Is the development of comprehensive health planning in the United States to be considered as an attempt at creative federalism? And what is creative federalism? This paper deals with these questions to see whether meaningful cooperation between different governmental and private elements has been established, and how effective this has been.

COMPREHENSIVE HEALTH PLANNING: A STUDY IN CREATIVE FEDERALISM

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HEALTH professionals often hear the terms federalism and creative federalism used in public discussions of the role of government in health care. Nelson Rockefeller defines federalism "as a concept of government by which a sovereign people, for their greater progress and protection, yield a portion of their sovereignty to a political system that has more than one center of sovereign power, energy and creativity."[1]

In discussing federalism, Graves states that "this idea of division of power is of paramount importance," and raises the difficult question of the manner in which powers are to be divided.[2]

The term creative federalism is used to describe a pluralistic approach to the solution of the problems of urban society. Creative federalism engenders a milieu which encourages what Rockefeller describes as "the free play of individual initiative, private enterprise, social institutions, political organizations, and voluntary association. . . ."[3]

It is the purpose of this paper to review the development of comprehensive health planning in the United States as an attempt in creative federalism. Three federal programs—the Hill-Burton Program, the Partnership for Health Program, and the Regional Medical Program—will be examined to determine the extent to which they have been successful in establishing meaningful cooperation between the federal, state, and local governments, and the private sector, and their effectiveness in improving the state of the nation's health.

The Hill-Burton Program

Prior to the enactment of the Hill-Burton Program in 1946, hospitals developed independently with practically no coordinated planning. Funds for hospital expansion were obtained largely through philanthrophy. From 1910 to 1930, hospital beds were very poorly distributed. By 1928, there were 6,852 hospitals with nearly one million beds. During the depression, hospital construction nearly ceased, so that it became apparent during World War II that the shortage of health facilities was reaching crisis proportions.

The purposes of the Hospital Survey and Construction Act, Title VI of the

Public Health Service Act, popularly known as the Hill-Burton Act, were to assist the states in making an inventory of existing facilities as a basis for determining future need and for developing a comprehensive plan, and to provide a mechanism through which financial assistance could be provided to the states for the construction of public and nonprofit health facilities.

An initial sum of $78 million was authorized to be appropriated under the provisions of the law through the fiscal year ended June 30, 1947. To participate, a state was required to designate a single agency to carry out the law's purposes. The state also had to appoint an advisory council composed of professional health and consumer representatives.

The Surgeon General was charged with the responsibility to establish criteria for bed needs, priority classifications, and construction standards. The Surgeon General's action was subject to the approval of the Federal Hospital Council which was provided for under the terms of the law.

The scope of the Hill-Burton Program has been expanded considerably through the years. In 1949, grants were authorized for demonstrations leading to better utilization of hospital facilities, services, and resources. Grants for construction of rehabilitation centers, chronic disease hospitals, nursing homes, and diagnostic and treatment centers were authorized in 1954. Then, in 1964, through the Hill-Harris Amendments, emphasis was shifted from rural hospital needs—which had been substantially met—to the serious need for modernization funds for the nation's urban hospitals that were rapidly becoming obsolete.

In 1962, through the Hill-Burton mechanism, grants were made available to support the development of agencies engaged in the areawide planning of hospitals and related health facilities. To date, more than $13 million has been expended for that purpose. Areawide planning is now in operation in more than 70 localities, most of them in metropolitan centers. Despite this progress, of 22 metropolitan areas in the United States with a population in excess of one million, only 16 have areawide planning agencies. Of the 30 metropolitan areas with a population between 500,000 and one million, only 14 have areawide planning councils.

Areawide Agencies Expand Activities

The scope of activities of the areawide agencies has varied. All have been concerned with discouraging construction of unnecessary facilities. Some have been concerned exclusively with acute care needs, while others have been also involved in extended care, mental health, and ambulatory care problems. Some of the agencies have been involved in pioneering studies and research work involving a wide range of subjects, such as plant obsolescence, effects of Medicare, ambulatory care, manpower shortages, and the like.

