Health Planning in the United States and the Decline of Public-interest Policymaking

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In the 1960s and 1970s, health planning formed a major theme of American health policy. Planners aimed to improve health services and make them broadly available while using resources efficiently. This article provides a history, both intellectual and political, of the origins of planning, its rise, and—in the face of mounting problems—its decline. The story also illustrates broader changes in the culture of policymaking in American health care. From the Progressive Era through the 1960s, reform-minded experts in health worked to advance the public interest. Thereafter, they increasingly left behind public-interest ideals and their underlying extramarket values in favor of organizing and improving health care markets. Whatever the deficiencies of traditional policymaking may be, this study suggests the need to resurrect extramarket values in health policy.

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FROM THE LATE 1950S TO THE EARLY 1980S, HEALTH planning formed a major theme of American health policy. Seen by its advocates as a "movement," planning aimed to make widely available coordinated health facilities and services, especially hospitals, and to foster their orderly and efficient development, that is, to meet need without duplication. Planning programs provided grants or loans to develop private and governmental planning bodies and health facilities, supported research to establish scientific foundations for planning, and eventually invoked regulation through certificate (or certification) of

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need (CON) to align the development of hospitals with planning goals. Although planning ideas had already influenced health policy during the first two-thirds of the last century, only in the 1960s and 1970s (labeled here "the planning era") did advocates of planning undertake major efforts to realize their agenda. Planning heavily occupied analysts and policymakers at all levels of government, in the voluntary-hospital sector, the medical profession, the nascent profession of health planning, and the emergent field of health services research. It elicited support from advocates of national health insurance, who saw it as a precondition for universal entitlement, and it engaged activists in struggles over whose needs should be served by health care providers (this last point is not treated here; see Brown 1982; Morone 1998, chap. 7). By early in the Reagan administration, however, the planning movement, stymied by intractable cost escalation, stung by criticism of its political dimensions, and obstructed by diverse other problems, ended in failure. This article provides a history, largely intellectual but also political, of the origins of planning, its rise, and its decline; and it uses this episode to illustrate broader changes in the culture of policymaking in American health care.

Planning began as a private, voluntary effort to induce the self-governing elites of the hospital world to engage in self-limitation in the public interest, as reformers conceived it; but the characteristic features of planning gradually changed over the course of the planning era, and, toward its end, the movement lost legitimacy and came to an inglorious end. At first, planning stressed community-based, voluntary institutions, but it took wing through federal and state legislation—from Hill-Burton in 1946 through Comprehensive Health Planning (1966) and its successor under the National Health Planning and Resources Development Act (NHPRDA) of 1974. Planners initially engaged local social and economic elites, philanthropists (originally individual or familial and later corporate), and local or locally oriented nonprofit institutions (chiefly hospitals and Blue Cross), but later regional and national economic forces loosened community ties and set planning adrift. Originally, planners sought to make incremental improvements in the distribution of health services (especially acute-care hospitals) and to moderate cost increases that had only just begun to elicit serious concern; but later they struggled in vain to curb overbedding and duplication of facilities and to slow dramatic and intensifying cost escalation. They originally hoped they would be able to predicate planning on science (and not politics), but eventually the failure of rational planning methods and the dominance of politics in planning decisions exposed planning-cum-regulation to charges of arbitrariness and lack of accountability. Both early in the movement and near its end, planners tried sanctions to enforce decisions, but hospitals, physicians, and the planning-agency boards they dominated refused to bow to the planners' ideas of the public interest. Moreover, experts' public-interest orientation diminished as they increasingly resembled economic agents selling their professional services. At the same time, market advocates discredited disinterestedness, regulation in the public interest, and indeed the very idea of the public interest as an expression of collective values. By the early 1980s, planning had failed to devise rational foundations for its practice, to escape politics, to stem cost escalation, and to preserve its practitioners' legitimacy; the movement fizzled out. Planning of health care facilities and services would become the work of private providers of medical care operating in public markets; and the providers' economic success would be the measure of public service and acceptability. Not surprisingly, planning has since been little lamented.

It has also been little remembered and, as a historical phenomenon, little understood.[1] Nevertheless, historical analysis of planning has two benefits. First, it reveals fundamental features of a long-standing but now heavily eroded policy world: (1) its major parameters were voluntary institutions, community settings, and professional self-regulation; (2) its actors were experts *qua* reformers, who saw themselves as either wholly disinterested or enlightened servants of the prevailing interests; (3) its domain of activities for such experts included identifying problems of public concern, envisioning solutions, translating them into practical goals, and organizing local coalitions to achieve change; and (4) its presupposition was that reformers, often in alliance with government, could elicit socially enlightened behavior from the interests. Second, historical analysis of planning shows the disintegration of that world in the face of new forces: intense cost escalation; decline of local communities as foci of policy; novel ideas about markets and novel market arrangements; doubts about disinterested expertise; changing perceptions of government; unanticipated complexity revealed by researchers in the structure of health care; and changing values regarding the roles of the individual, community, and society in securing citizens' well-being. In exploring planning, this article reveals many features that characterized public policy for much of the last century; and it analyzes their transformation by some of these novel forces—reserving others for study elsewhere—as that century gave way to a new one. There is little reason to suppose that the older approach to policymaking or planning in particular could or should be resurrected, but the story of planning does suggest that something valuable may well have been lost from the formation of public policy in general and health policy in particular: the recognition of nonmarket values (as opposed to economic theory) and a commitment to respect and serve them. This and related inquiries aim to encourage discussion among those who formulate and make health policy, about whether and, if so, how to give those values weight in the American health care system (cf. Melhado 1998).

The history of planning falls into stages. The intellectual foundations of planning began in the 1920s and 1930s and persisted thereafter through rearticulation and refinement of its themes. Between the two world wars, planners' ideas found partial realization in philanthropically supported programs promoting rural health care and later in novel urban programs. Although the federal-state Hill-Burton program (1946–74), which subsidized the construction of especially rural hospitals, rested on planning ideas, it honored them only in the breach. The planning movement began in the late 1950s in response to pressures on urban hospitals resulting from suburbanization and to public concern about costs. It took form in a series of programs that, despite early promise, foundered in the face of multiple problems. Payers, public and private, then abandoned planning and took up other solutions to the problems of health care. The next section discusses the antecedents of the planning movement itself, and subsequent sections examine planning in its various stages, culminating with a detailed analysis of the planning era. The article concludes with reflections about the changing nature of policy formulation and decision making in American health care.

The Antecedents

Reformers' Vision

Voluntary community hospitals were the planners' original focus. Through the late nineteenth century, these hospitals had been charitable institutions serving the chronically sick poor. However, in the early twentieth century their transformation into providers of scientific, acute care for paying patients made them objects of broad community concern (Brown 1963; CFHC 1955, 14; Schlesinger 1997, 948–50). Some chronic patients continued to occupy beds in acute-care institutions, but most chronic care shifted to municipal and county hospitals, state mental institutions, and, eventually, a proprietary nursing-home industry (Dowling 1982; Grob 1983; Hawes and Phillips 1986; Vladeck 1980). In the 1920s, a consensus among professional associations, such as the American Medical Association and the American College of Surgeons, supported by government and the courts, fostered "small-town [acute-care] hospitals as ideal American institutions—institutions which simultaneously demonstrated community initiative, professional altruism, and diffusion of medical technology to consumers throughout the population" (Stevens 1989, 125). Responsibility for meeting the need for health care, analysts claimed, lay in the local communities. They had to provide capital for physical plant and equipment, encourage patients' self-reliance (and thus willingness to pay for services), and offer free care to the poor (e.g., Brown 1968b; CFHC 1954–55; CHC 1947; Rorem 1930). The hospital was to be the central community institution for providing acute care, and it gradually absorbed and replaced many other kinds of acute-care facilities, notably specialty hospitals (e.g., maternity, infectious disease, and industrial hospitals) (Abbe and Baney 1958, 47–48; Bourke 1947; CHC 1947, 27, 94; Ginzberg 1949, 330; Parran 1944, 1789; Rorem 1930). Typically under voluntary, private ownership, the community hospital served as an eleemosynary institution, and its services resembled public goods. Public policy thus aimed to create, sustain, and nurture it (Brown 1959a, 1968b; CFHC 1954; CHC 1947; Rorem 1930, 1964b; Somers 1969).

Intellectual antecedents of planning lie in the British Dawson Report of 1920 and its American echoes in the recommendations of the Committee on the Costs of Medical Care (CCMC) (British Ministry of Health 1920; CCMC 1932; Fox 1986b, 26–32, 48, 80–81, 165–66). Thereafter, the goals of planning, its potential utility, and its preferred form repeatedly found expression (Mountin, Pennell, and Hoge 1945; Parran 1944; Palmiere 1975), especially under the broad but malleable perspective characterized by Fox as "hierarchical regionalism" (Fox 1986b). Both planning institutions and health facilities and services, analysts believed, were best distributed through regional hierarchies descending from the urban center and its medical schools and teaching hospitals, through smaller towns with their community hospitals, to the rural periphery with its clinics.

Some practical antecedents for planning lay in scattered early projects that rested on public or philanthropic funds. They aimed to improve rural health care through professional exchanges and referrals of patients among institutions, particularly via connections between cities and rural areas (Fox 1986b, 163–68; Shonick 1976, 148–49). As early as 1931, the Bingham Associates Fund at the Tufts New England Medical Center organized a program to support health services in rural New England; and the Rochester Regional Hospital Council, organized with the support of the Commonwealth Fund in 1946, arranged for teaching hospitals to cooperate with small community hospitals. For advocates of planning, these programs exemplified coordinated planning and provision of urban-based health services in rural areas (e.g., Bodenheimer 1969; CCI 1956–59: vol. 2, 292; Health Preparedness Commission 1945, 51–54; Lembcke 1951; McNerney and Riedel 1962). Another prominent example was the Hunterdon medical center in Flemington, New Jersey, created in the late 1940s with support of the Commonwealth Fund and the participation of the New York University–Bellevue Medical Center (Flook and Sanazaro 1973, 86–88; Garland 1960; Harvey and Abrams 1986, 318–28; Pellegrino 1957; Rosenfeld and Makover 1956; Trussell 1956). At Hunterdon, physicians in primary care specialties, who held full-time academic appointments and kept professionally up-to-date through frequent visits to New York, provided medical education for students, interns, and residents, as well as the supervision and training of primary care practitioners in the local community. This arrangement found echoes in some academic medical centers, which emphasized primary care and community medicine on their clinical campuses and avoided subordinating local practitioners to their clinical collaborators at the central medical center (Fox 1977, and private communication 2003; Pellegrino 1966, 1977). These three programs differed in their conceptions of regionalism and in their influence, but by exemplifying the better distribution of medical resources and efficient deployment of professionals, they provided models that advocates of planning could invoke and imitate.

In the 1930s and 1940s, this goal of achieving a rationalized system of health facilities, services, and professionals animated diverse "men of goodwill" (e.g., HSNY 1938, 97; Rosenberg 1988, 14–17), inspired the CCMC to inventory the health system and call for its expansion and rationalization, and elicited a lay coalition that sought (but before World War II failed to achieve) a major expansion of medical facilities and services. However, during and just after the war, the coalition laid the groundwork for the Hill-Burton program passed in 1946 to support growth of the hospital system (Fox 1986b, chap. 7; Somers and Somers 1961; Stevens 1989, chap. 8). The coalition also found its voice in studies that called for a planned expansion of hospital services to bring well-trained professionals and the technology they wielded within the reach of all communities (e.g., CCI 1956–59; CHC 1947). Blue Cross and the American Hospital Association (AHA) saw themselves as serving the public as well as hospital interests by facilitating patients' access to modern medicine (CFHC 1954–55; McNerney 1963; Rothman 1991). Similarly, physicians, finding hospital care increasingly informed by scientific rather than traditional social criteria, took a leading role in the development of hospitals. Physicians served their own needs by encouraging the public to supply the capital requisite for scientific practice, but they also regarded themselves as bringing to the public modern hospital services and the benefits of scientific advance (Rosenberg 1987; Stevens 1989, esp. chap. 5).

Advocates of planning thus saw themselves as pursuing both the interests of their own organizations and professions—the medical profession, the voluntary hospitals and (from the 1930s) Blue Cross—and those of a broad public. Their role can be illuminated with reference to scholarly studies of the relation of experts and professionals to public policy. Planners and analysts drawn from these backgrounds instantiated the social-trustee professionalism that marked reform-minded experts, particularly in governmental and nonprofit sectors, from the Progressive Era into the 1960s and, to a declining extent, thereafter (Brint 1994). They expressed the "pragmatic humanitarianism" of Progressive-Era reformers: although perhaps "captured" by the interests, they yet resisted serving simply as their agents (Brown 1991). This cluster of conceptions about professional expertise fit easily into a broader American pattern (Hall 1992; Morone 1998) that, beginning in the Progressive Era, granted to voluntary, private, and often nonprofit groups much responsibility for articulating, interpreting, and achieving public goals in the realms of policy in which they were implicated (Fox 1986b; Starr 1982a; Stevens 1989, 1998).

