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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Health Systems Plans: A Poor Framework For Promoting Health Care Improvements

Each of the Nation's 204 health systems agencies spends considerable time and effort developing a health systems plan--a document describing what needs to be done to improve health care in a particular geographic area. GAO's review of these plans found that they set forth too many objectives, many of which are too general, unrealistic, or unattainable. Thus, the plans cannot be used as intended--as a framework for making needed changes to the health care system.

GAO also identified planning problems in the 13 States having a statewide health systems agency and problems in evaluating the impact of the health planning program.

Information in this report should be useful to the Congress as it considers the merits of the President's proposal to phase out the health planning program.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

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

This report discusses the adequacy of health systems plans developed by health systems agencies and recommends actions the Department of Health and Human Services should take to improve the plans. We made this review because of the importance of adequate plans to a successful health planning program. Since completion of our work, the President has proposed phasing out the program. Although the purpose of our review was not to determine whether the program should be continued, we believe the information in this report describing the significant deficiencies in health systems plans should be useful to the Congress in considering the merits of the President's proposal.

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Health and Human Services.

Milton J. Socolar
Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

HEALTH SYSTEMS PLANS: A POOR FRAMEWORK FOR PROMOTING HEALTH CARE IMPROVEMENTS

D I G E S T

The National Health Planning and Resources Development Act of 1974 established 204 health systems agencies (HSAs) with responsibility for planning health services within a particular geographic area. The law also established State health planning and development agencies (State agencies) and statewide health coordinating councils (statewide councils) to deal with health care needs from the perspective of the entire State. Through fiscal year 1980, the Congress had made about $715 million available for the health planning program.

The President has proposed that the health planning program be phased out by 1983. This report provides important information on the adequacy of health systems plans developed by HSAs that should be useful to the Congress in considering the merits of the President's proposal.

INADEQUATELY DEVELOPED HEALTH SYSTEMS PLANS

A high priority of each HSA is to develop a health systems plan--a document describing what needs to be done to improve the health care system and the health status of area residents. The plan is fundamental for accomplishing the HSA objectives.

Despite substantial resources and community effort, GAO found that health systems plans were inadequately developed. Substantive deficiencies existed with the plans' stated objectives, recommended actions for accomplishing those objectives, and resource requirements for carrying out those actions. As a result, the plans did not represent a well-developed framework for making needed changes in the health care system. Often GAO found:

--Objectives lacked measurability, which limits the ability to assess the progress toward meeting them.

--Objectives were not limited to priority goals, and many more objectives were established than could be accomplished within a reasonable time frame.

--Objectives were questionable because they concerned further planning or were unattainable or unrealistic in what they sought to achieve through local community resources.

--Recommended actions for accomplishing objectives were nonexistent or poorly developed.

--Resource requirements (personnel, facility, and financing costs) for implementing each recommended action were unspecified or inadequate. (See pp. 8 to 16.)

The failure of the HSAs to follow HHS guidance and insufficient HHS involvement with HSAs during plan development contributed to the plans' inadequacies.

HSAs also prepare annual implementation plans, which identify yearly priorities in the health systems plans. The HSAs GAO visited had placed little emphasis on implementation because most of their efforts had been directed toward developing and improving the health systems plans. (See p. 18.)

STATEWIDE HSAs' ROLES VARY WIDELY

The process established in the act for developing health plans is inappropriate for the 13 States that established statewide HSAs. Normally, the State agency and statewide council are responsible for consolidating various health systems plans into a State health plan. Since there is only one HSA (and one health systems plan) in each of these 13 States, the consolidation role does not exist, and HSAs and statewide councils (assisted by State agencies) prepare separate health plans for the same geographic area--the entire State. (See pp. 23 to 25.)

HHS has provided little guidance in addressing the statewide HSA situation. In four of five States GAO visited, the roles assumed by the HSAs and State agencies in developing health plans varied widely. (See pp. 25 to 30.)

PROGRAM IMPACT DIFFICULT TO ASSESS

Evaluating the impact of the health planning program is difficult. The major problem is distinguishing the impact of the health planning agencies from the impact of other entities that are also attempting to influence the health care system. HHS recognizes the problems and has several completed, ongoing, and planned efforts to assess various functions of HSAs and the impact of HSAs and State agencies on accomplishing their objectives. (See pp. 32 to 35.)

One evaluation of program impact has been completed. In early 1979, the American Health Planning Association, a national organization representing HSAs and State agencies, examined one function of the program--the review of proposed capital investment projects submitted under State certificate-of-need legislation or section 1122 of the Social Security Act. The Association reported that the health planning agencies had disapproved or discouraged proposed projects totaling $3.4 billion between August 1976 and August 1978. GAO concluded that this estimate was not reliable and, therefore, not an accurate measure of the health planning program's impact. The Association strongly objected to those conclusions; however, GAO developed 23 case studies to substantiate its position. (See pp. 35 to 40.)

