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Status of the Implementation of the National Health Planning and Resources Development Act of 1974. HRD-77-157; B-164031(5). November 2, 1978. 48 pp. + 3 appendices (16 pp.).

Report to the Congress; by Elmer B. Staats, Comptroller General.

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Authority: National Health Planning and Resources Development Act of 1974 (P.L. 93-641). Hospital Survey and Construction Act; Hill-Burton Act (P.L. 79-725). Heart Disease, Cancer, and Stroke Amendments of 1965 (P.L. 89-239). Comprehensive Health Planning and Public Health Service Amendments (P.L. 89-749). Public Health Service Act, as amended. Social Security Amendments of 1972. Community Mental Health Centers Act. P.L. 92-603. P.L. 95-142. United States v. Wittek, 337 U.S. 346, 358-359. B-164031(2) (1974).

The National Health Planning and Resources Development Act of 1974 provided for: the development of guidelines for national health planning; the establishment of areawide and State health planning agencies to deal with needed planning for health services, manpower, and facilities; and financial assistance for the development of resources.
Findings/Conclusions: Since passage of the act, the country has been divided into 205 health service areas; health systems agencies have been designated in all of these areas; all State planning agencies have been designated; and centers for health planning have been established in each of the 10 Department of Health, Education, and Welfare (HEW) regions. It is too early to determine the effect of areawide and State agencies in achieving the objectives of the act. HEW has been slow in publishing regulations and guidelines needed to carry out the act primarily because of new regulation development procedures, organizational problems, and litigation against the act. Planning agencies were handicapped in developing and completing health systems plans because of the unavailability of health data and national standards and criteria for the health care system, inability to recruit staff, conflicts between local and State planning agencies over respective responsibilities, and delays in receiving technical assistance. Recommendations: The Secretary of HEW should: publish needed regulations and guidelines in a timely manner, resolve organizational problems within the Bureau of Health Planning and Resources Development, develop health system standards and criteria, address the problems of

inadequate and insufficient health data, develop a policy statement to clarify the relative emphasis to be placed on cost containment and health care accessibility, and direct regional planning centers to emphasize health plan development and board member orientation and educational activities. The Congress should expand the provisions of the act to allow more States to have only a State health planning and development agency and require that all other States have a minimum of two health systems agencies. If the Congress does not amend the act, it should clarify the responsibilities of health systems agencies and State health planning agencies in those States that have only one health systems agency. (RRS)

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Status Of The Implementation Of The National Health Planning And Resources Development Act Of 1974

Health planning agencies have been hindered by many of the same problems experienced by the Department of Health, Education, and Welfare in previous health planning efforts.

--Lack of adequate health data, national standards, and criteria for the health care system.

--Inability to recruit experienced staff.

--Delays in receiving needed technical assistance.

Confusion exists as to the respective responsibilities of local and State planning agencies, particularly in States having just one health systems agency.

Necessary support of local governments, community and professional groups, and others working in the health care field has been slow. Health planning agencies must establish their credibility among these groups so that goals may be met.

HRD-77-157
NOVEMBER 2, 1978

COMPTROLLER GENERAL OF THE 'JNITED STATES
WASHINGTON, D.C. 20548

B-164031(5)

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the status of the implementation of the National Health Planning and Resources Development Act of 1974. The report describes problems being experienced by (1) local and State health planning agencies in carrying out the provisions of the act and (2) the Department of Health, Education, and Welfare in developing guidelines, regulations, and other needed materials for planning agencies.

We made our review early in the implementation of this important program so that initial problems could be identified and corrected in order to foster the development and success of the program in achieving the act's objectives. The review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Secretary of Health, Education, and Welfare and the Director, Office of Management and Budget.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

STATUS OF THE IMPLEMENTATION OF THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974

D I G E S T

In January 1975, the President signed into law the National Health Planning and Resources Development Act of 1974 which

--established areawide and State health planning agencies, statewide health coordinating councils, and regional centers for health planning;

--identified national health priorities; and

--required the Secretary of Health, Education, and Welfare (HEW) to appoint a National Council on Health Planning and Development and to develop guidelines for a national health planning policy. The act's primary goals are to contain health care costs and improve access to quality health care.

Since enactment of the law, the country has been divided into 205 health service areas, areawide health systems agencies have been designated and are operating in all of these areas, all State health planning agencies have been designated, and regional centers for health planning have been established in each of HEW's 10 regions.

GAO reviewed 15 local and 11 State planning agencies, as well as 4 regional planning centers and 4 HEW regional offices, to determine the status of the implementation of the act.

It is too early to determine the effect of areawide and State agencies in achieving the objectives of the act. Such an analysis probably cannot be done for several more years.

HRD-77-157

HEW has been slow in publishing regulations and guidelines planning agencies need to carry out the act primarily because of new regulation development procedures, organizational problems, and litigation against the act. The National Council on Health Planning and Development held its first meeting in September 1977. National guidelines on health planning were not issued until March 1978.

Planning agencies were handicapped in developing and completing required health systems plans because of unavailability of health data and national standards and criteria for the health care system, inability to recruit staff, conflicts between local and State planning agencies over their respective responsibilities especially in States having only one health systems agency, and delays in receiving technical assistance. Regional centers for health planning had made limited progress in assisting planning agencies and educating local agency board members.

Planning agencies also were experiencing difficulties in establishing their credibility among consumer and provider groups and local government entities.

RECOMMENDATIONS

The Congress should expand the provisions of section 1536 of the National Health Planning and Resources Development Act to allow more States to have only a State health planning and development agency and require that all other States have a minimum of two health systems agencies.

If the Congress chooses not to amend the act as suggested above, the Congress should amend it to clarify the responsibilities of health systems agencies and State health planning and development agencies in those States which have only one

health systems agency. The Congress should also amend the National Health Planning and Resources Development Act to provide for local and State health planning agencies review of proposed projects involving Federal health facilities. The act should require that their recommendations regarding the appropriateness of the projects be sent to the cognizant Federal agencies. Federal agencies should be required to provide these recommendations along with their written responses to congressional committees before any decisions are made to fund a project. Specific legislative language regarding these changes will be furnished by GAO upon request.

The Secretary of HEW should take action to

--publish needed regulations and guidelines in a timely manner,

--resolve organizational problems within the Bureau of Health Planning and Resources Development,

--develop health system standards and criteria,

--address the problems of inadequate and insufficient health data,

--develop a policy statement to clarify the relative emphasis health systems agencies and State health planning and development agencies should place on cost containment and health care accessibility, and

--direct regional planning centers to emphasize health plan development and board member orientation and educational activities in future assistance in planning agencies.

HEW concurred with most of GAO's recommendations and outlined actions taken or planned. (See app. III.)

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HRA	Health Resources Administration
HSA	health systems agency
PSRO	Professional Standards Review Organizations
SHCC	statewide health coordinating council
SHPDA	State health planning and development agency

CHAPTER 1

INTRODUCTION

On January 4, 1975, the President signed into law the National Health Planning and Resources Development Act of 1974, Public Law 93-641. The act provides for the development of guidelines for national health planning; the establishment of areawide and State health planning agencies to deal with needed planning for health services, manpower, and facilities; and financial assistance for the development of resources.

The Bureau of Health Planning and Resources Development (Bureau) of the Department of Health, Education, and Welfare's (HEW's) Health Resources Administration (HRA) is responsible for implementing this act. The Bureau was established in March 1975 and was formed by combining the staffs of three separate programs--the Comprehensive Health Planning program; the Hospital and Medical Facilities Construction program, authorized by the Hospital Survey and Construction Act (Hill-Burton program), and the Regional Medical program. As shown in the following table, Federal funding for activities under the act amounted to about $487 million through fiscal year 1978.

Funding Levels for Health Planning

Activity	Allocations by fiscal years				
	1975	1976	Transition quarter	1977	1978
	(thousands)				
Transition costs:					
Comprehensive health planning	$ -	$ -	$ -	$ -	$ -
Regional Medical program	-	-	-	-	-
Emergency health services delivery system	-	-	-	-	-
Total	$80,200	$ 30,000	$ -	$ -	$ -
Health systems agencies	-	48,000	16,090	97,000	107,000
State agencies	-	19,000	-	19,500	29,500
Planning methods and technical assistance:	10,000	6,500		6,500	6,500
Planning methods	a/(5,115)				
	b/(1,349)	(2,450)	-	(5,250)	
Technical assistance	a/(820)				(2,000)
	b/(316)	(1,150)	-	(1,250)	
Planning centers	(2,400)	(3,900)	-	-	(4,500)
Capital expenditures review	-	8,000	-	-	-
Rate review	-	-	-	2,000	-
Total	$90,200	$112,500	$16,090	$125,000	$143,000

a/Expenditures actually made in fiscal year 1976 because of 2-year authority (1975 and 1976) for the fiscal year 1975 allocation.

b/These expenditures were made in fiscal year 1975.

HISTORY OF FEDERAL HEALTH PLANNING EFFORTS

Congressional interest in effective health planning and resources development began with the enactment of the Hospital Survey and Construction Act (Public Law 79-725) in 1946. This act, commonly known as the Hill-Burton program, authorized grants to States for (1) surveying State needs and developing State plans for the construction of public and voluntary nonprofit hospitals and public health centers and (2) assisting in constructing and equipping such facilities. The act was amended in 1964 to provide legislative authority to fund regional or areawide voluntary health facilities planning agencies. The Hospital Survey and Construction Act expired on June 30, 1974.

The Heart Disease, Cancer, and Stroke Amendments of 1965 (Public Law 89-239) and the Comprehensive Health Planning and Public Health Service Amendments of 1966 (Public Law 89-749) amended the Public Health Service Act and created the Regional Medical and the Comprehensive Health Planning programs.

The purpose of the Regional Medical program was to establish regional cooperative agreements among health care facilities, medical schools, and research institutions. These programs were to make available advances in the diagnosis and treatment of heart disease, cancer, stroke, and kidney disease to patients. However, in 1970, legislation extended the original concept of this program as a disease focused program with primary responsibility for the dissemination of knowledge to health care providers to one similar to the Comprehensive Health Planning program's (the development of primary ambulatory services, comprehensive services, emergency medical services, and generally the implementation of HEW health priorities). The Regional Medical program expired on June 30, 1974.

The Comprehensive Health Planning program 1/ provided for (1) grants to States for the support of statewide comprehensive health planning programs, (2) project grants to public or nonprofit private agencies for areawide health planning, and (3) project grants to public and other organizations to cover all or part of the costs of training, studies, or demonstration projects to improve health planning.

1/The results of our review of this program are summarized on p. 6.

The Public Health Service Act was amended in 1967 and 1970. The 1967 amendment required State comprehensive health planning agencies to assist health facilities in developing programs for capital expenditures. The 1970 amendment required applications for grants for health service development to be referred to areawide comprehensive health planning agencies for review and comment.

The Social Security Amendments of 1972 (Public Law 92-603) strengthened the role of the State planning agencies. These amendments added section 1122 to the Social Security Act which provides that health care facilities and health maintenance organizations will not be reimbursed by Medicare, Medicaid, and Maternal and Child Health programs for depreciation, interest, or return on equity capital for capital expenditures in excess of $100,000 not approved by the State health planning agency. However, State participation in section 1122 review is voluntary. As of April 30, 1978, Missouri was the only State to have neither an 1122 agreement with HEW nor a "certificate of need" program (generally a program requiring that a certificate of need be obtained from the State before health facilities are constructed, services provided are changed, or expensive equipment is purchased, usually over $150,000).

The National Health Planning and Resources Development Act of 1974

The National Health Planning and Resources Development Act of 1974 builds on the experience of the Hill-Burton, Regional Medical, and Comprehensive Health Planning programs and seeks to combine their best features into a new national health planning and resources development effort.

In the act, the Congress identified the achievement of equal access to quality health care at a reasonable cost to be a priority of the Federal Government. The Congress also noted that

--the massive infusion of Federal funds into the existing health care system has contributed to the inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently, has not made possible equal access for everyone to such resources;

--neither the public nor private sector has been successful in dealing with the (1) lack of uniformly effective methods of delivering health care, (2) maldistribution of health care facilities and manpower, and (3) increasing cost of health care;

--increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care; and

--large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services.

The act added title XV, "National Health Planning and Development," and title XVI, "Health Resources Development," to the Public Health Service Act.

Title XV provides for the country to be divided into health service areas that are appropriate for the effective planning and development of health services. The act also establishes areawide health planning agencies called health systems agencies (HSAs), State health planning and development agencies (SHPDAs), and statewide health coordinating councils (SHCCs). The process used in determining health service areas and the functions of HSAs, SHPDAs, and SHCCs are discussed in chapter 2.