In health care, many policy experts, including planners, espoused either a "collective welfare" model that viewed health care as something that society owed to individual citizens to support the well-being of all; or a "social conflict" model that anticipated the provision of health services to the subordinate classes only through struggle with the wealthy ones (Fox 1990). Both models carried implications for research and advocacy on behalf of citizens lacking access to high-quality care. Planners perceived the dominance of nonprofit organization of both hospitals—which lay at the focus of planning—and Blue Cross as a legacy of older patterns of charity and stewardship and as a reflection of the intermediate position occupied by these institutions between business and government; their public-service orientation; and their ability to regulate their affairs, without governmental intervention, in the public interest (Eilers 1963, 80–85; Seay and Vladeck 1988; Stevens 1989, 40–46, 258–62, 359–61). Although physicians were clearly profit-making professionals, their cultural authority (Starr 1982a), competence to organize scientifically based services, and insistence on patients' free choice of physicians encouraged a pattern of deference that invested the medical profession with the aura of public service (Stone 1997). Planning agencies and their staffs similarly partook of these features of disinterested, voluntary public service. Planning professionals and their institutions thus exemplified enduring American patterns of disinterested, meliorative reform in the context of enlightened private interest.

Hill-Burton

Reformers of the kind just described populated the political coalition that in 1946 achieved passage of the Hospital Survey and Construction Act (PL 79-725), which established Hill-Burton. Helping spur the coalition into action was experience under Title II of the Lanham Act (PL 76-849 of 1940, as amended by PL 77-137 of 1941), a program of public works for areas affected by the war effort (CHC 1947, 533–36, 599–601; Federal Works Agency 1943). From 1941 to 1945, the construction of hospitals, including private, nonprofit ones, was one of its targets, and its precedent for federal subsidy of local, nonprofit hospitals informed Hill-Burton. The latter, named after its two initial Senate sponsors, Lister Hill of Alabama and Harold H. Burton of Ohio, built a state-federal partnership to survey the need for acute-care hospitals and subsidize their construction, mostly as voluntary, nonprofit institutions. The act required each state to designate a single agency—most chose the state health department—to survey hospital resources in the state, create a state plan to guide the distribution of resources, evaluate applications from local sponsors for new construction or expansion, and supervise construction. To administer the act, the Public Health Service (PHS) called on its Hospital Facilities Section, which had been created in connection with the Lanham Act and in 1955 was renamed the Division of Hospital and Medical Facilities (DHMF) (CHC 1947, 533; NARA n.d.). After federal approval of state Hill-Burton plans, the states could approve funding for local projects deemed consistent with the plans. The formula for distributing the funds gave priority to poor states and rural areas. Congress frequently amended and extended the program until 1974, when it became moribund upon its incorporation into the NHPRDA (Shonick 1995, chap. 12; Treloar and Chill 1961).

The Hill-Burton Act paid lip service to a planned, regionalized system but provided no means to achieve it; the sponsoring coalition had downplayed hierarchy to avoid opposition (May 1967; Rome 1959a). Instead, the backers hoped that by eliciting regional coalitions to build hospitals, Hill-Burton would create a hierarchy through mutual engagement of the interests. The arena of engagement would be the one that advocates of regionalization traditionally envisioned: a regional planning council representing all the major interests of the community (hospitals, the medical profession, eventually Blue Cross, philanthropists—whether traditional or corporate—business, and organized labor) (Palmiere 1975). The sponsors' expectations were not realized, however. Hill-Burton resulted in planless proliferation in small towns in less-populated areas of small, freestanding community hospitals (CCI 1956–59, vol. 2, 295; McNerney and Riedel 1962; McNerney and Staff 1962, vol. 2, chap. 92).

Urban Developments

Hospitals also proliferated after the war in urban areas, where Hill-Burton was less significant (Elling 1963; Morris 1963a, 1963b; Rorem 1954), and experts grew concerned. Diverse communities, distinguished by culture, religion, ethnicity, and class, met their needs by separate networks of patrons, institutions, and caregivers (Brown 1959a, 29; Cardwell and Klicka 1961b; Hall 1948; Starr 1982a, 173–77). However, distinctions among such networks waned under the influence of professionalism (of both physicians and hospital administrators); the replacement, among benefactors of hospitals, of wealthy individuals and families by corporations and corporate foundations aiming to rationalize the use of capital across a metropolitan area; and the rise in the suburbs of a culturally relatively uniform middle class (K. Fox 1986, esp. chap. 2; Rorem 1930, 81–82; Rothman 1990; Schlesinger 1997). Professionalizing experts, as well as corporate donors facing growing demands for capital, saw culturally distinct institutions as duplicating scientifically equivalent resources, lowering utilization within each facility, reducing the quality of care, and generating unwarranted operating costs (Brown 1959a, 29; CHC 1947, 286–87, 376–77; Rorem 1930, 206–9). The growing interest in chronic care also directed experts' attention to the need for rationalizing the distribution of urban health resources (CCI 1956–59; Rorem 1954). They pressed for voluntary local planning agencies to guide the development of individual institutions in light not only of their own interests but also of the functions, patient base, and goals of neighboring ones (CFHC 1955, 303–4; CCMC 1932, 53–55, 93–94, 134–37; Falk, Rorem, and Ring 1933, 429–34, 589–91).

Two of the factors just mentioned (the growing interest in chronic care and changes in philanthropy) that piqued interest in urban health resources are examined in this section, and a third (postwar growth of suburbs) is discussed in the next section. Chronic disease emerged as a theme of planning in the rural context, especially after World War II, but it became an urban issue in the 1950s (Fox 1995; Grob 2002, chap. 9). Originally, planners expected regionalization to bring urban-based chronic-care services to outlying populations (e.g., Bourke and Wagner 1950; Health Preparedness Commission 1945 and 1947). Similarly, Hill-Burton originally anticipated some support in rural areas for chronic-care beds (Shonick 1976, 25, 39) and earmarked funds for them in 1954 (under the "Wolverton" amendment, i.e., the Medical Facilities Survey and Construction Act of 1954 [PL 83-482]; see Treloar and Chill 1961, 13, 14, 24, 29; U.S. House 1954). Chronic care in urban settings, however, began to pose planning issues. Because chronic patients often occupied acute-care beds, experts saw chronic care rendered in acute settings as unnecessarily expensive and ill suited to patients' needs, and they found physicians little interested in chronic disease. However, major medical insurance, which emerged after the war, paid for some chronic-care services (Melhado 1998, 231–33). To exploit the new funds and efficiently meet patients' needs, planners applied their vision of rural hierarchy to the urban setting: they anticipated a tight cluster of coordinated facilities and services, that is, a medical center (Brown 1968b;

Haldeman 1962b, 1963, 47, 1966, 1967; Morris 1963b). There, care—acute or chronic—could be so organized as to put "the right patient, in the right bed, with the right services, at the right time" (Haldeman 1961, 39; for antecedents in discussion of "progressive patient care," see Fairman and Lynaugh 1998, 13, 123, n. 22; Somers and Somers 1967, 206; Vladeck 1980, 43).

Changes in philanthropy for urban hospitals similarly affected planners' thinking. The replacement of traditional individual and family donors by corporations and corporate foundations and the growing competition among potential beneficiaries of corporate philanthropy reduced the capital available to hospitals and elicited donors' skepticism toward hospitals' claims about the need for costly facilities and services. Donors wanted to avoid wasting capital on unneeded services and paying, as the purchasers of their employees' insurance benefits, for unnecessary operating costs. Similarly, governmental payers of operating expenses were interested in providing community health care resources efficiently. These developments led planners to analyze the relation between capital expenditures and operating costs, further encouraged them to shift their attention from the hierarchical connections between urban center and rural periphery toward methods of coordinating care in the metropolitan setting, and led them to establish new planning institutions oriented toward metropolitan health planning.

Planners recognized, first, that the long-term operating costs of new plant and equipment would vastly exceed the original capital investments and would have to be paid by corporate-sponsored insurance and, second, that a physical plant ill suited to its use (because of conversion from a prior use, a poor original design, or superannuation resulting from technological advance or population growth) constituted a drain on operating funds that could be avoided by proper initial design or remediated by the eventual modernization (if not outright replacement) of physical plant (CFHC 1954, 72–73; Klarman 1964, 743; Somers 1969, 132). These problems loomed chiefly in metropolitan areas. There, the ideal solution was, again, if not a tightly clustered urban medical center, then at least a set of institutions standing in rationalized, hierarchical relations with one another (AHA 1962b, esp. chaps. 6, 8, 19, 20; CFHC 1954, 70; HIF 1958; Rome 1959a, 1959b; Sigmond 1967b).

To conserve the capital available to hospitals and therefore to reduce their operating expenses following capital investment as well as to improve the distribution of health services, planners created new, mostly metropolitan planning agencies (Activities in Hospital Councils 1958b, 1959; AHA 1962b; CFHC 1954, 70; Rorem 1954; Sigmond 1964). Among the more prominent were the earliest such agency, the Hospital Council of Greater New York (1938), the Columbus (Ohio) Hospital Federation (1945), the Greater Detroit Area Hospital Council (reorganized in 1956 to focus on controlling the bed supply), the Hospital Planning Council for Metropolitan Chicago (1958), and the highly influential Hospital Planning Association of Allegheny County (1959) (Columbus Hospital Federation 1966; Hood 1961; HPCMC 1958–59; HSNY 1937–38; Klarman 1963, vi–viii; McNerney and Staff 1962, vol. 2, 1255; Pennsylvania Economy League 1959; Rome 1959a, 1959b). These agencies emerged through the work of ad hoc community committees (e.g., Elling 1963; Thompson 1977; Willie and Notkin 1958), the creation of new hospital councils, or the reorientation of existing ones. Except for the Rochester council, they lacked antecedents in the rurally oriented programs that had inspired early advocates of regionalization. Instead, they typically reflected the concerns of the larger urban donors of capital, and planning was their principal activity (AHA 1962b, chaps. 19–20; Brown 1973; Sibley 1962; U.S. Public Health Service 1961, 11–13, 52–53).

Two Modes of Urban Health Planning

Planners who hoped these agencies could control the volume and distribution of capital for hospitals in metropolitan areas considered two approaches, here called "hard" and "soft." Both responded to the difficulty of gaining the compliance of individual hospitals with planning goals. Although the leaders of hospitals came from the same elites as did the leaders of rationalizing corporate donors, most hospital trustees and administrators and the ranking physicians on their medical staffs focused narrowly on their individual institutions, and many shared the economic boosterism of traditional local elites. Hard planning aimed to compel their cooperation with planning goals. This approach became prominent at two points when hospitals faced crises of legitimacy, once early in the planning era, when cost escalation first became an issue, and once after midcourse, when cost escalation and widespread concern about other problems in health care led to the regulation of hospital capacity by CON (and, in some states, control of hospital charges by rate setting, not further considered here) (Davis et al. 1990, chap. 5; Lewin and Associates 1974; McDonough 1997). The time horizon of hard planning was short. Particularly in the earlier case, planners saw themselves as working to "put out fires," that is, to prevent obviously expensive cases of duplication by persuading autonomous institutions to practice self-limitation for the good of the community (Brown 1973; Bugbee 1966, 5–6; Jenkins 1966; Lentz 1969). Indeed, the prevention of construction was the operational measure of hard planning (Columbia University 1960; Shain and Roemer 1961; Sibley 1962; Somers and Somers 1967, 200, 205). By putting out fires, planners hoped to gain the breathing room to install a more deliberate, rational, but soft planning regime. Later, however, the pressure of cost escalation offered no respite; a major factor in the fall of planning was its failure to stem cost escalation in the short term.

For a decade or more before the spread of CON in the 1970s, statutory controls over hospital capital had been on the agenda. Ray E. Brown, a prominent spokesman of voluntary hospitals and an advocate of planning (Blanks, Corley, and Smith 1991; Cohodes 1962), called for controls in a famous speech (Brown 1959b, 1959c) that elicited persistent discussion (for Ray Brown's now famous speech, see Bugbee 1966, 1–2; for the speech as "the provocative bomb," see Lentz 1969, 48; Shain and Roemer 1961; Somers and Somers 1961, 88–90, 509–13). Just as Brown issued his call, an economic rationale appeared for regulating the supply of capital. Milton Roemer showed that given widely available insurance, the utilization of hospital beds reflects their supply (Roemer and Shain 1959; Shain and Roemer 1959). That is, a bed created is a bed used; supply creates its own demand; operating costs follow from investment. Proponents of supply regulation used the "Roemer effect" or "Roemer's law," as the phenomenon came to be called, to help secure passage of the first CON law in New York State in 1964. However, CON was rarely applied to hospitals until the early and middle 1970s. In its absence, would-be hard planners used other incentives for compliance.

In particular, planners exploited corporate donors' newfound desire to parse competing requests for capital to pack the boards of planning agencies with members of the donor class who were most concerned about efficiency (Bugbee 1966; Conant 1968), and they tried to encourage leadership by respected, effective individuals from the same group. With such leadership, planners hoped to convince the public of the high-mindedness and public-interest orientation of their agency; to expose, via a thus-legitimized agency, resistance by a hospital to planning goals and to refuse to support its fund drives; and to assist local donors, the state Hill-Burton agency, or the local Blue Cross agency by reviewing proposed capital projects (e.g., Bourke and Wagner 1950; Conant 1968; Hood 1961; Palmiere 1975, 136–37, 140–41; Pennsylvania Economy League 1959; Somers 1969, chap. 7; U.S. Public Health Service 1961, 6, 14, 18, 32; Wisowaty, Edwards, and White 1964).