GAO's efforts suggest that evaluating the impact of the health planning program is very difficult and may not produce clear and dramatic evidence concerning the effectiveness of health planning organizations. (See pp. 40 and 41.)

RECOMMENDATION TO THE CONGRESS

If the Congress decides to continue the health planning program under the same or a similar structure, the health planning legislation should be amended to allow health planning organizations in States with statewide HSAs to jointly develop one health plan.

RECOMMENDATIONS TO THE SECRETARY OF HHS

The Secretary should:

--Assess the adequacy of the latest health systems plan at each HSA.

--Require HSAs to revise inadequate plans so that such plans (1) concentrate on a few significant objectives that can be achieved in a reasonable time frame, (2) specify a strategy for and organizations for accomplishing the objectives, and (3) identify the resources needed to carry out the objectives.

--Actively work with HSAs during the development of future health systems plans to ensure that future plans do not contain the deficiencies currently existing.

--Require HSAs to actively pursue the implementation of health systems plans and annual implementation plans after plans are determined to be consistent with HHS guidance.

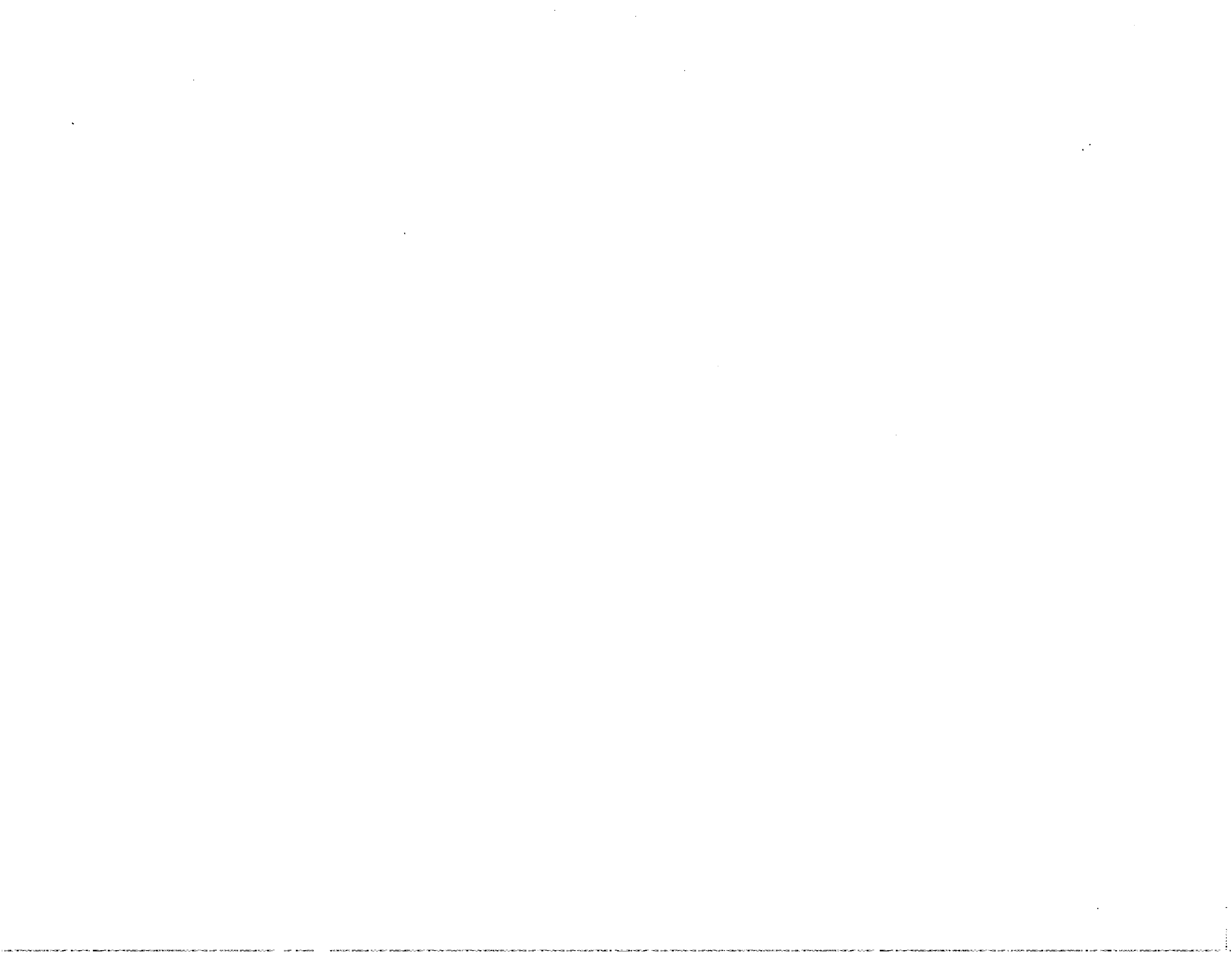
--Issue regulations and guidelines concerning the implementation of the health planning program in statewide HSAs that would include requiring written agreements between the statewide HSA and the State agency which set forth their respective roles in carrying out the planning process.

