

Community Health Planning and Health Care Reform

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The benefits that may be achieved by giving community health planning a major role in establishing and operating health care systems are made evident in a careful review of its short history.

Health planning began as regional hospital planning by citizen councils in major cities. Cleveland established a Hospital Council in 1916 and issued a landmark survey of health care resources in 1920. However, the “consumer” members of such councils were civic leaders selected less for their skills in evaluating resource needs and costs than for their connections in fundraising to facilitate the financing of hospital projects.

Community health planning in the full sense of planning by members of the affected community began in 1960-61 in Rochester, NY when Marion Folsom who had served as the first secretary of the federal Department of Health, Education and Welfare (1955) formed a citizen planning council to review the community’s need for hospital beds and hospital plans to fund their construction. Folsom was an executive at Kodak where it was believed that, as the city’s largest purchaser of health care, it had the right to ask such questions, and Blue Cross saw itself as a beneficiary too.¹ In 1964-65, New York State formalized that process in law and regulation by enacting the nation’s first Certificate of Need (CON) legislation.

The 1960s were the era of community action in which community health centers were developed with federal support. At that time, the Congress believed that consumers deserved to have a policymaking role in the institutions that served them, and so these centers were required to have community governing boards with consumer majorities. This marked the first federal initiative to put the community in charge of its health services as a major step toward “health reform.” However, with the ascendancy of conservative politics in subsequent years, the centers were relegated to the welfare system as a medical “safety net.”

In 1966, the federal Partnership for Health Care Act supported a network of state and local agencies to engage in comprehensive health planning, and they too were required to have boards reflective of their communities with consumer majorities. These agencies were able to go wherever their community health assessment and promotion activities led them, and they were expected to coordinate government planning to better serve their communities. They were the first agencies ever empowered to look at the organization of health care delivery in the community in its entirety.

The principal rationale for the federal role in health planning was to contain costs by controlling utilization of services funded by Medicare and Medicaid that had been enacted in 1965 without utilization controls. At the time, most businesses and Blue Cross plans throughout the nation supported health planning to reduce their costs too.

In the 1970s, the prospect of developing a national health insurance program furnished an additional reason for cost control. It also made it desirable to develop an understanding of health care delivery amongst the electorate, and with it a consensus of support for an adequate solution that would take the form of a national health care system.² The hearings in the Congress 35 years ago debated the same issues being debated there now, and Sen. Ted Kennedy was one of the principal authors/proponents of national health insurance and of community health planning’s role in it even then.

In 1974, the National Health Planning and Resources Development Act created a network of 205 local health systems agencies (HSAs) and corresponding state health planning and coordinating agencies, following a template of one HSA for every one million people, on average, in each state. Their legitimacy was firmly grounded in their being mirrors of their communities, but their volunteer members had much to learn about health care delivery and about their communities before they could act as fiduciaries for those communities. Orienting them to their roles was the function of health planning agency staff that over time delivered a practicum to the volunteers about all the factors involved in their deliberations.

The introduction of health systems agencies was seen to provide “the first serious opportunity for a comprehensive approach to the entire health care system.”³ It was an investment in the “democratization of health care” by a government that wished to make health care more accountable to the people. And for 12 years, it did just that, for the real significance of HSAs is that they were all about transforming the *politics* of health care through a new paradigm that gave a role to ordinary people and their community organizations. Among the unintended consequences of that political experiment was the deconstruction of the mystique, and with it the sovereignty, of modern medicine. Among the intended consequences was advancement of an ideal – the autonomy of individuals to make their own choices with regard to as fundamental a good as health and health care, i.e., consumer empowerment.

Consumer empowerment was the most progressive principle embodied in community health planning and regulation, and it was always in conflict with the ability of business to manage competitively in a “free market.” Today, the move away from reliance on market solutions once again provides an opening for government regulation.⁴ The HSAs were an attempt to engage and realize “the democratic wish” by institutionalizing a communitarian process,⁵ and once again we have an opportunity to design a comprehensive approach to the entire health care system that requires “broad, workable forms of popular participation.”⁶

I have traced this brief history so that it may inform our current efforts toward a national health care system that best serves all of us. I hope too, that by understanding it, we may avoid being condemned to repeat it.

