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Health Planning: Progress, Prospects, and Issues

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A NEW STRUCTURE OF HEALTH PLANNING AGENCIES covering the entire nation and comprising three layers of governance is being put in place. The procedures to be followed by these agencies and their respective functions have been prescribed, and some are already being exercised. This new system is the product of the enactment of the National Health Planning and Resource Development Act of 1974, commonly referred to as PL 93-641 (1975).

It is likely that each of these facets of health planning—structure, procedures, and functions—will be transformed in the course of time. Yet any appreciable change will not be manifest for a number of years. A major piece of legislation is always granted a period of grace, a shakedown cruise—to get organized, recruit staff, write regulations, start to do things, perhaps go to court, report, and be evaluated. The evidence for appraising the probable effects of much of this activity is as adequate today as it is likely to be 2 or 3 years hence. And it is easier to accept today than later that not all such evidence derives from direct experience. Rather, a good proportion of such evidence derives from theory in one or more of the disciplines involved and from analogous experience.

The fact is that health planning in this country is *not* altogether a new activity. It goes back to the 1930s or 1940s, depending on how one reads the annals of health planning (May, 1967). What is indisputably new for health planning is its current prominence. Even 2

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or 3 years ago a national conference on health policy would have dealt with financing, organization, and manpower, as this one does; the fourth item might have been "quality of care." Ten years ago, "the hospital" might have been the fourth agenda item. It is doubtful that "health planning" would have appeared on a short, serious agenda, for at the local area level health planning was a sporadic activity, taken seriously by only a few. At the state level, health planning often consisted of routine paper work, a necessary annual precondition for receiving and awarding federal construction grants under the Hill-Burton program. At the national level, health planning consisted of ringing pronouncements in preambles to legislation, supported by modest appropriations. At best, health planning was viewed as inconsequential, and often it was irrelevant to the development of health care delivery, utilization of services, or health care expenditures (Klarman, 1974).

Health planning has gained new prominence since 1974 for a number of reasons, all of them, I believe, connected with PL 93-641. Throughout the nation, a structure of over 200 local or area-wide Health Systems Agencies (HSAs) has been created. Boundaries have been delineated, governing groups assembled, planning grants awarded, and staffs recruited. State governments are being geared administratively to issue health care plans and grant or deny Certificates of Need (CONs) to applicants for new institutional health services. With or without assistance of the provision of the 1974 law for experiments, more than 10 states have begun rate regulation (McMahon and Drake, 1976).

The federal government has issued a stream of decisions, guidelines, regulations, and manuals, and is working on more. Although implementation of the new law is still in its formative period, a noteworthy feature of all this activity is that health planning has become an expanding sector for employment at a time of curtailment in some segments of the health care industry. For non-clinicians concerned with the shape and direction of the health care system, health planning may be the "only game in town." Moreover, the 1974 law has enjoyed substantial stature from its inception, since it simultaneously terminated and replaced three health planning programs—Hill-Burton, Regional Medical Program, and Comprehensive Health Planning. Finally, many students of health planning would emphasize the element of regulatory power in the 1974 law, an element formerly missing but deemed necessary by some to make

health planning effective (U.S. Public Health Service, 1976). Henceforth, institutions will or will not establish new services, depending on the award of a CON by the state agency acting upon the recommendation of the HSA; and applicants will receive grants, contracts, loans, or loan guarantees under specified federal public health programs for resource development only upon approval by the HSA.

Evidently, health planning is to be taken seriously as a major component of this nation's health policy. In enacting the 1974 law, Congress broadened the scope of health planning, even as it sharpened the focus on specific components of the health care delivery system. The new law recognizes that to plan for inpatient care is not enough, since ambulatory care may be a partial substitute. Facilities are not enough; it is people who render services. Personal health services are not enough; the environment and individual life style are important determinants of health status. Real resources and services are not enough; money is also to be taken into account, as a source of purchasing power, a measure of the value of alternatives, and a determinant of the utilization of services and location of manpower.

Notwithstanding, one must resist the temptation to treat health planning as if it were the totality of health policy—the ultimate all-encompassing umbrella—while we await major new developments in health care financing (such as national health insurance), health care organization (perhaps the Health Maintenance Organization or the consortium), and health manpower (large-scale substitution of the physician's assistant for the physician, even as the supply of physicians is increasing). From a sense of realism, I shall try to put health planning in its proper place. In my view, this place will not be a modest one, both because health planning has an important contribution to make and because decisions on other components of a national health policy, which might help shape the course of the health care system, are at a standstill.

Most important, in my judgment, is the establishment of a pervasive, elaborate, and intricately balanced structure of planning joined to regulation; a linkage among federal programs for planning, resource development, and purchase of health care services; a distribution of authority and responsibility between the federal government and the states, between the state governments and local areas, between public employees and advisory groups at the federal and state levels, and between governmental auspices and voluntary,

nonprofit auspices at the local or areawide level; and a distribution of representation between consumers and several types of provider on the boards of HSAs, statewide Health Coordinating Councils (SHCCs), and the National Council on Health Planning and Development (NCHPD). A multitude of interests are being brought into the act, and all have a stake in the outcome.

It is helpful to list the topics omitted from this paper, and therefore also the possible links between health planning, on the one hand, and health care organization, manpower, or financing, on the other hand. Not dealt with here are: how providers are paid and how much, although these items increasingly fall under the purview of health planning agencies that engage in rate regulation; copayment by patients or expansion of the Health Maintenance Organization (HMO), which might serve as potential alternatives to public intervention via health planning; certain manpower policies available to the states, if not to localities, such as the selective application of licensure (Goldblatt et al., 1975), which could properly be the concern of health planning below the federal level; and the future role of the hospital, which is certainly important for implementing whatever goals may be agreed upon. The explicit omission of these topics, and others, signifies what is perhaps obvious, that even a long paper on health planning is not the same as a full-fledged discussion of alternative health policies.

Given that the new health planning law looms so important because its provisions on structure, procedures, and functions are pervasive and overriding—a judgment that eventually could turn out to be mistaken—it seems reasonable to focus a discussion of health planning on the 1974 omnibus law. The remainder of this paper consists therefore of two principal parts, followed by a concluding section. Part 1 deals with the 1974 law. A sketch of its provisions is preceded by a statement of background and followed by a short appraisal; this appraisal turns out to be altogether positive. Part 2 raises several fundamental issues in health planning, some of which are treated in the 1974 law while others are neglected. The concluding section is a summation of the preceding argument and, to a small extent, an amplification of it.

Part 1: The 1974 Law

Background

It is my impression that a major factor behind the passage of the 1974 law, as well as an overwhelming influence on the public discussion of health policy in this country in recent years, has been the persistent rise in health care expenditures after World War II, augmented by a marked acceleration in the expenditure of tax funds in the Medicare-Medicaid era. Annual articles in the *Social Security Bulletin* report that the average rate of increase in health care expenditures rose from 8.1% per year in 1950–65 to 12.7% per year in 1966–76 (Gibson and Mueller, 1977). The proportion of the Gross National Product (GNP) devoted to health care rose from 4.5% in 1950, to 5.9% in 1965, and 8.6% in 1976. It took 20 years, from 1940 to 1960, for the proportion of the GNP spent on health care in this country to rise by a single percentage point—from 4.1% to 5.2%. Subsequent increases of 1% took 7 years, from 1960 to 1967; only 3 years, from 1967 to 1970; and 5 years, from 1970 to 1975, of which 3 include the period of the Nixon Administration's Economic Stabilization Program for controlling wages and prices, when the proportion of health care expenditures to the GNP fluctuated about 7.8%.

