COMPREHENSIVE HEALTH PLANNING IN THE UNITED STATES

José Duarte de Araújo, M.P.H.

The author reviews the history of health planning in the United States, describes attitudes likely to affect future planning, and explores relationships between health planning and the political process. Personal observations about operation of the Bay Area Comprehensive Health Planning Council in San Francisco are also included. It should be noted that the views presented here are the author's and do not have any bearing on the views of the Pan American Health Organization.

Introduction

After a long period of neglect, the politics of health (particularly the politics of health planning) has become a favorite topic for political scientists; and for this reason the past five years have seen many important aspects of the politics of health planning subjected to thorough analysis. This heightened interest can be viewed, at least in part, as a consequence of the institutionalization of comprehensive health planning in the United States of America.

Though opinions differ on many issues, as is normal, we would expect to encounter unanimity on at least one point: i.e., the recognition "that the planner’s ability to understand and turn the political process to his advantage is a prime determinant of success" (18). On one hand, according to Mott (19) "in accepting politics as a part of health we are more able to recognize our relationships with others having different perspectives, and thus to increase our effectiveness in attaining what we seek." On the other hand, according to Kaufman (18), if health planners continue to chant their battle hymn "Keep our specialty out of politics, and politics out of our specialty," they will find that "politically sophisticated groups outside the field [will] come to assert new claims and to voice new expectations concerning public health services. If ... health planners are less sophisticated about the political process than their competitors, they will soon find that others have taken over the field."

For health planning to play a significant innovative role in shaping the future of health care in any country, it is essential that both students and professionals in the health planning field be willing to spend much of their time in gaining better understanding of the tools of political power and political influence and in learning how to use them. From this premise stems the interest in exploring the subject further by inquiring into various aspects of the politics of health planning, such as: the historical perspective and organizational structure of health planning in the U.S.A., as well as the present planning environment and its effect upon the planning process.

In order to examine these matters the following activities were carried out: (1) a review of the pertinent literature; (2) a study of some basic documents prepared by health planning agencies in the State of California (3, 5, 23, 24); (3) direct observation of the San Francisco Bay Area Comprehensive Health Planning Agency (which involved regular attendance at the meetings of the Task Force on Organization of Personal Health Services and active participation in the work of its finance committee for a period of ten weeks); and (4) completion of a series of interviews with executive directors of county comprehensive health planning agencies in the bay area, and

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2 Chief, Department of Preventive Medicine, School of Medicine of the University of Bahia, Brazil.
also with members and staff workers of the Bay Area Comprehensive Health Planning Council.

The Historical Perspective

As Arnold and Welsh (3) point out very clearly, "the idea of planning conflicts with some strong values of [American] society" such as the emphasis on individualism, the desire for local autonomy and local rule, and the fear of an all-controlling, all-encompassing "Big Brother." Furthermore, in the U.S. there has been a pervasive belief that government planning started in the Soviet Union, so that many people have seen the very concept of planning as associated with socialist government, and in fact have regarded planning as synonymous with socialism.

Despite these attitudes, however, the time eventually came for U.S. leaders and citizens to accept the idea of planning activities that were at least partly government-sponsored, and for the Congress to approve an institutionalized nationwide planning program in the health field (12, 14).

As a matter of fact, voluntary private health planning goes back as far as the beginning of the twentieth century, to the activities of the National Tuberculosis Association and its plans to fight tuberculosis on a national scale (25). Similar categorical disease-oriented approaches to health planning by private groups were also undertaken by the Cancer Society, the National Foundation for Infant Paralysis, and others, eventually leading to a more concerted effort by the National Health Council.

The first law involving government-induced or government-supported health planning in the United States was the Hill-Burton Act of 1946 (26). Intended essentially to provide the states with federal funds for constructing hospital facilities, this law also required that each state create a Hospital Planning Council responsible for assessing hospital construction needs. This step was still a long way from anything resembling comprehensive health planning. Nevertheless, it was an important step toward making the concept of a state planning council politically acceptable.

