also from a nursing home to a hospital. Modular construction is an obvious device; another is to enable expansion and reorganization of facilities to take place at the outer edges of buildings (Llewelyn-Davies, 1966). There is a danger, however, that the resulting standards of construction may be raised excessively.

It is important to acknowledge that such policies cost more than it would cost to operate at some single optimum level (Stigler, 1946: 118). However, there is no single optimum level of operation that is likely to be realized and sustained in an obdurate world.

Natural experiments. Similarly, a useful step would be for the federal government to develop an informational network for keeping track of the occurrence of natural experiments. In real life, in any attempt to evaluate what works and what does not work; and if it works, why it works, natural experiments are far superior to demonstration projects, which are often undertaken under especially favorable conditions. Natural experiments may even be superior to designed experiments, which are surrounded by a "halo" effect or may abstract from one or more important variables.

The idea would be to develop an information system to feed news of impending natural experiments to a central office, which, in turn, will be in touch with teams of competent empirical workers

who will move in, prepared to help evaluate or themselves to evaluate an interesting natural experiment that is about to begin.

Preference might be given to natural experiments that occur on a large scale, such as those that encompass an entire state. This would mark somewhat of a return to the notion of the state and local communities as social laboratories, as they were regarded in this country before the First World War; it would also give recognition to one of the presumed advantages of a federal system of government.

An example of natural experiments that have taken place in this country are the numerous efforts made by communities to attract physicians. Among them a high rate of failure is reported; there have been some successes as well. A compilation and review of the record, describing the factors associated with success or failure in the past, would be a necessary prerequisite for analyzing past efforts; a useful precursor for evaluating future programs; and would provide a suggestion list of things to do and to avoid on the part of those undertaking such a venture today.

Elucidate implications of research and theory. It would be useful for a central technical service to elucidate in terms that are comprehensible both to the professional planner and to the intelligent layman—generally it is the intelligent layman who employs the planner and is the decision maker—the policy implications of important empirical research findings that have secured wide acceptance. Such writings would then be widely disseminated.

There is, for example, Roemer's Law, a well-known proposition in the health field. It states that, within the range of past experience, when short-term hospital care is financed through prepayment, the tendency is for short-term hospital beds, if built, to be used, whatever the number of beds in operation or the bed-to-population ratio. In Feldstein's language (1971b), there is a "pure availability effect," so that an increase in the number of beds induces an upward shift in the demand schedule.

The import of this proposition is that there appears to be no such thing as an optimum number of general hospital beds in a community. It follows, if the proposition is accepted, that the appropriate public policy is to try to limit the total bed capacity in an area and to reduce it step by step as the opportunity beckons, such as an existing hospital wanting to modernize or a hospital contemplating relocation to another site.

Since the proposition is simple and offers clear and definite policy implication, it seems appropriate to turn for its implementation to government, which can exercise powers of enforcement. More uncertain facets of the health planning agenda are perhaps better left, for the time being, to voluntary mechanisms and processes (Klarman, 1969a).

Another suggestion, which may appear to run against common sense, is for a central technical service to elucidate in terms that can be understood by the intelligent lay person the implications of important propositions derived from theory. For illustration I draw on health economics. As previously discussed, the present policy is to pay hospitals in relation to their own individual costs. Whether we pay hospitals at cost retrospectively or whether we adopt some way of paying them prospectively, it is likely that for the foreseeable future we shall have to coninue paying each hospital at a rate of its own. The reason is that we do not yet know how to measure and explain differences in cost among hospitals.

Aside from differences in patient mix, differences in cost are usually attributed to differences in the quality of care. In the ongoing search for greater understanding, it will certainly help to learn to disaggregate the concept of quality in operational terms. Perhaps it will become possible to peel off certain measurable layers and call them by separate names, such as privacy, convenience of access, or the comfort of reduced waiting time, until the core is reached, which for the time being continues to escape explanation. However, until close to a full understanding of variation in cost among hospitals is attained, there is no responsible choice but for third parties to continue to pay each hospital at a rate that reflects its own cost experience. Paying hospitals at stated rates, determined without reference to individual cost experience, is simply not practical.

The question arises, What does the fact that it is necessary to pay hospitals in this manner signify for how nursing homes are paid? My best guess is that we pay nursing homes in relation to their own cost, because nursing homes and hospitals are covered under the same laws, Medicare and Medicaid. But nursing homes are unlike hospitals in several significant respects (Klarman, 1975b). To begin with, price can play a larger role because the patient does not move with his doctor, as he or she does in the case of hospital care. More important, it should be possible for the

patient, or a relative, or members of a neighborhood Golden Age Club, or a lay public official to make a reasonable judgment about the quality of care in a nursing home in a way that the lay person cannot judge the complex care rendered in a hospital.

Accordingly, it should be possible to pay for nursing home care at stated rates for specified classes of patients, perhaps with an adjustment for geographic differences in wages and even with penalties for below-standard care and bonuses for super-standard care, when desired. It is difficult to gauge in a climate of crisis and exposé, such as the present in New York State, just how advantageous such a change in payment policy would be and which measures of a regulatory nature would still be necessary.