In addition, the act requires the Secretary of HEW to issue guidelines concerning national health planning policy. The guidelines are to include:

--Standards concerning the appropriate supply, distribution, and organization of health resources.

--A statement of national health planning goals developed after considering the national health priorities identified in the act. These goals, to the maximum extent practicable, are to be expressed in quantitative terms.

The guidelines are to be developed with the assistance of HSAs, SHPDAs, and SHCCs, as well as the National Council on Health Planning and Development which the act established to advise the Secretary in the implementation of the act.

The national health priorities identified by the Congress in the act are

--providing primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas;

--developing multiinstitutional systems for coordination of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services);

--developing medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care;

--training and increased use of physician assistants, especially nurse clinicians;

--developing multiinstitutional arrangements for the sharing of support services necessary to all health service institutions;

--promoting activities to improve the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations (PSROs) 1/ under part 3 of title XI of the Social Security Act;

--developing health service institutions with the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis;

--promoting activities to prevent disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services;

--adopting uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions; and

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1/Organizations established throughout the country having the responsibility for the comprehensive and ongoing review of health services provided under the Medicare, Medicaid, and Maternal and Child Health programs. PSROs are to determine, for the purpose of reimbursement under these programs, whether services are (1) medically necessary, (2) provided in accordance with professional standards, and (3) in the case of institutional services, rendered in the appropriate setting.

--developing effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

GAO REPORT ON THE COMPREHENSIVE HEALTH PLANNING PROGRAM

In our report 1/, we identified a number of problems regarding the Comprehensive Health Planning program. Specifically, we noted that

--difficulties in raising required local matching funds were being experienced;

--planning agencies lacked adequate staffs;

--participation of volunteers was limited in planning activities because of lack of time, interest, and knowledge of the planning process and the health care system;

--some planning councils were not geographically and socioeconomically representative;

--relationships between State and areawide agencies were ineffective;

--project review functions were often done without using sound criteria and systematic procedures;

--areawide agencies were not always given the opportunity to review and comment on proposed Federal health projects; and

--State and areawide agencies had difficulties in establishing data bases.

We also addressed the need for HEW to have an adequate assessment program so that problems could be identified and corrected.

1/"Comprehensive Health Planning as Carried Out by State and Areawide Agencies in Three States" (B-164031(2), Apr. 8, 1974).

CHAPTER 2

DEVELOPMENT OF FRAMEWORK TO IMPLEMENT THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Since passage of the National Health Planning and Resources Development Act of 1974, the country has been divided into 205 health service areas, health systems agencies have been designated in all of these areas, all State planning agencies have been designated, and centers for health planning have been established in each of the 10 HEW regions. The National Council on Health Planning and Development held its first meeting on September 23 and 24, 1977. National guidelines for health planning for nine types of health services and facilities were issued on March 28, 1978.

DESIGNATION OF HEALTH SERVICE AREAS

Section 1511 of the act requires that the country be divided into health service areas. The act includes the following requirements for each health service area.

--The area is to be a geographic region appropriate for the effective planning and development of health services considering factors such as population and the availability of resources to provide all necessary health services for area residents.

--If possible, the area should include at least one highly specialized health service center.

--The area's population should not, except under certain circumstances, be less than 500,000 or more than 3,000,000.

--To the extent feasible, the boundaries of the area are to be coordinated with the boundaries of PSROs, existing regional planning areas, and State planning and administrative areas.

The act required boundaries of health service areas in nonmetropolitan areas to be established based on economic or geographic factors. Also, each standard metropolitan statistical area is normally to be within the boundaries of one health service area.

The act placed the major responsibility for designating health service areas on the governors of the individual States. HEW's role was essentially limited to insuring that the health service areas proposed by the governors met the above requirements.

The Secretary of HEW in a January 21, 1975, letter, formally requested the governors to designate the health service areas in their respective States. The act requires that governors, in developing health service area boundaries, consult with State health planning agencies and any agency in the State that had developed a comprehensive regional, metropolitan, or other local area plan, as well as each Regional Medical program established in the State.

HEW guidelines urged that governors consult with additional agencies, groups, and organizations such as (1) the Appalachian Regional Commission and local planning agencies involved in health planning, but not funded under section 314(b), (2) PSROs, (3) major health provider groups such as State medical societies and hospital associations, (4) voluntary health organizations such as State heart associations and mental retardation chapters, and (5) appropriate consumer and public interest groups.

HEW regional offices reviewed the governors' recommendations for health service area designations. When waivers of population requirements were requested and the regional offices denied them, an Ad Hoc Area Designation Review Panel consisting of program officials from both HEW's central and regional offices reviewed the cases to insure national consistency in application of criteria. The regional offices and the panel then submitted the recommendations to the Secretary of HEW for his concurrence.

After the denied recommendations had been resubmitted and reviewed, the Secretary of HEW had the designated health service areas published in the Federal Register on September 2, 1975. The act required that this be accomplished a month earlier. In only eight States did the designated health service areas differ from those recommended by the governors.

Four States and the District of Columbia applied for exemption from designating health service areas under section 1536 of the act. This section relates to States that (1) have no county or municipal public health institution or department and (2) have, prior to the date of enactment of the law, maintained a health planning system which substantially complies with the purposes of the act. States meeting

these criteria are not required to establish health service areas or have designated health systems agencies. Instead, the State agency designated under section 1521 of the act also functions as the health systems agency. Rhode Island, Hawaii, and the District of Columbia received section 1536 exemption approval.

Fifteen of the 205 designated health service areas are interstate, while the governors of 12 States designated single, statewide health service areas. Since the original designation of these areas, three changes have been made affecting six health service areas. An additional three changes were pending as of May 10, 1978. Only 45 health service areas are coterminous with PSRO areas.

HEALTH SYSTEMS AGENCIES

Section 1515 of the act provides for the establishment of HSAs in each health service area. An HSA can be either a nonprofit private corporation, a public regional planning body, or a single unit of general local government. HSAs can be regional planning bodies or single units of local government if their area of jurisdiction is identical to the health service area.

As of September 21, 1977, all 205 HSAs had been designated (148 had been designated by July 1976, 52 by October 1976, and 5 after October 1976). Of the 205 HSAs, 106 had been comprehensive health planning agencies under the Comprehensive Health Planning program. Four HSAs are units of local government and 21 are regional planning bodies. Each HSA has a staff which is directed by a governing board consisting of a majority (but not more than 60 percent) of residents who are consumers of health care but not providers of health care. The consumers must broadly represent the social, economic, linguistic, and racial populations; geographic areas of the health service area; and major purchasers of health care.

The remainder of the board is to consist of area residents who provide health care, including physicians, dentists, nurses, health care insurers, and hospital administrators. The board's members must also include (either through consumer or provider members) elected public officials and other representatives of governmental authority in the health service area. If the health service area contains a Veterans Administration health care facility, the board must include a Veterans Administration representative as an ex officio member. The governing board must have 10 to 30 members, but it may be larger if an executive committee of not more than

25 members is established. An HSA may establish subarea advisory councils to advise the governing board of its functions.

The governing boards for 11 of the 15 HSAs we visited appeared to meet the above requirements. Four boards did not meet the requirement because (1) one board did not appear to represent the age and economic characteristics of its health service area, (2) two HSAs did not provide proper geographic representation of their health service areas, and (3) one HSA had not completed its board selection.

The purposes of HSAs, as specified in section 1513, include

--improving the health status of residents of the health service area;

--increasing the accessability, acceptability, continuity, and quality of the health services provided;

--restraining increases in the cost of providing health services; and

--preventing unnecessary duplication of health resources.

This section also defines the functions of HSAs in providing health planning and resources development in the health service area. Among these functions are:

--Gathering and analyzing data on the health status of area residents and the health care delivery system; the effect the system is having on area residents; the number, type, and location of the health resources (including health services, manpower, and facilities) in the area; the pattern of utilization of the health resources; and the environmental and occupational exposure factors affecting health conditions.

--Preparing a health systems plan (a detailed statement of goals regarding the health needs and resources of the health service area).

--Preparing an annual implementation plan which describes objectives which will achieve the goals of the health systems plan.

--Coordinating activities with PSROs and regional planning and administrative agencies.

--Reviewing and making recommendations to State agencies regarding the need for new institutional health services.

--Reviewing on a periodic basis (at least every 5 years) all institutional health services offered in the health service area and making recommendations to the State agency regarding the appropriateness of the services.

The HSA's governing board is responsible for directing the internal affairs of the agency, establishing the health systems and annual implementation plans, and approving all HSA recommendations to the State agency on the need for new institutional health services.

Initially the act provided that HSAs could be conditionally designated for no more than 2 years. In December 1977 the act was amended to allow HEW to extend HSA-conditional designations for an additional 12 months under certain circumstances. Thereafter, HSAs become fully designated if HEW determines that they can carry out all functions and responsibilities of the act. As of September 30, 1978, 168 HSAs had become fully designated. The act requires HEW to develop performance standards for HSAs and to evaluate their performance at least every 3 years.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

Section 1521 of the act requires the Secretary of HEW to enter into agreements with each State governor to designate a SHPDA. As with HSAs, SHPDAs can be conditionally designated up to 3 years whereupon they can become fully designated if HEW determines that they are functioning satisfactorily.

SHPDAs in each of the 50 States, plus the District of Columbia, Guam, the Virgin Islands, American Samoa, the Trust Territories of the Pacific, and the Commonwealth of Puerto Rico, have been conditionally designated. Of these, 44 were formerly State health planning agencies under the Comprehensive Health Planning program.

Section 1523 of the act provides that SHPDAs are to:

--Conduct the State health planning activities and implement those parts of the State health plan and the plans of HSAs within the State which relate to their government.

--Prepare, review, and revise as necessary (at least annually) a preliminary State health plan consisting of the health systems plans of the HSAs within the State.

--Assist the SHCC in reviewing the State medical facilities plan and in performing its functions generally.

--Serve as the designated planning agency of the State for the purposes of section 1122 of the Social Security Act if the State has an agreement with the Secretary of HEW pursuant to this section and administer a State certificate of need program which applies to new institutional health services to be offered or developed within the State.

--After consideration of HSA recommendations on new institutional health services proposed within the State, make findings as to the need for such services.

--Review periodically (at least every 5 years) all institutional health services offered in the State and, after consideration of HSA recommendations on the appropriateness of these services, make public their findings.

STATEWIDE HEALTH COORDINATING COUNCILS

Section 1524 of the act provides that SHCCs will advise SHPDAs. A SHCC is to:

--Review annually and coordinate the health systems plan and annual implementation plan of each HSA within the State and report to the Secretary of HEW its comments on these plans.

--Prepare, review, and revise as necessary (but at least annually) a State health plan made up of the health systems plans of the HSAs in the State.

--Review the annual budget of each HSA and report to the Secretary of HEW.

--Review applications submitted by HSAs for planning grants and area health services development funds provided by the act.

--Advise SHPDA on the performance of its functions.

--Review annually and approve any State plan and any application submitted to HEW as a condition to receive any funds under allotments made to States under the act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

The governor appoints at least 16 representatives from a list of at least 5 nominees submitted by each HSA within the State to the SHCC. The SHCC must include at least two members from each HSA, with each HSA being represented equally. The governor may appoint additional members, but they must not exceed 40 percent of the total SHCC membership. The act requires that the majority of the SHCC's members be consumers of health care who are not providers of health care and that not less than one-third of the members be direct providers of health care.

CENTERS FOR HEALTH PLANNING

Section 1534 of the act requires the establishment of at least five centers for health planning to assist HEW in implementing the act. These centers should provide technical and consulting assistance to HSAs and SHPDAs; conduct research, studies, and analyses of health planning and resources development; and develop health planning approaches, methodologies, policies, and standards.

The act requires that each center for health planning have a full-time director with demonstrated health planning ability and a staff with many relevant skills.

Ten regional centers for health planning, one in each of the HEW regions, were established. Five centers were established by December 30, 1975, and the remainder were established by June 1976.

NATIONAL GUIDELINES FOR HEALTH PLANNING AND NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

Section 1501 of the act required the Secretary of HEW to issue guidelines concerning national health planning policy within 18 months of enactment or about July 1976. However, national guidelines for health planning for nine types of health services and facilities were not published in final form until March 28, 1978. HEW is continuing to develop additional national health planning goals and standards for future issuance.