The work of the Presidential Commission on the Health Needs of the Nation in the early fifties produced a voluminous report entitled "Building America's Health" (11). However, this had little impact on health planning because it was published at a time when the administration in power was leaving office.

Between 1962 and 1966 the National Commission on Community Services (supported by the National Health Council and the American Public Health Association) undertook a nationwide study focusing on community health needs and existing services, and tried to come up with a blueprint of services for the years ahead (20). Though some consider the Commission's report "disappointing" (30), it contains some recommendations of irrefutable value for our study, such as its "Position N," a strong call for comprehensive health planning.3

Regional Medical Programs

In addition, around this time another presidential commission successfully prompted legislation establishing what would later be known as the Regional Medical Program (13). This body, the "Commission on Heart Disease, Cancer, and Stroke," presented its report in 1964 (10), and Congress enacted the relevant legislation less than a year later, partly because favorable political currents had made the 89th Congress particularly responsive to presidential demands in the health field.

It is important to point out that although in some measure this action embodied a categorical approach to the problem, the "Heart Disease, Cancer, and Stroke Amendment" represented a very significant step toward regionalization of the country's health facilities and personnel, cutting as it did across internal political boundaries. In other words, it managed to deal successfully with the question of states' rights, one of the country's most delicate internal political issues.

3 As stated therein, "The Commission believes that planning is an action process and is basic to development and maintenance of quality community health services. Action planning for health should be community-wide in area, continuous in nature, comprehensive in scope and all-inclusive in design." (22)
Comprehensive Health Planning

The same 89th Congress also approved the “Comprehensive Health Planning Amendment” of 1966 (12), which was complemented the following year by the “Partnership for Health Amendment” (14). This legislation, contained in Public Law 89-749 and Public Law 90-174, was the cornerstone of a new US health planning system, which will be discussed later on. It is a matter of speculation how much influence the previously mentioned report of the National Commission on Community Health Services had on the enactment of these measures.

A Planning, Programming, and Budgeting System

Another very significant development took place at approximately the same time. That is, the so-called “Planning, Programming, and Budgeting System” (PPBS) was introduced into the health field at the federal level in direct response to presidential instructions (28).

Emergence of these three separate activities—namely, regional medical programs, comprehensive health planning (CHP), and PPBS in the health field—different as they were in principle and method, carried the same message: the stage was set for planning at all levels of the health system in the United States.

The Organizational Structure of CHP

Because application of the PPBS has been limited essentially to government agencies and the regional medical program does not have the comprehensiveness deemed essential for health planning as such, the remainder of this discussion is limited to the comprehensive health planning (CHP) system created by PL89-749 and PL90-174.

The Comprehensive Health Planning Act and the Partnership for Health Act called for establishing a State Health Planning Council in every state. This council, known as the CHP “A” agency, is conceived as an advisory body responsible for developing the overall state health plan. The legislation also called for creation of public or private (non-profit) CHP “B” agencies responsible for planning at the local (county or city) level and at the regional (metropolitan or multi-county) level. The state council (the “A” agency) is not responsible for detailed planning, but rather for supervising and coordinating the planning efforts of the “B” agencies. The council is also supposed to encourage cooperation among the body of private and public agencies concerned with health services, manpower, and facilities in its state. Despite this apparent concentration of power at the state level, the CHP program specifically emphasizes health planning at the local and regional levels.

In addition to the planning bodies themselves, the CHP legislation called for training programs to improve health planning skills among health professionals, other professionals, and consumers. There are about two dozen of these so-called “C” agencies (all university-based) throughout the country.

An important feature of this legislation is its preoccupation with consumer participation. For instance, over half of the CHP council members must be consumers. In addition, broad representation of various community groups and interests, including ethnic minorities, is considered desirable but is not specifically required. Regarding finances, federal grants pay up to 50 per cent of the “A,” “B,” and “C” agencies’ total expenditures, the remainder coming from state and local appropriations and from donations.

These basic features reveal a decentralized and rather open system of planning. The system encourages horizontal integration among the various health interests and agencies at any given geographic location, and also establishes some degree of vertical integration (but not direct subordination) among agencies at different hierarchical levels.

