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Public Law 93-641: Health becomes the public's business

By Larry Diamond

On January 4, 1975, President Ford signed into law PL 93-641, the National Health-Planning and Resources-Development Act of 1974. This law, in one bold stroke, dramatically increases the federal role in health policy development, regulation, and initiation of new services and programs at all levels of the organized health delivery system. In effect, the government will oversee and regulate both the quality and quantity of the health delivery system in the years ahead.

It is not surprising, therefore, that the new law is already being called by many the most important piece of legislation since Medicare a decade ago. This article will analyze PI 93-641 with a particular view to its future implications for health care practitioners and federal, state and local health officials.

The Law:

The law itself begins with a detailed rationale based on congressional findings in review of the concurrent status of health-care delivery. These findings indicate that rising costs, continuing unavailability and inaccessibility of needed services and lack of effective methods of delivery are continuing major problems. A variety of new organizational modes and manpower deployment are suggested as potential solutions.

The law then specifies in exact detail the organizational mechanisms and central procedures which will affect such changes. These planning territories, to the extent practicable, will coincide with existing standard metropolitan statistical areas, PSROs and other federal and state planning areas. The agencies themselves will be either public or private nonprofit corporations with governing boards composed of 51 to 60 per cent consumers. Contrasted to other programs with such boards, the definition given in the law for providers is so extensive as to mandate a heavy proportion of grass roots community participants representative of the geographical areas encompassed by the agency.

The HSA functions will be to develop areawide health plans; review all relevant proposals for new services or capital construction outlays and all existing areawide services in place; and to let contracts as seed monies for the organization and development of new services identified in health plans as priority needs. The health plan will be the central standard against which other activities will be undertaken. The funding base will be a straight 50 cents per capita for operations based on the total population served, with another 50 cents per capita available for the seed monies for service development to be matched on a three-to-one basis. No agency will function with a professional staff of fewer than five persons; it is suggested that a ratio of one staff person per 100,000 population served be used as a guideline.

At the state level, newly designated State Planning Authorities will be created to produce annual state health plans reflecting the Health-Systems Plans of the state's planning regions. This plan will in turn infuence the use of federal monies in the state that are available for facility construction and modernization; 25 per cent of the funds must be earmarked for ambulatory care services. Attached to the state agency will be a Statewide Health Coordinating Council, composed of representatives of the individual HSA boards and other appointees of the governors, which will insure that the individual areawide health plans are incorporated into the State Health Plan as the major component parts.

At the federal level, four previously separate and sometimes competing programs -- Hill-Burton, Regional Medical Programs, Comprehensive Health Planning, and Experimental Health Services Delivery Systems -- have merged into the new Bureau of Health Resources Planning and Development. This unit will oversee all aspects of implementation of the law and will become the chief health-planning unit of DHEW. Its staff will support the efforts of a new National Health Task Force which will develop a

national health strategy.

For a law as significant and extensive as is PL 93-641, the lead time available before its impact is felt is surprisingly short. Governors have had 90 days to respond to DHEW with specific area designations for HSAs; by August 3 these designations will be formally approved for all areas across the country. A first draft of regulations is being prepared for issue on July 15. Key national organizations have already been asked to respond in writing with specific comments. HSA regulations will be finalized by Sept. 30, and new agencies will then apply for funding, to be approved by December. Thus, as of Dec. 31, 1975--if the intensive reorganizational effort now underway is successful--the last vestiges of the old federal health-planning machinery will be fast fading and the work of health systems and state planning agencies will commence.

Implications for Health Care Providers: Probably the most significant message of the law is that for the first time a federally mandated development of a national health strategy is underway. Its implementation will be made fully accountable to the tax-paying public. As one observer noted, the government has decided to regulate health in this country, and has set up quasi-public agents called HSAs to do the great bulk of the work in this regard.

The cooperation and leadership of a broad spectrum of health professionals seem to be imperative to the success of the new effort proposed.

Health-care practitioners can make vital contributions to the implementation of this law. One immediate need is to sensitize and educate a wide cross-section of health-related professionals about the law, its major findings and provisions. To date, the law remains a "sleeper"; most have heard something about it, but are unclear about the specifics and purposes. A corollary need is public comment on the law pertaining specifically to area designations and draft regulations from those most affected--the health-care providers. We are in the midst of a five-month process of DHEW solicitation of specific comment about major aspects of the law from professional health associations of all types; it is an unusual opportunity for solid cooperation between the government and health leadership at all levels.

Also needing participation and support is a general community development effort. Two critical decisions must be made in the coming months: what boundaries make the most sense given federal criteria for individual HSAs; and which specific agencies in the area can best meet the demands set for HSAs. Local health-care professionals are in an extremely good position to make concrete suggestions in the public arena on both counts.

Finally, the three functions of the agencies once organized and operational — development of areawide Health-System Plans, letting contracts for new services development, and comprehensive service and facility review — are dependent upon direct involvement of health-care providers for a data base, advice and judgment, and for the day-to-day diligence and effort required to see these ends achieved and made meaningful and sensible. The Health Systems Agencies from a functional perspective represent a vehicle for testing the kind of shared planning and program development leading health institutions have desired in the past but did not provide the resources or create the mechanism to do on any large scale.

In a provocative and challenging article in the March 13 issue of the New England Journal of Medicine, Dr. Charles C. Edwards, former Assistant Secretary for Health Affairs in the Dept. of Health, Education, and Welfare, reacted with disappointment and apprehension to the growing trend of federal intervention in health regulation and policy development. The disappointment is that health-care practitioners themselves have not provided the leadership and commitment for internal self-regulation; the apprehension is whether the federal government is a capable instrument for providing such leadership and commitment to fill the void.

One thing is certain, however, he writes: regulation, planning, and orderly introduction of new components or health-care delivery are imperative. The hope now is that PL 93-641 can act as a stimulus for these procedures to begin to effect desired change.

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