AGENCY COMMENTS AND GAO'S EVALUATION

HHS agreed with GAO's recommendations to assess the latest plans and to require revision of inadequate plans but did not agree that it should actively work with HSAs in developing future plans. HHS maintained that the Congress clearly intended that the plans reflect local choices made through an open process that considers national priorities. GAO agrees but continues to believe that involvement by HHS with HSAs during plan development would ensure that plans do not suffer from the current deficiencies and that such involvement need not preclude the plans from reflecting local needs and choices.

HHS concurred in the importance of stressing the need for plan implementation but disagreed that implementation should be deferred until plans are improved. In GAO's opinion, implementation of inadequate plans could result in HSAs expending valuable time and resources in addressing objectives that may not be of a high priority, and HSAs should therefore defer implementation activities until their plans are improved.

HHS agreed with the intent of GAO's recommendation regarding clarifying the roles of statewide HSAs and State agencies but added that it may be inappropriate to issue new Federal regulations until the Congress acts on the President's proposal to phase out the health planning program. GAO does not disagree but continues to believe the recommendation is appropriate if the program continues under the same or a similar structure.



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ABBREVIATIONS

AIP	annual implementation plan
GAO	General Accounting Office
HHS	Department of Health and Human Services
HSA	health systems agency
HSP	health systems plan

CHAPTER 1

INTRODUCTION

The health care system in the United States is large and costly. National health care costs have risen dramatically, far exceeding the Nation's inflation rate. Health expenditures increased from about $39 billion in 1965 (6 percent of the gross national product) to an estimated $226 billion in 1980 (over 9 percent of the projected gross national product). Further, Federal health care outlays increased from about $5 billion in 1965 to over $63 billion in 1979. The 1979 outlay, which was split among over 200 programs, represents nearly 13 percent of the total Federal budget. This tremendous increase in Federal costs, coupled with the parallel growth of the entire health care system, has prompted increased congressional concern that health resources be used effectively and efficiently.

The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) combined and redirected the efforts of a number of federally supported State and local programs relating to health planning and the development of health resources. (See app. II for a summary of Federal health planning efforts.) In the act, the Congress identified achieving equal access to quality health care at a reasonable cost to be a priority goal of the Federal Government. The act cited significant problems in the health care system, including the failure of the public and private sectors to deal with the (1) lack of uniformly effective methods of delivering health care, (2) maldistribution of health care facilities and personnel, and (3) increasing cost of health care.

THE HEALTH PLANNING PROGRAM--HOW DOES IT WORK?

The Bureau of Health Planning of the Department of Health and Human Services' (HHS') Health Resources Administration is responsible for overall management of the health planning program established by the act. The program provides that decisions about health care needs and priorities are to be made by areawide (community-oriented) organizations in close cooperation with the State and Federal governments. At the areawide level, health systems agencies (HSAs) are to perform health planning and development activities within local geographic areas. The States are to organize State health planning and development agencies (State agencies) and statewide health coordinating councils (statewide councils) to deal with the health care needs from the perspective of the entire State. The Federal Government provides funding and technical assistance to these health planning organizations, as well as planning at the national level.

The health planning program depends heavily on the public for carrying out the act's provisions. An HSA's governing board and the statewide council are made up of consumer representatives as well as health care providers. Each HSA is directed by a governing board consisting of a majority (but not more than 60 percent) of residents who are consumers 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 are health care providers, including physicians, dentists, nurses, health care insurers, and hospital administrators. The membership must include (either through consumer or provider members) elected public officials and other representatives of local governmental authority in the health service area. The board must have between 10 and 30 members. If the HSA establishes an executive committee, it is subject to the same size constraints. An HSA may also establish advisory councils to advise and assist the board.