Two major structural “flaws” in this model have obvious functional consequences. First, national-level planning is conspicuously absent. This is a serious problem when one considers that the main issues presently facing the health
system require solutions that are national in scope. Second, the effort toward decentralization stops short of the sub-local (neighborhood) level which is nowadays considered of great significance in the country. Another "flaw" might also be mentioned, i.e., the absence of any link between health planning and planning in related areas (such as city planning, housing, education, etc.), though nothing impedes efforts by health planners to establish these vital relationships.

The Planning Environment

To reasonably understand the health planning activities in any country, state, or region, it is necessary to appreciate the context in which the planning process is taking place. This means knowing the nature of the setting and also appreciating how contextual characteristics affect the planning process (22). In other words, it means knowing something about the planning environment. In the opinion of Bicanic (6) "this environment is neither neutral nor passive to planning action, but reacts to it in different ways, strengthening or weakening the action, presenting obstacles to it, and requiring specific methods for different situations."

The first consideration in this regard relates to the government framework of support, for according to Waterston (29) "insufficient government support is the prime reason why most plans are never carried out successfully."

How does this apply to health planning in the United States? There are different ways to answer this question. One of them is to consider passage of the necessary legislation as a sufficient expression of government commitment to health planning, a true demonstration of what some would call a "will to plan" (16) and an indication of an ideological framework congenial to planned change.

Another approach is to examine the relevant legislation more critically, so as to find whether the commitment to planning is qualified or not; for such qualification may indicate that there is really no formal commitment to planned change, and even that a contrary situation prevails. This sort of qualification is evident in the preamble of PL89-749, which states that the goals of comprehensive health planning are to be pursued "without interference with existing patterns of private professional practice of medicine" (12), an obvious constraint on the concept of change.

Throughout the literature, planning is consistently identified with the possibility of change, or even with an express desire for change. Blackman and Blum (8) consider that "people who plan obviously think that social change is possible." Arnold and Welsh (2) recognize that "when the process of planning is institutionalized in a society there is an indication that the society is not satisfied with the image of what the unplanned future will bring," and consequently it engages in planning to produce desired change.

There is, then, an evident conflict between the basic philosophy of planning and the half-hearted position of the government in relation to health planning. ("You must plan but you cannot change.") What can thus be said of the sociocultural framework in relation to planning?

The fundamental antagonism between the idea of planning and the American credo has already been noted. Nevertheless, among those who understand the need for change and who see planning as the most adequate instrument for bringing it about, there is an effort to defend the idea of change, to convince the majority that planning may perfectly well be part of the democratic process, and that it can be conducted without upsetting the present socioeconomic system.

A few years before the forementioned health planning legislation was enacted, Duhl (15) recognized that a serious dilemma was "how to strengthen our planning and still at the same time optimize the freedom of individual groups and cultures." In his opinion, the only way out of this dilemma was "organized rational planning in which governmental and quasi-govermental bodies, including business and labor, play important roles." Yet he recognized
that "The word 'planning' is likely to bring forth negative images such as 'totalitarianism' and that... to some, equating planning with democracy seems paradoxical, since they claim that planning subjugates and makes people dependent." He further noted that "Planning in a closed society does have this effect [but that] planning in an open society can only facilitate democracy by reducing the inequities, maximizing the range of choice... and making these choices more widely available."

More recently, Mary Arnold (7) addressed herself in different terms to the same dilemma, manifesting her opposition to a "planned society," but suggesting that "there is another alternative to us...: the development of a political structure and the social capacity to make ourselves into a planning society."

This schizophrenic social attitude toward planning indicates that much remains to be done before health planning (or any other planning activity) can play a major role in changing unsatisfactory features of the present system in the United States. Furthermore, most of what remains to be done directly involves the current power structure in the health field.

One of the most peculiar characteristics of the health planning agencies established by PL89-749 is their lack of power. Neither the state-wide and regional comprehensive health planning councils nor the counties' CHP agencies are vested with authority to assure implementation of their plans. They do have authority to review projects proposed by various entities for building or expanding health facilities, and the regional agencies also review grant applications for health programs in their areas. However, these are limited and indirect sources of power, with little impact on the planning process—especially at the implementation stage.