Planners hoped eventually to predicate their use of such tools on scientific analysis of the need and distribution of health services and facilities. The persuasiveness of objective science would help garner at least the acquiescence if not the active support of providers and philanthropists. Indeed, early advances in research led some planners to advocate a "master plan" that, because of its supposed scientific objectivity, could compel compliance (Fox 1991, 731; Ginzberg 1949, 353–54; Klarman 1964; U.S. Public Health Service 1961). However, should a master plan inspire resistance by suggesting inflexibility and coerciveness, planners hoped that at least a clear statement of bed needs (their kinds and distribution) could serve as a banner for organizing community institutions and elites (Brown 1973; Cardwell 1964; U.S. Public Health Service 1961). In the main, however, planners around 1960 could only hope that scientific foundations for their work would emerge in the future. In the meantime, they focused on seemingly clear cases of over- or underbedding, difficulties of populations in gaining access to needed services, surveys of patients and providers, and data gathering on the geographic distribution of patients and resources. In sum, they produced informed but still informal estimates. The resultant "controls," however, often hardly merited the name, amounting, for example, to promising potentially uncooperative institutions that planning would boost their resources and prestige (e.g., Morris 1963b); or, as in the approval of a project by the Hill-Burton agency, to honoring agreements reached in prior negotiations (e.g., Palmiere 1975, 136). Thus the effort to achieve rational planning early on gave way to coalition building, community organizing, and consultation, that is, soft planning. Disinterested social science was the method favored by reformers in many spheres to make narrow interests yield to the public interest (Morone 1998); but in this case, as in others, scientific practices that could garner assent proved elusive, and the effort to replace them with informal procedures proved fruitless. Neither moments of crisis nor the banner of science could long sustain hard planning.

The soft approach similarly aimed to limit capital outlays. However, it invoked broader goals than cost control, such as optimizing the distribution of health facilities and services, enhancing access to them, and improving the financing of health services; relied less on coercion and more on persuasion; emphasized less specific results than the virtues of consultation and mutual engagement of the interests; and worked within a long time horizon. The Hospital Planning Association of Allegheny County consistently advocated this model (Rorem 1964b; Sigmond 1964, 1965b, 1969; Somers and Somers 1967, 204–9); the AHA adopted and promoted it (AHA 1962a, 1967, 1968, 1969a); and leading figures and institutions pursued it (Brown 1973; Bugbee 1966; Gehrig 1968; Lentz 1969; Morris 1963b; Stewart 1968). Planners needed time and patience to gain providers' trust; establish legitimacy in the community; develop a broad perspective on community programs, facilities, and need; conduct studies; and build forums for constructive engagement: in brief, to keep the process going. Such work inevitably moved at a slow pace (Klarman 1978, 98; U.S. House 1967, 1974a, 58).

Origins of the National Planning Movement

The planning movement began in the late 1950s and early 1960s as new forces aroused a relatively complacent hospital world. It aimed to protect itself against the dissipation of urban hospital resources resulting from suburbanization and against the governmental intervention into the hospital field that could result from untamed cost escalation.

Stresses on Urban Hospitals

Suburbanization encompassed the departure of firms, manufacturing plants, unionized labor, and middle-class managers and professionals (including physicians, especially providers of primary care) to the suburbs and the decapitalization of the central city (the deterioration of remaining housing stock and other forms of capital, both public and private). Impoverished African Americans and other minorities suffering extensive unemployment and underemployment succeeded the older inner-city cultural and religious groups (Gelfand 1975; Teaford 1979).

The impact of suburban growth on central cities severely stressed the urban hospitals (Ginzberg and Staff 1971; Miller 1977; Navarro 1971; Shannon and Dever 1974, chap. 4). Smaller hospitals, most founded by ethnic and religious communities, lost their clienteles and their primary care physicians to the suburbs. Their physical plants were small, aging, and hemmed in by areas with few paying patients, high crime rates, a fearful environment for middle-class staff and patients, and little land for expansion and modernization. A symposium, "The Urban Community Hospital in Transition," gave voice to these stresses and described diverse solutions attempted (University of Chicago 1970). Another symposium addressed, as its title indicated, the stark choices now confronting urban hospitals: "move, grow, or change" (Johnson 1967). Another choice was close, which many did, especially the smaller ones (Sager 1983). Many of those that did not followed their clientele and doctors to the suburbs.

The suburban hospitals that resulted from these moves or arose de novo functioned in mutually enhancing relationships with voluntary health insurance and public policy supporting research, technological advance, and training of scientifically skilled specialists. High capitalization, generous insurance, and specialty training allowed these institutions to offer advanced services that had been formerly confined to central-city teaching hospitals and that now kept middle-class patients from returning there. The decline of ethnic, cultural, and religious distinctions among suburban patients and the eclipse of particularistic cultural criteria by professional and scientific ones for selecting physicians and hospitals reinforced patients' preference for the new institutions. Even those hospitals that had followed their ethnic clientele to the suburbs could now appeal to a broad base of middle-class patients who were culturally relatively undifferentiated and well insured (Miller 1977; Rothman 1990; Schlesinger 1997). Suburban institutions thus threatened to take over many of the traditional functions of the declining urban teaching hospitals (CFHC 1954, chap. 4; Piland 1971; Wennberg and Gittelsohn 1981, 213–14).

Faced with this competition, central-city tertiary care hospitals worked to preserve their roles in teaching, research, and specialty care. They sought to rebuild and recapitalize in the city, maintain a middle-class clientele, and limit the growth of suburban hospitals. Other central-city hospitals survived by expanding, merging, and often affiliating with medical schools—which used them to offer advanced training through residency programs—and attracting the house staff needed to provide scientifically advanced services; in a word, they imitated the large teaching hospitals. These large, urban hospitals also supported research that thrived on federal money and exploited the "clinical material" provided by nearby minority patients. Medical-school affiliation, postgraduate specialty training, provision of advanced services, and conduct of research suggested the prestige and quality that could attract the suburban middle class. Moreover, urban renewal, begun under the Housing Act of 1954 (PL 81-171) (K. Fox 1986; Friedland 1982; Mollenkopf 1983), created neighborhoods acceptable to middle-class patients to visit and staff to live in, provided both with middle-class amenities, facilitated transportation to and from suburbs, and offered convenient parking. Furthermore, the often close relationships and physical proximity of these hospitals to medical schools fostered the prestigious urban medical center. Surviving urban hospitals thus could either preserve and enhance or fashion from scratch their leading positions in patient care, teaching, and research (Faber, Hall, and Bobrow 1967; Klicka 1961); and central-city academic physicians could resist competition by the highly trained medical staffs of suburban community hospitals.

Planners' vision of urban medical care aroused them to the defense of urban teaching hospitals. Two themes framed these efforts. First, their medical-center model offered a vision of a regional, metropolitan areawide system that would link central-city institutions to subordinate ones, both urban and suburban. It could be achieved by "areawide planning." That term was a shorthand reference to "metropolitan areawide planning," an idea proposed by urban analysts around 1960 to solve the "metropolitan problems" to which the jurisdictional diversity of metropolitan areas had given rise and allowed to fester (Fitch 1956). It was from this context that health planners seem to have adopted "areawide planning" (e.g., cf. Rorem 1954 with his 1964c), rather than to have taken it from the hospital "areas" that health experts in the 1940s had envisaged in connection with rural hierarchies of health services (e.g., Mountin, Pennell, and Hoge 1945). Second, the need to modernize urban hospitals, already under discussion in the mid-1950s among the PHS, urban hospital interests, and planners, helped advocates develop their case, seek congressional support, and eventually justify much borrowing of capital funds. In 1956, the AHA endorsed the use of Hill-Burton for this purpose, subsequently reiterated its position (Blair 1961; Editorial 1966), and prepared an estimate of need (AHA 1958). State and territorial health officers took a similar position (Abbe and Baney

1958, 31; U.S. Public Health Service 1960, 6), and the PHS did its own study of need (Haldeman and Abbe 1960). Advocates pressed the case in Congress for reorienting Hill-Burton toward modernization (Celebrezze 1964; Sigmond 1965a; Terry 1964; Williamson 1964). Congress responded modestly in the Hill-Harris amendments to Hill-Burton (Hospital and Medical Facilities Amendments of 1964, PL 88-443) (Graning and Reichert 1964) but resisted more generous funding (CQS 1969, 666, 683; Somers and Somers 1967, 204). The hospitals, however, later found ways to borrow needed capital (U.S. Public Health Service 1979). Modernization would keep the teaching hospitals in leading roles, and by supporting them, planners could pursue their goal of regionalized, metropolitan hospital systems based on urban medical centers.

Cost Escalation

Cost escalation, more pronounced after the war, intensified in the late 1950s. Driving it were the same forces—the spread of insurance and public policies supporting technically advanced care—that permitted suburban hospitals to compete with central-city tertiary care ones. Government encouraged (1) the supply of advanced facilities and services by subsidizing research, postgraduate medical education, and hospital construction; and (2) demand by supporting collective bargaining over fringe benefits and offering tax subsidies for health insurance (Fein 1989, 23–26; Feldstein 1971a, 1971b; Glaser 1963; Stevens 1989, chaps. 4–5). Rising costs, at first not seen as threatening, gradually loomed as a problem for insurers, especially Blue Cross (CFHC 1954; Reed 1947, 43–44, 48–49; Somers and Somers 1961, chaps. 9, 10, 20). In 1958 and 1959, rapidly escalating insurance premiums for Blue Cross elicited a public outcry. State insurance commissioners held public hearings that blamed the hospital industry (together with physicians) for surging costs and that resulted in the denial or paring of requests for large premium increases in Blue Cross plans (BCA/BCC 1958; Eilers 1963, chap. 7 and 288–96; Law 1976, 13–18; Somers and Somers 1961, 294–95, 312–13).

Critics' growing belief that hospitals could no longer be taken as interpreters and servants of the public interest stung hospital leaders, who feared the voluntary system was losing legitimacy and could face governmental controls (e.g., Brown 1959b; Bugbee 1960; Cunningham and Cunningham 1997, 116; Griffith 1960; McNerney 1963; Sigmond 1958). Squeezed between the contradictory demands of the public for more, better, and more conveniently located health care and its complaints about steeply rising costs, hospital interests struggled to respond (e.g., Brown 1959c; Nelson 1959). Their principal solution was planning as a form of altruistic self-limitation in the public interest. Against the background of stressed urban hospitals, cost escalation, and a chorus of criticisms, the voluntary hospitals launched the national planning movement.

Inaugurating the Planning Movement

Even before this crisis, the AHA had inventoried planning bodies and specified goals and principles for their operation (Activities in Hospital Councils 1958a and 1959). With the uproar over costs, the AHA and the DHMF in the PHS jointly arranged four regional conferences to seek consensus on *Principles for Planning the Future Hospital System* (U.S. Public Health Service 1959). The proceedings voiced the themes of suburbanization, modernization, cost escalation, and chronic care. The consensus favored representative, voluntary planning institutions to address these problems. Afterward, a joint AHA-PHS committee, chaired by George Bugbee, a prominent figure in the hospital field (Anderson 1991; Weeks and Berman 1985), stated the case for planning, outlined its principles, and suggested means to institutionalize it. Its report, *Areawide Planning for Hospitals and Related Facilities* (U.S. Public Health Service 1961), which started "areawide" on its career in health planning, was a founding document of the movement.

Illustrating this consensus were the activities of what proved to be a model areawide agency, the new Hospital Planning Council of Allegheny County, where Pittsburgh is located. At one of the four conferences, Walter J. Rome, president of the Hospital Association of Pennsylvania and a hospital executive in Pittsburgh, promoted this agency as exemplary (Hood 1961; Rome 1959a, 1959b). It began operation in 1960 on the recommendation, in a study made the year before by the Pennsylvania Economy League (Pennsylvania Economy League 1959), that the already existing Hospital Council of Western Pennsylvania create a new, independent planning agency. The agency hired as its first executive director C. Rufus Rorem, a strong advocate and practitioner of hospital planning, and retained on staff Rorem's protégé, Robert M. Sigmond, who had been the executive director of the Hospital Council. Sigmond developed a prominent national reputation as a partisan and practitioner of areawide planning (Hood 1961; Sigmond 1964; Weeks and Berman 1985, 131–32, 149–52). Rorem, Sigmond, and the council hoped that with areawide planning they could remedy the newly emergent problems of urban hospitals in the Pittsburgh metropolitan area.

Novel practices among planners reflected their shift from rural to metropolitan planning. In Pittsburgh, the new council successfully petitioned the Pennsylvania Hill-Burton agency in 1962 to replace local suburban hospital planning regions surrounding the ostensibly overbedded Pittsburgh "base" by five new regions, each including part of the city (Rorem, Davie, and Donaher 1965; cf. U.S. Public Health Service 1961, 2, n. 3). A study of demography, topography, and traffic showed that one such suburban area, supposedly underbedded, could be served by hospitals in others; no new construction was needed. Similarly, the DHMF, soliciting annual Hill-Burton state plans in light of the Hill-Harris amendments of 1964, abandoned the rural hierarchies and the corresponding structure of state plans (which devoted a chapter to each kind of facility and relied on traditional bed-to-population ratios). Instead, it called for planning for all categories of facilities within a given area, for which bed need would be determined by analyzing utilization, population projections, and desired occupancy rates (DuBois 1966a, 1966b; Lovelace 1961; U.S. Public Health Service 1968). The choice of this goal reflected a typically urban maldistribution of resources that juxtaposed overcrowding in teaching hospitals with low occupancy in nearby small hospitals. The new method would favor larger urban hospitals and reinforce existing trends toward either the closure of the smaller ones or their merger in imitation of the larger. New York State, a pioneer in rurally oriented, regional hospital planning, provides another example. Under the Metcalf-McCloskey Act of 1964, the state reorganized its regional planning councils as private, nonprofit corporations that stressed urban areawide planning (Battistella 1967; Bourke 1947, 1963; Ginzberg 1949, chap. 22; Somers 1969, 143–48).