Another example of a possible contribution to health planning by economic theory is taken largely from the New York press. Several communities and neighborhoods have reacted strongly against the concentration of discharged mental hospital patients in their areas.

In my judgment it would be healthy to concede that initially, when we embarked on emptying the state mental hospitals in the mid-1950s, it did not occur to anyone that what would happen to the discharged patients outside the hospital might pose a problem. It turned out that many of them had no homes to return to. Instead of distributing themselves among the general population, they tended to congregate.

Evidently a mistake in policy was made, a mistake that may not have been avoidable at the time. In general, it is helpful to recognize that no policy in the real world is infallible, and that all side effects cannot be anticipated. Recognizing that a mistake was made may be the first enabling step toward successful reform; conversely, not to acknowledge the original mistake is to continue to search for scapegoats.

In retrospect, it is easy to see that the application of a modest dose of economics to this policy decision might have been highly beneficial. We have here a textbook case of geographic externalities, that is, some of the negative effects of a transaction falling heavily on persons in another geographic area.

The case of externalities can be extended further to consideration of the optimum size of a facility. Frequently, economies of scale are present, so that the average unit cost of operation falls as the size of facility increases. However, these gains may be offset

by other costs, such as costs of travel by patients and visitors plus the social costs of neighborhood disamenities. If so, it may be sound policy to aim for smaller and more numerous facilities for certain types of patient.

In general, it would be useful to disseminate the proposition that major programs are likely to have multiple effects, some of which are foreseen and others not. The unanticipated extra rise in unit cost or price following the advent of Medicare and Medicaid is a splendid example of an unforeseen effect. The small increase in per capita utilization is a good example of an effect that was expected only by a few; many observers at the time foresaw a huge increase in utilization.

Explore selected controversial issues. Another desirable step is to develop avenues for exploring important controversial issues that are often left undiscussed or are not discussed with reasoned objectivity. As a result, we tend to act on them blindly or with bias. As an example, I pose the question, What difference does the ownership of a health facility make? Is it true that in the health field proprietary ownership is per se inferior, as many people believe? Or is it true that proprietary ownership is more efficient and no different in the quality of care rendered, as is argued by Ellwood (1971)? Is there perhaps a tendency, as Kenneth Arrow has suggested (Klarman, 1965:113), for an adverse self-selection process to take place that in turn leads to a self-fulfilling prophecy, so that if it is widely believed that proprietary owners are a bad lot, proprietary owners will be attracted who either are at the outset, or become, a bad lot?

Another example of an issue in health planning that warrants ventilation is the responsibility of a hospital or a group of hospitals in a geographic area for providing staff appointments to practicing physicians. Should the medical staffs of hospitals comprise only the most highly qualified physicians in the community? Or should they consist of all physicians practicing in the community, with due provision for supervising their work in accordance with their respective qualifications? If the latter is the desired policy because a hospital staff appointment enhances the quality of a practitioner's total work, does supervision apply only within the hospital or does it extend also to what the physician does outside? Further, if hospitals as a group are responsible for providing staff appointments to all physicians in an area, what are the method and

mechanism for assigning to an individual hospital the responsibility for a particular physician, when two or more hospitals serve an area? To my knowledge these problems have scarcely received attention from health planning agencies.

Hospital staff appointments for physicians obviously bear on the quality of medical care received by a population, but they go beyond that. The provision of such appointments, in my judgment, affects directly the prospects for success of any effort to regionalize health services. To decide that Hospital A will operate a certain facility while Hospital B will not is to deprive physicians associated with Hospital B of the opportunity to practice their skills, let alone to earn income, unless it is also arranged for them to have access to the facilities in Hospital A and to care for their own patients there.

Another example of an issue in health planning that has not received adequate discussion over the years is the nature of regulation. My observation is that many persons trained in the health sciences, public health particularly, believe in detailed or highly specific regulation. One outcome of retail regulation is frustration for all interested parties, culminating in periodic crises and intervening remissions.

Most economists who deal with the health field seem to incline toward devising a broad framework within which, with proper incentives, people will tend to work in consonance with the broad public interest. The question is how applicable the latter approach is in practice, since the same economic literature that advocates the application of incentives often concludes with the admonition that further research is needed or that experiments must be designed, observed, and evaluated (Schultze, 1970).

Educate board members. It would be useful to provide technical assistance for the education of board members, the ultimate decision makers in the voluntary non-profit sector. Although the composition of boards has been changing, the perennial question remains, What is it that concerned board members ought to know?

Should they know statutes and regulations like lawyers, which is what they are often taught? Or should they learn to play the role of textbook consumers? Informed to the best extent possible about the relative utility of a service, such board members, possessing knowledge of resource constraints as well, may act on behalf of the large numbers of consumers who are only capable of recognizing certain elements of care, such as convenience or inconvenience,

comfort or discomfort, but are not able to judge the scientific elements of care. Again, these matters have received too little attention.