AREAWIDE PLANNING

The act required that the country be divided into health service areas--geographic regions considered appropriate for effective planning and development of health services. The act placed the major responsibility for designating health service areas on State Governors. HHS' role was to insure that the health service areas proposed by the Governors met certain requirements specified in the act. As of November 1980, there were 203 HSAs in the Nation's 204 health service areas. 1/

HSAs, the foundation of the health planning program set forth under the act, are to perform health planning and development activities for the local geographic area. By developing plans and working with local health service organizations, HSAs attempt to improve the health of the residents; increase the accessibility, acceptability, continuity, and quality of health services; restrain increases in the cost of health services; and prevent unnecessary duplication of health resources. Through their boards of directors, professional staff, and community participants, the HSAs perform the functions of planning and regulation:

Planning--HSAs assess what facilities, services, and personnel are necessary to meet the health needs of the people. HSAs must prepare health systems plans (HSPs) for improving the health care system and the health status of area residents. Through annual implementation plans (AIPs), HSAs encourage the development of specific actions to meet the identified needs.

1/There was no HSA in Clark County, Nevada, as of November 1980.

Regulation--HSAs review and make recommendations to State agencies regarding the need for new institutional health services in accordance with section 1122 of the Social Security Act or State certificate-of-need laws. These laws require State agency approval of major construction projects, equipment purchases, or changes in health service. Also, HSAs review the proposed use of Federal funds to be awarded to grant applicants in their service area under certain Federal health programs, and make recommendations to the State agency on the appropriateness of certain institutional health services already existing in the area.

However, HSAs have no direct authority over State, local, and private funds to be used to develop health services, nor do they have authority over the expenditures of Federal funds for health facilities and programs of the Department of Defense and the Veterans Administration.

Health systems plans

HHS requires the HSAs to place a high priority on developing the HSP and AIP because these plans are fundamental to accomplishing the act's objectives. The HSP is to describe what needs to be done to improve the health care system and the health status of the people and how the plan will be carried out.

HSPs consist of many components that address an element in the health care system or the health status of area residents. For example, one component would discuss care for persons who, because of their physical or mental condition, require special nursing or supportive services for a prolonged period (long-term care). Each component has a narrative summarizing issues and problems the HSA identified. The narrative is followed by goals, objectives, recommended actions, and resource requirements for solving the problems. Goals represent long-range achievements that are desired for the area's health system or the health status of area residents. Objectives are quantitative statements of what should be achieved within a specific period and should lead to at least partial attainment of the goals. Recommended actions are the strategies proposed for achieving the objectives. Resource requirements estimate the personnel, facility, and financing costs necessary to achieve the recommended actions. The AIP identifies priorities in the HSP that will be addressed during the next 1-year period.

HSPs and AIPs are developed through a lengthy process involving extensive community participation by citizens, local governments, professional organizations, and consumer and other interest groups. An HSA's board of directors, comprised of consumers and providers from the community, establishes permanent and temporary committees to help it develop the plans. The committees usually consist of board members and other interested community members--often persons with special expertise in the area of study. The

committees, in cooperation with the HSA professional staff and subarea advisory council members, develop the draft plans. After public hearings--which allow area residents to suggest modifications to the draft plans--the board finalizes the plans and submits them to the statewide council, which determines whether the plans are acceptable as a base for the State health plan. HHS reviews the HSP and AIP for overall acceptability.

Statewide HSAs and section 1536 States

Health service areas in 13 States encompassed the entire State. Since the act required having an HSA for each health service area, a single statewide HSA was established in each of these States. The health service area's boundary is the State boundary in 11 States--Delaware, Idaho, Maine, Mississippi, Montana, New Hampshire, Oklahoma, South Dakota, Vermont, West Virginia, and Wyoming. Two other States--New Mexico and Utah--are considered to have statewide HSAs although a small portion of each State is within the boundaries of an HSA in a neighboring State. These 13 States are generally rural and have moderate to very small populations.

Section 1536 of the act exempts certain States, territories, and possessions from establishing health service areas and HSAs. Instead, the State agency performs the combined functions of an HSA and State agency. To qualify for section 1536 exemption, States must (1) have no county or municipal public health institution or department, and (2) have maintained, before the law's enactment, a health planning system which substantially complies with the act's purpose. American Samoa, the District of Columbia, Guam, Hawaii, the Northern Mariana Islands, Rhode Island, the Trust Territory of the Pacific Islands, and the Virgin Islands were determined to meet the requirements of section 1536 designation under the act. Puerto Rico originally established a statewide HSA, but the health planning amendments of 1979 allowed Puerto Rico to be designated a section 1536 agency.

STATE PLANNING

The State agency is selected by the Governor and designated by the Secretary of HHS to perform State health planning activities under the act. Similar to HSAs, State agencies hire staff to carry out their responsibilities. The State agencies are responsible for:

--Preparing, reviewing, and revising a preliminary State health plan based on the HSPs within the State.