The urban orientation of planners is evident in still another phenomenon, social scientists' growing involvement in planning after 1960 in a movement that helped give rise to health services research (Flook and Sanazaro 1973; Shonick 1976, chap. 6). Researchers devised new ways to determine bed needs and optimize locations of facilities, giving up traditional, normative trading areas for hospital catchment areas or catchment areas for particular services within individual hospitals (e.g., Blumberg 1961). Such practices would hardly make sense in a broadly disseminated rural hierarchy but were eminently suited to urban areas, with many hospitals in close proximity.

Early Federal Action: Building Momentum

These new social-scientific studies benefited from federal amendments to Hill-Burton intended to encourage (but not yet mandate) areawide planning. A program of PHS grants to governmental and nonprofit groups for research and demonstrations of the effective use of hospitals began in fiscal 1956, with funds (up to $1.2 million) authorized under earlier amendments to Hill-Burton (the Hospital Construction Act of 1949, PL-81-380). The resulting studies, described by their supporters as "hospital research" (Davis and Block 1959; U.S. House 1961, esp. 15–30, 65–72), included data collection and the development of planning methods. Under the Community Health Services and Facilities Act of 1961 (PL-87-395), Congress raised the authorization to $10 million, appropriating $1.8 million for the first year. Aimed at "areawide planning service demonstrations," the grants went to either existing planning agencies or organizations fostering new ones (Advisory Commission 1964, 94–96; Haldeman 1962a, 46). By 1964 the grants had been used "in some thirty major metropolitan areas to demonstrate the role and feasibility of areawide planning agencies"; the program, advocates claimed, having exhibited the virtues of planning, implied a need for stronger federal support (Celebrezze 1964, esp. 46; Graning and Reichert 1964, xxxi). Under Hill-Harris in 1964, Congress not only supported modernization but also created project grants (authorized at $2.5 million for the first year and $5 million for each of the next four) to cover up to half the cost of areawide planning by private, voluntary organizations (sometimes known, after the pertinent section of the Public Health Service Act, as "318 agencies").

The creation and activation of these organizations under PHS grants conveyed a palpable sense that a movement had been set in motion. Its proponents charted its development (Brown 1973; Cavanaugh 1965; Hutton 1964) and sought to characterize and influence its direction (Bugbee 1966; Palmiere 1975; Rorem 1964a; Sibley 1962; Wisowaty, Edwards, and White 1964), particularly after the passage of Comprehensive Health Planning (CHP) (Gottlieb 1974; Lentz 1969; May 1967). Organized medicine also took notice: it studied the growth of planning institutions, pressed physicians to participate, insisted on keeping planning voluntary, and organized an early conference (American Medical Association 1965; Medicine Takes Wary Stand on Planning 1964; Palmiere 1975, 146–51). Planners and their partisans had launched areawide planning on its national career, and they now struggled to give it form and direction.

Federal Mandates I: Comprehensive Health Planning

The effort to develop planning took wing just as the cost crisis of the late 1950s dissipated. Contradictory impulses emerged. Most planners emphasized the soft, consultative approach. It responded to the desire to expand access to health services and to improve their distribution, motivated and informed much health-related federal legislation, and gave rise to the first federal mandate for planning, the CHP program (PL 89-749), enacted in 1966 and amended, with expanded authorizations, in 1967 (PL-90-174) (Cavanaugh and Hiscock 1967). At the same time, cost escalation, especially in states with burgeoning Medicaid budgets, encouraged hard planning, that is, applying means—especially CON—to compel the compliance of hospitals and other institutional providers with planning goals. State CON laws became widespread in the early 1970s, New York having enacted the first in 1964 (Fox 1991; Somers 1969, 143–48); and the federal government, under the National Health Planning and Resources Development Act (NHPRDA), later mandated state-level CON. This mandate formed a part of the broader national effort in the 1970s to contain costs. Both soft and hard planning thus became implicated, respectively, in one of the two contradictory tendencies of American health policy in the 1960s and 1970s, expanding entitlement and containing costs.

The CHP Program

The legislation that created CHP joined it with the first modern consolidation of federal categorical grants to the states into block grants (U.S. House 1966a, 55–57, 72, 1966c, passim; U.S. Senate 1966b, 80–88; Venable 1969). Congress aimed to give the states greater flexibility in the design of public health programs and authority in their administration and to reduce the fragmentation of programs resulting from the federal tendency to create direct federal-local links that bypassed the states (Advisory Commission 1978, chap. 1; Raab 1979). Planning received support on two levels: (1) formula grants for statewide comprehensive health planning under a single state agency (in the event, usually the state health department) (GAO 1974, 7; U.S. House 1974a, 9–10; U.S. Senate 1974a, 9)—later named after the pertinent section of the Public Health Service Act as a "314(a) agency" or just "A [or a] agency"—guided by a representative advisory council with a majority of consumers (U.S. House 1966a, 5, 1974a, 6); and (2) project grants to local public or nonprofit agencies for comprehensive areawide planning (in the event, mostly nonprofit) (GAO 1974, 9)—"314(b)" or just "B [or b] agencies," which either emerged from or replaced section 318 agencies (Gottlieb 1974; May 1974). At both levels, planning was to move beyond the traditional focus on hospitals to comprehensive health care (Cavanaugh and Hiscock 1967; Gehrig 1968; U.S. Senate 1966b). The two tiers would be linked, moreover, in that the project grants to the "b" agency required approval by the "a" agency. The act did create something of a federal mandate for planning, in that programs under the block grants would have to conform to state plans, which in turn required the approval of the surgeon general. However, it was political exigencies, not rational program design, that united block grants, which were to serve traditional public health purposes, with areawide planning for personal health services (Stevens 1998, 518–22; U.S. House 1966c, 294).

The legislation gave planning a political complexion. To remedy the fragmentation of public policy, the administration pressed its "Creative Federalism," featuring "partnerships" with lower levels of government and private groups (Cater 1968; Derthick 1970, 219–25; Gardner 1966). CHP, dubbed by the administration the "Partnership for Health," would exploit relations among governments at all levels, state and local planning agencies, and private, voluntary groups. In line with the current stress on engagement by citizens and consumers (Altman, Greene, and Sapolsky 1981; Gottlieb 1974; Morone 1998; Sundquist 1969), the act required that the advisory councils to state-level planning or "a" agencies be broadly representative and that their majorities represent consumers. Regulations and further legislation also stipulated consumer majorities on the boards of areawide "b" agencies (U.S. House 1974a, 7; U.S. Public Health Service 1967a, 6; 1972, 13183; U.S. Senate 1974a, 6). Similar requirements for representation later marked the NHPRDA (Sieverts

1977, chap. 3). Planning bodies, advocates hoped, would catalyze the parties' mutual engagement, lead them to a consensus embodying the public interest, and unite them behind measures to meet it. This expectation that agencies would obtain the participation of community groups found expression in the funding arrangements for the agency. In a manner reminiscent of the Hill-Burton requirement for local funding, the CHP program stipulated that one-fourth of the funding for "b" agencies be supplied from local sources. The program thus lodged the center of action in communities, and it gave planning a political (as opposed to a scientific, technical, or legal) structure; that is, it institutionalized the soft approach, but the implications of partnership grew apparent only gradually.

The law created expectations of planning but no structure or authority to meet them. Congress left in place diverse federal health programs that required state or substate planning—notably Hill-Burton, the Regional Medical Programs (RMP) (Bodenheimer 1969; Shonick 1995, 456–57; U.S. Senate 1974a, 13–18, 40–41), and community mental health and mental retardation programs—and expected CHP to coordinate them (Gehrig 1968; Stewart 1966, 33, 1967b; U.S. House 1966a, 1966b, 32–33; U.S. Senate 1966a, 5; Venable 1969, 10–11). However, the law gave the CHP agencies no authority or mechanism to do so; similar problems later marked the NHPRDA (U.S. House 1974a, 62–63). Regarding block grants, the act gave few powers to the planning bodies. Although services financed by block grants were to conform to state plans, the law did not require the approval of the "a" agency to spend the grants, and despite the expectation that areawide planning would inform the local use of federal funds, the "a" agencies had no obligation even to take notice of local plans. Moreover, although the state agencies as governmental entities could have been invested with enforcement powers, they typically were not. They served only to bring together diverse interests, not to compel them to conform to planning goals (U.S. House 1967, 22–23).

Indeed, just what planning was to accomplish remained vague. Like other federal enactments at the time (Sundquist 1969), the legislation that created CHP opened with a declaration of purpose; here a ringing one:

> Fulfillment of our National purpose depends on promoting and assuring the highest level of health attainable for every person . . . ; this goal

> depends on . . . partnership, involving close intergovernmental collaboration, official and voluntary efforts and participation of individuals and organizations; [and] Federal financial assistance must . . . support the marshaling of all health resources—national, State, and local—to assure comprehensive health services of high quality for every person. (U.S. House 1966b, 9; cf. Cohen 1966, 40)

These lofty phrases introduced a jerry-built program that attached planning awkwardly to a largely unrelated program of block grants; conferred little formal authority on the planning agencies it created; offered them no rational basis for operation; and exposed them to political maneuvering by hospitals, insurers, physicians, and other interests. Clearly, the act could achieve nothing remotely resembling its resounding preface. At most, the program allowed Congress to acknowledge symbolically the national goals of universal access to care and coordination of an unwieldy cluster of programs, but at the same time it shifted responsibility for the goals from federal to state governments and local interests (cf. Brown 1978, 54–55). Congress and state health officers expected that with federal assistance, the states could improve their capacity to meet the increasing responsibilities imposed under diverse federal laws to supply and administer health programs and services (Advisory Commission 1977, 21–22; Cohen 1966), and advocates of planning hoped they had acquired something beyond the valuable but still tentative support that planning had thus far received from Congress.

Experience under CHP

The act led to the creation of an "a" agency in every state and territory and about 200 "b" agencies (for various counts, see GAO 1974, 8; U.S. Senate 1974a, 10). Many problems burdened their work (Conant 1968; Dickey, Kestell, and Ross 1970; GAO 1974; West and Stevens 1976), some methodological and others political, administrative, and economic. Salient among the former category were (1) the planners' confusion about goals and priorities, especially in the absence of federal guidance (e.g., Colt 1970; Gottlieb 1974; Lentz 1969); (2) their inexperience with planning comprehensive health services, lack of suitable planning models, and uncertainty about methods; (3) their failure to devise rational principles and procedures to affect the development and distribution of health care resources; and (4) (discussed later) their inability to control new sources of hospital capital. Problems in the second category arose in (1) fulfilling representational requirements (shared by the Health Systems Agencies that replaced the "b" agencies under PL 93-641; see Lefkowitz 1983, 73–74); (2) losing, as a result of those requirements, planners' previously favored method to secure providers' cooperation, packing the agency board with influential local interests committed to cost control (also a problem under the NHPRDA [Lefkowitz 1983, 186], this effect was intensified by the decline, noted in the conclusion to this article, in the importance of local influentials in the affairs of voluntary hospitals); (3) granting heavy influence in "b" agencies to local health care providers, which paid most of the local share of funding that Congress required for the agencies; (4) failing to induce the affected interests to achieve consensus, especially given the power of local providers over agency proceedings; and (5) staffing and operating the agencies because the low overall funding levels stipulated by Congress compelled staff to waste time on fund-raising (Blumstein and Sloan 1978, 8, n. 38). Under CHP, the planners at most succeeded in carrying on their consultative practices, later dubbed the "forum" function of planning, and perhaps related ones of education and research (Blum 1967; O'Connor 1974, 407; Roseman 1972). Form, in a word, trumped substance, and politics trumped science. As a method to rationalize health care, CHP was vacuous; as a political exercise, it privileged health care interests over reformers' conceptions of the public interest.

What kept the architects of the program from foreseeing these outcomes? First, in regard to methods, planners did recognize the novelty of planning for comprehensive care (as opposed to just hospital facilities); but precedents in Hill-Burton, areawide planning, and planning for mental health programs had afforded the confidence that CHP was an incremental advance in a doable kind of policy (Cavanaugh and Hiscock 1967; Stewart 1967a, 36–37; U.S. House 1966a, 5; U.S. Senate 1966a, 3). The anticipated development of planning science, moreover, suggested that the planners would soon acquire better tools (Cardwell and Klicka 1961a; Klarman 1964). Second, in regard to the politics, the precedents made political jockeying among the interests seem similarly manageable. CHP was one more expression of the conviction that "men of goodwill" who shared a commitment to the public interest would curb their own (or their organizations') interests in favor of the goals set out by the administration, Congress, and local elites and planners. Diverse commissions, agencies of federal and state governments, interest groups, policy leaders, and planning professionals seemed univocal in calling for broad access to efficiently organized, high-quality health services. If the same goal drew the allegiance of so many interests, they could be expected to defer to it (Cain and Thornberry 1977, 18–19; Colt 1970, 1197; Dickey, Kestell, and Ross 1970, 864–65, 869–71; Mott 1969, 801; Stewart 1968, 199–200).