Although the desire to curb the upward trend in health care expenditures was a principal motivating factor behind the new law, the decision to rely on health planning for this purpose is by no means evident. Indeed, the discussion that surrounded the new law consistently underscored the past failures of health planning, which were bound to be magnified when viewed from the perspective of our current concerns (U.S. Senate Report No. 93-1285, 1974: 39–41), which may differ from our past concerns and objectives. Apparently the past failures of health planning were regarded as man-made and not intrinsic to health planning, and therefore susceptible to legislative remedy. The remedy devised consisted of: enunciation of more specific concerns, objectives, and agency structures, so that the intentions of Congress could no longer be misapprehended or evaded; total coverage of the country with health planning agencies, to demonstrate a national commitment; legislative provision for steady formula-funding of the activity, if not ample funding; and, above all, assignment to designated agencies of specific functions along with

commensurate authority for continuous review, recommendations, and decisions on health care plans and implementation mechanisms.

Two other considerations supported a sizable undertaking in health planning by the federal government in 1974. First, health planning, however remiss in meeting the nation's current concerns, was in 1974 a symbol of benign, perhaps even benevolent, public-spirited community activity, a mixture of the voluntary and mandatory, under nonprofit and governmental auspices. Second, while health planning had aroused little opposition, other approaches to urgent health care problems, such as national health insurance, containment of expenditures, or even manpower policy, were still beset by controversies that could not be resolved by the 93rd Congress. A Congress that had been preoccupied with Watergate and the Vietnam conflict was eager to end on a positive note.

Provisions of the 1974 Law

Congress passed the *National Health Planning and Resources Development Act of 1974* in late December. Under this law the federal government's interest in health planning would be consolidated and rendered more consistent and coherent than in the past. The country would be covered by a network of local or area-wide HSAs, whose size, governance, staffing, funding, and functions are spelled out in the law as matters of national policy. The states would establish Health Planning and Development Agencies (HPDAs) and statewide HCCs, to represent the states in health planning, to collect and bring together the HSA plans, to serve as bridges between the HSAs and the federal government, and to administer the newly mandated state CON programs.

The 1974 law lists 10 federal health planning priorities. These pertain to several different dimensions—two to desired levels of care, three to health care organization, one to manpower, one to quality of care, two to health promotion and health care prevention, and one to uniform, improved data systems. While some might be said to pertain to fundamental goals, others may be regarded as being more instrumental.

The statute promises that federal guidelines will be issued, taking the form of standards plus national health planning goals, which are to be expressed in quantitative terms insofar as possible. The federal priorities, standards, and goals are intended to replace what had been a national non-policy for health planning. Despite an asserted national interest in health planning, the federal government had been permissive toward a diversity of activities pursued by numerous health planning agencies receiving federal funds.

Under the 1974 law, the federal government specifies the subject areas for which data are to be assembled and analyzed; considerable emphasis is put on health status measures and on the health care and environmental determinants of health status. Inventories of health resources and utilization data are required. Under the heading of "Federal Technical Assistance," the Secretary of Health, Education, and Welfare will specify minimum data sets in the form of possible data lists pertaining to health status, utilization, etc. The Secretary will also establish a uniform system for calculating total costs, for cost accounting for health service institutions, for calculating rates of payment to providers, and for reporting cost and rates.

For the local or area-wide HSAs, boundary lines are to be drawn by each state, subject to federal approval. The local agencies will be financed by a federal grant of $0.50 per person, with up to $0.25 additional federal money available to match local monies. The HSA may be a governmental body or a nonprofit corporation. Although the nonprofit corporation is reported to predominate, the influence of public officials within the nonprofit corporations is often substantial, at least in the early phase of agency designation and organization. Consumers living in the Health Service Area will constitute a majority of the governing board, but providers are also explicitly required to be represented. Classified as providers are direct providers, such as practicing clinicians and hospital administrators, and indirect providers, including faculty at health professional schools. (Presumably the source of earnings of such faculty submerges and subverts the consumer interest.) Provision is made for representation on the board from Veterans Administration hospitals and from health maintenance organizations qualified under the 1973 law (PL 93-222). Staff expertise is specifically required in administration, gathering and analyzing data, health planning, and

developing and using health resources. The functions of health planning and development, the 1974 law states, will be performed by staff members who possess appropriate skills.

Each HSA will prepare a Health Systems Plan and an Annual Implementation Plan geared to it. On the basis of such plans, the HSA will review and: approve or disapprove applications for certain federal planning and development funds or subsidies; comment on matters pertaining to Indians; officially make recommendations to the state on applications to establish new services and facilities (CONs); assess periodically the appropriateness of use of existing institutional health services, and recommend annually to the state individual projects for construction, modernization, or conversion, with priorities assigned among them. At least every 3 years, HSAs will prepare reports for the Secretary of Health, Education, and Welfare, which demonstrate their effectiveness. All reviews of applications and accompanying actions will be subject to documentation and open hearings, flowing upward through channels. In cases of reversal, reasons are to be given. No matter what else happens, there will be a vast paper flow.

The designated state Health Planning and Development Agency (HPDA) will help organize the HSAs; review their actions; compile the local plans and convert them into an annual State Health Plan; prepare an annual state medical facilities plan, which is part of the State Health Plan; periodically compile for the entire state a review of the appropriateness with which existing institutional health services are used; administer a CON program for new services on a continuing basis; and, in six states, conduct demonstrations in rate regulation.

The degree of control imposed by the federal government on the total health planning mechanism will depend on the types of guidelines that are issued and their specificity. It remains to be seen how much leeway is left for attending to local problems.

It is difficult to discern the ultimate seat of power between the states and the HSAs (Sieverts, 1976). The relative distribution of power will be influenced by the types of problem that emerge as important, by how the health planning agencies deal with them, and by the quality of governance and technical competence displayed by the agencies at the state and local levels. It is reasonable to suppose that the quality of governance and management will vary among the states and among HSAs.

Appraisal of the 1974 Law

In my judgment, a good many provisions of the 1974 law definitely represent progress; these are listed below. The desirability of some provisions is doubtful, however, and much will depend on how they are implemented. Most troublesome are certain provisions and concepts that recur frequently in the statute but are nowhere elaborated. To appraise them, it is necessary to examine the assumptions underlying such important concepts as need and health services area, and such provisions as review and recommendation on individual applications and data requirements. In the absence of experience with the 1974 law, such an examination must rely on theoretical considerations and experience derived from other, analogous areas. The discussion of a small number of such fundamental issues comprises Part 2 of this paper.