--Implementing those parts of the State health plan and the HSPs that relate to State government.

--Serving as the planning agency for operation of the project review program authorized by section 1122 of the Social

Security Act and administering a certificate-of-need program. In these programs, the State agency approves or disapproves proposed new institutional health services after considering HSA recommendations.

--Reviewing the appropriateness of certain health services offered in the State and, after considering HSA recommendations, publishing the findings.

--Assisting the statewide council in performing its functions.

The statewide council coordinates the State's health planning activities, finalizes a State health plan based on the preliminary State plan and HSPs, comments on the HSAs' budgets and programs, and approves or disapproves State plans and applications for funds under certain Federal health legislation. The statewide council serves as advisor and coordinator in developing State health policy. The Governor appoints members to the council from nominees submitted by each HSA. With certain exceptions, each HSA must be equally represented on the council, and there must be at least two members from each HSA. The Governor may appoint additional members, but they must not exceed 40 percent of the total membership. The act also requires that the majority of members be consumers.

FEDERAL PLANNING

The Bureau of Health Planning is responsible for overall management of the health planning program. It has authority to develop and issue program policy through regulations, guidelines, and policy notices and to approve and fund individual HSAs. This authority includes determining the adequacy of the health plans, State certificate-of-need programs, agency work programs, and other conditions specified in the statute and regulations. Other Bureau activities include formulating the budget, developing regional office work program priorities, assessing performance of health planning agencies, identifying their technical assistance needs, and evaluating the health planning program.

At the HHS regional office level, the 10 regional health administrators have responsibility for monitoring the progress of the health planning agencies, providing day-to-day program guidance and technical assistance, determining compliance with grant conditions, assessing performance of the agencies, and making recommendations to the Bureau concerning the approval of the agencies. Before April 1979, the regional offices were responsible for approving the HSPs within their respective regions; these responsibilities were centralized because the quality of accepted HSPs varied among regions.

The Secretary of HHS approves HSAs and State agencies on a conditional basis. They become fully approved when the Secretary determines that they can successfully carry out the functions and

responsibilities in the act. As of November 1980, 199 of 203 HSAs and 41 of 57 State agencies 1/ had become fully approved.

Program funding

Through fiscal year 1980, the Congress made about $715 million available for the health planning activities authorized under the act. HSAs have received about $500 million and State agencies about $135 million. HHS personnel, administrative, and technical assistance expenses essentially represent the balance of the appropriations. Funding for fiscal year 1980 totaled about $177 million.

As shown above, considerable amounts of funds have been devoted to health planning activities nationwide. HHS estimated that about 20 percent ($100 million) of HSA funds have been spent on developing HSPs at the 204 HSAs. Of equal importance, considerable volunteer effort has been exerted by local citizens who serve on the boards of directors of health planning organizations and others who participate in the health planning process.

OBJECTIVES, SCOPE, AND METHODOLOGY

The major purpose of our review was to evaluate how well HSAs have carried out their high-priority responsibility of developing health systems plans. To assess the adequacy of HSPs, we reviewed the latest HHS accepted plan at six HSAs in four regions. The six plans were selected on a judgment basis to obtain a geographic distribution between rural and urban settings as well as different regions of the Nation. We also reviewed a statistical sample of 200 goals and associated objectives, recommended actions, and resource requirements (goal packages) which was drawn from 193 approved plans as of August 1979. HHS plan development guidelines were used to assess the six plans and statistical sample. Our methodology enabled us to make nationwide projections concerning plan components (objectives, recommended actions, and resource requirements) but did not enable us to make a nationwide assessment of the number of plans that were inadequately developed in their entirety. (See app. III, which describes the methodology and results of our statistical sample of HSPs.)

Our Chief Medical Advisor reviewed one HSP and the 200 goal packages to assess whether the goals and their associated objectives, recommended actions, and resource requirements were realistic and reasonable from a medical viewpoint.

1/In addition to the 50 States, State agencies were established in American Samoa, the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico, the Trust Territory of the Pacific Islands, and the Virgin Islands.

In early 1979, the American Health Planning Association, a national organization representing HSAs and State agencies, completed a survey of the impact of the health planning program. The Association reported that planning agencies had disapproved or discouraged proposed capital investment projects totaling $3.4 billion between August 1976 and August 1978. We reviewed records supporting the savings estimate and met with the Association's staff to determine the reliability of the savings estimate. On March 13, 1980, we presented our findings on our audit of the Association's supporting data in a report to the Secretary of HHS. We also analyzed 23 proposed projects nationwide to further evaluate the Association's claim of savings for a number of representative projects. The analysis of six of these projects is provided in chapter 4.