Superseding Level of Authority

In general, an important purpose of public policy, including planning, is to try to internalize externalities when the latter are substantial. Sometimes close coordination among decision makers suffices to achieve balance among conflicting local interests. At other times, as in the case of water-pollution control, it becomes necessary to create a decision maker at a higher, superseding level.

However, the creation of new and additional organizations for making decisions is not to be undertaken lightly. We have learned that the seemingly simple device of the quasi-public corporation or authority tends to create problems of its own, such as inability to control expenditures on the part of elected officials and lack of responsiveness to the desires of the electorate. The latter raises basic questions concerning the legitimacy of governance in the public sector.

Finally, one of the things that the federal government can—perhaps must—do is to take superseding action in certain instances in which local areas or the states restrict entry by health care providers or limit access to health services by consumers. An obvious example of desirable federal action today is the attempt to negate the application of state laws against prepaid group practice. Such laws have had a notorious history, and preemptive federal action is called for, quite apart from the merits or demerits of the health maintenance organization (HMO) concept.

What Local Agencies Can Do For Themselves

Reference has already been made to a well-educated board of directors. How such a board can be imbued with the broad public interest is a task for selection and leadership.

The professional staff of the health planning agency will be prepared through appropriate education and training; see below. It is important that both staff and board, relieved of financial crises, bring institutional stability to the agency and work on persistent problems.

It is my observation that a qualified staff, encouraged and prompted by such a board, can do a good deal to develop and

maintain inventories of health manpower and facilities. This requires diligence and ingenuity, as Anderson and Kravits (1968) and Klarman (1963) have shown. Successful performance of the task also depends on ready access to the data that are actually being collected, as well as their continuous scrutiny and editing for consistency and aptness. A sensible combination of a routine data base and special ad hoc surveys will evolve if the mechanism is solid.

A desirable step is to begin to integrate financial and cost data with the more traditional data employed by health planning agencies on population, utilization of services, manpower, and facilities. It is noteworthy that when two or more services are produced jointly, such as inpatient care and ambulatory care or services and education, the average cost of any single service is an ambiguous figure. The reason is that the allocation of joint costs is always arbitrary, even when calculated according to an objective formula (Stigler, 1952). Incremental or marginal cost is uniquely determinable, however.

Above all it is important that both the board and staff of a local health planning agency adhere to standards of accountability to the public. Citation of authority is never enough. Rather, the agency's recommendations should follow from conclusions that derive from an analysis of data that are shown and from assumptions that are made explicit.

Health Planning vs. Policy Analysis

How different are these two terms—health policy and health planning—and the activities they connote? In this country national health policy is more apt to deal with the financing of health services, while local health planning is more likely to pertain directly to the assurance of adequate resources and the provision of services.

Notwithstanding, my own view is that the two activities are not too different. Both entail the application of appropriate techniques to relevant data; both should allow for the weight of value judgments; both require an awareness of the constraints imposed by history and existing resources, as well as by the distribution of political power. If so, policy analysis (the analytical aspect of policy formulation) and planning (as advisory to the decision maker) call for the same qualities of mind, if both activities are taken seriously, whether as analysis or as problem solving. It is a

historical accident that in this country health planning is associated largely with the local area and policy analysis with the federal government.

If the two activities—policy analysis and planning—are not different, then education and training for them should be similar, when not identical. It is crucial that we now turn to the challenging task of training health planners, giving them initial technical skills while also endowing them with a capability for future career development and growth. Technical training can be narrow, but the requisite ability to grow and adapt calls for a broader, more general education. The latter entails the acquisition of mastery in appreciable depth of at least one of the disciplines applied by health planners or policy analysts on the job.

Summary

The paper begins with a discussion of a problem that newly emerged in the 1960s, that of provider reimbursement, as a result of the wholesale recourse by major public programs to the purchase of health services from existing providers. We have gained some understanding of this problem.

There is a more persistent, older problem, that of the extra difficulty of planning for health services at the local level, which is yet to be apprehended. Nor have we come to terms with the numerous instances in which the interests of the individual institution and those of the broader community tend to diverge. The implication of such divergence is that voluntary coordination alone is not a sound basis for health planning.

To some extent past federal policies and practices have not been helpful to health planning, and some may have been harmful. Even if some of the adverse activities ceased, there are still other, affirmative, federal actions to be taken that promise to be useful, particularly the provision of a variety of forms of technical assistance.

The local agency can also undertake some measures of self-help.

Finally, I venture the belief that whether one is working at the national level on health policy or at the local level on health planning, the same requirements of education, training, understanding, and judgment apply.

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This paper represents a substantial revision in organization and style of the first William D. Bryant Memorial Lecture delivered by the author on the campus of the University of Missouri-Columbia on January 21, 1975. The substantive points are the same, however, and the new National Health Planning and Resource Development Act of 1974 (P.L. 93-641) is not dealt with.

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