Here, without any attempt at exhaustiveness, the features of the 1974 law that are positive for the most part may be listed as follows:

1. A single program replaces several federal health planning programs that were often divergent and sometimes conflicting. A national policy on health planning is thereby manifested.
2. A strong federal interest in health planning is enunciated. The notion of priorities is raised, and 10 priorities are listed. Guidelines will be issued, including goals expressed in quantitative terms.
3. State government is involved in health planning and is assigned definite functions.
4. Yet health planning will be performed primarily, or at least initially, at the local or area-wide level under the aegis of the 200 and more newly created HSAs.
5. Governance of health planning agencies will be shared among consumers, direct providers, and other providers.
6. The importance of staff expertise is recognized.
7. Open procedures are provided for review and appeal.
8. Documentation is emphasized, mainly through data, presumably in contrast with recommendations based on opinion.
9. At long last, traditional health planning types of data—such as population, vital statistics, utilization of services, and inventories of resources—are to be brought together with financial data—expenditures, cost, charges, and sources of payment.

10. Applications for new institutional health services will be reviewed in relation to the community's need, and individual applications will be recommended for approval only upon an affirmative finding that a need for the proposed project or program exists. In addition, from time to time, existing health care services will be reviewed for appropriateness.

11. Although the state health plan encompasses more than facilities, special attention is reserved for facilities, which are to be listed individually in a separate plan. Indeed, the 1960s' emphasis on comprehensive health planning is replaced by a sharp focus on specific components of the health care delivery system.

12. The HSA's annual Health Systems Plan will be accompanied by an Annual Implementation Plan.

13. There is ample provision for technical assistance: from the federal government to the states and localities; from the 10 new federal centers for health planning (one located in each geographic region of the nation) to the states and localities; from the HSAs to individual institutions; and from the Cooperative Data System to all health planning agencies. (The Cooperative Health Statistics System, under the leadership of the National Center for Health Statistics, is a coalition of producers and users of health statistics organized to minimize duplication of data collection.)

14. Funding of health planning agencies will be based on a formula, in contrast to project funding under Regional Medical Programs and Comprehensive Health Planning. It remains to be seen whether the level of funding will be adequate when the organizational phase is over.

15. Finally, perhaps in recognition of a lesson learned over the past decade, the 1974 law has nothing to say—one way or the other—about government interference in the practice of medicine.

Part 2: Some Fundamental Issues

The selection of issues to be explored here in some depth reflects my experience in teaching and research in health economics and health planning, and in working at a local health planning agency. The following topics are important and warrant extensive discussion: 1) the implications of the criterion of need for health planning and of its apparent demise; 2) obstacles to curtailing the supply of health care

resources; 3) how to allocate a given total among multiple providers; 4) the additional difficulties and hazards of local or area-wide health planning, as compared with planning at the national level; and 5) the potential uses and limitations of uniform data sets.

Why Health Planning?

Before examining the criterion of need, it is helpful to reflect upon a basic question: Why embark on health planning?

As a staff member of a local health planning agency, the Hospital Council of Greater New York, from 1949 to 1962, I came to appreciate that the appeal of health planning was twofold: its obvious rationality and the apparent simplicity of the criterion of need. These two features were sometimes joined by a third concept that had emerged in the 1920s from the United Kingdom, namely, regionalization, which may be described briefly as a hierarchical arrangement of facilities designed to provide health care of adequate quality to a defined population at least cost.

In the Depression of the 1930s, rationality meant avoiding both waste and gaps in service in the effort to meet the medical care needs of a population. It was obviously a waste for the municipal hospitals in New York City to be overcrowded while the voluntary hospitals were half empty. When hospital planning councils were established in other cities, such as Rochester, New York, in 1948, leading businessmen could see the merits of rationalizing hospital facilities in the same way that they would approach integrating a large business (Thompson, 1977). In the mid-1960s in Pittsburgh, rationality was given the meaning of simply thinking ahead, as in preparing a travel itinerary (Sigmond, 1967). The idea was that if providers were brought together and properly informed, they would come to appreciate the mutuality of interests among them and with the communities they served. With technical assistance furnished by the planning agency, each hospital would willingly plan for its own development. The sum of such internal plans would be the plan for the community.

The unexamined underlying premise of this view of health planning is that voluntary cooperation among providers, based on reliable information furnished by a disinterested agency, would suffice to meet the public interest. The missing ingredient, reliable and objective information, would be produced and disseminated by the

local health planning agency, and the separate actions taken by autonomous providers would then cohere to serve the broad public interest. But why should this be? The conditions under which the free market is said to promote the benefits of all parties are well known, namely, the presence of large numbers of knowledgeable consumers and producers, all of whose interests are captured in the transactions in which they participate, with each party acting as if none exerted any influence on price.

In health care, however, consumer knowledge is often scanty, and externalities—effects on parties not directly involved in a transaction—can be large. Historically, consumer ignorance of the quality and effectiveness of health care led to major reliance on the judgment and advice of the physician. More recently, with the growth of insurance and prepayment, the physician's influential role has been magnified to the point that a new concept has emerged, that of the availability effect. What this concept proposes is that the supply of a service exerts an important, independent effect on the demand for it. It is believed that the demand function has been shifted upward, whether through lowering the price of a service at the time it is consumed, or through broadening the physician's discretion in choosing which services to recommend, or even through the possible wealth-enhancing effect of being insured.

The availability effect drew wide attention, if not universal acceptance, when it was first posited for the short-term hospital by Milton Roemer about 1960 (Roemer, 1961; Shain and Roemer, 1959). Substantial controversy then ensued, especially among economists, some of whom argued that an increase in supply was a response to pressures from the demand side. A similar effect of supply on utilization had been noted earlier for physician services by Willard Rappleye (1950), and was reported as an empirical research finding by Victor Fuchs about 1970 (Fuchs and Kramer, 1972: 17).

In the present context, externalities go far beyond the standard example of communicable diseases, for which a vaccination serves as a preventive measure for persons vaccinated, and also for neighbors not vaccinated. What the availability effect denotes is that supply and demand will not settle at a point of competitive equilibrium, representing optimum economic efficiency, because the financial discipline exerted by vacant beds on the individual hospital had ceased to apply under conditions of prepayment and continuing consumer ignorance. Rather, as the quantity of services offered increases, the

provider and the consumer jointly arrange for the use of more and more health care services, diverting scarce resources from other uses.

Other examples of externalities (or spillover effects) in health care arise from the coupling of services and education; and from the fact that the hospital and its own medical staff usually do not concern themselves with the quality of health care rendered outside its walls, in physicians' offices.

Over the years I have arrived at the conclusion that the substantive case for health planning rests largely on the divergence of interests between autonomous providers, gladly supported by their patients under conditions of prepayment, and the broader public interest in curbing the rise in health care expenditures. The presumption is that observed differences in the utilization of services or in expenditures among geographic areas and their populations have not led to visible differences in health status. This presumption is certainly not conclusive, and may be rebutted by future research findings. For the time being, the presumption of no effect on health status does justify the inference that, if the availability effect is valid, it points to a policy of interposing an external, superseding level of judgment and decision-making as to what is taken to be a socially desired level of resources. It is helpful if that desired level can be made acceptable to the several parties participating in the transaction through the provision of incentives (see below).

Economic planning taking the form of imposing an outside, superseding level of authority is not common practice in the United States. Why, then, have leading businessmen and prominent public officials, including conservative ones, endorsed and promoted health planning? One reason is the expressed wish to rationalize the health care industry, to make a system out of what appears to be a nonsystem. It is worth noting that, to those who are not economists, virtually any area of economic activity deemed vital, such as the provision of bread, fruits, vegetables, or clothing, looks fragile and incapable of assuring the delivery of the right goods at the right time and place in the absence of a visible guiding hand. Lay persons are unaware of the intricate, informal links that pervade every economy. However, few persons focus their attention on other areas of the economy as intensely as they do on health care. Both by traditional practice among health care providers and as accepted political rhetoric in this country for many years, health care is not to be denied to those who need it, regardless of individual ability to pay for

care. Furthermore, when health care is provided to the needy, it often takes the form of a service benefit, rather than as additional cash to be disposed of at the discretion of the consumer.