Where then lies the decision-making power, and what are the relationships of the CHP agencies to the source of this power?

U.S. health expenditures for fiscal year 1970 were $67,240 million dollars, of which 38 per cent were disbursed by the Government and 62 per cent by private entities (27). As would be expected in a "free enterprise" economy, the health industry is largely dominated by the private sector, and those who provide and sell the majority of its services exercise a controlling influence over the decisions that are made.

Aside from these private vested interests, the Federal Government is gradually increasing its share of these expenditures, and has thus come to exert an increasing degree of control, mainly through regulations. By and large, however, private vested interests—especially the organized medical profession, the hospital industry, and the insurance companies—have dominated the field.

The health planning agencies have no obvious way of exerting any effective control over these groups in order to assure compliance with their policies and plans. In fact, not even government sources of health disbursements are within their sphere of influence. This is not necessarily bad; some authors, like Blum (9) "do not favor investing the planning body with any means of enforcement or even with significant sanctioning powers," and consider that "the duties and authority of planning bodies should be circumscribed to the area of making plans (hopefully, not of enforcing them)." But what recourse do health planners then have if they want to engage in what might be called "effective" planning (7), i.e., if they want to have a real impact on the health system?

This subject has recently received considerable attention in medical and social science literature. The main approach that seems open to planners is that of trying to gain influence by participating in the political process, an approach traditionally avoided by those who consider planning a purely technical matter. The belief that there is a close link between planning and the political process is well-expressed by Waterston (29): "It is impossible for a planning agency to be both autonomous and effective. A plan which is to have a good chance of being implemented must be a joint project [of the planners and] of those who have the power to carry it out, and must express their coordinated aspirations in the context of a common goal. Moreover, the very essence of planning, indeed, the very decision to begin
planning, is political. There is no way of avoiding this, even if it were desirable."

Increasing awareness that the present health care system is unable to make adequate services available to the entire population at reasonable cost has brought the general public, and consequently the politicians, into the debate over health issues and policies to an extent never seen before. In this new environment the planners must be particularly attentive to enlisting as much outside support as possible, sometimes through a complicated and seemingly unholy alliance of conflicting interests.

This does not imply that health planning agencies should be considered mere mechanisms for generating consensus. Meaningful health planning has to be controversial; to meet society's needs the planners must not be satisfied with improved coordination of the existing health system, but instead must strive to change that system. This will inevitably bring conflict. However, such conflict should not be feared; according to Resemen (2) it "must be utilized for creative energy and not suppressed to maintain consensus." In other words, one of the most important functions of health planning boards will be to serve as forums where a broad variety of represented interest will have to master the not-so-easy art of resolving conflicts between professionals and politicians, between state, regional, and local needs, and between different vested interest groups. This is the essence of democratic planning in an open society.

Personal Observations

The comments that follow are based on direct observation of activities of the San Francisco Bay Area CHP Council, exchanges of information with staff members of four county "B" agencies, and study of state and regional planning documents.

The "California State Plan for Health" is not a plan in the strict sense. Instead it is a statement of overall health goals, a master list of state health priorities, and a set of broad planning guidelines for regional and local planning bodies. It also contains a substantial amount of information regarding health problems in California. With respect to politics it is a neutral document.

In my opinion this kind of product is within the spirit of the CHP legislation at this stage of development, before the regional and local agencies have produced their own plans. In the future, however, it would seem appropriate for the state plan to deal increasingly directly with existing problems, and to present a real statewide plan of action encompassing activities at the various levels of administration and in the various geographic areas covered by the responsible regional and local agencies.

The Bay Area CHP is now in the process of finishing its first "Regional Plan for Health" (5). Preliminary observations indicate this will probably be another statement of goals, priorities, and general policies that, though more specific than those of the state plan, will not (strictly speaking) constitute a health plan. However, it is my understanding that the plans prepared by each of the county "B" agencies in the region will be incorporated into the Bay Area Plan.