Section 1503 of the act also established a National Council on Health Planning and Development to advise, consult, and make recommendations to the Secretary of HEW in several areas including the development of the national health planning policy guidelines. The full Council was appointed on August 1, 1977, and held its first meeting on September 23 and 24, 1977.

CHAPTER 3

PROBLEMS EXPERIENCED BY HEW IN ADMINISTERING THE HEALTH PLANNING PROGRAMS

HEW has experienced difficulty in providing its regional offices, HSAs, SHPDAs, and SHCCs with timely regulations and guidelines to assist them in implementing the provisions of title XV of the act. Delays have been due primarily to

--new procedures for finalizing regulations instituted by the Secretary of HEW,

--organizational problems caused primarily by combining personnel from three programs to implement the act, and

--an inordinate amount of litigation regarding the act.

As a result, HEW regional offices have had to make policy decisions and augment Bureau guidance, thus creating the possibility that the act or parts thereof are not being implemented consistently throughout the country.

In addition, HSAs may not be able to develop the necessary health systems plans and annual implementation plans required for full designation within the prescribed 2-year conditional designation period.

The number of employees assigned to implement the act varied among the four HEW regional offices we visited. Some regional officials believed the number of employees assigned was not adequate.

STATUS OF REGULATIONS FOR TITLE XV OF THE ACT

To implement title XV of the act, HEW is developing six sets of regulations. The status of these regulations, as of September 1978, is shown on the following page.

Regulations governing	Date completed
1. Designation of HSAs	3/26/78
2. Certificate of need	1/21/77
3. Designation of State planning agencies and establishment of SHCCs	3/10/78
4. Section 1122 (see p. 3)	a/12/78
5. Review and approval of proposed health services	(b)
6. Appropriateness reviews of existing health services	(b)

a/Expected completion date.

b/No expected completion date pending passage of amendments to the act.

HEW PROCEDURES FOR DEVELOPING REGULATIONS

HEW regulations are based on the Administrative Procedure Act, chapter III of the HEW General Administrative Manual, and chapter III of the Public Health Service Administrative Manual.

HEW generally publishes (1) notice of proposed rulemaking--proposed rules are published and public comment is invited, (2) interim final regulations--while not final rulemaking, HEW's Office of General Council interprets regulations as having the force of final regulations, and (3) final regulations.

According to the Bureau's Deputy Director, a program was started on July 25, 1976, to further open the regulations process to the public. The following five stages must be completed before final regulations are developed.

--A regulation implementation plan must be developed and the Secretary or Under Secretary must approve the plan.

--A notice of intent must be published in the Federal Register.

--A notice of proposed rulemaking must be published in the Federal Register followed by a 45-day comment period.

--Final rules must be published in the Federal Register.

--A written plan must be developed to continuously review and monitor the final rules.

According to Bureau officials, final regulations have been delayed because of this new program. They estimate that the current regulation development process extends the publication time by about 18 months. On February 4, 1977, we issued a report to the Chairman, Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce (HRD-77-23) entitled "Fundamental Improvements Needed for Timely Promulgation of Health Program Regulations." We concluded that new policies and procedures could further delay publishing regulations and recommended that additional changes be made to improve the timely publication of regulations.

ORGANIZATIONAL PROBLEMS

To implement the act, HEW combined the personnel from three programs that were eliminated as a result of the act--the Comprehensive Health Planning, Regional Medical, and Hill-Burton Hospital Construction programs--to form the Bureau of Health Planning and Resources Development. This action has resulted in employee morale and dissatisfaction problems, employees functioning without approved job descriptions, and poor communication among the various offices and divisions within the Bureau. These problems contributed to the delays in developing and publishing regulations and guidelines needed by HSAs and SHPDAs to implement the act.

A task force established by the Administator of HRA prepared a December 17, 1975, report which stated that divisions and offices within the Bureau were operating as relatively autonomous units, were not coordinating program operations, and that some persons did not know who their supervisors were. The report quoted one manager as having received no delegations of authority and no clear definitions

of responsibility either for himself or for his work groups. A Bureau official said that no actions had been taken on this report.

In January 1976 the Civil Service Commission's Bureau of Personnel Management Evaluation reviewed the personnel management operations of HRA. The Commission's May 1976 evaluation report identified several personnel management problems and recommended actions to correct these problems.

The report stated that "the primary cause of the HRA's position management problems lies with successive reorganizations in which obsolete positions from abolished functions were absorbed intact and encumbered into the new organization." The report concluded that HEW's reluctance to use reductions-in-force procedures in implementing reorganizations resulted in persons whose functions were abolished one or more reorganizations ago being placed at their existing grade levels in other organizations. The Commission's report also cited the Bureau for having inaccurate position descriptions and overgraded positions.

The Bureau is currently authorized eight GS-15 positions. As of January 1978, about 3 years since the Bureau was established, it had 16 GS-15s. In addition, the Bureau had 17 employees whose job descriptions were not consistent with their duties and who had not had specific positions within the Bureau's organization since it was established in March 1975. According to an HEW official, positions could not be found in the Bureau for these persons because they had little or no experience or expertise in health planning.

In April 1977 HRA requested that HEW approve changes in its organization and functions in order to (1) restructure the organization to accommodate new programs authorized by the Congress since it was created in 1973 and (2) respond to the Commission's evaluation report recommendation of placing all employees on current and accurate position descriptions. In September 1977 the Secretary of HEW announced a proposed reorganization of the Public Health Service involving HRA. According to an HRA official, however, the proposed reorganization will have a limited impact on the management and organization problems being experienced by the Bureau of Health Planning and Resources Development. Also, we were advised that reduction-in-force procedures would not be used to correct the Bureau's organizational problems. Instead, HEW plans to use its special employee program to find positions for persons whose functions have been abolished.

At the completion of our review, the Bureau was still experiencing employee dissatisfaction and morale problems.

LARGE AMOUNT OF LITIGATION

The enactment of the National Health Planning and Resources Development Act of 1974 has led to many legal challenges. According to an HEW official, several employees who would normally have been engaged in regulation development were needed to deal with these legal challenges.

According to HEW, as of May 17, 1978, 23 law suits 1/ had been filed concerning the implementation of Public Law 93-641. Of these cases, (1) seven cases questioned the constitutionality of the act, (2) seven cases dealt with the health service area designation process, (3) six cases challenged the designation of health systems agencies, (4) seven cases challenged the validity of the selection of HSA governing bodies, and (5) four cases challenged the validity of departmental regulations.

As of May 1978 eleven cases had been settled. The most significant decision related to the constitutionality of the act. In September 1977 a Federal court found nothing unconstitutional in the act or in the conditions the Congress attached to the receipt of Federal health grants. The Supreme Court upheld this decision in April 1978.

AUGMENTATION OF REGULATIONS AND GUIDELINES BY REGIONAL OFFICES

Because HEW has not provided timely and adequate regulations and guidelines regarding the implementation of the act, HEW regional offices have (1) augmented the guidelines provided, (2) developed their own guidelines, and (3) made policy decisions without HEW guidance. As a result, the act may not be consistently implemented throughout the country.

The most significant example of regional office initiative in making policy decisions we found dealt with the approach the HSAs were to use in developing their health systems plans. HEW's Denver regional office directed its

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1/Categorization of law suits does not total 23 because some deal with more than one issue.

HSAs to use an approach that was not consistent with the Bureau guidelines on health system plan development which were published in December 1976.

While the regional approach to plan development is similar to the one in the Bureau guidelines, it differs in some significant respects. For example, the Bureau guidelines state that HSA plans should assess the health status of the population in the health service area, whereas the region's approach is for HSAs to analyze the health resources in the health service area. Also, the Bureau guidelines require that the plans cover the entire system of health services and attempt to establish a correlation between the health status of area residents and the results of the health planning activity. In contrast, the regional approach provides that HSAs focus their initial planning efforts on the review of capital expenditures at the tertiary level 1/ of health care. Using this approach, data collection and analysis are limited essentially to obtaining data pertaining to the tertiary level of the health care system.

According to a Denver regional office official the philosophy behind the regional approach is that if HSAs are successful in putting a "cap" on cost increases associated with tertiary level care, the funds previously flowing to this level will "filter down" to the primary and other levels of the health care system. The official acknowledged, however, that there can be no assurance that such funds would, in fact, find their way to the other levels of the health care system where they may be needed most.

This HEW regional office, due to lack of Bureau guidance and inadequate guidelines, has also augmented Bureau guidelines or developed its own in the following areas.

--Guidelines for applications for HSA designation and funding developed by the Bureau were augmented to underscore a regional emphasis on the performance aspects of HSAs such as the work program.

1/Includes highly sophisticated diagnostic and therapeutic procedures such as complex surgical procedures, X-ray, cobalt and radium therapy, etc. Defined as those special services that because of complexity, cost and/or relatively low levels of use are planned to be used by a large population.

--An interim regional reporting system was developed to track the progress of HSAs in completing their work programs and to comply with section 1535(b) of the act. Regional officials said the Bureau provided no guidelines in this area.

--Guidelines covering grant application instructions for SHPDAs were augmented in a fashion similar to the HSA guidelines to stress regional emphasis on program performance and to assure consistency in application format.

According to regional officials, the Bureau developed other guidelines which may require regional office augmentation.

Each of the three other regional offices we visited also found it necessary to augment HEW guidance but to a lesser extent. One regional official said that the Bureau sometimes takes 5 to 6 months to respond to HSAs' questions on policy. Because the Bureau was not responsive, regional officials provided verbal guidance based on their experience with other programs. One regional official told us that each of HEW's 10 regions is probably implementing the act in a different way because of the delays in receiving guidance.

To address this problem, HEW developed a new system where the health planning program is an integral part of the immediate office of each Regional Health Administrator's office. The Regional Health Administrator is accountable for assuring that other decentralized health programs allocate resources supportive of health systems plans and State health plans developed under the planning act. According to HEW, the Bureau of Health Planning and Resources Development is developing ways to improve uniform implementation of the health planning program under this system.

STAFFING AT REGIONAL LEVEL

The Bureau is primarily responsible for implementing the act, but certain responsibilities have been delegated to each Regional Health Administrator. These responsibilities include (1) providing technical assistance to HSAs and SHPDAs, (2) designating and funding HSAs and SHPDAs, (3) assisting regional centers for health planning in carrying out their functions, and (4) reviewing and monitoring the activities of HSAs and SHPDAs.

Each Regional Health Administrator has the authority to develop his own organizational structure, including the assignment of staff, to carry out the responsibilities delegated to him for Federal health programs. At the four HEW regional offices, we found similar organizational structures--a health planning branch within a division of resources development was responsible for carrying out the health planning responsibilities delegated to the Regional Health Administrator.

The amount of staff assigned to these branches varied. The following chart shows the number of full-time and part-time staff assigned to health planning at the time of our review in each of the 10 regions along with the number of client agencies (HSAs, SHPDAs, and regional centers for health planning). Our review included regions I, IV, VIII, and IX.

Health Planning Staff

	Full time	Part time (note a)	Client agencies			Total
			HSA	SHPDA	Centers	
Region I	5	1	14	6	1	21
Region II	3	1	14	b/4	1	19
Region III	5	-	20	6	1	27
Region IV	-	16	40	8	1	49
Region V	7	-	42	6	1	49
Region VI	-	11	21	5	1	27
Region VII	7	-	12	4	1	17
Region VIII	7	-	10	6	1	17
Region IX	9	-	19	c/7	1	27
Region X	8	-	11	4	1	16

a/Staff members having dual responsibilities in both health planning and facilities construction.

b/Includes Puerto Rico and the Virgin Islands.

c/Includes American Samoa, Guam, and the Trust Territories of the Pacific.

Officials in two regions we visited said that the amount of staff assigned to health planning was inadequate. One official said that he needed about seven additional professionals to provide technical assistance and to monitor client agencies at a satisfactory level. One of these officials, as well as an official in another region, also complained about insufficient travel funds being available.

The professionals assigned to health planning in the four regional offices appeared to be qualified in terms of experience and educational backgrounds.

CONCLUSIONS

The Bureau of Health Planning and Resources Development must act to finalize regulations and provide adequate guidance to the HEW regional offices as quickly as possible. Delays in providing instructions to the regions have already resulted in inconsistent implementation of the health planning act and of the planning program throughout the country.

New regulations development procedures primarily designed to open the process to the public have delayed finalization of regulations. HSAs and SHPDAs need these regulations to properly and consistently implement the act.

The Bureau's organizational problems need to be remedied as soon as possible to insure the orderly implementation of the health planning program. Job descriptions and responsibilities should be clarified and steps should be taken to insure adequate communication among the various offices and divisions within the Bureau.