In my opinion, perhaps the principal reason that health planning has been so readily acceptable a form of public intervention is the widespread, unquestioned acceptance of need as the proper criterion for health care policy. Most lay persons believe, as do many health care professionals, that there exist objective, measurable needs for health care, and that such measured needs, no more and no less, should be fulfilled by a society like ours, which professes or aspires to be humane. According to George Bugbee, this strong belief underlay Senator Robert Taft's sponsorship of the Hill-Burton Act (Klarman, 1977). Contrary to some interpretations of the legislative history of the Hill-Burton Act, its provision on health planning was not an afterthought by the American Hospital Association, eager to launch a flow of federal construction subsidies to its members after World War II. Rather, the planning provision was from the outset an integral element of a program of federal grants for facilities construction to be administered without political favor or bureaucratic discretion, a program drafted in close cooperation among the U.S. Public Health Service, the American Hospital Association, and Senator Taft. This belief in the criterion of need, measured objectively by professional experts, led to the organization of numerous area-wide hospital planning agencies throughout the country, with lay membership on the board of directors and often medical leadership of the professional staff. The same belief underlies the CON movement, a program that will be required in all states under the 1974 law.

The Criterion of Need

As the measure of requirements for health care, the criterion of need has been more talked about and cited than made operational through empirical studies. The most systematic attempt to measure need for health care resources is also the first. As part of the work of the Committee on the Cost of Medical Care about 1930, Lee and Jones set out to measure this nation's requirements for physicians, nurses, and hospital beds (Lee and Jones, 1933). They assembled data on the occurrence of disease and injury in a population and then asked a panel of experts how many services were indicated for each diag-

nostic condition. Estimates of volumes of services were then aggregated for a population and converted into ratios of manpower and facilities to population.

Subsequent estimates of the quantities of health care resources needed by a population tended to be abbreviated versions or adaptations of the Lee-Jones procedure. Usually the step calling for morbidity data was skipped. Estimates of requirements for health manpower drew directly on comparative personnel to population ratios (Klarman, 1965: 98–99). Calculations of hospital bed needs came to draw on inpatient utilization data. Ironically, the Hospital Council of Greater New York adopted existing utilization as the standard of need in 1947, on the ground that nobody in need of hospital care went without it in New York City. Today, this interpretation of the data would be questioned on the ground that, with third-party financing predominant, the tendency is to use whatever facilities exist, within a wide range whose limits are still untested. Deviations from this tendency can be attributed to temporary lags in response to large geographic shifts in population and physicians from city to suburb; large shifts in utilization away from public hospitals, when major public financing programs introduce free choice of physician; and a reduction in the overall rate of hospital occupancy, possibly associated with the rapid expansion of hospital reimbursement by third-party payers on the basis of retrospectively calculated costs.

The criterion of need, as measured by Lee and Jones, was intended to reflect what medical science and technology are capable of delivering at a given time, according to the best practice of the day. Individual ability to pay for health care was obviously to be ruled out as a factor. Less obvious was the decision to disregard the patient's awareness of his condition (and of the potential effectiveness of medical care) in setting the quantitative standard. It follows that resources might be mustered that could go unused (Klarman, 1969b).

Other, technical objections have been raised to the criterion of need. Expert opinion as to the quantity of services required to diagnose and treat various conditions may not be reproducible, that is, different groups of experts will produce different numbers. Usually it is not possible to reconcile the different numbers, since the bases on which the experts render their opinions are seldom made explicit.

Economists have leveled additional criticisms at the criterion of need. By assumption, a technological standard of need is a single

point. There is, therefore, no room for substitution among inputs into the process of producing health care or for trade-offs among simultaneously desired, competing objectives (Hansen, 1970). Thus, the standard of need accords an absolute priority to particular ways of delivering specified services, without regard to relative cost or to a community's total ability to pay. Clearly, there is a contradiction here. On the one hand, most of us would agree that no society, however well endowed, can afford to have everything; to obtain more of one thing, it is necessary to give up something else. Yet in health care policy documents, we read unequivocal estimates—precise to the last digit—of the numbers of physicians, dentists, or hospital beds needed; and usually these numbers are widely publicized.

This contradiction can be expressed in another way. Most empirical studies show that social, demographic, and economic factors are significant determinants of utilization; that is, education, urban or rural residence, prices, or health insurance influence utilization. Notwithstanding, in estimates of need prepared by health planning agencies, upward deviations attributable to any of these factors are regarded as "inappropriate use."

The contradiction is compounded when the availability effect is taken into account. The proposition then is that a major, perhaps *the* major, influence on health care utilization is the existing supply of resources, that is, population groups in certain areas have become accustomed to using more services than others. Within a fairly wide band of experience, and without any apparent effects on health status, populations and their providers appear to adapt to existing levels of resources. As far as is known today, and with a few specific exceptions, people seem to get along equally well with more or with less. Indeed, proponents of prepaid group practice have come to argue that, with respect to hospital care, more is not necessarily better. Under diverse arrangements for delivering health care, then, no single standard of need can be applied. Rather, there is a known range of resource to population ratios, without any evident effects on health status, but with still unknown differential impacts on access to services and on utilization by subgroups of the population.

This interpretation of the evidence has never been obvious or unanimously accepted. I have been convinced of the strong effect of supply on utilization by the data from England, where regional differences in inpatient utilization persist despite a uniform national health service but where hospital construction was at a standstill for

a generation and longer; and by experience and observation in New York City, where some hospitals built by apparent mistake did succeed in attracting clientele (Klarman, 1964; Klarman, 1969a). Supporting this interpretation are reported differences in inpatient utilization across state and local areas. Differences among federal employees subscribing to various health insurance plans cannot be interpreted unequivocally.

To summarize the argument, the criterion of need posed difficulties before the availability effect was introduced into the literature, and becomes untenable when the availability effect is taken seriously. I am unable to see how the availability effect justifies the CON program, as was recently suggested (Willemain and Farber, 1976). Recognition of the availability effect may lead to a policy of supply curtailment or even reduction, but such a policy cannot be sensibly implemented by reference to the criterion of need.

In determining the desirable amount of resources to seek for a population or a geographic area, there is no solace in the criterion of need. Nor is recourse to a standard of need necessary, as was demonstrated in World War II, when the military draft for physicians took account of the existing physician to population ratios in the states. At the aggregate national level, the established policy was to reduce the number of civilian physicians. Interim targets were set, without ascertaining what the final goals might be. Although the drift of the policy was to move toward equalization among the states in the civilian physician-to-population ratios, there was no intention to achieve equality.