It also appears noteworthy that the executive directors of "B" agencies with whom I had the chance to talk seem to have a clear understanding of the need to deal with the political aspect of the planning process. One of these directors, when asked for his opinion of the relationships between planning and politics answered that "for me they are the same thing."

In addition to its concern with preparation of the regional plan, the Bay Area CHP has been dealing with its usual agenda. Brief mention of a few of the issues discussed and dealt with will serve to illustrate day-to-day CHP operations during my period of observation.

The question of a controversial "medical" reform and its consequences for low-income groups, providers of health care, and county finances was taken up in the Finance Committee, where a proposal to deal with the problem in an organized manner was presented and accepted. From there the matter went to the
Board of Directors, where a statement prepared by the Finance Committee calling for a "concerted effort initiated by the CHP...for mounting a public campaign to bring about needed changes" was approved (4).

Another subject, identification of underserved groups in the bay area, was considered by the Task Force on Personal Health Services. Starting with reports from the bay area counties describing possible underserved groups in their area, a study was made by health planning students from the University of California at Berkeley to identify and define the condition of being "under-served" and to determine its causes. As a result of this study a suggestion was made to hold community health forums in areas indicated by the county agencies as harboring under-served groups. This suggestion was approved by the task force, and the Bay Area CHP sponsored the first of these forums. The latter meeting took place on 4 May 1972 in Dixon County. In terms of achieving community participation, revealing health service inadequacies, and suggesting possible corrective measures, this forum met with considerable success (4).

These two examples show CHP work at its best—with the planners dealing realistically and positively with significant issues falling within their area of jurisdiction.

On the other hand, the same task force also dealt with two other issues where the possibility of exerting any influence was very slight: establishment of guidelines for development of health maintenance organizations, and definition of principles for an ideal health insurance program (4). In both instances, though the ideas discussed and the recommendations approved appeared worthy and often very rational, there is little chance that these recommendations will have any effect on the future shape of national programs currently being discussed at the congressional level.

Perhaps in the future, when CHP agencies will possibly have a much stronger voice in health affairs, they may be called on to have their say in shaping health policies at the national level. However, it is my belief that dealing with issues outside the CHP agencies' area of influence at the current time is unlikely to enhance CHP authority or prestige.

Conclusions

In sum, personal observations and a review of existing literature on the politics of health planning have led the author to draw the following conclusions:

1) The Comprehensive Health Planning (CHP) system is based on an essentially decentralized planning model, is open to broad community participation, and is endowed with very limited authority. This arrangement is in accord with U.S. politics and with the nature of U.S. society at large. Planning models that are more centralized, more technocratic, and less participatory would not be acceptable in the United States at the present time.

2) In order to be effective, CHP agencies must seek political influence by actively exploring the interface between planning and politics. During this process they should strengthen their authority by dealing preferentially with issues upon which they can have a clear positive impact. In dealing with such issues, CHP bodies should not necessarily seek consensus and should not fear becoming involved in conflicts.

3) If CHP agencies do not succeed in acquiring political sophistication and in generating substantial authority for themselves, they may never play a significant role in shaping national health policy. The CHP system may thus perpetuate itself as a bureaucracy, while in essence confirming Roseman's caustic words and becoming "the booming echo of a tree that never fell."(21)

SUMMARY

Despite resistance to the concept of planning within U.S. society, health planning efforts by private U.S. organizations began early in the twentieth century. These were supplemented in
1946 by passage of the Hill-Burton Act, which promoted organized public planning of hospital services at the state level. However, nationwide comprehensive health planning did not begin until passage of the Comprehensive Health Planning Amendment in 1966.

Since then health planning has been carried out by local, regional, and state agencies. These activities have offered an excellent opportunity for studying the interrelationships between health planning and the political process.

A review of the literature on this subject, and personal observations of the Bay Area Comprehensive Health Planning Council's activities in San Francisco, led the author to the following conclusions:

1) The Comprehensive Health Planning (CHP) system is based on an essentially decentralized planning model open to broad community participation.

2) In order to make their planning effective, CHP agencies must actively explore the interface between planning and politics.

3) If CHP agencies do not succeed in acquiring political sophistication they may never play a significant role in shaping national health policy.

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