Additional factors reinforced this conviction. One was the very notion of partnership, for the architects of CHP saw themselves building on the traditional pluralism of American health care (e.g., Colt 1970, 1199, 1202–3; Gehrig 1968; Ginzberg and Staff 1971, chap. 1; Stewart 1968, esp. 199–200). Moreover, because federal policy increasingly recognized and legitimized formerly excluded interests, their inclusion in standard consensus-building practices seemed only natural. In addition, while becoming professionalized early in the last century, public health experts had come to see themselves as standing above politics. They appealed to science to separate themselves from social activists, disdained politics for rational analysis in devising and justifying new programs, and encouraged public deference to themselves as disinterested servants of the public good. CHP presented another opportunity for such disinterested experts to rally the interests to the banner of science, but here as elsewhere public health professionals found themselves engaged in frank political mediation (Binstock 1969; Colt 1970; Feingold 1969, 805, 807; Hall 1972, 74; Mott 1969, 799, 802; Roseman 1972, 16; for the persistence of similar issues under PL 93-641, see Fee 1991, 158–63; IOM 1980, 10, 34, 44). Hard, supposedly scientifically based suasion was thus unaccustomed, whereas consensus building was a familiar way forward and, in the absence of strong incentives to elicit compliance, the only open pathway.

Expanding Access to Capital and the Rise of Regulatory Controls

Persistent cost escalation in the late 1960s and early 1970s gradually pushed policymakers away from soft planning and consensus building toward hard planning and regulation. More formal powers emerged under CHP over both capital expenditures and changes in service (later known jointly as CES controls; see U.S. DHEW 1975). These powers reflected the belief that capital investment was the chief source of cost increases. They appeared just as access to capital on the part of voluntary hospitals was increasing, very much as a result of public policies. Ironically, planning policy was becoming a remedy for the excesses of capital policy.

Expanding Access to Capital

Through and beyond the life of CHP, hospitals enjoyed expanding access to capital. Judged by the perceived need for new or modernized facilities, philanthropy was proving inadequate; although still growing, it accounted for a declining proportion of capital expenditures (AHA 1974, 17; Brown and Saltman 1985; Rorem 1968a, 17; Terenzio 1978). Three main sources made up the deficit: surpluses from net income, governmental grants (primarily under Hill-Burton), and the increasingly prevalent borrowing (Cohodes and Kinkead 1984; Sigmond 1965a). The three were linked: donated capital, required under Hill-Burton, served commercial lenders as a measure of risk, and operating income replaced collateral and allowed hospitals to secure debt financing (AHA 1962b, esp. chaps. 1 and 5, 1974, 17, 20; Barron 1966a; Kenny 1963; U.S. Public Health Service 1979).

The linchpin was the use of revenues in place of collateral. Borrowing had been rare, because the only collateral, physical plant, had few alternative uses, and in any case public opinion typically ruled out foreclosure (AHA 1974, 24; Clapp and Spector 1978, 298; CFHC 1954, 71; Sears 1966, esp. 132). In the mid-1960s, however, several factors spurred borrowing. New, specialized firms arose that arranged loans, usually as taxable mortgage bonds secured by land, buildings, and equipment (AHA 1962b, chaps. 2 and 5, 1974, 12, 39–42; Cohodes 1961; Ryan 1958; Stambaugh 1967). To obviate problems with collateral, charitable (especially sectarian) organizations often provided credit guarantees (typically in an application to Hill-Burton) (Klarman 1965, 118–19). Third-party reimbursement, however, eventually made both collateral and guarantees unnecessary (Sigmond 1965a). Even in the mid-1950s, payers, especially Blue Cross, had begun to reimburse hospitals for depreciation. (Interest expenses also were paid, but until the importance of philanthropy was clearly in decline and that of borrowing on the rise, it received far less attention than did depreciation. Eventually, however, its guaranteed repayment further encouraged borrowing; Kinney and Lefkowitz 1982; U.S. Public Health Service 1979.) Although at first little noticed or analyzed, reimbursement for depreciation slowly spread (Barbatelli

1967; CFHC 1954, 66, 71; McNerney and Staff 1962, vol. 2, 935–40; Ryan 1958; Sigmond 1967a, 80). Because such revenues eventually contributed heavily to debt service, they supplanted capital as security for loans (AHA 1974, 17, 23, 26–33, 42). By the early 1960s, hospitals secured capital roughly equally from borrowing, fund-raising—through fund drives, philanthropy, and governmental grants—and revenues (Barron 1966a; Cohodes 1961; Johnson 1965; Rorem 1968a, 7, 23); but the trend favored borrowing.

That trend drew strength from better recognition of capital costs by third-party payers and further improvements in the access of hospitals to capital. Hospital leaders secured greater recognition by arguing against the standard use of historical costs as the basis for capital reimbursement (Rorem 1968b; Somers and Somers 1977, chap. 8; U.S. Public Health Service 1959, 152–64). Because replacement costs exceeded historical costs, standard practice did not cover the consumption of current assets and could not finance new ones (Barbatelli 1967; Columbia University 1960, 174; Rorem 1968b; Ryan 1958). Hospital interests held that over the long term, hospital income provided only 30 percent of new capital (Brown 1967, 1968a; Foster and McNeil 1971). In its negotiations with the Social Security Administration after the passage of Medicare in 1965, the AHA, seeking funds for new capital assets, tried to establish replacement cost as the basis for reimbursement (AHA 1965b, 15, 1969b, 1974, 21; Feder 1977, 59; Somers and Somers 1977, chap. 8; Stagl 1968; U.S. Public Health Service 1979, 14). Although the agency refused, the administration, and following its example other payers, deferred in other ways to the hospitals' appetite for capital. From 1965, both government grants and philanthropy, formerly the chief sources of capital, had become ancillary, and reimbursement provided the bulk of capital financing (Foster and McNeil 1971; Stagl 1968; cf. Rorem 1968b).

Improvements in access to capital through debt financing also resulted from both state and federal innovations. Until 1966, borrowing usually consisted of real-estate mortgage notes and bonds paying taxable interest (Barron 1966b; Cohodes and Kinkead 1984, 19). However, interest rates would be lower with tax-exempt bonds (Cain and Gilbert 1978, chap. 2; Kinney 1981; Sears 1966; Van Nostrand 1977). Starting in 1963, Internal Revenue Service Ruling 63-20 permitted their issuance for voluntary, nonprofit corporations. The ruling required that a governmental entity issue the bonds and, on retirement of the debt, assume title of the institution they had supported (Johnson 1966; Sears 1966). Although the bonds featured typically long maturities (up to forty years), boards of voluntary hospitals were generally unwilling to accept eventual loss of ownership as the price of tax-exempt financing. Starting with legislation in Connecticut in 1966, however, the states created special finance authorities that obviated the loss of ownership while granting access to a large supply of tax-exempt investors and thus a large pool of capital (AHA 1974, 39–44; Cain and Gilbert 1978, 65–67; Cohodes and Kinkead 1984, esp. 19, 54; Kinkead 1984, 28–32).

Federal programs also facilitated hospitals' access to capital. The Nixon administration, anticipating the expiration of Hill-Burton at the end of fiscal 1970, asked Congress to replace its categorical grant program with a combination of direct grants, direct loans, and guaranteed loans. The administration also sought block grants to accord the states greater flexibility in setting priorities for their use of federal funds (CQS 1971, 221–28, 1973, 553–54; U.S. Senate 1973, 17). The proposals reflected partly the knowledge that hospitals' access to capital markets had allowed them to avoid Hill-Burton grants and their associated planning requirements and partly the conviction that other health facilities were more urgently needed than acute beds. Over a presidential veto, Congress extended the program for three years (Medical Facilities Construction and Modernization Amendments of 1970, PL 91-296), but in the light of both the view of the administration and the belief that grants were insufficient, it also provided loan guarantees and interest subsidies for private, nonprofit hospitals (CQS 1971, 224–25). Grants did soon end under the NHPRDA, but as late as 1981, "the Hill-Burton loan portfolio still included . . . 281 loan guarantees of nearly $1.2 billion" (Lefkowitz 1983, 167).

Of the other federal programs that improved the access of hospitals to capital, most were minor, and few aided voluntary hospitals, but one was significant: loan guarantees created by the Housing and Urban Development Act of 1968 (PL 90-448) and administered by the Federal Housing Administration (FHA) (AHA 1974, 37–39; Cain and Gilbert 1978, chap. 4; Lefkowitz 1983, 166–68; U.S. Public Health Service 1979, 16; U.S. Senate 1970). Supplemented in 1971 by the Government National Mortgage Association (Cain and Gilbert 1978, 38), the guarantees created "a new market for hospital debt within the mortgage financing industry" (AHA 1974, 39), and as of (apparently) 1982, "there were 165 FHA-242 insured mortgages outstanding, totaling $2.6 billion"

(Lefkowitz 1983, 167). Thus, by the late 1970s and early 1980s, as federal grants and philanthropy waned, hospitals secured a high volume of capital through third-party payment (private and federal), tax-exempt borrowing aided by the states, and federal loan guarantees.

Simultaneously, cost escalation intensified, and thinking epitomized by Roemer's law made capital expenditures by hospitals the chief culprit. Both Congress and hospital interests offered policy responses, the former providing the first federal program of frank, though limited, capital controls, and the latter pressing for state-level regulation by CON. Finally, unrelieved frustration led Congress to rebuild the planning program under NHPRDA. Each of these developments is discussed here.

Early Regulatory Powers

The earliest new form of regulatory controls under CHP was the power of review-and-comment. This power emerged partly as a response to the weakening of planners' formerly favored method of capital control, packing agency boards with leaders of rationalizing donor organizations, now impeded by the representational requirements of CHP and the declining significance of local philanthropy. Review-and-comment began with the CHP act itself, its regulations, and its administrative directions (HSMHA 1973; Stiles and Johnson 1976; U.S. DHEW 1973). Agencies were to review and comment on proposals for grants under other paragraphs of section 314, including the block grants featured in the law. Other programs imposed similar duties on CHP agencies. For example, (1) the extension of Hill-Burton passed in 1970 (PL 91-296) allowed areawide ("b") agencies the opportunity to consider Hill-Burton grant applications before they went for approval to the secretary of the Department of Health, Education and Welfare (HEW) (CQS 1971, 222); (2) the Public Health Service Amendments of 1970 (Title II of PL 91-515) required that "applications for grants for health services development be referred to the . . . areawide CHP ['b'] agency for review and comment and that the services . . . be in accordance with plans developed by the state [planning or 'a'] agency" (U.S. Senate 1974a, 7; see also U.S. House 1970, 10); (3) the same act also provided for CHP review-and-comment on proposals under RMP (HSMHA 1973, 17–19; U.S. House 1970, 3); and (4) regulations effective in 1972 provided for review and comment on state Hill-Burton plans. During phase two of President Nixon's Economic Stabilization Program (ESP, starting in December 1971) (Davis et al. 1990, 16), "over half of the State CHP agencies served by reviewing requests for rate increases by institutional providers prior to their submission to the Internal Revenue Service for final action" (U.S. Senate 1974a, 9). Other federal programs, particularly if they required planning for state or local provision of facilities or services, began to exploit CHP review-and-comment.

Further controls emerged under the landmark Social Security Amendments of 1972 (PL 92-603), which reflected persistent congressional concern about the twin themes of entitlement and costs. The amendments not only further socialized health costs by extending Medicare to the disabled and those with end-stage renal disease, but also, for the first time, created cost control measures for Medicare, Medicaid, and other programs (implemented for the most part only as the ESP was ending in 1975) (Davis et al. 1990, 17–25; Shonick 1995, 296, 299–303, 459–60; U.S. Public Health Service 1977). For planning, the most important of these measures was section 221, which created section 1122 of the Social Security Act, providing a form of capital control over hospitals.

Section 1122 "authorized [but did not compel] Federally financed, State administered review of proposed capital expenditures and resulting service changes and provided that capital costs incurred without State approval [by the state Designated Planning Agency, or DPA] would be denied reimbursement by Medicare, Medicaid and the Maternal and Child Health programs" (U.S. Public Health Service 1977, 2). The CHP program "was designated by the Secretary of HEW to administer the program nationally, and most governors nominated their state CHP [314 (a)] agency as their DPA" (Shonick 1976, 161, 1995, 460; see also U.S. Public Health Service 1976; cf. Needleman and Stiles 1985, 12). The DPA could act only after receiving comments on any capital proposal from the 314 (b) agency covering the area in which the capital was to be used (Chayet and Sonnenreich 1978; Needleman and Stiles 1985, chap. 2; U.S. DHEW 1973). By the end of August 1977, thirty-seven states and two territories had section 1122 agreements with DHEW (Chayet and Sonnenreich 1978; Needleman and Stiles 1985; Simpson 1986). Section 1122 review was the first form of capital control under federal mandate; it made formal, if modest and indirect, CES control a feature of the federal health-planning program. However, planners' attachment to the broad goals of soft planning and the modest level of sanctions under the program minimized its impact (U.S. Public Health Service 1977). Still, it presaged the apparently more stringent regulation sought by Congress through reconstruction of the federal planning program, which began early in 1975 under the National Health Planning and Resources Development Act (NHPRDA). It mandated state-level CON.