The recent trend has been toward expansion of the scope of interest of the agencies from hospitals to all aspects of health services. One of the most successful areawide agencies, the Hospital Review and Planning Council of Southern New York, recently changed its name to the Health and Hospital Council of Southern New York to reflect this changing emphasis.

Areawide planning agencies have been confronted with many problems. Most agencies, with the notable exception of those in New York State, do not have any statutory power, or formal relationship to a statutory body which would provide the authority necessary to implement their recommendations. The primary source of leverage of the planning agencies has been the ability to influence the allocation of public and

philanthropic funds for capital programs. Since many institutions have had adequate sources of private capital, they have usually been able to ignore the planning body's recommendations.

Evaluation of Hill-Burton Program

Haldeman points to seven accomplishments of the Hill-Burton Program.[4] They are the introduction of systematic statewide planning, establishment of standards of need, more even distribution of facilities, promulgation of minimum construction and equipment standards, improved hospital operations, upgrading of quality of care in rural areas, and, finally, encouragement of medical education through support for facilities at major teaching hospitals.

As a legislative program leading to improved intergovernmental relationships, Hill-Burton has been largely successful. Through the years, Hill-Burton has received the wholehearted support of a bipartisan Congress and four Presidents. It has been hailed by people within the health professions and government as one of the most successful federal-state programs in the postwar era. Since 1947, the federal government has participated in 7,400 projects involving the addition of more than 300,000 beds. The federal share was $2.2 billion of total project costs of $7 billion. Total outlays for hospital construction, during this period, exceeded $15 billion.

Despite its major accomplishments, Hill-Burton has had some shortcomings which, if they are to be understood, must be viewed in terms of the program's purposes. Hill-Burton did, as intended, provide a successful mechanism for financing hospital and health facility construction. It also succeeded in encouraging the development of comprehensive state plans. What, then, are its shortcomings?

A major criticism of Hill-Burton must be that, while it succeeded in averting a crisis that would have been caused by an insufficient supply of beds in the decade following World War II, it did not provide the flexibility necessary to adapt to changing circumstances, once the crisis had been averted. Nursing home, chronic disease, and rehabilitation needs were not recognized by Hill-Burton until 1954. The shift of emphasis from rural health needs to the problems of hospital obsolescence in our urban centers did not occur until 1964, and even then on a scale nowhere in proportion to the need.

Despite its role as the primary sponsor of areawide planning in the United States, Hill-Burton failed to meet the need for a more sophisticated approach which would provide for sufficient federal incentives, state initiative, and local and voluntary cooperation. This failure contributed to a situation characterized by duplication of facilities and equipment, improper manpower utilization, inefficient use of community resources, and standards of quality not consistent with that which is achievable.

Thus, in spite of the existence of a mechanism for successful federal, state, local, and voluntary cooperation, Hill-Burton—through lack of congressional action and administrative initiative—failed to sufficiently encourage and mandate alternate patterns in the planning, organization, and distribution of health care services.

Public Law 89-239

Public Law 89-239, the Heart Disease, Cancer and Stroke Amendments to the Public Health Service Act, authorizing grants to establish Regional Medical Programs to help combat the aforementioned diseases, was signed into law by President Johnson in October of 1965. This law emanated from a series of recommendations by a special Presidential Commission on Heart Disease,

Cancer and Stroke chaired by Dr. Michael De Bakey.

In the words of President Johnson, the goal of the program is "to speed miracles of medical research from the laboratory to the bedside."[5] The purposes of the program are (1) to encourage the development of regional cooperative arrangements among medical schools, research institutions, and hospitals; (2) to enable the medical profession to make available to its patients the latest advances in medical science; and (3) to improve the quantity and quality of health manpower and facilities, all as they relate to heart disease, cancer, and stroke. The act authorizes Congress to appropriate up to $340 million, through the fiscal year ending June 30, 1968, for grants to assist in planning, feasibility studies, and operation of pilot projects designed to carry out the purposes of the program.