The large amount of litigation regarding the act has tied up Bureau personnel and resources and has delayed implementing the health planning program. Resolution of the various legal challenges to the act and the way it is being implemented could greatly affect the program.

Overall, there appears to be little doubt that the problems experienced by the Bureau have contributed to the delay in implementing the program and will delay the time period required for HSAs to achieve full designation and become fully operational.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator, HRA, to see that regulations and guidelines are prepared and issued more expeditiously in order that the act can be implemented consistently throughout the country and to take the necessary actions to resolve the organizational problems within the Bureau.

AGENCY COMMENTS

The new Administrator of HRA has taken action or will take action to overcome the problems we identified. He has elevated the health planning program to a high priority position in the agency and taken action to reorganize the Bureau to correct its organizational problems. In addition, HEW has acted to speed the issuance of regulations for the health planning program. All outstanding regulations have been published in proposed form.

CHAPTER 4

NUMEROUS PROBLEMS NEED TO BE OVERCOME AT STATE AND LOCAL LEVELS BEFORE ADEQUATE AREAWIDE AND STATE HEALTH PLANS CAN BE DEVELOPED

The impact of areawide health systems agencies and State health planning and development agencies in restraining increases in health care costs and improving accessibility to health services cannot be determined because these agencies have been in existence for only a short time. The impact of these agencies in accomplishing these two goals probably will not be known for several years.

In order for areawide and State health planning agencies to have an impact on the health care system, meaningful, specific, and thorough areawide and State health plans that are supported by both consumers and providers, as well as local governmental entities, will be needed. Without such plans and support, areawide and State health planning agencies will experience serious problems in achieving these goals.

At the time of our review, areawide and State planning agencies were limited in developing the necessary quality health plans because

- --limited useful data was available on the existing health care system and status of health of residents;
- --no approved national standards or criteria were available regarding the appropriate supply, distribution, and organization of health resources and services;
- --adequate numbers of qualified staff were not available in some areas; and
- --timely guidance on health plan development from HEW and regional centers for health planning had not been provided.

The development of adequate health systems plans was impeded indirectly because

- --responsibilities of HSAs and SHPDAs had not been clearly defined, especially in States with statewide HSAs;

--HSA board members were not optimistic about achieving the goals of restraining health care costs and improving accessibility to health care, they believed additional legislative authority was needed; and

--controversy existed over the compatability of the objectives of the act.

In addition, local health professional groups and public officials doubted that the goals of the act could be achieved and questioned the authority and ability of areawide HSAs to accomplish the goals. Many of these problems are similar to those identified in our 1974 report to the Congress on the former Comprehensive Health Planning program as noted in chapter 1. (See p. 6.)

LIMITED DATA AVAILABILITY

All of the 15 HSAs we visited were experiencing some difficulty in obtaining the data necessary to develop their health systems plans. Data sharing relationships between HSAs and PSROs were uncertain. In some cases, needed data was not available, current, or in the necessary form. As a result, existing information may not have accurately reflected the actual health status of area residents and the health resource needs of the area.

HSA/PSRO cooperation

HSAs and PSROs share certain common long-range goals, such as to improve quality of care and to contain health care costs. They are also charged with improving the health care system, though in different ways. Consequently, HSAs and PSROs need to cooperate and coordinate their efforts with each other. The most basic and initial need is to share data.

PSROs have data available which can assist HSAs in determining the hospital bed and other facility needs. Such data would include routine information on hospitalizations, including the diseases and surgical operations involved and the lengths of stay in hospitals.

At the time of our review, HSAs were experiencing some difficulty in obtaining data from PSROs primarily because of data confidentiality provisions in the PSRO authorizing legislation. Since that time, the President has signed Public Law 95-142 which provides for the sharing of data by PSROs with HSAs. Implementation of this law should resolve PSRO/HSA data sharing problems.

Other data problems

Data problems were particularly apparent at HSAs having no prior health planning experience. For example, one such HSA cited the following problems regarding health data.

--Almost no morbidity data existed on a State or county level.

--Physician manpower data was incomplete and unreliable.

--Admission and discharge data from hospitals by service or diagnosis was not available.

--Financial data on costs of services was difficult or impossible to obtain.

--Environmental and occupational health information was not collected by any health agency.

--No centralized statewide health data bank existed.

--Data on private services, facilities, and unlicensed health personnel was almost nonexistent.

Other HSAs noted that they rely too often on outdated or unreliable health data from Federal, State, and local agencies. For example, one HSA we visited was using data developed by a regional council of governments which was more than 3 years old. An official at another HSA told us that only between 10 and 20 of 200 health status indicators were going to be used in its health system plan because data for most of the indicators was not available. Another HSA had to limit its health planning activities because of the quantity and quality of health data.

Officials at several HSAs noted that the act itself makes it difficult for an HSA to develop its own data. Section 1513(b) requires that existing data be used to the maximum extent possible.

NEED FOR STANDARDS AND CRITERIA FOR HEALTH RESOURCES AND SERVICES

The health systems plan is the HSA's statement of desired achievements for improvements in the health status of area residents and in the health systems serving that population. The plan should provide a basis for the HSA to promote a healthful environment, to review proposed health systems

changes, to reduce documented deficiencies and inefficiencies within the area, and to foster desired achievements which meet identified health needs of the community. In order for HSAs to efficiently and effectively plan health delivery systems and to judge the proposed changes to the system, standards and criteria for the various types of health resources and services are needed. The act recognizes the need for such standards in section 1501(b) which directs the Secretary of HEW to include in the National Guidelines for Health Planning "Standards respecting the appropriate supply, distribution, and organization of health resources."

HEW awarded contracts costing about $1.4 million to develop standards and criteria for 17 different types of health services for the use of HSAs. These standards and criteria were distributed informally to HSAs with the stipulation that they were not endorsed by HEW and were to be used at their own discretion. According to an HEW official, HEW was reluctant to endorse these standards and criteria because in some cases they did not reflect HEW policy and in other cases HEW had not yet established policy.

Several HSAs indicated the need for national standards and criteria. One HSA official said that until such standards and criteria are available, he would not review proposed health services because legal actions challenging the basis of the HSA's decision could occur. According to the HSA executive director, these actions could tie up a considerable amount of the HSA's resources.

On March 28, 1978, subsequent to the completion of our review and almost 2 years after most of the HSAs had been designated, HEW issued final national guidelines for health planning in nine types of health services and facilities. HEW is developing further guidelines setting forth national health planning goals and additional standards.

Project review experience

We obtained statistics from several of the States on the approval rate of applications for new institutional services under certificate of need programs and section 1122 project review responsibilities (see p. 3). As the table on the following page shows, the approval rate was about 92 percent. We believe that one reason for the high approval rate is the lack of standards and criteria on which to evaluate these applications.

Summary of Project Applications Reviewed and Approved by 10 State Health Planning Agencies During Calendar Year 1976

State	Projects reviewed	Projects approved	Percent approved
Colorado	54	48	89
Wyoming	13	13	100
Utah	31	30	97
Florida	176	165	94
Alabama	159	150	94
Arizona	35	35	100
Maine (note a)	18	15	83
New Hampshire	18	16	89
Massachusetts (note b)	71	57	80
Virginia (note a)	61	55	90
Total	636	584	92

a/Review period covered 7/1/76-3/31/77.

b/Review period covered 7/1/76-1/31/77.

Many applications for new or expanded facilities or services are never submitted because of project review procedures. Several HSAs, as well as HEW, brought this fact to our attention.

The need for timely standards and criteria is particularly important when new technology is developed. For example, considerable concern has recently been expressed about the number of computerized tomography 1/ scanners being acquired throughout the country. In the absence of standards and criteria, HSAs and SHPDAs have little basis to disapprove a hospital's request for one of these expensive ($400,000-$700,000) machines. As a result, the health care system could be buying unnecessary scanners which could cause increased health care costs.

1/The computerized tomography scanner is a relatively new radiological (X-ray) device that is based on the same principles as conventional X-ray techniques but collects and processes information using a computer to transmit three dimensional "pictures" of the body. It has been hailed as the greatest advance in radiology since the discovery of X-rays.

The schedule below shows the approval rate of applications to purchase scanners.

State	Applications	Number approved	Percent approved
Florida	17	16	94
Alabama	7	7	100
Colorado	16	15	94
Wyoming	1	1	100
Utah	7	7	100
Maine	3	2	66
New Hampshire	1	1	100
Massachusetts	3	2	66
Virginia	21	20	95
Total	76	71	93

NEED FOR MORE TIMELY GUIDANCE ON DEVELOPING HEALTH SYSTEMS PLANS

HEW did not provide guidelines for developing health systems plans until late in December 1976, almost 2 years after the act's passage.

Several of the HSAs we visited indicated that the lack of formal guidelines from HEW has delayed them from preparing their health systems plans. The delays had not yet affected some of the remaining HSAs because their activities were centered on hiring staff and other organizational and administrative functions, and plan development was in the preliminary stages.

As discussed in chapter 3, at least one HEW regional office provided HSAs guidance on health systems plan development that was not consistent with the December 1976 HEW guidelines. More timely HEW guidance may have prevented this inconsistency from occurring and eliminated the confusion that exists as a result of not having HEW guidelines.

STAFFING PROBLEMS

Some of the HSAs we visited were experiencing difficulty in employing health planning staff. Limited numbers of persons having experience in health planning were available in certain areas and, in some cases, HSAs had been unable to offer salaries that would attract potential employees. Also, one HSA official indicated that qualified persons were reluctant to work for HSAs because of the uncertainty surrounding the continuance of the program.

To assist HSAs in employing qualified staff, HEW awarded a 2-year $215,000 contract in August 1975 to the American Association for Comprehensive Health Planning. The purpose of this contract was to (1) design and operate a program for recruiting persons with certain professional skills and competencies in the health planning area to be used by HSAs in meeting their staffing requirements and (2) design and operate an employment referral service as a national focal point to provide linkage between qualified candidates for jobs in health planning agencies and those health planning agencies seeking employees. As of April 30, 1978, the Association had placed about 220 persons at HSAs and SHPDAs.

Several HSAs said that their inability to offer competitive salaries had seriously hindered them in employing qualified staff. Salaries for HSA executive directors of the 15 HSAs ranged from about $19,300 to $35,000. Salaries of subordinate staff were generally in the $13,000 to $25,000 range.

ADEQUACY OF HSA FUNDING

Officials at only 6 of the 15 HSAs said they were satisfied with the funding they received during the first year grant period. One of these officials anticipated returning about $200,000 of the first year grant to HEW.

Officials at six other HSAs said that funding levels were inadequate for the first year, while officials at several HSAs complained that the method used by HEW regional offices to award grant funds on an incremental basis caused problems, particularly in hiring needed staff at an early date.

For example, one HSA applied for $1.1 million for its initial 1-year grant period. The initial grant received from HEW, however, amounted to only about $325,000. Because of this low funding level, this HSA, which was a former comprehensive health planning agency, had to lay off nine staff members and stretch out its work program. Five months after this HSA received its initial grant award, HEW increased the grant by about $311,000 bringing the first year funding to a total of about $636,000.

Several HSAs noted that the incremental grant funding also caused their budget and workplans to be revised.

NEED TO CLARIFY HSA AND SHPDA FUNCTIONS

The act requires that HSAs and SHPDAs perform many similar functions. For example, both develop comprehensive health plans, review projects, and periodically review the appropriateness of existing institutional health services. Relationships between HSAs and SHPDAs in several of the States visited need to be clarified, particularly in States having statewide HSAs. There are 12 States that have such HSAs.

Health systems plan development activities

Several SHPDAs had agreements with their respective HSAs regarding the format and methodology to be used in developing health systems plans. This is particularly important so that the State health plan can be readily developed from the local health systems plans.

The HSAs and SHPDAs in one State, however, were proceeding initially with health systems plan development efforts in a manner that appeared to be inconsistent with the intent of the act. Sections of the State plan were to be developed for all three HSAs by an individual HSA. For example, one HSA was responsible for developing the burn care section of plans for the other HSAs. According to a SHPDA official, this process was being considered to avert problems associated with combining the health systems plans prepared by the individual HSA into the State health plan.

During our visit to the SHPDA, a new agency director was hired. At the conclusion of our review, the new director was reconsidering the methodology to be used in developing the State health plan.

We believe that the initial methodology which was to be used in developing the State plan was inconsistent with the goals and objectives of the act. The autonomy of the HSAs in the State could be jeopardized because of its limited influence over health systems plan development within its own health service area if this methodology is used.

