

A Bit of History....

By John Steen

The time seems right for a bit of reflection on the history of health planning. What led me to this subject is the passing of Dr. Henrik Blum who is known at Berkeley as "The Father of Health Planning," and was surely its most devoted mentor. Along with Dr. Herman Hilleboe, Dr. Leonard S. Rosenfeld, Robert M. Sigmond and others, he first outlined the principles and methods we know as health planning some forty years ago.

Dr. Henrik L. Blum, professor emeritus of health administration and planning at the University of California, Berkeley, and a champion of public health as social justice, died on January 3, 2006 at his home in Oakland, Calif. at the age of 90. Among his contributions is that of using community organizing skills along with social and economic concepts in the development and implementation of healthcare delivery and health policy.

From 1950 to 1966, he served as Health Officer of the Contra Costa County (California) Health Department. There he learned principles, novel to planning at the time, that he taught concurrently as a lecturer at UC Berkeley: Effective health planning requires a thorough knowledge of the many environmental, social, cultural, economic, and educational forces that shape a community, and the community's participation is essential to the resolution of its problems. He believed that health services should be located where most needed so as to best serve as resources in those communities, and among those he helped to establish there are vision screening in schools, community mental health, and genetic counseling. Concurrently, he published on subjects such as diabetes detection, genetic counseling, school lunch programs, mental health, vision screening, safety education, and fluoridation of water. Public health practice at the time took a medical perspective on communities, seeking primarily to eradicate and prevent the spread of infectious diseases. His approach was to see the community itself as his patient.

It was in 1966, when he joined the faculty of Berkeley's School of Public Health as a clinical professor, that Blum foresaw the development of a national health system, one that would involve consumers and providers in shaping healthcare policy and healthcare delivery. In 1968, Blum became a professor of community health planning. In 1970, he established the school's Program in Planning and Policy, chairing the program until his retirement in 1984. In 1985, he was given the American Health Planning Association's Schlesinger Award.

An example of his influence in health planning is the Orange County Health Planning Council, which was the designated Health Systems Agency for Orange County, Calif. under Public Law 93-641 (1974). Several members of the Council staff were his student graduates, and Dr. Blum's planning concepts were incorporated into much of its work. Its publications served, in turn, as teaching materials for his classes in health planning. He was also one of the founders of the Western Center for Health Planning in San Francisco.

He was the author of three seminal texts focusing on the health needs of communities: *Public Administration: A Public Health Viewpoint* (1963), *Planning for Health: Development and Application of Social Change Theory* (1974), and *Health*

Planning; Notes on Comprehensive Planning for Health (1968), which was the first set of readings ever published on health planning, and a landmark in its field.

Antecedents

It is well to be reminded that health planning arose out of communities with its roots both in public health and in medicine. And to find its antecedents, we need to go to Rochester, NY, where a form of health planning can be traced back to 1918 when its Community Chest Plan was established. In the 1920s, the Plan's executive committee reviewed requests for hospital capital fund drives. In the 1930s, administrators of six local hospitals began to meet formally to discuss problems. In 1936, The Community Chest commissioned a series of studies of healthcare in Rochester. In 1939, the Rochester Hospital Council was incorporated by the six local hospitals. Such early planning efforts were also taking place in those cities, like Pittsburgh and Detroit, that were centers of major industries. The Hospital Planning Council of Greater New York was the first in 1938. But only eight such hospital planning councils were formed between 1938 and 1962.

Federal health planning efforts may be traced back to the monumental report of the Committee on the Costs of Medical Care, which analyzed the inadequacies of the health system in 1933.* The first major effort of the federal government to promote health planning began with the Hill-Burton Hospital Construction Act in 1946, which mandated that states assess the need for hospitals and establish statewide priorities for the allocation of funds for new hospitals. Hospitals receiving Hill-Burton funds were required to provide charity care to the medically indigent. In Rochester, the Council of Rochester Regional Hospitals was formed to upgrade healthcare in rural hospitals.