Obstacles to Curtailing Supply

How far and how fast a policy of curtailing the supply of health care resources can be pursued in a time of peace will depend on how much is known about the long-range consequences of such a policy and on our ability to carry it out. Little is known in any systematic way about the consequences of a permanent reduction in health care resources. Do all population subgroups sustain a proportional reduction or do some lose more than others? When utilization declines, do perceived requirements for services also decline? Or does the queue merely lengthen? It is not too soon to start pursuing these questions. Indeed, the more uniform are the means adopted in various parts of the country for curtailing health care resources, the more difficult it

will be to ascertain their effects. Although variation in practices is sometimes the mark of failure to carry out a policy, such variation expands opportunities for obtaining empirical research findings through statistical techniques.

The ability to carry out successfully a policy of supply curtailment is to a considerable extent a matter of authority and power. Some things people will not do without coercion. Making compliance mandatory may even be a precondition for virtually voluntary compliance, as exemplified by individual willingness to pay taxes when others also pay. In large part, the willingness of participants in the health care system to accept their respective shares of a reduction will rest on their perception of the legitimacy and fairness of the claims made upon them. Legitimacy of authority is surely a subtle, multidimensional affair. Included are such elements as confidence in the decision-making agencies and their advisory bodies; adherence by the agencies to due process; competence displayed by the professional staff; and the understanding and wisdom conveyed by the recommendations and the supporting documentation. The ultimate test is whether participants deem the planning agency's recommendations and decisions to do good.

Whether the conditions of compliance with a planning agency's decisions be voluntary or compulsory, in the long run the decisions of planning agencies are judged in the same way. For when compliance is voluntary, unwise decisions can be disregarded; and when compliance is compulsory, decisions can be circumvented in numerous ways, and their implementation delayed or aborted through litigation. A health planning agency can become so preoccupied with satisfying legal requirements, that it spends the bulk of its time writing and rewriting regulations to make them foolproof and applicable, without exception, to individual cases. In such a climate it is easy to lose sight of the original reasons for undertaking health planning.

Not all recommendations or decisions adopted by health planning agencies can be based on firm knowledge, derived from experience. When such knowledge is lacking, the most solid and least costly foundation for action may still be cooperation on a voluntary basis, involving negotiation and a good deal of give and take (Klarman, 1969a).

However, I believe that recommendations or decisions requiring mandatory compliance should be imposed by the government.

Although the extent to which government may legally delegate its authority to unofficial agencies is not clearly delineated, wholesale and substantial delegation to others is of questionable wisdom. In the case of the accreditation of hospitals as a condition for provider participation in Medicare, even the effects on the body whose standards were adopted, the Joint Commission on the Accreditation of Hospitals, have not been altogether salutary.

Adherence to decisions made by superior authority is facilitated if those subject to the authority have a sense of participation in the deliberations leading to the decisions. The past decade has witnessed progress in opening up meetings of legislative bodies, executive agencies, and regulatory commissions. In general, "sunshine laws" may be expected to produce salubrious effect; how much good they accomplish will depend on the acuity of those who attend the proceedings.

More important for getting a sense of participation is the appointment of consumers to the boards of health planning agencies. The 1974 law follows this trend, but expressly also requires provider participation. The question is: How much do consumer members understand of the substance of discussion at meetings and how much do they contribute to it? Clearly, there are bound to be some differences in background and in interest. Even so, it is my impression that the information furnished to consumer representatives to help them carry out their duties in comprehensive health planning agencies bears excessively on procedures, rules, and regulations, and sheds insufficient light on the problems of patients and the health care system or on the alternative means and opportunities available to solve such problems.

At the outset, the willingness to accept one's share of a reduction in supply was linked to legitimacy of authority and fairness. Fairness denotes taking into account the distributional effects of a decision. The burden may fall disproportionately on different population groups; and not all costs are explicit. The most obvious exclusion from health care expenditures are travel costs of patients and their families, plus their inconvenience and discomfort costs. The former are pecuniary costs, but the latter are non-pecuniary costs that are not readily measurable. For physicians, as amplified below, treating them fairly means giving due consideration to the retention of their professional skills and to their ability to earn a living, when a facility is closed or denied to them. For hospitals, treating them

fairly means paying attention to the caliber of the institution as a whole, when applications for a special facility are reviewed.

Although fairness is by no means ensured by stability of health planning policies, practices, and rules, instability and frequent modifications are almost bound to be perceived as unfair by those who were not aware of impending changes. If persons outside the decision-making body were not informed of possible changes ahead of time, such changes, when adopted, may be seen as manifesting capricious, and therefore arbitrary, behavior. Both the general direction of policy and the various means under consideration for carrying it out should be widely disseminated.

Moreover, the principle of fairness would seem to imply that health planning, coupled with regulation, would address itself to "real" problems and solutions. Thus, it is difficult to know what to make of certain devices smacking of "gimmickry" that have emerged in New York City and New York State in recent years. For example, reported bed capacity is officially reduced in order to raise a hospital's computed rate of occupancy, without anything having really changed in the operation of the hospital. A large hospital buys a small hospital, in order to acquire its bed capacity as a basis for future expansion when the small hospital, slated for closure, does close. Two hospitals are merged legally, so that the smaller one may enjoy a higher reimbursement rate under the protective umbrella of the larger one, thereby evading the reimbursement ceiling imposed on the smaller hospital's peer group of hospitals.

Legitimacy and fairness are necessary conditions for the successful implementation of a supply curtailment policy, but are not sufficient to guarantee the policy's success. Planning can be a risky enterprise, because daring leaps are tempting when there is so much room for good to be done. The temptation to embark on such leaps is strongest when unexpected adverse effects fall on others. Even more to the point are the dangers posed by regulation, which is increasingly being coupled with planning. Regulation is suspect, not only because regulators may be corrupted by the power they wield, but also because, like the rest of mankind, regulators are eager to succeed and get things done. Regulation is suspect in part because of the danger that the regulated may take over the regulatory mechanism, as has been known to happen. Indeed, in the modern economy, the regulated providers may at some point prefer to cooperate and be rewarded by a system in which the ability to live with complex

regulations becomes in itself a new, scarce commodity with a high market value. Consumer participants in the regulatory process may be coopted by accepting prestige-carrying inducements, however small, or by adopting the value system of the regulated industry. As the anonymous reviewer of this article observes, consumer representatives sometimes form an alliance with provider representatives, in opposition to local public officials.

With authority or power goes responsibility. Is a health planning agency acting responsibly when it issues a list of hospitals to be closed at some undetermined, future date? Is not such a statement virtually tantamount to a self-fulfilling prophecy? Is it a legitimate exercise of authority to close an institution on some specious ground, such as failure to comply with sanitary standards, which is not applied equally to other hospitals, just because the real reason cannot be documented in accordance with prevailing rules?

To require legitimacy, fairness, stability, and restraint in the exercise of health planning will undeniably hinder the effectuation of a policy to curtail the supply of resources. Nevertheless, I believe that observing these requirements is a necessary price for securing the willing participation of consumers and providers and for protecting the health care system against large mistakes in judgment. If the price paid is a delay in implementing good and sound decisions, this price may be lowered over time as mutual trust develops among all parties and those in authority exercise power with restraint. Time will tell whether the requisite trust can and will be achieved. A policy of curtailing or reducing supply is always more difficult to execute than one of expansion, because there are bound to be some losers. However, once a policy of curtailment is decided upon, it is more likely to be effectuated if the decision commands confidence and appears to be fair to those affected by it.