Single State HSAs

Some statewide HSAs and their respective SHPDAs were having difficulty in communicating. Officials from both agencies were concerned about potential conflicts and duplication of effort because of their similar responsibilities. HEW has provided little assistance to statewide HSAs and their SHPDAs in dealing with this situation.

A SHPDA official in a State having a statewide HSA was concerned about the power which the HSA could execute through its representation on the SHCC. The act requires that the SHCC be representative of at least 60 percent of the HSAs in the State, which in the case of a State having only one HSA, would give the HSA a majority on the SHCC. The SHCC advises the SHPDA and has final approval of the State health plan.

Project review cooperation

The executive director at another HSA brought another problem to our attention. He said that the SHPDA in his State was consistently overruling HSA recommendations on new health service applications. He said that the SHPDA often gave little justification of its decision to the HSA. He was also concerned that if this trend continues, the effectiveness of the HSA would be minimal and that applications for new services would place little importance on the HSA review and recommendation.

In one State having a statewide HSA, conflict had developed regarding the certificate of need law. Both the HSA and the SHPDA submitted bills to the State legislature. The HSA bill provided for joint HSA/SHPDA determination of project review procedures, standards, and criteria. It also allowed the HSA to decide what questions would be asked of applicants and the scope of the review process. The SHPDA bill, however, provided that the State would be responsible for the project review procedures and that only the State should have final authority to set review procedures, standards, and criteria.

AUTHORITY OVER FEDERAL HEALTH FACILITIES

The act did not provide HSAs and SHPDAs the authority to control Federal health care facilities. HEW has interpreted this silence as an expression of congressional intent not to provide HSA jurisdiction over Federal health care facilities. HEW's interpretation follows the Supreme Court statement in Federal Power Commission v. Tuscarora Indian Nation, 362 U.S. 99, 120 (1960):

"The law is now well settled that:

> 'A general statute imposing restrictions does not impose them upon the Government itself without a clear expression or implication to that effect.' United States v. Wittek, 337 U.S. 346,358-359."

Our legislative review of the act provided no indications as to congressional intent regarding the question of Federal health facilities.

The act, however, does provide that if a health service area includes a Veterans Administration health care facility, the HSA's governing board must include a Veterans Administration representative as an ex-officio member.

Approximately 10 percent of all general medical-surgical hospital beds in the Nation are under the authority of the Veterans Administration, Department of Defense, and Public Health Service. Most of the HSAs we visited had Federal health care facilities within their health service areas.

Generally, HSA officials did not consider the exclusion of Federal health facilities from their authority to be one of the major problems confronting them at the time of our review. Several, however, stated that to have a meaningful health planning system, Federal health care facilities should have the same restrictions as other health care facilities. The expansion of Federal health care facilities or the purchase of new technology could have a significant impact on the non-Federal system, particularly where the non-Federal system has been providing services to Federal beneficiaries. According to an Institute of Medicine study entitled, "Controlling the Supply of Hospital Beds," over 3 million dependents of military personnel are now covered in a program that purchases health care in the private sector--the Department of Defense's Civilian Health and Medical Program of the Uniformed Services, more commonly known as CHAMPUS.

The Veterans Administration announced in 1976 that it planned to replace seven hospitals and construct one new hospital for about $850 million. The Department of Defense's Five Year Military Department Medical Construction Programs dated June 1, 1977, included plans to replace 10 hospitals and construct 3 new hospitals for about $758 million.

Among the national health planning goals identified in the act are

--developing multiinstitutional systems to coordinate or consolidate institutional health services,

--developing multiinstitutional arrangements to share support services necessary to all health institutions, and

--developing health service institutions which can provide various levels of care on a geographically integrated basis.

We believe that including Federal health care facilities in the health planning system authorized by the act could further the achievement of these national goals, as well as assist in restraining increases in health care costs.

LACK OF OPTIMISM IN ACHIEVING GOALS OF THE ACT

In order for HSAs to have a positive effect on improving accessibility to health care and restraining increases in health care costs, persons involved in the process should believe that these goals can be achieved. HSA board members and staff, however, were generally not optimistic about the success of the health planning program authorized by Public Law 93-641.

In a questionnaire, we asked the board members of each of the 15 HSAs to what extent their HSA could accomplish several objectives associated with health planning. The table below summarizes the results of 462 board members' responses (83.1 percent of those queried).

HSA Board Members' Perceptions
About Achieving Objectives of Public Law 93-641

Objectives	Responses				
	Very large extent	Substantial extent	Moderate extent	Some extent	Little or no extent
	(Percent)				
Contain overall health care costs	2.3	13.1	27.2	28.7	28.7
Improve access to health care	6.0	17.6	27.8	27.0	21.6
Restrain construction of unneeded health facilities	18.1	38.7	21.6	11.4	10.2
Restrain acquisition of unneeded equipment	13.4	31.4	26.4	15.9	12.9
Educate the public in use of health care system	15.0	24.9	22.4	22.2	15.5

While these statistics can be interpreted several ways, we believe that they show that members felt the goals could not be accomplished. This is noteworthy when it is acknowledged that the health planning program is relatively new and that under such a circumstance more optimism could be expected. The responses to containing health care costs and improving accessibility to health care are particularly alarming since these are the primary objectives of the act.

As shown below, provider board members were slightly less optimistic than consumers about HSAs achieving these two goals.

Comparison of Responses of Consumer and Provider HSA Board Members on the Ability of HSAs to Contain Costs and Improve Accessibility to Health Care

Objective		Responses				
		Very large extent	Substantial extent	Moderate extent	Some extent	Little or no extent
		(Percent)				
Contain overall health care costs	Consumers	3.4	14.2	27.5	26.5	28.4
	Providers	1.0	11.9	27.0	31.1	29.0
Improve access to health care	Consumers	8.6	18.6	29.7	26.8	16.3
	Providers	3.1	16.5	25.8	27.3	27.3

There are many possible reasons for this apparent lack of optimism of board members in accomplishing the goals of the act. One is the perceived lack of authority on the part of HSAs. The following schedule summarizes the responses to questions regarding the authority given to HSAs to contain health care costs and improve access to health care.

Board Members Perception of Authority to Contain Costs and Improve Health Care Accessibility

Question	Responses				
	Much more authority than necessary	More authority than necessary	Just the right amount of authority	Less authority than necessary	Much less authority than necessary
	(Percent)				
In your opinion, have HSAs been given the necessary authority to achieve the goals of:					
containing health care costs	4.6	4.4	24.9	43.7	22.4
improving access to health care	2.7	4.1	30.3	46.7	16.2

As can be seen, HSA board members believed that the act did not provide sufficient authority to accomplish these goals.

Officials at several HSAs were also not very optimistic about the success of HSAs in achieving these two goals of the act. Some HSAs believed project review activities would reduce the unnecessary construction of health facilities and the purchase of unneeded expensive medical equipment. One HSA official, however, described the project review process as "putting a band-aid on the problem of cost escalation" since HSAs have no authority over the activities of private clinics and physicians' offices. Also, several HSA officials said that State agencies have too much authority in the project review process. One HSA official said that the project review functions were often meaningless because the State agency had final approval and that such decisions were often made without regard to the HSA's recommendations. Another HSA official said that the greatest benefit his HSA can presently provide is to educate the public in the availability and use of the health care system and solicit the involvement of the community in health planning through subarea councils.

HSA officials noted that the act does not provide authority over health manpower distribution or the purchase of expensive medical equipment by physicians, both of which can effect the cost and accessibility of health care. One official said that HSAs should have hospital rate review authority in order to have a positive influence on health care costs.

SUPPORT OF LOCAL GOVERNMENTAL, COMMUNITY, AND PROFESSIONAL GROUPS TO HEALTH PLANNING

The involvement of local consumers, providers, and government officials in the health planning system is provided through their memberships on HSA governing boards. The support of the health planning activities directed by HSA governing boards, particularly the approval and support of the health systems plan by local consumers and health professional groups and local governmental entities, will be needed if HSAs are to be successful in achieving the act's goals.

We asked consumers, health professionals, and local government representatives in the health service areas their opinions regarding the ultimate success of HSAs in achieving the goals of the act. Generally, they believed that HSAs have not yet established the needed credibility in the community and, thus, have not gained the confidence and support of the above groups.

Some of the concerns brought to our attention were:

--HSA staffs in general have no real knowledge of the operation of the health care system.

--HSAs seem to be dedicated to the destruction of the existing health care system.

--HSAs are not accountable to the people and, thus, should not be making decisions that elected officials are responsible for.

--Health providers will dominate and control HSAs, thus reducing their effectiveness in controlling costs.

--The methodologies needed to measure cost, availability, accessibility, and quality of health care have not been developed.

--HSAs do not have enough power to contain health care costs and improve accessibility.

--The goals of containing health care costs and improving accessibility to the health care system conflict with one another.

--Medical standards and criteria are the responsibility of the medical profession, not HSAs.

--HSAs' reviews and comments on new projects will not be an effective means of containing health care costs.

--The savings attributable to preventing the construction of unnecessary health care facilities or the acquisition of unneeded equipment may be offset by the costs associated with preventing such expenditures.

Several groups had not formulated opinions and were waiting to see what will happen in the next few years. They acknowledged that HSAs will experience difficulties in improving the health care system without the support of consumers, providers, and local governments.

COMPATIBILITY OF THE ACT'S OBJECTIVES

Since the passage of the National Health Planning and Resources Development Act of 1974, considerable concern has been expressed regarding the compatability of providing

access to quality health care and restraining increases in health care costs. Some Federal, State, and local officials have agreed that the objectives are not compatible because costs cannot be restrained while the health care system is being expanded to provide access to all persons.

An HSA official was confused as to where emphasis should be placed--improving access or restraining costs. HEW has provided limited guidance in regard to this question. The HEW guidelines on developing health systems plans do, however, state that HSAs should "place priority on restraining cost increases." The guidelines also state that "efforts should be made to estimate current needs of area residents to reduce the inequity in the provision of care."

While the legislative history of the act is not explicit as to congressional intent regarding the question of health care accessibility and containment of health care costs, section 1502 does list first, as 1 of the 10 national health priorities, "the provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas." Several of the remaining nine priorities also deal with accessibility to health care.

We believe that health systems plans can emphasize accessibility to primary care as a priority (for example, an economically depressed area), while at the same time stress that increased costs from such things as overbedding, the questionable purchasing of expensive equipment, or duplicating certain services such as intensive care or cardiac care units should be minimized. Therefore, in our opinion, the act's objectives of cost containment and health care accessibility need to be addressed by health systems agencies.

CONCLUSIONS

The HSAs in our review were concerned, as were their predecessor local Comprehensive Health Planning agencies, with the availability and adequacy of data on which to develop a health systems plan. At the time of our review, agreements between HSAs and PSROs were being formalized but little data was being exchanged. A recent amendment to the PSRO authorizing legislation provided for the exchange of data between PSROs and HSAs and should resolve the problems HSAs were encountering.

HSAs were being hampered in making project reviews because of a lack of standards or criteria on which to make

decisions. HEW's slowness in developing guidelines had also delayed the preparation of health systems plans. Since our review, HEW has issued national standards and criteria for nine types of health services and facilities for use in the development of areawide and State health plans. HEW should continue to expedite the issuance of national guidelines and standards so that they can be used by HSAs and SHPDAs in developing health plans and making judgments on proposed changes to the health care system.

Concern about the adequacy of salaries and whether the health planning program will be continued hampered HSAs in their ability to attract qualified staff. The job faced by HSAs is at best a difficult one; without adequate staff it may well be an impossible one.

In those States having only one HSA, the HSA was confused about its responsibilities as opposed to those of the State health planning agency. This situation exists in 12 States. We see no need for having a State health planning agency and an HSA which covers the entire State. The provisions of section 1536 of the act could be expanded to allow more States to have only a State health planning agency. Another alternative would be to require States to have at least two HSAs.

In passing the National Health Planning and Resources Development Act of 1974, the Congress did not provide HSAs with any specific authority over Federal health facilities. Since these facilities are an important part of our national health resources and serve millions of people, these facilities cannot be disregarded by HSAs. If the health planning program is to become the vital force that the Congress expects it to become and to have major impact on containing costs and improving accessibility to health care, then we believe the institutions created to achieve those objectives must interact with all parts of the health care system. To specifically exclude Federal facilities from the national health planning program, in our opinion, is to seriously impede the ability of the local and State health planning agencies to carry out the responsibilities given to them by the Congress.