The Push for Accountability: Hospitals Demand CON

By 1974, when Congress passed the NHPRDA, state-level CON controls on hospitals and other health facilities and services were already commonplace (Simpson 1986, 1041). The chief proponents of CON were hospital interests and planners. From the outset of the planning movement, they had justified planning as a way to constrain costs, specifically by aligning the supply of facilities and services with need. However, in the late 1960s, intensifying cost escalation again threatened the legitimacy of hospitals as custodians of the public interest. Fearing governmental intrusion into their industry—and failing to envision what later ensued, the emergence of competitive markets—hospital interests believed they would have to confine their use of capital within politically acceptable limits. To sustain their legitimacy, they invoked a new basis of accountability, not to philanthropic donors with limited pocketbooks and competing claimants, but to the public in the face of rising costs. Hospitals offered a quid pro quo: in exchange for expanded access to capital, they would accept discipline in its use. The regulatory measure they sought was to combine planning with state-level CON.

Under CON, sponsors of new health facilities or owners of existing ones who anticipated significant capital expenditures or (less often) changes of service could proceed with a project only after having obtained a certificate of need from a state agency. CON was thus a direct form of CES control; its model lay more or less closely in public-utility regulation (Havighurst 1974; Priest 1970; cf. Robinson 1999, 30–32; Somers 1969). Hospital interests adopted the public-utility model because it left intact ownership, management, and even self-regulation (Fox 1991). Ostensibly hard planning, it suffered subversion at the hand of planners and hospital interests committed to soft goals.

Already foreshadowed in 1963, this quid pro quo became fully explicit in 1969 as the AHA revised its long-standing "principles of payment for hospital care" (now renamed "financial requirements") (AHA 1963, 1969b; cf. Sigmond 1967a; Stagl 1968). Two nationally prominent studies, the Gorham and Barr Committee reports (U.S. DHEW 1967; U.S. Public Health Service 1967b), also reflected the planners' desire to link planning with state-level capital controls. Beginning in 1968, the AHA, its constituent state hospital associations, and advocates of planning supported and in many cases led state coalitions backing CON laws. From about 1970 many states introduced them in accordance with the earlier example of New York (AHA 1968, 1969a, 1969b, 1972a, 1972b, 1975; Chayet and Sonnenreich 1978; Cohodes 1981b; Curran 1974; Elsasser and Galinski 1971; Lewin and Associates 1974; Modern Hospital 1970). The AHA and soft planners, although long skeptical of linking planning and regulation (AHA 1968; Brown 1973; Bugbee 1966; Lentz 1969; Sieverts 1970), acquiesced as cost escalation preoccupied state and federal governments, the former especially with Medicaid (Altman 1978, 569–70; Bovbjerg 1978, 83, 88; Cohodes 1981a, vol. 2, 60, and 1981b; Sieverts 1977) and the latter with Medicare and health care generally. As of 1974, however, few states gave the power to grant certification (i.e., to review-and-approve) to the planning agencies themselves. Rather, most, in line with the views of planners and hospital interests, confined planning agencies to review-and-comment, reserving the decision-making power for a state agency other than the state planning or "a" agency (Lewin and Associates 1974, 186–90).

Most planners thus accepted statutory enforcement powers, but few gave up their broad goals for rationalizing the health system or their preference for consultation. The two national studies mentioned earlier voiced the usual pluralistic conceptions (see also Cain and Thornberry 1977, 18–19); the AHA proposed controls as but one part of a broad effort to improve quality, access, and financing; and other advocates saw them in the same light (e.g., Foley 1978; Gottlieb 1981, 63; Somers 1969, 148). Moreover, the new state CON laws avoided coercive measures and encouraged a broad view of health care (Cain and Thornberry 1977; Curran 1974, 97; Joskow 1981, 88–99; Sieverts 1977, 82). Not surprisingly, experience with CON under CHP was similar to that under section 1122: agencies gave priority not to cost controls but to broader goals of rationalization, and they avoided rigorous efforts to limit the use of capital (U.S. Public Health Service 1977). As cost inflation persisted, Congress rebuilt planning.

Federal Mandates II: NHPRDA

The vehicle for the reconstruction of planning was the NHPRDA (PL 93-641), the last major federal expression of the planning agenda (for a succinct account, Shonick 1976, 161–67; for insightful analyses, Blumstein and Sloan 1978; Lefkowitz 1983; Sieverts 1977; Wennberg and Gittelsohn 1981). The occasion for reform was the simultaneous expiration at the end of fiscal 1973 of authorizations for three programs, CHP, RMP, and Hill-Burton. Congress extended them for one year, allowing time for analysis and decision making, and then supposedly subsumed all three under the NHPRDA (Lefkowitz 1983, 14; U.S. House 1974a; U.S. Senate 1974a). The federal administrative agency for the new program did indeed arise from the consolidation of the staffs of the three predecessor programs, but RMP and Hill-Burton were already moribund (Lefkowitz 1983, 67, 167; Sieverts 1977, 14 and note; Stevens 1989, 299). The act therefore amounted to a reform only of planning. Although apparently targeted at cost escalation (which appeared among its explicit legislative findings; see Blumstein and Sloan 1978, 11), it retained the broader goals of its predecessor. Whether it could do better at cost control (or was really expected to) was thus uncertain from the outset, but the administration clearly tried to focus the law on cost containment. Hard planning seemed resurgent.

Like CHP, the new program implicated planning in contradictory themes of national health policy. The program responded to renewed calls for national health insurance (NHI), which, paradoxically, had resulted from the inauguration of the most recent expansions in entitlement, Medicare and Medicaid. By socializing costs that were both large and rapidly escalating, these programs had led to an intensified scrutiny of health care and analysis of its problems. The solution, for proponents of still broader entitlement, was NHI: it could rationalize the health care system, moderate its cost escalation, and finance improved entitlement with the resultant efficiency gains. Because planning had a long record of pursuing efficiency, it became enmeshed in the call for NHI. Planning provisions were lacking in most proposals for NHI, but their backers, like the planners, held that a viable NHI required effective planning (CQS 1975, 406, 410; Greenberg 1974; Iglehart 1975a, 1975b; U.S. House 1974b, 393; U.S. Senate 1974a, 5, 1974b, 20). The NHPRDA itself, reflecting the planners' customary, broad goals, emphasized that planning would help improve the distribution and delivery of health care facilities and manpower (Blumstein and Sloan 1978, 11–12). Hence planning rode on and benefited from the calls for NHI as the best response to the opposing impulses to expand entitlement and control costs. In a policy environment that made NHI seem imminent, the reform of planning looked not merely timely but urgent.

The law created a new generation of state and local planning bodies (the latter dubbed Health Systems Agencies, or HSAs) (Cain and Thornberry 1977; Sieverts 1977; West and Stevens 1976), put the entire country under their purview, and mandated state-level CON. The legislation bespoke disillusionment, from experience under CHP, with the capacity of the states to meet their responsibilities for health programs (Altman 1978; IOM 1981, vol. 1, chap. 3; Lefkowitz 1983, 16, 52, 77; Raab 1979, 1981, 118–23, 131–32). While stipulating some state-level functions, the legislation provided little support to the states in meeting their responsibilities under the law and emphasized instead federal links to the local HSAs. The law thus partially restored the federal bypass of the states that CHP had aimed to remedy (Curran 1976; IOM 1981, vol. 2; Schonbrun 1979, 1278, 1279; Wennberg and Gittelsohn 1981, 225). Congress, moreover, provided no clear statement in the act of national goals, in effect delegating their formulation to HEW by requiring it to issue national planning guidelines. The tortured effort to produce them, however, yielded no consensus; local interests therefore remained the primary interpreters of federal intentions (IOM 1980; Lefkowitz 1983, 113–22; Mott 1977). The legislation attempted to give national focus to a program that had rested on federal encouragement of state and local initiatives (Raab 1981), but it produced only a marginal change in federal health policy (Foley 1981). Observers mindful of the flaws of CHP predicted poor results from this modest reconstruction (e.g., Mott 1977; Vladeck 1977; West and Stevens 1976).

In the event, the will of hospitals to escape coercion, the broad goals of soft planners, and the fear of Congress to disturb coalitions and impose limits on popularly valued facilities and services eclipsed the urge to control costs. While the act was under deliberation, the AHA and medical interests succeeded in weakening its more stringent provisions (Iglehart 1975b, 384–85; Wennberg and Gittelsohn 1981, 29). All observers understood that the law reflected the hope of Congress to rein in costs, but cost control was absent from the objectives stipulated in the law and little stressed even in its treatment of CON (Sieverts 1977, chap. 11). Preserving the forum function, instead of instituting regulatory stringency, would sustain both local coalitions that backed areawide agencies and the networks in the administration and Congress that supported planning (Lefkowitz 1983, chap. 4). Moreover, cost escalation, however dire it may have seemed, failed to compel Congress to apply firm measures to an industry dealing with life and death (AHA 1981, 128; Brown 1978, 57, 1981, 45, 1982, 89). In addition, state CON laws that conformed to the federal mandate were long in coming, and further problems in their development resulted from amendments to the program passed in 1979. Local planning bodies responded to the federal failure to stipulate goals by taking a scattershot approach rather than focusing on cost containment (Lefkowitz 1983, 121–22), and the incentives facing local regulators, moreover, gave no encouragement to stringency and left them exposed to local, expansionary pressures (Brown 1992, 25–26; Ginsburg 1976; Lefkowitz 1983, chap. 6; Vladeck 1977). In both its aims and execution, the new program that Congress created was a poor vehicle for cost control.

Policy Failure

Despite its weaknesses, the new planning program was the program of choice for the Carter administration's efforts to contain costs (Cain and Gilbert 1978; Lave and Lave 1974, 26; U.S. House 1974a, 27; U.S. Senate 1973, 1974a, 39; Van Nostrand 1977). Having tried and failed to secure legislation squeezing hospitals through reimbursement reforms (Davis et al. 1990, 25–32; Joskow 1981, 130–37), the administration turned to planning-cum-regulation as the best federal cost-control mechanism available (Brown 1983; IOM 1981, vol. 1, 7, 24–25; Wennberg and Gittelsohn 1981, 219–20). Two factors rationalized this approach. One was the knowledge that hospitals' improved access to capital helped shield them from planning and controls (Cohodes and Kinkead 1984, chap. 7; Kane 1969; Sigmond 1965a). This effect had already motivated the unsuccessful attempt by the Nixon administration in 1970 to replace grants under Hill-Burton with loans; and in 1973 it concerned the Senate as it contemplated the fate of Hill-Burton (U.S. Senate 1973, 17). Revitalizing planning now seemed contingent on capital controls. The second factor was Roemer's law. Roemer himself denied its utility for cost control, as planners also quietly acknowledged, but they did not therefore refrain from selling the first CON law to New York legislators in part as a mechanism of cost control. Thereafter, Roemer's law became the standard justification of CON (Brown 1983; Fox 1991; Salkever and Bice 1976, 187, n. 3). With the support of business and labor leaders concerned about rising costs and erosion of benefits, federal policymakers now hoped to narrow the focus onto cost control.

This turn created an opening for health services researchers to prove their then little-tested mettle; the outcome was to cast doubt on the wisdom of federal regulatory policy (Brown 1983; Budrys 1986, chap. 5; Joskow 1981; Lefkowitz 1983, chap. 3; USRE 1978). Researchers wanted to identify measurable outcomes and then to measure them. Unlike the planners' broad goals—or even the hard planners' favored indicator, construction prevented—cost control seemed measurable (Potetz 1982; Salkever and Bice 1976, 187, 191–92). In the mid- and late 1970s and early 1980s, various analyses found little evidence for the effectiveness of CON at limiting capital investment and controlling costs. Salkever and Bice (1976) provided the earliest and one of the most influential such studies. It employed regression analyses to isolate the effects of CON from those of other variables. The researchers found that CON did diminish expansions of bed supply but permitted increases in capital per bed. Another, similar study by Sloan and Steinwald (1980) examined data for individual hospitals during the early 1970s. They found that CON programs covering expansions of bed supply and service did not affect per diem or admissions costs but that these costs increased under CON programs covering only bed supply. The most comprehensive study (Policy Analysis 1981) covered a slightly longer period than that by Steinwald and Sloan, and it also updated their data and examined state and county data. The study discerned no effect of CON regulation on the investments of hospitals, per diem costs, the distribution of facilities, or the structure of the industry (Lefkowitz 1983, 35–36). Analysts also observed that capital projects for diagnostic and therapeutic modalities for both inpatient and ambulatory care often escaped CON review, since their costs lay below legal thresholds (typically in the range of $100,000 to $150,000; as mandated under the NHPRDA, $150,000) (Abt Associates 1975, 124; Salkever and Bice 1976, 189–90; Wennberg and Gittelsohn 1981, 184; Wing and Craige 1979, 1191). Thus, when applied, capital controls seemed to have done little, and in many instances, they had not been applied. The picture was not totally bleak, however. By taking into account the ages of CON programs as well as variability in the programs among the states, other studies did provide modest evidence of effectiveness and the possibility that reforms could improve the performance of CON (Brown 1983; Lefkowitz 1983, 36–37). Nevertheless, this evidence carried little weight among federal policymakers. The early, pejorative studies and the persistence of cost escalation, coming when criticism of regulation both inside and outside health care was growing louder (Melhado 1988), had tainted CON (Budrys 1986, 61–64).