Allocating a Given Total Among Many Providers

The 1974 law says nothing about the question: How is a given target total to be allocated among multiple providers? One implication is that the solution is self-evident. Perhaps the solution was obvious, when expansion of resources was the prevailing tendency. In a climate of expansion it was but necessary to exclude from the inventory of existing facilities those that failed to meet standards of fire-

resistiveness or could not meet the modest conditions for accreditation. Indeed, while such facilities were omitted from the total count, they continued to operate. Moreover, even if all facilities in operation were counted, it was possible to convert some from one use to another.

Today, the problem of proceeding to allocate a total among its components warrants close examination. In theory, the solution is, given the desired total, the optimum size of the firm will determine the number of firms. The notion of an optimum size derives from economics; it means the size of firm at which production in the long run, when all inputs may vary, can be carried out at least cost per unit of standardized product. Studies of hospital cost functions have failed to find appreciable economies of scale; beyond 100 beds or so, it seems, hospitals operate at constant cost over a wide range (Lave and Lave, 1970). Yet health planning agencies have steadily proclaimed larger and larger minimum sizes of hospital. Clearly, other factors than cost are being taken into account, but we are seldom told what they are. Basing the minimum size of hospital on programs for the graduate training of physicians, as was explicitly done in New York City in the 1940s, is one exception (The Hospital Council of Greater New York, 1947). The numbers of beds serving as standards should have declined over the years, as increasing proportions of private patients became available for teaching. Subsequently, doubts arose about the very validity of this basis for determining the minimum size of hospital, when the positions in some residency training programs came to be filled by graduates of medical schools who were perceived to have poorer qualifications than the graduates of American medical schools.

An economic approach that measures only the costs incurred by the provider is too narrow. With the disappearance of house calls, travel costs fall exclusively on consumers. Larger, hence fewer, facilities serve to raise transportation costs, as well as some intangible inconvenience costs associated with travel.

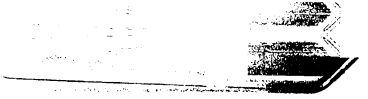
The problem of allocating a total is vastly complicated in an atmosphere of overall contraction. If a specialized facility in a hospital is closed, its medical staff members may lose out and the institution as a whole is truncated, with repercussions on other parts of it. If an entire hospital is closed, its physicians, other staff, and the population residing in the immediate neighborhood may be affected adversely. A responsive and responsible health planning agency must

demonstrate its awareness of these potential effects, and should move to mitigate them.

With few exceptions, all antecedent health planning agencies and programs in this country, as well as the 1974 law, have disregarded the problem of hospital staff appointments for physicians. When a hospital or unit is closed, some physicians will lose access to a hospital unless offsetting action is taken. Naturally these physicians object to the potential erosion of their skills and loss of earnings. The public also stands to lose, because the same physicians who will no longer practice in a hospital, where they are subject to a measure of peer scrutiny and stay in touch with medical advances, will continue to practice medicine in their offices. When a hospital is denied a costly specialized facility because another hospital in the community has such a facility, its physician staff members will object for the same reasons—potential loss of skills and earnings. Perhaps the importance of hospital appointments for practicing physicians has been overlooked in this country, because the problem does not arise in the United Kingdom, where the major portion of the health planning literature on regionalization originates (Pearson, 1975: 19).

Under some organizational arrangements the problem of physician-hospital relationships solves itself. For example, if a Health Maintenance Organization (HMO) owns a hospital and is self-sufficient, all physician members are assured of access to appropriate facilities. Similarly, consortia are being organized, which take action on hospital staff appointments for specialists. In the case of consortia, it seems easier to concentrate costly facilities for definitive treatment than for diagnosis, and easier to concentrate costly facilities for patients with rare diagnoses than for patients requiring intensive care for common diagnoses. At any rate, HMOs and consortia are still exceptional forms of medical care organization in this country. The challenge is to arrange for hospital staff appointments for physicians under the most common, ordinary circumstances. I have come to believe that dealing with physician staff appointments is a necessary precondition to carrying out a successful policy of facilities curtailment, as well as to making appreciable progress toward regionalization in this country.

It is also necessary to scrutinize the standards issued by various specialty organizations on the optimum size of specialized facility. Why is the minimum load for open heart surgery 200 operations a



year? Is such a standard based on the desirability of spreading high fixed costs over a large volume of services, or does it reflect a judgment about the quality of care in a smaller facility, such as mortality rates in surgery? If both considerations enter, what is the relative weight of each? Indeed, how is one balanced against the other, if the two factors point in opposite directions? In any case, where is the documentation that a sharp discontinuity exists? My own impression is that little is known in systematic fashion about the cost behavior of specialized facilities in hospitals.

The very procedure for reviewing individual applications for new facilities or services may create a problem. The process of getting approval resembles too often drawing from a grab bag, with contents unknown. Since the typical rule is first come, first served, there is a scramble to file applications, whatever the state of readiness. Whoever has established a specialized facility is invariably protected by a grandfather clause. Even a Veterans Administration hospital is so protected, although the presence of its facility in a community may be disregarded when applications from the other hospitals are under consideration.

For these reasons and from my experience in a health planning agency, I cannot see how such an agency can routinely review and make recommendations on individual applications as they arrive and also develop considered annual plans. One of these plans, according to the 1974 law, will list recommendations on individual projects, with a priority attached to each. How are the results of the two processes to jibe? A better procedure would be to review and recommend on all pending applications at the same time. The pool of applications could be enlarged by announcing a decision date publicly and inviting the timely submission of applications. Performing this task once a year is probably too infrequent; doing it quarterly may be too burdensome on the staff.

Whatever addition to an agency's work load may ensue from the process of simultaneous review of an enlarged pool of applications could be offset by reducing the frequency with which health systems plans are prepared. If a plan is good today, why can't it be good for a second year, and for a third year? Even the HSA's Annual Implementation Plan could apply over a longer interval, if converted into a moving plan. The agency would then have to compare the projections it made for the most recent year with what actually happened and adjust targets for subsequent years accordingly. This

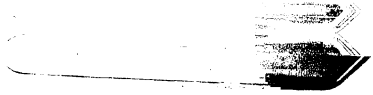
is highly desirable. By contrast, in the state Hill-Burton plans, each year was treated as a self-contained interval, with the slate always wiped clean at the end of the year. Each year's plan served, in effect, as a rationale for the distribution of federal construction subsidies in the coming year. Periodic adjustment of an area's multi-year plan could be further improved by drawing on the plans developed internally by individual institutions with the assistance of health planning funds, as authorized by the 1974 law. Some health planning experts continue to regard the individual hospital as the key health planning agency (Sigmond, 1966).

Planning for Small Areas

Fairly recently I have written at length about the additional difficulties of planning for small areas, compared with planning for the nation as a whole (Klarman, 1976). There are two reasons: the greater variation or instability that is associated with small numbers; and the relative ease with which small area boundaries can be crossed.

By tradition, health planning in this country has been isolated from other types of urban planning. Some of the practitioners of health planning may not know that population trends for small areas are inherently unstable. The smaller the area planned for, the more volatile is the total population figure. Projections for components of the population are even more volatile, since migration in and out of a small area tends to be selective. Clearly, it is futile to try to project the population of a small area 40 years or more, which is the physical lifetime of a hospital. Yet it is evasive to rely on a 5-year population projection, calculated with great precision, after much effort is spent on developing an accurate, up-to-date intracensal estimate that serves as a baseline. At least the new, 5-year U.S. Census will save this costly piece of work.