The extent to which HSAs will be successful is largely dependent upon their board members and their attitudes. Recognizing that their task is not an easy one, we were disappointed to see the relatively low level of optimism expressed by HSA board members in achieving the goals in the act. In some respects, board members seemed to feel they were faced with impossible and sometimes conflicting objectives. We believe the goals of containing health care costs

and improving accessibility are not necessarily conflicting. In many health service areas, there are areas where duplicative health services are available and other areas where services are not available. In these situations, we believe HSAs could be active in attempting to redistribute or reallocate resources. In our opinion, HEW should provide HSAs with additional guidance in this area.

If HSAs are to achieve their objectives, they must have the support of local governments, community and professional groups, private health care providers, and others working in the health care field. As could be expected, this support has been slow in developing, and many look upon the health planning agencies with distrust and suspicion. We believe that HSAs must establish their credibility in the health care field as soon as possible. The longer this process takes, the less likely success will be achieved. Consequently, we believe HEW should stress the importance of each HSA developing positive relationships with all who are active in the health care field. If fear and mistrust can be successfully overcome, then HSAs will have a much greater chance of succeeding.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator, HRA, to

--develop and publish, as required by the act, (1) regulations and guidelines for implementing the act and (2) national standards and criteria regarding the appropriate supply, distribution, and organization of health resources and services;

--determine the extent to which HSAs are experiencing problems as a result of inadequate or insufficient data and, if warranted, propose legislation which would give HSAs more authority and funds for developing necessary data to use in preparing health systems plans; and

--develop a policy statement to clarify the relative emphasis HSAs and SHPDAs should place on cost containment and health care accessibility.

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress expand the provisions of section 1536 of the National Health Planning and Resources

Development Act of 1974 to allow more States to have only a State health planning agency and require that all other States have a minimum of two HSAs.

If the Congress chooses not to amend the act as we suggested, it should amend the act to clarify the responsibilities of HSAs and SHPDAs in those States which have only one HSA.

The Congress should also amend the National Health Planning and Resources Development Act to provide for HSA and SHPDA review of proposed projects involving Federal health facilities and equipment and require their recommendations regarding the appropriateness of the projects be sent to the cognizant Federal agencies. Federal agencies should be required to provide these recommendations, along with their written responses, to congressional committees before any decisions are made to fund a project. Specific legislative language regarding these changes will be furnished to the appropriate committees upon request.

AGENCY COMMENTS

HEW generally concurred with our recommendation regarding the need to develop and publish program regulations and national standards for health services and facilities and added that the development of national guidelines will be a progressive and difficult process. HEW also concurred with our recommendation regarding the need to clarify HSAs emphasis on cost containment and health care accessibility. In addition, HEW concurred with our findings regarding difficulties being experienced in States having only one HSA and the need to include Federal health facilities in the health planning process.

While HEW generally concurred with our recommendation concerning data issues, HEW stated that "the recommendation should give increased emphasis to further coordination of data efforts rather than additional mandatory and costly data collection activities." HEW described steps being taken to deal with data problems being experienced by local planning agencies and stated that additional legislation is not needed to deal with this problem. We will assess the effectiveness of these steps in a future review of the health planning program.

CHAPTER 5

REGIONAL CENTERS FOR HEALTH PLANNING HAVE NOT BEEN EFFECTIVE

The act requires the establishment of regional centers for health planning to assist HEW in providing technical and consulting assistance to HSAs, SHPDAs, and SHCCs. The four regional centers for health planning we visited have made limited progress in assisting health planning agencies because of (1) difficulties in identifying technical assistance needs of planning agencies, (2) delays in issuance of HEW regulations and guidelines, (3) lack of receptiveness of planning agencies to center assistance, and (4) inappropriate requests for assistance.

According to the 2-year contracts awarded to the four regional centers for health planning, the centers are to increase the health planning and resources development capabilities of governing board members and staffs of HSAs, SHPDAs, and SHCCs. Other responsibilities are to assist HSAs and SHPDAs in developing and implementing health systems plans through onsite technical and consulting assistance. The centers also develop written technical documents for use of health planning agencies.

The following table provides basic data on these four regional centers.

Regional Centers for Health Planning

Center	Date of contract award	Contract amount	Professional staff authorized	Client agencies	
				HSAs	SHPDAs
1	6/28/76	$667,000	2	24	7
2	12/24/75	450,000	3	14	6
3	6/30/76	564,000	3	10	6
4	1/27/76	722,660	3	40	8

Regional planning centers rely greatly on consultants to provide training and consultation services to client agencies. For example, one planning center has allocated one-third of its budget for consultants' services. According to a planning center official, the use of consultants enables the center to provide a greater variety of technical assistance to its client agencies.

IDENTIFYING HSA NEEDS

The regional centers for health planning identified the needs of HSAs in different ways. Three centers sent a questionnaire to each HSA in their region. Two of these centers used the questionnaire responses along with personal interviews, site visits, and project applications to determine needs.

Another center used an informal process to assess HSA needs. The center's director said that site visits, examinations of HSA applications and progress reports, and discussions with HEW officials, the center's advisory board, and HSA staff were used to determine needs.

Officials at two centers related problems in identifying the needs of HSAs. They said that many agencies were so new that their needs were not well defined. According to an official at one of these centers, more advanced HSAs know their needs and ask for assistance.

ASSISTANCE PROVIDED

The amount of assistance provided HSAs varied among the four regional centers for health planning. Each, however, was behind schedule. One center had visited only 3 of 16 HSAs and SHPDAs in its region and had provided very limited assistance. The other three centers were somewhat more active.

For example, at one center, 9 of 14 planned training sessions for HSAs had been held. However, this center was behind schedule in making consultation visits to HSAs and developing written materials for HSAs. According to a center official, training sessions have been delayed because (1) staff resources were limited to onsite consultation requests, (2) HSAs have not been requesting training workshops, (3) HEW shifted emphasis for center activities, and (4) tight budgets of HSAs have limited HSAs' ability to send staff and board members to training workshops.

One regional center had organizational difficulties that resulted in the initial center director being replaced 8 months after the contract had been awarded. During that 8 month period, the center had only one professional on its staff. None of the 15 task orders submitted by the center to provide assistance to HSAs had been approved

by HEW. According to an HEW regional official, these task orders (1) provided for only minimal assistance, (2) did not constitute fulfillment of the centers training and consultation contract requirements (3) were primarily a reaction to a needs assessment questionnaire, and (4) did not represent the actual consultation and training needs of HSAs and SHPDAs.

Another center cited the HEW delays in providing guidelines as a reason for lack of assistance to HSAs and SHPDAs. A center official noted that centers are not policymaking organizations and thus cannot develop needed criteria and guidelines.

One of the functions of the regional centers for health planning is to train HSA board members. The governing board makes decisions regarding new project applications and is generally responsible for HSA activities. Apparently, consumer board members need assistance in understanding the health care system, the act, the functions and responsibilities of HSAs, and the relationships between HSAs, SHPDAs, SHCCs and other planning organizations in the health service area. This, we believe, is demonstrated by the responses (shown below) to our questionnaire, where we asked HSA board members to characterize their knowledge of the health care system.

Board Member Knowledge of Health Care System

Amount of knowledge	Percentage of respondents: Consumer board members	Provider board members
Very great	2.0	28.4
Substantial	25.4	55.9
Moderate	42.2	14.1
Small	21.4	1.6
Little or none	9.0	-
Total	100	100

We also asked board members to characterize the assistance provided by the regional centers for health planning. The following chart summarizes their responses.

HSA Board Members' Rating of Assistance Provided by Regional Centers for Health Planning

Responses	Centers				
	1	2	3	4	Total
	(Percent)				
Very good	5	1	8	-	4
Good	27	13	24	16	21
Neither good nor poor	16	20	23	30	21
Poor	2	3	9	13	6
Very poor	2	6	2	6	4
Have had no contact	48	57	34	35	44
Total	100	100	100	100	100

We believe that the most significant statistic in the above summary is that 44 percent of the board members had no contact with the regional planning centers which indicates that the centers had not provided the members any orientation or educational programs.

The director of one center said that he did not believe the regional planning centers should be providing training programs for orientation and education of HSA board members. He believed that the HSA staff should have this function and the centers should be doing research to develop new health planning methodologies for HSAs.

RECEPTIVENESS TO ASSISTANCE PROVIDED

Officials and staff at many of the HSAs and SHPDAs we visited were not enthusiastic about the assistance they had received from regional planning centers. A group of HSAs in one region had advised the planning center that their assistance had not been responsive to their requests. Several HSAs believed that the regional planning center staff was no more qualified or knowledgeable in the health planning field than their HSA staff.

Some HSAs, however, thought the concept of having regional planning centers was good and that the centers offered a good potential source of assistance.

INAPPROPRIATE REQUESTS FOR ASSISTANCE

Officials at two regional planning centers told us that some HSAs did not understand the limitations of the regional planning centers and sometimes made inappropriate requests. An HEW official said that this was a problem nationally because HSAs often asked centers for administrative assistance when the centers were to be providing technical assistance.

CONCLUSION

We believe that the most important task confronting HSAs at this time is the development of adequate health systems plans. The assistance of regional centers for health planning in health plan development could significantly effect the ability of HSAs to develop health plans. Also, we believe that HSA board members need to be trained and educated in health planning in order that they may intelligently carry out their functions and responsibilities.

RECOMMENDATION TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator, HRA, to direct regional centers for health planning to emphasize health plan development and to stress the importance of orientation and educational activities for board members.

AGENCY COMMENTS

HEW concurred with our recommendation and has issued an appropriate directive to the regional centers for health planning.

CHAPTER 6

SCOPE OF REVIEW

We made our review at HRA headquarters in Hyattsville, Maryland, and at four HEW regional offices (I--Boston, IV--Atlanta, VIII-Denver, IX--San Francisco). We also visited 15 HSAs, 11 SHPDAs, and 4 regional centers for health planning.

We reviewed applicable legislation, HEW regulations, draft guidelines, and other related instructions; reviewed contract and grant files; reviewed the literature and professional publications on health planning; and interviewed local and State agency officials, regional centers for health planning officials, and HEW program officials. We also obtained the opinions of various local officials and various consumer and provider groups.

We also sent a questionnaire to members of the governing boards of the 15 HSAs we visited. Five hundred and fifty-six questionnaires were sent out and 462 were returned (244 consumers and 218 providers--a response rate of 83.1 percent. (See app. I for a copy of the questionnaire.)

Our field work was done between November 1976 and June 1977. A draft report was submitted to HEW for comment on September 30, 1977. HEW comments were contained in a letter dated September 25, 1978. (See app. II.)

APPENDIX I

U. S. GENERAL ACCOUNTING OFFICE
SURVEY OF HEALTH SYSTEM AGENCY
BOARD MEMBERS

1. For the purposes of your membership on the Health System Agency (HSA) board are you considered a consumer or a provider? (Check one.)

   1 - ☐ Consumer

   2 - ☐ Provider

2. How long have you been a board member? (Check one.)

   1 - ☐ Previously served on Comprehensive Health Planning Agency board and then transferred to HSA board

   2 - ☐ 7 months or more

   3 - ☐ At least 3 months but less than 7 months

   4 - ☐ Less than 3 months

3. How were you selected to serve on the board? (Check one.)

   1 - ☐ Appointed by local government

   2 - ☐ Appointed by local planning authority

   3 - ☐ Other (Please specify _____)

4. According to the law at least 51% but not more than 60% of the board must be composed of consumers. Do you believe that this type of representation is proper?

   1 - ☐ Yes (GO TO QUESTION 6)

   2 - ☐ No (GO TO QUESTION 5)

5. What percent of the board do you feel should be composed of consumers?

   _____%

6. Consider the composition of the consumers on your board. For each category of consumer representative mentioned below indicate whether you feel the representation needs to be increased, decreased or should remain the same. (Check one box for each item.)

Type of Consumer	Increase 1	Decrease 2	Remain Same 3	Don't know or N/A 4
(1) Low income people				
(2) Minority groups				
(3) Elderly				
(4) Young people				
(5) Elected officials				
(6) Blue collar workers				
(7) White collar workers				
(8) Urban residents				
(9) Surburban residents				
(10) Rural residents				
(11) Women				
(12) Men				
(13) Other (Specify) _____				
(14) _____				

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7. Consider the composition of the providers on your board. For each category of provider mentioned below, indicate whether you feel the representation needs to be increased, decreased or should remain the same. (Check one box for each item.)