Moreover, other kinds of evidence suggested that CON was ill suited to the job of cost containment. Several investigations revealed previously unimagined complexity in the links between capital investments and operating costs and in the basis and effects of decisions by hospitals to acquire capital equipment. They therefore cast doubt on the expectation that constraining capital investment, even if successful, could curb costs (Abt Associates 1975; Brown and Marks 1981; Brown and Saltman 1985; ICF 1980; Joskow 1981; Kinkead 1984, 45–52; U.S. Public Health Service 1981). Perhaps more important historically, researchers found that the chief motors of cost escalation lay in features of the health system that planners and their backers knew lay beyond their reach (e.g., multiple sources of growing demand, retrospective cost reimbursement, constant generation of new technologies) (e.g., Altman 1978, 579; Blumstein and Sloan 1978, 18; Cain 1981a; Iglehart 1980, 581–82; Mott 1977; University of Texas at Austin 1978, 84). These studies also signaled features of the planning program that inhibited effective action (e.g., absence of scientific principles or clear procedures, vagueness of goals, fragmented organization lacking clear lines of authority, deficiency of coercive powers). Planning gave way to maneuvering among staff and board members and to political negotiation between the agency and the interests. Even in the few examples that researchers could find of apparently substantive planning, value judgments and politics still profoundly informed the results (Anderson and Anderson 1969; Brown 1981, 35–37, 1983; Cohodes 1981a; Schonbrun 1979; Sieverts 1977, 43–44; Wennberg and Gittelsohn 1981, chaps. 6–7). Researchers revealed, moreover, that planners in the HSAs subverted the federal commitment to stringent regulation by upholding the broad goals of soft planning (Brown 1981, 32–35; Cohodes 1981a, 60; IOM 1981, vol. 1, 24–25; Lewin and Associates 1974; University of Texas at Austin 1978, 84; Wennberg and Gittelsohn 1981, 137).

In sum, evidence for the complexity of the problem that planning-cum-regulation was to solve, the inaccessibility to regulatory agencies of the causes behind cost escalation, the fragmented structure of agencies and their vague lines of authority, the tendency of agencies to take up bargaining and unaccountable politics, and the subversion of agency goals by staff all undermined the case for using planning and CON regulation to constrain health care costs. Studies of CON regulation "elicited a remarkable evaluative consensus—that it does not work" (Brown 1983, 481).

Moreover, analysts showed that hard planning, whether resting on science or consensus-based guidelines, could elicit effective opposition (Dunham and Marmor 1976; Robins and Thompson 1980). Action in standard arenas—courts, state legislatures, Congress, political constituencies, and the administration—enabled provider interests to evade controls. So too did less visible expedients, such as the providers' logrolling within agency boards (Vladeck 1977) or stonewalling of regulators (by ignoring the stipulations of a CON or even failing to obtain one, given that statutory and administrative constraints inhibited remediation) (Gellatly and Chung 2004; Public Health Resource Group 2001). These varied forms of resistance drew strength from the progrowth orientation of hospital interests and local economic boosters. The conviction among community members of agency boards that more—as well as more advanced—care was better, their deference to representatives of providers seeking expansion and growth, and the broad desire of community interests to increase the supply of health services and obtain the benefits of the additional economic activity they generated routinely carried the day in agency deliberations over proposals to constrain the growth of providers and thus limit the availability of health facilities and services.

These accumulating indictments elicited planners' protests: critics' single-minded insistence on cost control was inconsistent with the intellectual foundations of planning; its benefits were of a sort that necessarily eluded measurement; and if left to proceed at its traditionally slow pace, the forum function would effect desirable change (Cain 1981a, 1981b; Foley 1981; IOM 1980, 1981, vol. 1; Schonbrun 1979, 1271–72). Yet it was the planners who had brought themselves to this pass by fostering misperceptions about their ability to rein in costs with capital controls. Early in the planning era, when trying to "put out fires," they had billed themselves as able to stem inflation. A few did aspire to hard planning, but most used the concern about costs to advance the soft approach. Later, planners cited Roemer's law as the chief rationale of CON, but they resisted stringent controls, upheld a broad agenda, and stuck with a leisurely pace. The few planners interested in hard planning lacked the necessary science, had to make do with a mechanism that research eventually showed to be ill fitting, found themselves unable to resist the drift toward consultation and bargaining, and left themselves exposed to claims of unaccountability. Planners had promised cost control, but in the end they lacked the will and the tools to deliver it.

By the late 1970s, planning had become part of a policy stalemate that thwarted substantive action against cost escalation. The failure of Congress to take a clear and firm stand against rising costs and of the administration to rally Congress and planners to the standard of cost control showed how federal temporizing gave the interests maneuvering room. State and local boosters of health services and facilities, health care providers, planners committed to the soft approach, members of Congress avoiding tough decisions, and some federal administrators committed to traditional consultative methods blocked those who sought restraint through hard planning (President Carter, some federal and state health administrators, some business and labor interests, and social activists) (Brown 1983; IOM 1981, vol. 1, 7; Lefkowitz 1983; Raab 1981, 136–37). This stalemate, the indictments developed by researchers, and the hollow protestations of planners that their enterprise had been misjudged and that their consultative practices (however slow) remained valuable all delegitimized planning as an instrument of public policy (Altman 1982).

Declining Community Ties

Broader forces also undermined planning by eroding its community context. Improved access of hospitals to capital and consequent governmental attempts to control its use induced hospitals to adopt practices more typical of businesses than of eleemosynary institutions. Having had to establish for lenders their suitability as risks (by exhibiting prospects for a reliable income stream) and for third-party payers the propriety and magnitude of anticipated capital expenses, hospitals needed to develop capital budgets and standardized accounting procedures (AHA 1969b), as well as tight managerial controls (AHA 1974, 32), practices formerly rare (Sigmond 1967a). Medicare reinforced these tendencies (Clapp and Spector 1978; Johnson 1966; Stevens 1989, chap. 11). So did the nascent investor-owned hospital industry, which elicited businesslike, competitive behavior from voluntary hospitals (Gray 1991, 65–84; Kuttner 1996; Schlesinger, Marmor, and Smithey 1987). The result was a more businesslike approach to the financial management, administration, and governance of voluntary hospitals and a reorientation of administrators from community service to economic and business objectives. A few advocates of planning thought that such rationalization augured well (e.g., Somers 1969, 14), but most perceived it as a major threat to the traditional public-service, community-oriented mission of the voluntary hospitals (e.g., Brown and Saltman 1985; Gottlieb 1969; Sigmond 1985).

Planning agencies, Blue Cross, and many philanthropists also grew distant from local communities. Early in the planning era, planners acknowledged the tension between the expected communitarian character of planning agencies and their need to operate over regions large enough to allow agencies to formulate regional goals and obtain professional staffing and monetary support. Especially as metropolitan planning eclipsed the old rural hierarchies, metropolitan regions transcended local urban communities, thereby distancing agencies and their staffs from local concerns and putting them in conflict with local conceptions of need (Domke 1962). Drafters of the NHPRDA hoped to resolve this problem with subarea councils; they did provide means to acknowledge tensions but not to resolve them, and they failed to discourage the duplication resulting from persistent local patterns (Arthur D. Little 1979; Curran 1976, 40; Rorem 1964a; Sieverts 1977, 29–31; Wennberg and Gittelsohn 1981, 210–12; West and Stevens 1976). Community groups, especially activists representing newly legitimized interests, saw HSAs as unsympathetic outsiders imposed from above and grew disenchanted with the top-down structure of planning (Arthur D. Little 1979; Lashof and Lepper 1976, 132–34; cf. Morone 1998, chap. 7). Similarly, Blue Cross, long the dominant third-party payer, was at first locally rooted and community oriented. However, beginning in the late 1950s, in competition with commercial firms to meet the needs of large regional or national employers, it abandoned community rating and created organizations that, like both the commercial firms and Medicare, transcended local markets (Brown 1991; Cunningham and Cunningham 1997, 107–9; Hedinger 1966, 80–81). Third-party payers thus grew less responsive to local health care needs and more responsive to national or at least large regional economic trends.

Changes in capital financing and the decline of distinct community cultures similarly weakened the links of hospitals to their communities, the proprietary attitude of local communities toward their hospitals, and the conviction that hospitals were invested with the public interest (Seay and Vladeck 1988). Even if still involved, corporate philanthropists often operated at a considerable remove, for many once-local businesses had merged into national firms little mindful of local concerns (Dobbin 1967, 1968; cf. Hall 1992, 138–39; Hedinger 1966). Investors in hospital bond issues were geographically remote and lacked ties to the institutions they financed; they cared less about the social-service role of hospitals than about their economic vitality (Schramm 1988, 82); and they were no longer available as potentially economy-minded recruits to local planning agency boards. The management of newly emergent multihospital systems, whether voluntary or proprietary, also was often detached from the local communities (Cohodes and Kinkead 1984, 43–44; Gray 1991, 73; Sapolsky 1981, 147; Spitz 1997). Similar distancing followed the decline of culturally distinct provider networks and the dissipation in the suburbs of their traditional clienteles. As waning cultural distinctions allowed hospitals to appeal broadly to the middle class, its members grew less likely to identify with "their hospitals" other than through simple geographic proximity—still significant perhaps, but an impoverished form of social capital. Hospital administrators, planners, and nonprofit insurers deferred far less readily to local and particularistic sensibilities, and in their work they hearkened to professional and business standards, not communitarian ones. The rationale for local control over local institutions was vanishing. Planning in the interest of local communities may have been routinely frustrated, but the aspiration to try it had become increasingly anachronistic.

The End of Planning

Health policy in the late 1970s and early 1980s had become inhospitable to planning. Its original congressional backers were gone; declining community ties eliminated the traditional context for planning; planning and regulation, once touted as the last best hope for cost control, increasingly appeared ineffective; their giving way to politics and their preservation of the status quo seemed illegitimate and irremediable; and cost containment and market improvements eclipsed the rationalization of health care and expanded entitlement as the main goals of health policy. Only the forum function, beloved by soft planners and excoriated by their critics, remained; but neither the Carter nor the Reagan administration nor Congress was willing to sustain it (Iglehart 1980; cf. Foley 1981).

On the national level, the movement had run its course (for state-level events, see the appendix).

Concluding Reflections

What does this history show? First, planning was always an unequal struggle between the reformers who thought of themselves, at least in part, as serving the public interest, and the private interests that shaped, ran, and benefited from the hospital system. Measured against planners' aspirations, American hospitals had consistently come up short. Even early in the twentieth century, just as the modern, acute-care hospital was becoming the central institution for medical care (Rosenberg 1987, chap. 13), many of the problems that planners would target already were apparent (Stevens 1989, 132–39 et passim). Emphasis on acute inpatient care and neglect of outpatient, ambulatory, and chronic care and rehabilitation; rising costs coupled with low occupancy and duplication and maldistribution of facilities; and inadequate and inefficient distribution of resources initially in rural and later in metropolitan areas were problems that experts perpetually rehearsed as subject to alleviation by planning. Both the persistence of the problems and the repetitive assertion of planning ideas over decades reflects the reformers' long-standing failure to make their image of the public interest—an efficient, coordinated, hierarchical system—prevail over parochial interests.

Planners met resistance at every turn. They had supposed that incentives favoring broader community interests in the provision of coordinated acute as well as chronic care could be built into Hill-Burton (PCHNN 1953) and that physicians and other interested parties could be educated both to acknowledge these concerns and to accommodate them (e.g., CCI 1956–59, vol. 1, chap. 6; vol. 2, chap. 5; Health Preparedness Commission 1947, 26, 28). In fact, Hill-Burton encouraged the already existing community interest in providing independent, local acute-care institutions and the medical staff needed to run them (Elling 1963; Treloar and Chill 1961). Community physicians resisted the imposition of limits on their practice or the creation of new modes for its organization, and they did not want to refer patients out (and thus risk losing them to specialists) but instead demanded that resources be made available locally (Arthur D. Little and Organization 1970, chaps. 2–3; Bodenheimer 1969; Fox 1986b, 167; cf. Stevens 1989, 215). They also resisted the burdens of service and teaching in regional arrangements and feared competition from hospitals or other institutions. Instead, they saw community hospitals as supports for and extensions of a private practice that gave priority (under the impact of their training and of the prevailing reimbursement mechanisms) to acute manifestations of chronic disease. They therefore resisted programs, favored by many planners, for ambulatory, domiciliary, and chronic-care services and lacked interest in developing systematized knowledge about chronic patients (CCI 1956–59, vol. 2, chap. 5; Fox 1995; Roemer and Friedman 1971; Starr 1982b, 178; Stevens 1989, 74, 87, 178, 195–97).

For community hospitals, the growing influence of professionalizing hospital administrators over medical staff might well have fostered more community-oriented ambulatory and chronic-care arrangements, at least until economic forces reoriented administrators toward commercial from eleemosynary goals (AHA 1965a; Rakich 1972; Roemer and Friedman 1971; Rosner 1988; Sigmond 1966b). Nevertheless, the hospitals failed to sustain an "outward glance" toward the community but consistently preferred an "inward vision" that emphasized in-house provision of technologically advanced, acute-care services and that depreciated or ignored chronic care (e.g., AHA, AMA, AMPHA, APWA 1947; CCI 1956–59, vol. 1, chap. 6, vol. 2, chap. 5; Rosenberg 1979). Prevailing incentives, professional and institutional interests, predominant priorities in local communities, and local pro-growth boosterism all led to a distribution of hospitals and services that defied the experts' standards of efficiency and comprehensiveness. The Progressive-Era model of disinterested public service, the presumptive role of "men of goodwill" as community champions of the public interest, and the animation of reformers by pragmatic humanism likewise all proved impotent in the face of hospitals, physicians, and the public. The failure of planning, therefore, instantiated both the power of the interests and the impotence of disinterested experts.