Improved techniques of population forecasting for small areas will not provide a solution. Rather, since most forecasts of population for small areas are bound to be somewhat mistaken, I suggest that emphasis be put on what steps to take when population rises or falls by a specified, sizable amount; this was the approach adopted by the Hospital Council of Greater New York in its study of hospital bed requirements by the borough of Staten Island. In general, however, it is necessary to rely on the flexible and versatile use of facilities. Flexibility is for the purpose of adjusting to fluctuations in



patient census in established facilities; versatility is for the purpose of accommodating desired changes in use over the long run (Klarman, 1976).

In the past, continuing expansion enabled the versatile use of facilities by means of modest expenditures for converting facilities from one use to another. But it is not evident how to proceed when the policy adopted is one of curtailment, since converting facilities to other, new uses usually leads to an increase in total health care expenditures. New ideas and methods must be devised for avoiding heavy capital costs and a high proportion of fixed costs in operating budgets.

The boundaries of small areas are porous: residents can leave and outsiders can move in for care in facilities deemed more attractive, nearer, or more appropriate for dealing with a particular medical condition. My own experience in health planning suggests that to adhere to defined small areas for the purpose of planning is not useful, while using such areas as bases for data compilation and for the study of problems is helpful. The appropriate boundaries for health planning depend a good deal on the particular problem or service to be planned for.

These difficulties are accentuated when health care facilities are located close to designated area boundaries or plans are prepared for people who reside at the periphery of an area. For the latter it may be nearer and more convenient to seek care in an adjacent Health Service Area. However, the crossing of boundaries of Health Service Areas is likely to be more frequent for patients in search of tertiary care, that is, conditions that occur with low frequency and require highly specialized services. These examples raise doubts about the wisdom of requiring all board members of a HSA to reside in that area. As sub-area health planning agencies are developed—the 1974 law supports this—the governance of such an agency might diverge sharply from the governance of the tertiary care institution, which draws patients from several Health Service Areas and is accountable to several constituencies.

At this early date it is easy to recognize the need for a good deal of coordination among neighboring HSAs. Undoubtedly there are many practical ways of going about this, and arrangements should be made even now for observing and evaluating the results of different approaches.

Uses and Limitations of Uniform Data Sets

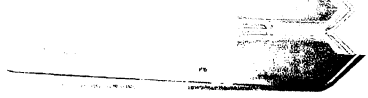
In the 1974 law, Congress undoubtedly intended to convey a message about the importance it attached to data in health planning. Not only are facts seen as superior to mere opinion; sometimes, facts are taken to point directly to policy. Congress also intended to take note of the existence of a multiplicity of data sources and to indicate numerous opportunities for cooperation in the collection of data. Both to save money and to improve the quality of data, cooperation is preferable to having every health planning agency try and collect its own data.

Unfortunately, it is customary in health planning in this country to compile voluminous data and process them with fine precision, with little concern for whether the particular data throw light on the problem at hand. In many health planning documents, the disjuncture between tables and text is glaring. Numbers are presented because readers expect to see some in a formal report. To many business leaders, politicians, and newspapers numbers convey an aura of objectivity and carry an air of authority.

In my opinion, numbers should be pertinent. Sometimes we show too much concern over the reliability, that is, the reproducibility and stability of data and too little over their validity, that is, measuring what is germane. The test for using and presenting data is perennial: Are we measuring what we seek to measure or what is easy to measure?

It is virtually certain that to prescribe specific types of data and uniform data sets will prove to be a mistake. The very availability of data will lead to their presentation, with or without analysis, to the neglect of real health care problems. Formulation of a problem in operational terms should lead to the search for pertinent data, not the reverse. As the problems to be dealt with change, so should the data compiled and analyzed.

The 1974 law prescribes the collection of data on health status and on the determinants of health status. Here is a fine example of a tendency to equate the things we know how to do and the things we would like to know how to do. Research on measuring health status is proceeding and deserves continued support. However, ascertaining the determinants of health status must await the measurement of health status, and cannot precede it. In any case, today both tasks—measuring health status and ascertaining its deter-



minants—are best treated as research undertakings that are far from ready for application in health planning. Neither task is useful work at this time for a HSA.

For many years, students of health planning have lamented the total separation of health planning from finances. Traditionally, once the need for additional facilities was determined, it was only necessary to price out the cost of construction. That revenues to meet operating cost would materialize once need was determined, was taken for granted; the dollar amount involved was of little consequence. In the 1974 law, Congress clearly expresses the intention to bring finances within the purview of health planning. This is a positive step, as previously noted. Congress has gone further, however, and prescribes the types of financial data to be accumulated and reported. My impression is that Congress is not altogether clear about the uses of such data. There seems to be some confusion between data useful for management and data useful for rate making. If there is one thing that economists and accountants agree upon, it is that allocated average costs are not a proper basis for setting prices in a firm that produces multiple products, like a hospital (Klarman, 1965: 120). Moreover, given the lack of experience in applying such data in health planning, it is sheer guesswork to predict what kind of financial data will prove to be most useful.

Accordingly, it is premature to freeze the data system today, and it is wrong to prescribe new, uniform data sets. In spite of common opinion to the contrary, the health care field is surfeited with data, often of a uniform and comparable nature. The task before us is to begin to link data with problems by trying to apply specific data to the analysis of real problems, and to evaluate the results. Whether particular data should be collected routinely ought to depend on the data's pertinence to the analysis of problems that occur frequently. For example, what kind of financial data do capable managers use? What kinds of averages are most useful for making actuarial projections? What types of frequency distributions would help monitor the health care system? Are data on individuals more useful or less useful than area data for explaining trends in health care expenditures? To explain changes in spending patterns, are data from experiments superior to data from surveys? Are findings from natural experiments perhaps more productive than findings from designed experiments? What kinds of data should be collected to describe trends in total health care expenditures and in the several compo-

nents? I have left the matter of pricing for the end of the list, because I doubt that under conditions of widespread reimbursement by third-party payers retail charges are a meaningful item of information.

I deal with financial data at some length, because they constitute a relatively new piece of data in health planning. Certainly, Congress had good reason to bring financial considerations into health planning, but it cannot do so merely by legal edict, where technical competence and experience are lacking. I refrain here from examining other bodies of data so closely. Suffice it to state my opinion that data requirements should always depend on the problem at hand. There is no reason why every HSA should work on the same set of problems; as the 1974 law provides, priorities for action will be determined locally.

The burden due to data collection is further increased by the law's requirement that each HSA will periodically submit an evaluation of its performance. For such an evaluation to be meaningful, not only must progress be traced, but changes must be attributable to the influence of health planning. To me it seems wise to leave the evaluation of the worthwhileness of an undertaking to outsiders. The obvious technical difficulty of the task serves to reinforce this dictum.

Over the years I have repeatedly observed that a large-scale, routine effort at data collection can be wasteful. The waste is not always obvious because once collected, the data are usually presented, whether or not they pertain to the problem at hand. An initial data set should be truly a minimum, and based on past experience whenever possible. I should think that every Health Service Area would want to know the number of physicians serving it and their distribution by specialty and location of practice, the number of facilities and their capacities, the utilization of resources, how much is spent, and perhaps also how much providers earn.