Type of Provider	Increase 1	Decrease 2	Remain Same 3	Don't know or N/A 4
(1) Direct providers in general				
(2) Indirect providers in general				
(3) Minorities				
(4) Women				
(5) Men				
(6) Urban providers				
(7) Suburban providers				
(8) Rural providers				
(9) Physicians				
(10) Dentists				
(11) Mental health practitioners				
(12) Administrators				
(13) Nurses				
(14) Physical therapists				
(15) Occupational therapists				
(16) Dieticians				
(17) Emergency medical service personnel				
(18) Other (Specify) _____				
(19) _____				

8. How many members in total do you feel should be on your board?

_____ members

9. How much knowledge of the health care system in your health service area do you feel each of the following groups has? (Check one box for each group.)

	Very great amount 1	Substantial amount 2	Moderate amount 3	Small amount 4	Little or no amount 5
(1) Consumer board members					
(2) Provider board members					
(3) HSA staff members					

10. What proportion of the board meetings are held at locations relatively convenient for you to attend? (Check one.)

1 - ☐ All or almost all are

2 - ☐ A large proportion are

3 - ☐ About half are

4 - ☐ A small proportion are

5 - ☐ None or hardly any are

11. What proportion of the board meetings are held at times relatively convenient for you to attend? (Check one.)

1 - ☐ All or almost all are

2 - ☐ A large proportion are

3 - ☐ About half are

4 - ☐ A small proportion are

5 - ☐ None or hardly any are

12. Do you believe board members should receive a per diem for participating on the board? (Check one.)

1 - ☐ Yes

2 - ☐ No

APPENDIX I

13. Consider an average board meeting. How would you characterize the attendance of each group? (Check one box per line.)

	Very good	Good	Neither good nor poor	Poor	Very poor
	1	2	3	4	5
(1) Consumer board members					
(2) Provider board members					

14. Consider the ents of board meetings which are concerned with project reviews. How would you characterize the amount of time that each of the following groups is given to voice its opinions on the projects? (Check one box per line.)

	Much more than adequate	More than adequate	Adequate	Less than adequate	Much less than adequate
	1	2	3	4	5
(1) Consumer board members					
(2) Provider board members					
(3) Relevant committee(s)					
(4) HSA staff					

15. During board meetings when projects are being d. ssed, to what extent is health care jargon or terminology used? (Check one.)

1 - ☐ Little or no extent

2 - ☐ Some extent

3 - ☐ Moderate extent

4 - ☐ Substantial extent

5 - ☐ Very great extent

16. To what extent does the use of health care jargon or terminology present a problem to you in understanding what is taking place? (Check one.)

1 - ☐ Little or no extent

2 - ☐ Some extent

3 - ☐ Moderate extent

4 - ☐ Substantial extent

5 - ☐ Very great extent

17. Generally, how would you rate the quality of the background information which is given to you for making decisions on the projects? (Check one.)

1 - ☐ Much more than adequate

2 - ☐ More than adequate

3 - ☐ Adequate

4 - ☐ Less than adequate

5 - ☐ Much less than adequate

18. Generally, how would you rate the usefulness of the background information which is given to you for making decisions on the projects? (Check one.)

1 - ☐ Much more than adequate

2 - ☐ More than adequate

3 - ☐ Adequate

4 - ☐ Less than adequate

5 - ☐ Much less than adequate

19. Since the HSA has been in existence, when final board decisions are made on projects, what proportion of the board's final decisions were in agreement with the recommendation presented by the board's project review committee? (Check one.)

1 - ☐ All or almost all

2 - ☐ A large proportion

3 - ☐ About half

4 - ☐ A small proportion

5 - ☐ None or hardly any

6 - ☐ HSA has not engaged in project review

APPENDIX I

20. Since the HSA has been in existence, when final board decisions are made on projects, what proportion of the board's final decisions were in agreement with the recommendation presented by the HSA staff? (Check one.)

1 - ☐ All or almost all

2 - ☐ A large proportion

3 - ☐ About half

4 - ☐ A small proportion

5 - ☐ None or hardly any

6 - ☐ HSA has not engaged in project review

21. Which of the following best describes your feeling. When board decisions involving projects are being made, the board is . . . . . (Check one.)

1 - ☐ influenced most by consumer board members

2 - ☐ influenced most by provider board members

3 - ☐ influenced most by HSA staff

4 - ☐ not influenced by any particular group

22. How would you characterize the capability of the HSA staff in performing its duties? (Check one.)

1 - ☐ Very good

2 - ☐ Good

3 - ☐ Neither good nor poor

4 - ☐ Poor

5 - ☐ Very poor

23. How would you characterize your relationship with the other board members? (Check one.)

1 - ☐ Very good

2 - ☐ Good

3 - ☐ Neither good nor poor

4 - ☐ Poor

5 - ☐ Very poor

24. How would you characterize your board's relationship with the HSA staff? (Check one.)

1 - ☐ Very good

2 - ☐ Good

3 - ☐ Neither good nor poor

4 - ☐ Poor

5 - ☐ Very poor

25. How would you characterize the assistance provided to your board by HEW regional officials? (Check one.)

1 - ☐ Very good

2 - ☐ Good

3 - ☐ Neither good nor poor

4 - ☐ Poor

5 - ☐ Very poor

6 - ☐ Have had no contact

Whether good or poor, please explain:

_____

_____

_____

26. How would you characterize the assistance provided to your board by the Regional Center for Health Planning? (Check one.)

1 - ☐ Very good

2 - ☐ Good

3 - ☐ Neither good nor poor

4 - ☐ Poor

5 - ☐ Very poor

6 - ☐ Have had no contact

Whether good or poor, please explain:

_____

_____

_____

APPENDIX I

27. How would you characterize the relationship between your HSA and the State Health Planning and Development Agency (the agency having final approval on project applications)? (Check one.)

1 - ☐ Very good

2 - ☐ Good

3 - ☐ Neither good nor poor

4 - ☐ Poor

5 - ☐ Very poor

6 - ☐ Have had no contact

Whether good or poor, please explain: _____

_____

_____

_____

28. How would you characterize the relationship between your HSA and the Professional Standards Review Organization (PSRO) in your area? (Check one.)

1 - ☐ Very good

2 - ☐ Good

3 - ☐ Neither good nor poor

4 - ☐ Poor

5 - ☐ Very poor

6 - ☐ No relationship with PSRO in area

7 - ☐ No knowledge of PSRO in area

Whether good or poor, please explain: _____

_____

_____

_____

29. Please estimate what proportion of the health providers in your area are supportive of the work of your HSA? (Check one.)

1 - ☐ All or almost all

2 - ☐ A large proportion

3 - ☐ About half

4 - ☐ A small proportion

5 - ☐ None or hardly any

30. To what extent can your HSA accomplish each of the following? (Check one box per line.)

	Very large extent	Substantial extent	Moderate extent	Some extent	Little or no extent
	1	2	3	4	5
(1) Restrain construction of unneeded health facilities					
(2) Restrain acquisition of unneeded equipment					
(3) Contain overall health care cost					
(4) Regulate rates charged by hospitals					
(5) Regulate health manpower supply					
(6) Regulate geographic distribution of health manpower					
(7) Improve access to health care					
(8) Educate the public in use of health care system					
(9) Other (Please specify) _____					

31. How would you rate the funding which your HSA has received? (Check one.)

1 - ☐ Much more than adequate

2 - ☐ More than adequate

3 - ☐ Adequate

4 - ☐ Less than adequate

5 - ☐ Much less than adequate

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32. In your opinion, have HSAs been given the necessary authority to achieve the goal of containing health care costs? (Check one.)

1 - ☐ Much more authority than necessary

2 - ☐ More authority than necessary

3 - ☐ Just the right amount of authority

4 - ☐ Less authority than necessary

5 - ☐ Much less authority than necessary

33. In your opinion, have HSAs been given the necessary authority to achieve the goal of improving access to health care? (Check one.)

1 - ☐ Much more authority than necessary

2 - ☐ More authority than necessary

3 - ☐ Just the right amount of authority

4 - ☐ Less authority than necessary

5 - ☐ Much less authority than necessary

34. If you can cite any specific examples of where your HSA has been particularly effective in any of the above areas or other areas you consider particularly important, please do so in the remaining space.

APPENDIX II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

SEP 25 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Status of the Implementation of the National Health Planning and Resources Development Act of 1974." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

APPENDIX II

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE COMPTROLLER GENERAL'S DRAFT REPORT ENTITLED "STATUS OF THE IMPLEMENTATION OF THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974"

GENERAL COMMENTS

The National Health Planning and Resources Development Act of 1974 directed the Department to implement numerous complex provisions designed to have a positive impact on the health care system. In addition to the complexity and scope of the provisions, the Congress included a very ambitious schedule for the Act's implementation. While there have been serious implementation problems in the past, the Department has acted in recent months in a positive and forceful manner to substantially improve the implementation effort.

While we generally concur with the findings, the Department believes that some specific issues and problems must be considered in the context of the conditions involved in overall implementation of the Act, the environment in which implementation has occurred, and the very high expectations placed upon the structure established by P.L. 93-641. Many problems the Department has encountered have been intensified by the high degree of interest expressed by many groups and agencies (both national and local levels) concerning the regulations and other planning agency activities, and the time required to carefully consider all such viewpoints. Developing understanding, consensus, and appropriate actions is often a difficult and time consuming process.

The draft report recognizes the complexity of the Act's diverse objectives. The report also discusses tensions concerning emphasis to be given cost containment objectives as well as to accessibility objectives. We agree with and would emphasize the observation in the report that:

> "Health systems plans can emphasize an accessibility to primary care as a priority (for example, an economically depressed area), while at the same time stress that increased costs from such things as overbedding, the questionable purchasing of expensive equipment, or duplication of certain services such as intensive care or cardiac care units should be minimized."

GAO RECOMMENDATION

"The Secretary of HEW should direct the Administrator, Health Resources Administration, to see that regulations and guidelines are prepared and issued more expeditiously in order that the Act can be implemented consistently throughout the country and to take the necessary actions to resolve the organizational problems within the Bureau of Health Planning and Resources Development."

DEPARTMENT COMMENT

A number of important actions have already been taken to overcome the identified problems. First, the recently appointed Administrator of the Health Resources Administration (HRA) has established the improvement and strengthening of the health planning program as a high priority. Action will be taken to expedite the policy development process and to provide effective leadership and direction.

Second, the Bureau of Health Planning and Resources Development (BHPRD) is being reorganized. This reorganization addresses the organizational problems discussed in the GAO report. It is expected to be completed soon.

Third, the Department has acted to speed the issuance of regulations for the health planning program, as indicated by the recently published National Guidelines. Most outstanding regulations have been published in proposed form. The Department has established new internal procedures to further expedite the resolution of policy issues and the issuance of regulations.

GAO RECOMMENDATION

"The Secretary of HEW should direct the Administrator, Health Resources Administration, to develop and publish, as required by the act, (1) regulations and guidelines for implementation of the act and (2) national standards and criteria regarding the appropriate supply, distribution, and organization of health resources and services."

DEPARTMENT COMMENT

The Department concurs. The Secretary has directed the HRA Administrator to ensure the appropriate actions are completed.

A Notice of Proposed Rulemaking (NPRM) was published in the Federal Register on September 23, 1977, containing proposed standards for nine institutional health resources and services. A revised NPRM was issued on January 20, 1978, to encourage further public consideration and comment. The standards were published in final form on March 28, following consideration of public comments. Additional standards will be developed and proposed rules concerning other National Guidelines for Health Planning (NGHP) will be published in the near future.

APPENDIX II

The final GAO report should reflect the concept that the development of National Guidelines will be a progressive and difficult process. It requires further advances in knowledge and the need to take into account the substantial diversity of conditions around the country. Since they will serve as benchmarks for the development of plans that ultimately serve as decisionmaking documents for all health planning activities, they must be carefully and soundly based.

GAO RECOMMENDATION

"The Secretary of HEW should direct the Administrator, Health Resources Administration, to determine the extent to which HSAs are experiencing problems as a result of inadequate or insufficient data and, if warranted, propose legislation which would give HSAs more authority and funds for developing necessary data for use in preparing health systems plans."

DEPARTMENT COMMENT

The Department concurs generally with the findings and recommendations concerning data issues. While the findings underscore the Department's awareness and concern with data problems encountered by many local planning agencies, the recommendation should give increased emphasis to further coordination of data efforts rather than additional mandatory and costly data collection activities.

Through a recent data gathering effort undertaken by BHPRD, local agencies have identified specific areas in which they experienced difficulties in obtaining pertinent and appropriate data. This is being followed by the necessary steps to help resolve the documented data problems. We do not anticipate that additional legislation will be needed.