To evaluate the administration of the health planning program, including the procedures followed in approving HSPs and the adequacy of guidance and assistance provided to HSAs, we performed work at HHS' Health Resources Administration in Hyattsville, Maryland, and at four HHS regional offices--Boston, Philadelphia, Chicago, and Denver. We researched applicable legislation and related documents to determine congressional intent in implementing the health planning legislation. The views of HHS officials were obtained on the adequacy of HSPs and on the program assessment efforts undertaken to date and planned. We visited 11 HSAs to determine the procedures and practices followed in developing their HSPs and interviewed HSA officials regarding the adequacy of HHS guidance and assistance in developing the plans. At five HSAs that had statewide responsibility, we assessed their plan development activities and relationship with the State planning agency to identify any problems unique to statewide HSAs. We also visited 10 State planning agencies to get a State perspective on the issues discussed in this report. Not all issues were discussed at each HSA and State agency.

CHAPTER 2

HEALTH SYSTEMS PLANS NEED TO BE IMPROVED

Despite substantial resources and extensive community effort, the HSPs that have been prepared to date by HSAs are inadequately developed. Substantive deficiencies existed in the plans' stated objectives, the recommended actions for accomplishing those objectives, and the resource requirements available for carrying out those actions. As a result, the plans did not represent a well-developed framework for improving the health care system and the health status of area residents. Deficiencies included:

--Objectives lacked measurability, which limited the ability to assess the progress being made toward accomplishing objectives.

--Objectives were not limited to priority goals, and there were many more objectives than could be accomplished within a reasonable time frame.

--Recommended actions were nonexistent or poorly developed since they did not specify a strategy, or the organizations responsible, for accomplishing the objectives.

--Resource requirements (personnel, facility, and financing costs) for implementing each recommended action were unspecified or inadequate.

Also, many of the objectives were questionable because they (1) concerned further planning, which was not appropriate according to HHS' guidance, or (2) were unattainable or unrealistic in what they sought to achieve through local community resources.

HSAs' failure to follow HHS guidance when developing plans was the primary cause of inadequate plans. The inclination by some HSAs to satisfy the perceived needs of those who participated in the plan development process and insufficient HHS involvement with HSAs during the plan development process also were factors that adversely affected plans.

HHS needs to assess the adequacy of the latest plans developed by HSAs and require them to revise inadequately developed plans. To give greater assurance that future plans will provide a better framework for improving the health care system and the health status of area residents, HHS should also become more actively involved during the plan development process to assure that the resulting plan conforms to the established guidelines.

PLANS ARE INADEQUATE

In December 1976, HHS issued guidelines for the development of HSPs. Those guidelines contained criteria for developing plan objectives, recommended actions for accomplishing those objectives, and resource requirements for carrying out those actions. The guidelines were very comprehensive in describing what HHS expected. In February 1979, HHS issued revised guidelines for developing HSPs'; however, the requirements pertaining to objectives, recommended actions, and resource requirements remained essentially the same.

We used the HHS guidelines as a basis for assessing the six HSPs; and the statistical sample of 200 goal packages. Five of the six plans were inadequately developed and did not represent a well-developed framework for making needed changes in the health care system and improving the health status of area residents. Our statistical sample showed that the deficiencies in the components of the five plans were generally representative of deficiencies in HSPs nationwide. While our methodology did not enable us to project the number of plans nationwide that are inadequately developed in their entirety, it did demonstrate that the deficiencies in HSP components are significant and widespread.

Unmeasurable objectives

As shown in the table below, five of the six plans that we reviewed had substantial numbers of unmeasurable objectives.

Plan	Number of objectives reviewed	Percent of unmeasurable objectives
1	129	83
2	a/162	75
3	a/115	50
4	123	48
5	19	68
6	16	6

a/We reviewed all the objectives contained in plans 1, 4, 5, and 6. Because of the large size of plans 2 and 3, we reviewed the objectives in selected chapters that were considered by HSA officials to be representative of the entire plan.

Further, we estimate that about 56 percent of the objectives in HSPs nationwide are unmeasurable. 1/

1/All estimates based on our statistical sample are at the 95-percent confidence level. Our estimates, with their associated sampling errors, are presented in appendix III.

HHS' December 1976 guidance is specific in requiring measurable objectives, as shown in the following excerpt.

> "Objectives are quantitative statements of what should be achieved within a specified time period. * * * An example of an objective is 'to reduce infant deaths per 1,000 live births to 12 by 1981.'"