Indeed, the very cultural legitimacy of disinterested expertise, of Progressive-Era notions of reform in the public interest, of the status of reformist professionals as trustees of collective values, and of the virtues of professional self-regulation and eleemosynary institutions was eroding. Not just policy failure but also fundamental criticisms of the now crumbling traditional policymaking world leveled by the proponents of the market as well as by analysts of professional expertise prompted doubts about these traditional themes. In the view of market advocates, the failures of past policy reflected the failures of the culture of policymaking that sought to limit the reach of market mechanisms and to substitute professional for consumer judgment and, paradoxically, cited the failure of markets in justifying a regulatory approach to health affairs. This article will not analyze the onslaught against the collective-welfare and social-conflict models for advocacy and research in health policy (Fox 1990, 1995; Goldsmith 1984; Melhado 1988, 1998; Schramm 1988), but just observe that critics traced the problems of health care to practices that, despite (or even because of) reformers' efforts, locked in the power of health care interests. Moreover, the motives of health care professionals and policy experts grew suspect, both because the critics of social-trustee professionalism portrayed professionals as selling services to employers and other interested parties rather than protecting collective values (Brint 1994) and because in fact health care experts increasingly found employment in a wider variety of settings, serving as agents for private interests with major economic stakes in health care (Fox 1990). The kinds of professionals who had advocated reforms in the public interest increasingly looked like guns for hire, and the public interest had been reduced to ensuring the proper functioning of health care markets.

A second conclusion suggested by this history is that planners not only underestimated the tenacity of the interests, but they also failed to see in that tenacity a measure of the magnitude of the changes they sought, thus of the threat that their aspirations posed to the interests, and therefore of the fragility of their approach to reform. Broad reform—planned coordination of services, facilities, and personnel in urban-based hierarchies; vastly enhanced priority for chronic care, both institutional and domiciliary; broad improvement of access to health services; and commitments to efficiencies achievable by rational program design and, where necessary, regulation—is what advocates of health planning wanted. In effect, that agenda implied overturning the whole edifice of American medical care. Soft planning, therefore, was in principle very hard, but the planners' long time horizon may have suggested their goals could be realized incrementally by pressing their case among "men of goodwill." When confronted with entrenched, powerful interests, a program of incremental change relying on the power of persuasion, example, and, perhaps, scientifically based insights and methods is not a viable mechanism of reform. Stronger measures, however, would have been uncongenial to planners who typically preferred consultation, and regulatory stringency would have been politically unacceptable to both the interests and—in a polity traditionally suspicious of government and in favor of development—the public.

Third, planning did not simply disappear but gave way to something else: market imperatives. The payers, especially Blue Cross and Medicare, began to impose market discipline and requirements for fiscal accountability on providers (Brown 1992, and private communication 2005; Stevens 1989). Blue Cross had long served as a "coregulator" of hospitals in New York City, for example, under a regime of planning and CON (Fox 1991); and in many locations the contracting provisions of Blue Cross plans required member hospitals to conform to planning requirements or face exclusion from coverage or reductions in reimbursement (AHA 1969a; Cunningham and Cunningham 1997, 172–74; Havighurst 1973, 1152, n. 24; Lewin and Associates 1974, 57, 160–64, 200–201, 209; Somers 1969, 138). The utility of such contracts has not been analyzed, and doubtless experience with them differed from place to place; but their subjection to diverse court tests suggests that they were not without effect. The decline of planning, however, led payers to detach contracting from it. Blue Cross, commercial payers, Medicaid, and Medicare increasingly imposed standards of accountability on providers by regulating their reimbursement through contractual arrangements (Davis et al. 1990; Robinson 1999; Stevens 1989, chap. 11). They no longer aimed to conform to planners' visions but instead to promote efficiency in hospitals and among physician providers, encourage their competition, and contain the costs of their services. Regulation of reimbursement, through such means as prospective payment (by Blue Cross and Medicare) and payers' support for managed care and out-of-hospital care, filled the void left by an impotent system of planning and a politically burdened apparatus of CON regulation (Goldsmith 1984). Markets, divorced from public-interest reforms and social planning, seem to have proven able, as their advocates had hoped, to impose a measure of efficiency and accountability on the interests.

Fourth, the story of planning exposes the decline of local communities as the chief context for the organization and financing of health services. Originally, local hospitals served communities in both small towns and urban, typically ethnic neighborhoods. Hill-Burton projects took root in the efforts of local coalitions, with support of local philanthropy; Blue Cross plans served limited areas and worked in close relationships with both hospitals and citizens; physicians understood themselves to be operating in the context of a locally structured profession marked by local hierarchies and referral patterns (Hall 1948); and even the federal government, in health planning and other policy areas, forged links with the local community. There, long-standing institutional arrangements and personal and social connections sustained the conviction that disinterested expertise could properly serve community interests. It was in this context that planners first hoped to exercise their craft. The economic forces that eroded community ties also eroded the extramarket culture—the social capital—of close community interactions and substituted the wider market nexus as the context for provision and organization of care. The decline of the community is perhaps best measured by the recent literature that seeks to temper the broader economic forces in health care by reinvigorating community activism, research, and decision making (e.g., Emanuel and Emanuel 1997; Merzel and D'Affliti 2003; Metzler et al. 2003; Mitchell and Shortell 2000; Morone and Kilbreth 2003; Schlesinger 1997; Sigmond 1995). Such practices can surely improve the health care available in those local communities or offered to local groups that are ill served by markets, but they are largely defensive and provide only modest prospects for reviving a communitarian focus in public policy.

Fifth and last, planning provides another instance in which reformers' confidence in the power of science to serve the public interest proved to be misplaced. At the core of the science in this case was determining the need for health facilities and services and specifying their rational geographic distribution (Fox 1986a, 1986b, 1991; Klarman 1951, 1978, 91–94; Shonick 1976, 1995, chap. 12). Through most of the twentieth century, analysts believed that health services were unequivocal merit goods and that the public interest demanded their broad dissemination (CCMC 1932; Fox 1986b, 45–51; Hoge 1958; PCHNN 1953; Starr 1982b; University of Pittsburgh 1958). Reformers regarded the development of health services as following from that of medical science and believed that planning could determine in the same scientific spirit that animated medical researchers the extent and distribution of resources appropriate to meeting the need thus defined. Health care was important but expensive; planning would ensure its efficient provision.

The resource to which planners gave priority in determining need was acute-care beds in general hospitals. Earlier thinking about acute beds helped lay the groundwork for Hill-Burton, which invoked simple bed-to-population ratios (Shonick 1976; Sieverts, private communication 2003; Treloar and Chill 1961). However, once the program had begun, scientific determination of bed need preoccupied researchers and planners (Flook and Sanazaro 1973; Reed and Hollingsworth 1953; Shonick 1976), and the PHS struggled, unsuccessfully, to introduce a method that would prove both intellectually sound and practically applicable. Intellectually, the paradigm of needs assessment came out of the work of the CCMC, particularly the study by Lee and Jones (1933) that confronted expert opinion about the resources required to provide scientifically based care with surveys of their availability. In practice, the planners relied not on the study by Lee and Jones, but on manifest demand, long held to reflect the structure of local populations and their patterns of disease. Instead, demand proved dependent on other variables, especially the extent of insurance coverage, the distribution of beds (itself a reflection of community leadership in providing hospitals and other health care resources), and the practice patterns of physicians (Anderson 1964; Arnould, Rich, and White 1993, chaps. 3, 7, 10; Klarman 1969, 1978; Sigmond 1966a). Evidence for the elasticity of the demand for care led some planners to see that value judgments—about what things communities wanted and what they were willing to pay for them—would have to underlie any "scientific" analysis of need (Melhado 1998).

This understanding is one reason that in practice planners allowed their principled commitment to science to give way to politics and consultation, but there were others. Between Roemer's law and the details of a regime of CON regulation lies "a body of ambiguous conceptual terrain" (Brown 1983, 484) navigable through trial and error, exercises in interpretation, and bargaining with the affected interests, that is, through consultation, and not, as researchers had clearly shown, through science. Moreover, planning faced difficulties that only consultation, not any clear scientific logic, had it existed, could solve. The rapid rate at which medical science rendered facilities and services obsolete implied the need to expand time horizons for planning. However, trends in population growth, economic development, urban settlement, and medical technology were little subject to prediction. Planners therefore advocated flexible designs for new facilities to allow for their future expansion or conversion to other uses (e.g., land acquisition for future construction and building designs suited to additions or reallocation of space). The resulting additional capital costs were uncompensated in the short term. Meeting those costs required not formal planning but education, consultation, and community organizing (Burgun 1964, 1969; Haldeman

1959, 1967; Rorem 1954; Sigmond 1958; Walker 1963). These activities, however, grew difficult to defend against the charge, leveled by advocates of the market, that supposedly scientific planning obscured unaccountable political activity. Hard planning proved impracticable; soft, unaccountable. The aspirations of planners to invoke science in the public interest lay in shambles.

So too, in sum, was the entire mode of public-interest policymaking that planning had instantiated. Deriving from the Progressive Era, it supposed that even if experts were responsible to parochial interests, they could envision and advance a broader public interest. It had found legitimacy in local communities and found support in the federal deference they enjoyed. Advocates of the public interest, regarding medical care as a merit good, had rejected its organization through markets. Instead, they invoked government as an ally of disinterested expertise in advancing the public interest and providing resources and guidance to organize socially progressive programs on state and local levels. They derived legitimacy from the social-trustee professionalism descended from the Progressive Era. Familiar through much of the last century, these features of public policy crumbled as the century ended. A sympathetic observer might conclude that this traditional approach brought valuable health services to a population that lacked them; a skeptical one would point to structures of privilege and economic advantage that subordinated the interests of patients and citizens to those of physicians, hospitals, and insurers. According to its advocates, by subjecting the interests to market discipline, the new health care economy serves citizens better, but it also privileges economic over extramarket values (Fox 1990; Mechanic 1993; Melhado 1998, 2000) and exposes care to the hazards, both economic and moral, that mark the culture of business (Barlett and Steele 2004; Schlesinger et al. 2005). There may be grounds, therefore, for revising the current priorities in health policy (Bloche 2003; Morone and Jacobs 2005; Pellegrino 1999; Robinson 2003; Stevens 2001). Therein may lie a new role for those policymakers still hoping to advance the public interest.

Endnote

1. A recent, respected textbook on health policy that offers historical background devotes only a few pages to planning (Patel and Rushefsky 1999, 41–43, 168–70). A major analysis of cost

containment that features a historical chapter barely mentions planning (Davis et al. 1990, 10, 23, 26). A few historians have treated bits of this story within larger studies (e.g., Fox 1986b, 1991; Stevens 1989). Near the end of the planning era, some analysts harnessed slight histories of planning to broader goals (Budrys 1986; Rodwin 1984) or focused on one element of planning (its attachment to supply regulation) to elicit policy lessons (e.g., Koff 1988; Lefkowitz 1983; Sofaer 1988) or exemplify and support a broader political analysis (Morone 1998). One participant in and reflective observer of planning (Shonick 1976, 1995) offers a substantive but narrow history within a broader account of health policy. Other close observers or participants present narrower but sometimes informative studies (Alford 1975; Brown 1973; Gottlieb 1974; May 1967; Pearson 1976). One analyst provides a broad view of planning within the shifting tableau of federal health policy (Brown 1992; cf. Scott et al. 2000); and one set of local studies provides useful insights (Fox, Rosner, and Stevens 1991).

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Appendix: The Persistence of CON on the State Level

Despite the failure of the federal planning effort, planning and especially CON have persisted on the state level. Federal legislation that kept the program alive with lower funding after September 30, 1982, included provisions that freed the states to depart from federal requirements regarding CON. The outright repeal of the federal program, effective at the beginning of 1987, left the states without any federal funding for CON regulation or federal requirements for its conduct (Simpson 1986). Since 1982, a number of states have repealed their programs, and others have introduced modifications (reduction in the kinds of services and facilities covered, increase in capital-investment thresholds, simplification of administrative procedures, and updating of decision-making methodologies) (ACHHSF 1998; Gellatly and Chung 2004; Harrington et al. 2004; McKinley 2004; Public Health Resource Group 2001). Although these changes vary from state to state, the overall trend has been toward deregulation. Nevertheless, many states continue CON coverage, in some cases for acute care and in many cases for nursing homes and other long-term care facilities and providers.

The motives for preserving CON vary as well. They include dampening cost escalation (based on the persistent belief of some state policymakers that CON can effectively serve this goal); sheltering nonprofit teaching and community hospitals from commercial competitors and/or controlling the distribution of services (either because providers successfully use political action to obtain shelter from competition or policymakers deem it in the public interest to afford such protection to certain providers); compensating for lack of competition, especially in less densely populated states or areas; constraining Medicaid spending and thus protecting state budgets by limiting the proliferation of especially nursing home beds; and, by so limiting beds, inducing providers of long-term care to shift to supposedly less costly services such as home health care, residential care, and community-based services. Very recently, cream-skimming of profitable services from community hospitals by specialty hospitals and specialized outpatient surgery centers has led to claims (from a public-interest standpoint) that CON can serve to protect community hospitals. Criticism of CON programs also persists (FTC and DOJ 2004, chap. 8), however, perhaps reinforcing the deregulatory trend. The days of state-level CON may be numbered.