At every turn, the effort devoted to collecting particular data ought to depend on the problem at hand. In general, we know how to measure capacity to care for inpatients but we lack a method for measuring the capacity for outpatients. An effort to devise such a method is in order. Even for inpatients, the same room is sometimes set up to accommodate either one or two patients, depending on momentary demand. Without a fixed measure of bed capacity, there is no way to compute a rate of occupancy. Indeed, any departure from the designation of space for a single use makes it difficult to measure its rate of occupancy. Yet the flexible use of facilities serves

to reduce operating costs, particularly under conditions of random variation in demand. All of these considerations are of a technical nature and call for careful treatment. Although the ideas and their elaboration tend to originate in academic circles, their dissemination has become largely a federal activity. It is important, however, that the staffs of local and state health planning agencies understand them.

With few exceptions, states and local areas do not have reliable figures on how much is spent in them on health care or how much their residents spend. The smaller the area, the greater the difference may be between the amount that the providers in an area receive and what its residents spend. Of course, if every Health Service Area served automatically as a catchment area, so that patients were precluded from leaving or entering the area, the discrepancy would disappear. However, limiting access in this way would be paying a high price, both in terms of freedom of choice and economic efficiency, for avoiding technical difficulties in data collection.

Data on expenditures must derive in part from data on utilization. It would be very useful to undertake a nationwide effort to collect information on the geographic origins of hospital patients, so that utilization rates by populations may be distinguished from utilization by location of facility. To collect similar data for physicians' patients would require the prior development of reliable and efficient instruments.

In light of my earlier comments on physician staff appointments, data on physician-hospital relationships are clearly required. We are interested in the nature and extent of physician privileges and obligations, as well as in their sheer occurrence and frequency. Such data may be too costly to collect routinely or annually. Perhaps they can be updated in the context of imminent hospital closures or denials of CONs for specialized facilities.

The 1974 law makes numerous references to priorities. Perhaps it was never intended that the list of 10 rest on an analytical foundation, combining data analysis and valuation. But how is a HSA to determine its own priorities, whether for its Annual Implementation Plan or for its annual recommendations of projects for construction, as required by law? In connection with the Annual Implementation Plan, the 1974 law adverts to costs and benefits, though not to cost-benefit analysis. At this juncture it is important to recognize that owing to difficulties in valuing the intangible benefits of

good health, especially the benefits of extending life expectancy, systematic policy analysis cannot yield priorities among health care programs. We must continue to rely on value judgments. I can but add a caution, based on my experience at the Hospital Council, that no single category of health care facility or program should be accorded an absolute priority over all other categories to the point of exhausting all available funds.

Priority usually denotes a sense of importance. As Sigmond has pointed out, however, priority may also denote a sense of timeliness, mainly because a particular task is considered doable (1976). As techniques improve or circumstances change, priorities in the second sense may change, even if the relative importance of problems does not.

Summation and Amplification

Health planning is a complex activity. It is easy to lose sight of the subject matter of planning amidst the daily preoccupation with structure, procedures, or even techniques.

Perhaps the most important step in health planning is selecting problems for study and recommendation. There is no scientific way to make these selections. Compromises are likely to be struck between what appear to be important problems to tackle and what is doable at a given time.

The technical difficulties described in this paper appear to be almost overwhelming. Not all of them can be solved. Knowing about these difficulties can often help us to evade them in the context of analyzing specific problems.

It is not evident how to allocate a reduction in total resources among many firms. It is all the more important that health planning agencies display understanding, objectivity, fairness, steadiness, and restraint in formulating their recommendations and decisions. Clearly we must try to devise means to compensate those who stand to lose the most when a particular plan is carried out.

The difficulties of health planning are magnified in an atmosphere in which contraction is sought for a major sector, the short-

term, acute general hospital for inpatients. We have had little or no experience in carrying out a policy of contraction.

Improved, more precise techniques for projecting population afford no solution for the technical difficulties of health planning for small areas. Rather, reliance must be put on developing and adopting devices for the flexible and versatile use of facilities.

It is important to distinguish between what we know and what we wish we knew. I have indicated several instances in which it would be worthwhile to acquire additional knowledge, but where routine data acquisition seems premature.

A major theme of this paper is that there is no refuge in numbers. The criterion of need breaks down upon close examination; and once the availability effect is recognized, the program of CON must take a new form. I recognize that this view is radical, perhaps subversive. Instead of numerical standards to be reached, there will be incremental, or decremental, directions to pursue, with interim targets. The data requirements will change accordingly, and a good deal of attention will focus on who stands to gain or lose from proposed policies.

The 1974 law may have prescribed the collection of a lot of data too soon. Data collection and analysis should pertain to the actual and emerging problems of communities. Moreover, data requirements differ for research purposes and for application to problems in health planning. Legislative prescriptions for data can be attenuated by the implementing regulations; but that is a dubious practice.

Even so, I am disposed to urge collection of data on the origin of inpatients by area of residence, so that corresponding estimates of expenditure may be prepared. Furthermore, I am prepared to add two types of data not listed in the 1974 law as potentially useful in many local areas: physician staff appointments in hospitals, as explained above, and information required to operate an efficient local network of referral and follow-up for long-term patients.

Data are useful when they illuminate a specific problem. Systematic analysis of data cannot yet help us make many of the decisions involved in health planning. Value judgments—political judgments in the best sense—are central in setting priorities among problems and programs.

A reading of the 1974 law suggests that it may produce an overload of paper work. Steps might be taken early to reduce the frequency with which plans are drawn and reviews are submitted.

The coupling of planning with regulation enhances the authority of health planning agencies, and thereby increases the agencies' responsibility. The exercise of authority legitimately and with restraint can help build a foundation of mutual trust. In an age of litigation such trust is not easy to establish and maintain.

Yet health planning is a necessary activity, in my judgment. There are no good, realistic alternatives to health planning for curbing the persistent rise in health care expenditures and for improving access to care of acceptable quality.

Who is fit to perform the numerous and varied activities described and prescribed in the 1974 law? Where are these paragons to be found? How are they to prepare for their tasks? Somehow the majority of board members must continue to retain their identities as consumers, be articulate in their complaints and resist cooptation and the arrogance of power, and begin to learn to weigh the merits and demerits of alternative solutions to real problems.

Staffs trained in policy analysis, with special application to the health field, will be required. Staff members will be called upon to apply their knowledge and skills to specific problems in the small geographic area with its porous boundaries, in a setting of multiple levels of control, both professional and governmental. Health planning activities are to be carried out at a time when the total number of physicians is increasing rapidly; when feelings run strongly in favor of reducing the supply of hospital beds and curtailing the proliferation of costly technologies; when uncertainty continues about how to provide long-term care; when the major emphasis at the federal level is on curbing health care expenditures; and when in many instances emergency efforts are being made at the state and local levels to reduce government expenditures. In addition, national health insurance and its particular complexion, though still in abeyance, loom on the horizon.

If the activities prescribed by the 1974 law, and the problems they pose, constitute an impossible task to boards and staffs of health planning agencies, perhaps these activities are not entirely necessary. For the ultimate test of health planning is, Have we done good? Under health planning with teeth the possible mistakes are greater than ever before; but large mistakes are not inevitable. Modesty in claims and moderation in the pursuit of currently fashionable goals are a becoming posture for the health planning enterprise. Certainly this holds true for the foreseeable future.

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