The legislation provided for a 12-man National Advisory Council on Regional Medical Programs to be appointed by the Surgeon General. The council's functions are to assist the Surgeon General in the formulation of regulations, and to make recommendations to the Surgeon General on applications for grants under the program.

The development of a regional medical program typically begins with the formation of an ad hoc committee, interested in health care, gathering together to study the provisions of the law and its applicability to the area. The next step is usually to enlarge membership in this group to include as many representatives of public and voluntary health and social welfare related agencies as possible.

Such a representative group will often become the Regional Advisory Group as required under the program's regulations. The next step is the legal incorporation of the regional program. The corporation is then in the position to apply for a planning grant to develop specific objectives, as described in its application. The planning grant provides necessary resources for recruitment of personnel and appropriate facilities, so that the planning effort can begin. After the completion of the initial planning study, the region is in a position to clarify and redefine objectives, set priorities, and seek assistance for operational programs.

As of June 30, 1967, 47 regions had been the recipients of planning grants totaling about $20 million. Approximately 90 per cent of the nation's population is contained in these regions. Four regions have begun work on operational programs. Of the 40 regions established, 27 encompass an entire state, 10 include several states or parts of states, and 10 are intrastate in nature. Thus, the pattern of regionalization does not appear to have followed any one scheme.

Public Law 89-239 created a categorical program; i.e., one that deals with specific disease categories. A categorical health program by definition lacks comprehensiveness vis-a-vis total health needs. The legislative history of the law reflects a desire to work within the existing public-voluntary partnership. Since the regional programs are cooperative arrangements, of necessity they must heavily rely on consensus as a means of achieving their objectives. Before discussing the role of the Regional Medical Program in comprehensive, coordinated health planning, let us turn to Public Law 89-749.

Public Law 89-749

The Comprehensive Health Planning and Public Health Services Amendments of 1966, Public Law 89-749, known alternately as the Partnership for Health Act of 1966, was signed into law on November 3, 1966, and took effect on July 1, 1967. The purpose of the law is to encourage the development of comprehensive planning for health serv-

ices, health manpower, and health facilities at every level of government in collaboration with voluntary and community efforts.

Public Law 89-749 has five major provisions which provide (1) formula grants for comprehensive health planning at the state level; (2) grants for comprehensive areawide health planning; (3) grants for training health planners; (4) formula grants to states for public health services; and (5) project grants for health services development.

In order to obtain funds under the law, a state must designate or establish a single state agency for administering the state's health planning function. The state must also create a State Health Planning Council, composed of representatives of public and voluntary agencies concerned with health services and consumers of health services. The function of the council, a majority of whose members must be consumers, is to advise the state agency.

The function of the state agency is to develop a comprehensive state plan that takes into consideration all factors influencing health, identifies health problems, assesses available resources, selects goals and priorities, and develops criteria for evaluating progress. The state agency is to work with political subdivisions and voluntary agencies to develop a rational distribution of health services and resources. The law authorizes $7.5 million for assistance to states.

With the approval of the state agency, the law authorizes an appropriation of $12.5 million to be awarded by the Surgeon General to public or nonprofit private agencies for the cost of developing a comprehensive regional, metropolitan area, or other local area plan to coordinate existing and future health services. The law also authorizes Congress to appropriate up to $4 million for training, studies, and demonstrations leading to better comprehensive health planning, and $70 million for assistance to states in establishing public health services, all through the fiscal year ending June 30, 1968, and according to priorities and criteria established by the Surgeon General.

An important aspect of Public Law 89-749 is that almost all categorical restrictions of existing legislation are removed. The states are therefore given much greater flexibility in the use of federal formula and project grants. The states will be able to direct federal funds to problems which the states determine to be most significant and which they believe would result in the most effective utilization of available resources.

Funds were not appropriated for comprehensive health planning under P.L. 89-749 until June 1967. To date all but one of the 55 states and territories have designated central planning agencies—33 within state health departments, 16 in the office of the governor, and 5 through interagencies or commissions.