There are a number of activities pertaining to data, including efforts of the National Center for Health Statistics (NCHS), the Cooperative Health Statistics System, the Vital and Health Statistics Offices in each State, and the State system supported by NCHS. Technical assistance and training for planning agencies are being provided by NCHS; and the interagency agreement between the Bureau and NCHS requires NCHS to provide statistical support services for the nationwide planning effort.

APPENDIX II

P.L. 95-142, which was recently signed by the President, contains provisions for the sharing of data by Professional Standards Review Organizations (PSROs) with the Health Systems Agencies (HSAs). This new directive for PSRO cooperation will assist the HSAs in fulfilling their data responsibilities. However, the Department does not concur with the emphasis on the data amassed by PSROs. While additional PSRO data would provide some assistance to planning agencies, the data which PSROs could contribute are only a small part of the data resources that the local agencies need to meet the broad Section 1513(b) requirements.

GAO RECOMMENDATION

"The Secretary of HEW should direct the Administrator, Health Resources Administration, to develop a policy statement to clarify the relative emphasis HSAs and SHPDAs should place on cost containment and health care accessibility."

DEPARTMENT COMMENT

The Department concurs that a statement of policy clarifying the relative emphasis HSAs and State Health Planning and Development Agencies (SHPDAs) should place on cost containment and health care accessibility is desirable.

This Department has consistently indicated in statements to the Congress and others that initial priority must be given to more effective cost containment activities, especially those concerning hospital costs, if resources are to be available to help achieve other health goals. These statements have been widely distributed to health planning agencies and others.

Activities to further cost containment and accessibility to health care services can and should be complementary. Better access to services aimed at the prevention and early detection of disease and disability and to ambulatory care and other community services can reduce needs for expensive institutional care.

Future issuances of the NGHP will address these issues. The HRA Administrator will also develop a statement of departmental policy for the guidance of HSAs and SHPDAs.

GAO RECOMMENDATION TO THE CONGRESS

"We recommend that the Congress should expand the provision of section 1536 of the National Health Planning and Resources Development Act of 1974 to allow more States to have only a State health planning agency and require that there be a minimum of two HSAs in all other States. If the Congress chooses not to amend the Act as suggested above, it should amend the Act to clarify the responsibilities of HSAs and SHPDAs in those States which have only one HSA."

APPENDIX II

DEPARTMENT COMMENT

The Department concurs with the reports of difficulties being encountered by some single State HSAs and the respective SHPDAs. A contract has recently been completed that:

--examined the rationale for original decisions for designation of single State HSAs and Section 1536 States,

--identified and analyzed the various problem areas encountered by Section 1537 States, statewide HSAs, and their respective SHPDAs; and,

--developed specific recommendations for resolving problems.

The Department is reviewing the contractor's final report. A copy of this report has been provided to GAO.

GAO RECOMMENDATION TO THE CONGRESS

We recommend that the Congress should also amend the National Health Planning and Resources Development Act to provide for HSA and SHPDA review of proposed projects involving Federal health facilities and require their recommendations regarding the appropriateness of the projects be sent to the cognizant Federal agencies. Federal agencies should be required to provide these recommendations along with their written responses to any congressional committees before any decisions are made to fund a project."

DEPARTMENT COMMENT

The Department concurs with the conclusion that Federal health facilities should be developed in ways consistent with the requirements of sound health planning, including local HSA and State agency planning. The Department has elicited significant voluntary cooperation of the Department of Defense (DOD) and the Veterans Administration (VA). Both DOD and VA have agreed to take into consideration the findings submitted by the HSAs and SHPDAs. The Department is subjecting its own health care facilities to local planning agency review.

GAO RECOMMENDATION TO THE CONGRESS

We recommend that the Congress should amend the Social Security Act to require all PSROs to make their data available to HSAs with the stipulation that HSAs can only release such data in summary form to respect the confidentiality of data provided to PSROs by individual health providers."

APPENDIX II

DEPARTMENT COMMENT

The enactment of P.L. 95-142 provides for expansion and clarification of those circumstances under which the provision of data or information by PSROs will be accomplished. P.L. 95-142 calls for the provision of aggregate statistical data by PSROs to agencies having health planning and related responsibilities under Federal or State law. The data and information furnished to the planning agencies are to be provided in a format and manner prescribed by the Department or agreed to by the agencies and the PSRO. Such data and information are to be in a form of aggregate statistical data on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished and the demographic characteristics of the population whose services are subject to review by the PSRO; the data are not to identify any individual.

GAO RECOMMENDATION TO THE SECRETARY, HEW

"The Secretary, HEW, should direct the Administrator, Health Resources Administration, to direct regional centers for health planning to emphasize health plan development and board member orientation and educational activities in future assistance to HSAs."

DEPARTMENT COMMENT

We concur and a directive has been issued. The centers are currently giving priority to assisting local planning agencies in the development of plans which will serve as an adequate basis for decisionmaking. The centers are also placing increased emphasis on training activities to assist both HSA governing boards and Statewide Health Coordinating Councils (SHCCs) members.

TECHNICAL COMMENTS

In the final report, the section on designation of HSAs (pp. 12-17) might consider the division of many Standard Metropolitan Statistical Areas in the designation process. Of additional significance is the experience in the redesignation of areas.

The statement at the bottom of page 14 that Governors in over 20 States had their HSA recommendations denied is misleading. The Department's final designations differed from Governors' recommendations in only eight States. Moreover, these differences generally involved only one or two areas among the several proposed. In a number of instances the Department was carrying out the requirements of the statute.

APPENDIX II

The second paragraph on page 17 should be revised to reflect that four HSAs are units of local government and 21 are regional planning bodies.

The discussion of governing bodies of HSAs (pp. 17-20) fails to address the issue of representation on such bodies. This is a crucial issue, especially in view of recent litigation challenging the representativeness" of the boards. Therefore, the final report might include the following example of such litigation: Legal action (Texas Acorn suit) was initiated which challenged the board composition of the Texas Area Five Health Systems Agency. The plaintiffs asserted that the board of directors and executive committee were not representative of the social and economic population of Texas Area Five because the consumer representation includes an insufficient number of persons with annual family incomes below $10,000. The United States District Court for the Eastern District of Texas granted partial summary judgment for plaintiffs and enjoined the HSA from operating. The Department appealed this decision to the United States Court of Appeals, Fifth Circuit. This decision by the higher court ruled in favor of the Department, by vacating the lower court's decision and remanding the case to the lower court.

The Department recognizes the uncertainties concerning what constitutes "broadly representative" of the demographic makeup of the area served (page 17). Proposed regulations intended to further define various characteristics which must be considered in determining board composition were published for public comment on May 26, 1978.

Page 20, paragraph 2, points out that "HSAs can be conditionally designated for no more than 2 years." The final report may want to note that the Congress has enacted a change that would permit the Department to waive this provision and extend HSA conditional designation for an additional 12 months under certain circumstances. Additionally, this amendment provides for a 36-month time frame for conditional designation of State agencies.

The number of States with SHCCs in place is erroneously reflected in the report (first complete paragraph, page 24). As of January 1978, a total of 48 States have established SHCCs.

The section entitled "Large Amount of Litigation" (pp. 31-33) fails to convey the workload generated by the litigation on the resources of the Office of the General Counsel (OGC). The deployment of OGC's resources to defend the Act has delayed their work regarding the issuance of regulations. Further, this section of the report should reflect the settlement in the Department's favor of the major legal case concerning constitutionality of the Act.

APPENDIX II

The section entitled "Augmentation of Regulations and Guidelines by Regional Offices" (pp. 33-36) indicates problems with respect to uniform implementation through the ten HEW regional offices. Early last year, the Department completed a study which concluded that the approach to the implementation of the program through the regional offices has worked well for the most part. However, some inconsistencies in implementation and policy interpretation have arisen among the regions which were due largely to a lack of timely and adequate guidance from headquarters. The Department has developed a new system which continues the program as a regionalized one but assigns the headquarters program with more responsibility to assure consistent policy interpretation and implementation across the ten regions. In this new system, the health planning program is an integral part of the immediate office of the Regional Health Administrator. The decentralized health programs allocate resources in ways supportive of the Health Systems Plans and State Health Plans developed under P.L. 93-641. The Bureau has already begun developing ways (e.g., integration of regional office work plans with major program initiatives) to improve the uniform implementation of the program under this new system.

The discussion of data (pp. 42-45) should note that the Bureau has issued data guidelines for use by the agencies.

The section entitled "Project Review Experience" (pp. 47-49) presents information, and some general recommendations, on the ". . . approval rate of applications for new institutional services . . . ." It appears, that GAO has mixed data from the section 1122 program in some States (e.g., Wyoming and Alabama) with the Certificate of Need Program (CNP) in other (e.g., Arizona and Massachusetts). No distinction is made between these two different programs. Further, the report defines the subject area as ". . . new health facility construction or establishment of a Health Maintenance Organization or any expenditure by an institution in excess of $150,000." This definition is not accurate for the section 1122 program and for the CNPs in some States.

The report takes a too simplistic approach to the effect of review programs. The absence of any discussion of the deterrent effect of certificate of need and section 1122 in terms of applications never submitted or withdrawn is an example. While the report's major conclusion in this section ("the need for timely standards and criteria is particularly important when new technology is developed") is correct and important, it does not follow from the data presented. There is no analysis or discussion of the tables. This is especially significant in light of the many questions that might be raised concerning the data (e.g., are these States representative, what are the dollar values of the approved and disapproved applications?).

APPENDIX II

Further, some of the data are misleading. For example, on page 48 the Arizona SHPDA is shown with an approval rate of 100 percent; in Arizona the effective decision level is the HSA and it is not surprising that the State agency approved all of the applications which it received. Similarly on page 49, since Wyoming approved one CAT scanner application out of one, it has an approval rate of 100 percent; the number is so small that the percentage is misleading. On page 48, Florida is shown as approving 94 percent of projects, but a more important figure is the percentage of dollar requests disapproved; our data show that under section 1122 reviews in Florida, the approval percentage rate was 91 percent in 1974, 89 in 1975, and 83 in 1976. This illustrates another weakness of the data: they do not show trends. Another figure more important than project applications approved is percentage of beds approved. In Florida, the percentages are: 1974, 89; 1975, 80; and 1976, 73.

Five States initiated CNPs before 1970. Studies of these programs indicate that between 1968 and 1972, growth in the number of hospital beds was reduced, but total hospital expenditures were not significantly affected because hospitals made other capital investments. By 1974, 20 more States initiated CNPs. Analysis of the period 1971-1974 indicates that the newer programs were not effective in reducing growth in the number of beds or other capital investments. However, more recent analysis suggests that the five early programs may have restrained growth in both beds and other capital investments between 1971 and 1974. At the end of this three-year period, hospital expenditures per person were tentatively estimated to have been somewhat lower (a maximum of 3.1 percent) than they would have been without a CNP.

Incorporation of some of these data in the final report would present a more complete picture of the effects of the regulatory activities encountered to date.

The comment on page 64 that "Medical standards and criteria are the responsibility of medicine, not HSAs" implies that HSAs have been assigned that responsibility. This is incorrect. PSROs are responsible for development of medical standards and criteria, and while HSA input is recommended, it is not required. Relationships between medical standards and resource standards might be considered.

APPENDIX III

PRINCIPAL HEW OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano	Jan. 1977	Present
David Mathews, Ph.D.	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
ASSISTANT SECRETARY FOR HEALTH		
Julius Richmond, M.D.	July 1977	Present
James Dickson, M.D. (acting)	Jan. 1977	July 1977
Theodore Cooper, M.D.	May 1975	Jan. 1977
Theodore Cooper, M.D. (acting)	Feb. 1975	Apr. 1975
Charles C. Edwards, M.D.	Mar. 1973	Jan. 1975
ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION:		
Henry A. Foley, Ph.D.	Dec. 1977	Present
Harold Margulies, M.D. (acting)	Jan. 1977	Dec. 1977
Kenneth M. Endicott, M.D.	Aug. 1973	Jan. 1977
DIRECTOR, BUREAU OF HEALTH PLANNING AND RESOURCES DEVELOPMENT:		
Colin C. Rorrie, Ph.D. (acting)	Apr. 1978	Present
Harry P. Cain II, Ph.D.	May 1976	Apr. 1978
Harry P. Cain II, Ph.D. (acting)	Mar. 1976	May 1976
Eugene J. Rubel	Aug. 1973	Mar. 1976

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