Mature community health planning in Rochester dates from 1961. In 1959, Rochester area hospitals initiated a drive to raise more than \$30 million to finance 500 additional hospital beds. In 1960-61, Marion Folsom (Vice President of Kodak, and former Secretary of the federal Department of Health, Education and Welfare) founded the Patient Care Planning Council to plan for Rochester's healthcare needs. He organized a committee of consumers, hospital administrators, physicians, and business and government representatives to objectively assess the capacity needs of Rochester's hospitals. Based on it, the Council reduced the hospital drive's objective from \$30 million to \$14 million, and reduced the number of additional hospital beds from 500 to 140. This was the paradigm for New York's certificate of need program in 1964, the first state regulation of capital expenditures by hospitals and nursing homes, and the earliest model for state-regional linkage of planning and regulation.**

Amendments to the Hill-Burton Act in 1962 mandated the formation of state and regional health planning agencies with federal support. A voluntary not-for-profit network of regional health planning agencies in major metropolitan areas conducted needs analyses and advised states on construction priorities in their areas. Their numbers grew from eight in 1962 to 33 in 1964 and 50 in 1965.

Through the Partnership for Health Act of 1966, the federal government established Comprehensive Health Planning Agencies, and in Rochester the following year, the Wadsworth Committee was formed to study inner city healthcare needs. It recommended creating a network of neighborhood health centers. In 1973, with business support, three HMOs were established.

The 1974 National Health Planning Law then created the most extensive system of community health planning agencies, known as Health Systems Agencies (HSAs), the nation has ever had, following a template of one HSA for every one million people, on average, in each state. In Rochester, the Finger Lakes Health Systems Agency was one of the 205 HSAs. In 1978, local hospitals established the Rochester Area Hospitals Corporation to promote continued cooperative planning among themselves. Beginning in 1980, along with insurers and government representatives, they managed community-wide hospital revenues and improved the solvency of their hospitals through the Hospital Experimental Payments Program (HEP). Throughout the decade, HEP established a global community-wide revenue cap for hospital-based inpatient and outpatient care.

These two historical streams of health planning – personal health in Rochester, and public health in California – have since come together around their common client, the community. In March 2004, the Finger Lakes HSA adopted a revised mission statement that moves from health systems analysis to seeking community solutions to problems of the health of the community, recognizing the broadened focus of the Agency that has been operationalized for at least a decade.

For more than a decade, the Alameda County Public Health Department in California has been moving away from a “service” to a “capacity-building” approach to public health. The Department is a leading practitioner of “the new public health,” strengthening communities from within to play a greater role in their own health. It actively involves residents in the planning, evaluation, and implementation of health activities in their communities. To do this it has Community Health Teams in 10 neighborhoods across Alameda County, and it has taken to training community leaders to work with their own neighbors to address common concerns. And so, the focus of “the new public health” is community organizing, and the community is the patient.

And that brings me back to Dr. Henrik Blum. In 1983, he gave us this insight into the political marginalization of health planning. The very same reasoning can be used to explain why we don't yet have a national healthcare system.

Can there be meaningful health planning when so little else is publicly planned? It is my conviction that how health planning is set up is not altogether a result of special interest forces. Its mandate is determined by such societal forces as traditions, socioeconomic political outlooks, formal governance structures, and availability of resources. A society such as ours has strong anticollective biases, fears of government expressed as endless built in checks and balances, many levels of government, and many regional differences. Thus we will surely require, but have a difficult time developing, a strong national sense of direction that is melded with powerful state if not local participation to allow for ample variation in accordance with local needs and yet falls within nationally set goals. Our planning machinery is likely to be set up in just those ways that have allowed the health sector to create the problems that upset us so. Only under truly stressful shortages of resources, major calamities, or war are major changes going to be demanded of a given sector. That is what we are seeing today, and the official health planning machinery continues very much to one side of the action.***

* Committee on the Costs of Medical Care, *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care*, Chicago: The University of Chicago Press. 1932.

** In 1971, New York State became the first to set hospital rates, greatly strengthening that linkage.

*** Book Review: "*Health Planning: Lessons for the Future*, by Bonnie Lefkowitz." *Inquiry*, 20, 390, 1983.