Because of the relatively short time since the enactment of P.L. 89-239 and P.L. 89-749, it is difficult to assess the impact that they will have on the organization and distribution of health services. Thus, the discussion that follows is based upon the legislative history and intent of these laws, and the patterns of implementation that have developed to date.

Discussion

Fragmentation and lack of continuity are constantly cited as problems plaguing our capacity to improve our nation's health. Yet one can point to P.L. 89-239 and P.L. 89-749 as examples of what Somers and Somers call "the planlessness of the planning movement."[6] Comprehensive Health Planning, said to encourage flexibility in use of funds, is a major departure from categorical programs; yet Heart Disease, Cancer and Stroke is a categorical program. Under

P.L. 89-749. Hill-Burton, Regional Medical Programs, Community Mental Health, and so on, will all continue to have their own planning mechanisms. Each will have a different orientation. Each may be imbued with the legislative purpose of the specific program rather than the over-all goal of better total health care.

As intergovernmental programs that must be coordinated, Hill-Burton, Regional Medical Program, and Comprehensive Health Planning pose serious problems. If all three programs, because of statutory requirements, were to be administered through the same state agency, which would in turn interact with the federal government and localities, a smooth relationship could easily result. Public Law 89-239 recognizes the need for consideration of the commonality of health problems between neighboring states. Public Law 89-749 does not take this factor into consideration, thereby creating an additional inconsistency. Many problems are created by not having the same political subdivision as the base unit for all three programs. These difficulties and inconsistencies create obstacles to the development of innovative approaches through interstate compacts, metropolitan area, or multistate region arrangements for the provision of health services.

It can be clearly established from a review of the legislative history that these bills were based upon a continuation of the pluralistic nature of our health care systems. A public-voluntary partnership is deemed worth while because of the voluntary sector's ability to experiment, innovate, and change. The purpose of P.L. 89-749 is not viewed as the imposition of a master plan by the federal government over the states or voluntary sector. Public Law 89-749 is based on the premise that responsible planning can only take place at the state and local level between public and private interaction.

To suggest that, despite the many contributions by voluntary organizations in the private sector, today's crisis in health care would not exist if the private sector had a true capacity for experimentation, innovation, and change, is not to suggest that the pluralistic approach be abandoned. Pluralism lies at the very foundation of the political, economic, and social fabric of the United States.

What is needed are the necessary constraints to make a pluralistic approach work. With proper constraints it would be possible to develop a system of organization and distribution within a pluralistic framework. The allocation of federal funds as the major if not only constraint, given the capacity of the private sector to generate funds, is not sufficient. With flexible, viable national standards, which would mandate the development of adequate state regulations for the planning and operation of health facilities, an integrated health care system composed of semiautonomous subsystems could evolve.

Conclusion

It has not been the author's intent to disparage the existing and possible future contributions of these legislative efforts. As previously stated, Hill-Burton has made a recognizable contribution to American federalism and health care. The Regional Medical Program and Comprehensive Health Planning Program have been designed as working models of creative federalism. However, the true measure of federalism is not the development of an intergovernmental program structure, but rather the ability of that structure to accomplish established goals. Whether—despite the weaknesses noted—Hill-Burton, Partnership for Health, and Heart Disease, Cancer, and Stroke can collectively accomplish more rational planning, organization, and distribution of health services through creative federalism, is a ques-

tion to which we must continue to devote our attention.

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Cities Test Pollution-Free Buses

In an effort to eliminate poison exhaust fumes given off by internal combustion engines, the United States Department of Transportation is underwriting experiments with test buses driven by freon-powered external combustion engines. San Francisco and Oakland (Calif.), and Dallas (Tex.) are the first cities to receive grants for this purpose.

Freon is a liquid with an extremely low boiling point. It is heated in a boiler by propane gas and converted into pressurized vapors that drive the engines' double-acting pistons. The new bus engines are soundless, and their only exhaust is carbon dioxide. (Newsletter. Division of Health, Wisconsin Department of Health and Social Service.)