Our review of the above excerpt suggested that it contained three important factors for establishing whether an objective is measurable. An objective should be (1) specific--it must identify what should be achieved, (2) quantified--the desirable achievements must be in numerical form, and (3) time oriented--time frames must be established for accomplishing it. Examples of measurable and unmeasurable objectives follow:

Measurable objectives:

--By 1982, at least 60 primary care physicians per 100,000 population should be available within the health service area and each of its subareas.

--By 1980, the health service area should have at least 235 placements in day-evening treatment programs (mental health).

Unmeasurable objectives:

--Consumers and providers should be motivated to help contain health care costs.

--By 1985, the number of physician extenders (e.g., nurse practitioners, physician assistants, and nurse midwives) to meet established professional standards should be substantially increased.

We believe that the first two objectives are measurable because the desired achievements are specific, quantified, and time oriented--the objectives state what the minimum supply of primary care physicians and treatment program placements should be by a specific date. The third objective is unmeasurable because it is unspecific as to what is meant by motivating consumers and providers to help contain health care costs. The fourth objective is unmeasurable because the desired achievement--an increase in physician extenders--has not been quantified.

Too many objectives

HHS guidance states that the overall planning time frame should be at least 5 years and should be the point in time when the plan objectives are anticipated or projected to be achieved.

For the six plans we reviewed, three contained no indication of the time frame covered, two implied it was a 5-year period, and one stated clearly it was a 5-year period.

As shown in the following table, four of the six plans we reviewed contained, in our opinion, many more objectives than could be accomplished in 5 years or any reasonable time period. 1/

Plan	Number of objectives
1	129
2	587
3	238
4	123
5	19
6	16

HHS guidance also states that objectives should be presented for goals that have been identified as high priority. The four HSAs with large numbers of objectives had not followed HHS guidance requiring HSAs to place priorities on goals and develop objectives for only high-priority goals. HSA officials said that, since HHS did not enforce conformance with the guidelines, it was easier to develop objectives for all goals.

One HSA official told us that the HSA members had difficulty in agreeing on which goals would have priority because members (1) represented various regions within the HSA, (2) had trouble determining which regional needs were most important, and (3) were reluctant to risk alienating members. As a result, the HSA developed objectives for all goals in the HSP.

Questionable objectives

HHS provides the following guidance concerning what should be considered an objective.

> "Generated from the goals contained in the HSP objectives express particular levels of expected achievements in health status or health systems by a specific year."

1/Our statistical sample was directed at evaluating the adequacy of the development of goal packages and did not provide information on the number of objectives in other plans.

The table below shows that five of the six plans contained many actions that may be inappropriately included as objectives in light of the HHS guidance.

Plan	Percent of inappropriate objectives
1	53
2	43
3	16
4	56
5	47
6	6

Also, based on our statistical sample, we estimate that about 19 percent of the objectives in HSPs nationwide may be inappropriate.

HSAs had established many objectives that concerned activities associated with further development of the HSP, such as conducting studies or gathering data, rather than being quantitative statements of desired changes in health status or the health care system. Although studies are necessary and important, they are only the first step in developing a specific HSP objective as defined by HHS guidance. Including such activities results in a health plan that has as its broad goals more planning rather than identifying necessary improvements in the health care system or health status as called for in the guidance.

The example below shows a goal and five objectives that represent studies to further develop the HSP:

> Goal: Medical surgical and pediatric beds should be reduced for hospital market areas identified for such action.
>
> Objective 1: A study should be conducted by October 1980 to analyze factors underlying use of inpatient services by residents of comparatively high use areas.
>
> Objective 2: A study should be conducted by October 1980 to identify and quantify factors that will affect the future need for inpatient services in the State.
>
> Objective 3: A study should be conducted by June 1980 to determine desirable occupancy rates by service by hospital size.
>
> Objective 4: Acute care bed needs should be determined by January 1981.
>
> Objective 5: Studies of consolidations of services potentials should be completed by April 1982.

Objectives are unattainable
or unrealistic

Also during our review of the goal packages in our statistical sample, we noted that a number of the objectives in HSPs were unattainable or unrealistic because they were broad or national in scope and related to problems, such as reducing cancer mortality, that were already being addressed nationally.

For example, the following goal and objectives were contained in one HSP in our statistical sample:

Goal: The death rate due to cancer should not exceed 113.5 deaths per 100,000 population and disability due to cancer should be reduced.

Objective 1: Reduce the incidence of death from cancer from 126.1 to 113.5 per 100,000 population by 1984.

Objective 2: By 1983 increase the number of arrested cancer cases to 50 percent of those treated--current level is one in three.

We question whether a local health planning organization could have such a significant impact on a difficult national health problem and whether a community benefits much from local planning efforts that address such broad national problems. We believe that the HSPs would be more useful if they focused on and addressed a few important local health problems whose solution is attainable with the resources available to the local public and private health service organizations that must ultimately implement the plan.