I am going to address health planning and regulation as if they were integral to each other, two sides of the same coin, because they are. CON is reactive; health status (social justice) goals can only be met through a proactive population health approach. The experience of the HSAs demonstrated that it was the health systems plan that identified all community health needs and the strategies for meeting them. CON was a weak implementation strategy best for translating private business plans into public information, and engaging the public in reviewing potential service changes in terms of their likely impact on their communities. The most democratic processes staffed by HSAs were the public hearings they held in the course of acquiring community input for their plans and their major CON reviews.

The process of community health planning is composed of three fundamental steps: First, survey health system resources, then determine how those resources could most efficiently meet area needs,⁷ and finally plan the redirection of those resources. The Finger Lakes HSA in Rochester succinctly describes its role as “collecting, analyzing and interpreting data, identifying problems and assessing service needs, convening stakeholders, advocating for and facilitating implementation of solutions, and evaluating and communicating results.”⁸

With their focus on how health issues impact their communities, health planning agencies must try to breach the barrier between medicine and public health, but the structure and funding of the medical care system is an impediment to the equitable provision of public health services. Medicine is focused on treatment as a personal health service rather than on prevention, and the most efficient prevention strategies are population health approaches. If we had a national health care system as a function of government as in European countries, both medicine and public health could be carried out by the same agencies in an integrated fashion. Over the past half-century, medicine and public health have become increasingly isolated, functioning as virtually independent disciplines. And most egregiously of all, all previous attempts to deliver a national health care system have totally ignored public health.

Logically if not politically, the only answer to this otherwise intractable problem is for reform to focus on **health**, rather than health care, on the end instead of the means, but to note too how much more effective public health is as a means. To reform our “system,” it must be refocused on the dignity and autonomy of those it serves who need to be educated about the true benefits of living a healthy life.

To the extent that there is public participation in community health planning, the public will come to demand that the system be more accountable for meeting its true needs.

¹ And thus the community health planning and health regulation movement had its inception as a smart business initiative. See William P. Brandon, “Rochester: Flower City and Flexnerian Seedling,” in *The Training of Primary Physicians*, ed. Stephen J. Kunitz, University Press of America, 1986.

² This step was overlooked by the Clinton Administration’s ill-fated Health Security Act (1993-94) that offered us instead a “black box” process and the advice to “trust them” with one-sixth of the entire domestic economy.

³ Anne and Herman Somers, “The Philadelphia Medical Commons: The Choices Ahead,” in *Health and Health Care*, ed. Somers and Somers, Aspen, 1977, p.251.

⁴ New York City has felt the loss of its HSA acutely since 1996, and ever since then its progressive organizations have lobbied local government to restore community health planning/regulation. See <http://www.phanyc.org/pdfs/NYCphiW2.pdf> (p.8ff); http://www.uhfnyc.org/usr_doc/Jim_Tallon_testimony_on_health_planning.pdf; http://www.uhfnyc.org/usr_doc/Reconsidering_Community_Health_Planning.pdf.

⁵ For an account of what it was like to be a volunteer health planner in an HSA in 1985, go to: <http://www.context.org/ICLIB/IC09/Bird.htm>.

⁶ James A. Morone, *The Democratic Wish: Popular Participation and the Limits of American Government*. Basic Books, 1990, p.336. Morone explains how “American policy makers used the democratic wish to reconfigure the power relations in the health care system.”(321) It may again be the time for us to tackle the challenge to “marry democratic wishes to contemporary institutions.”(338)

⁷ In the early health planning agencies, need was projected from existing service utilization; population-based need assessment came later. Mature health planning concentrated on increasing access to health care services for underserved populations.

⁸ Wade Norwood, Director of Community Engagement, FLHSA, 2007.