Recommended actions were
missing or poorly developed

In the six plans reviewed, overall, about 9 percent of the objectives had no recommended actions, and about 41 percent of measurable objectives had poorly developed recommended actions (i.e., carrying out the actions would not accomplish the objective). In our statistical sample, we examined all objectives and estimated that 26 percent of objectives had no recommended actions and 27 percent were poorly developed. The other 47 percent were either adequately developed or the data available were not sufficient to make a determination.

HHS guidance states that recommended actions

"* * * are a comprehensive collection of proposed changes in health and other community systems aimed at achievement of health status and health systems goals and objectives. They describe the

broad actions which were selected after consideration of possible alternative means of improving health and health systems performance to desired levels.

"The descriptions of such actions should include the alternative actions considered and not chosen and the basis for the decisions; the expected impact that selected actions will have in terms of improving health and the performance of health systems; the locus of responsibility for carrying out actions; and the types of services to be affected, the facility types involved and the population groups or geographic areas affected."

HSA officials gave varying reasons for poorly developed or missing recommended actions. According to an official at one HSA, the board, in preparing the plan, emphasized describing the health care system rather than establishing well-developed goals, objectives, and recommended actions. At another HSA, the assistant director said little emphasis was placed on developing recommended actions for the HSP because the board was primarily concerned with developing adequate recommended actions for objectives that would be addressed in the AIP.

Two examples of poorly developed recommended actions follow:

(1) Objective: By 1980, an experimental, long-term housing facility should be established for late stage alcoholics.

Recommended action: Support the State office of alcohol and drug abuse prevention's efforts to establish one long-term housing facility.

(2) Objective: By 1983, the infant mortality rate should not exceed 10 deaths per 1,000 live births in any planning area in the county.

Recommended action: At this time, prevention-oriented prenatal education and care, such as genetic counseling, amniocentesis, and nutrition, are usually available to selected providers and to consumers by referral. These services should become readily available to all providers and consumers.

In both examples, the recommended actions were not strategies for achieving the objectives. In the first instance, it is unclear what is meant by the term "support"--does the HSA consider mentioning the need for the facility in the plan as sufficient support, or does the HSA intend to lobby or take other actions to get the project underway? The latter example provides only that certain services should be readily available without detailing how this should be done.

The following example shows a recommended action that we believe was adequately developed.

> Objective: To increase immunization levels for diptheria, polio, measles, and rubella among children to 95 percent by 1983.
>
> Recommended actions:
>
> 1. The department of health and the board of education should conduct vigorous programs of public education on the importance of immunization.
>
> 2. All preschool programs receiving direct or indirect Federal funds should assure that all enrolled children are immunized.
>
> 3. The department of education (and local schools) should continue to enforce existing regulations on immunizations and expand their followup of children who have not been immunized.

In this example, the HSA had assessed that previous low immunization levels indicated that parents were either unaware of the importance of immunization or that existing immunization services were inaccessable. The recommended actions were specific and adequate based on the assessment of the problem.

Inadequate or nonexistent resource requirements

For the six plans reviewed in detail, three HSAs had not developed any resource requirements and another had developed very few. One of the other two plans had resource requirements specified for only about one-third of recommended actions, while the other plan had resource requirements for all recommended actions. Based on our statistical sample, we estimate that only 20 percent of objectives in all plans nationwide had recommended actions with adequately developed resource requirements.

HHS guidance provides that resource requirements should include:

> "* * * at a minimum, requirements for changes in facilities (including where appropriate the type and number of beds), manpower, and financing. Where feasible, resource requirements should also include estimates of those resources necessary to achieve desired changes in other, nonmedical, community systems."

Resource requirements are developed essentially to show the cost of implementing each recommended action. However, one HSA director said it would be difficult to determine the cost impact of each recommended action without further HHS guidance. The planning directors at two other HSAs said their HSPs contained far too many recommended actions to develop meaningful resource requirements; they said the HSAs will not be able to develop adequate resource requirements until many objectives and associated recommended actions are eliminated from their plans.

Example of an inadequately developed HSP

In July 1978, HHS fully approved this HSA after approval of the first HSP. The HSA amended its HSP. The amended plan had more than 1,000 pages and 14 chapters, containing 303 goals, 587 objectives, and 837 recommended actions. Because of this plan's size, we reviewed the three chapters selected by the HSA director as being the best developed. These chapters dealt with ambulatory, acute, and long-term care issues. Despite HHS guidance, the HSA did not set priorities for the goals and developed objectives for almost all of them. The three chapters include 79 goals, 216 objectives, and 384 recommended actions. We found that

--162 of the 216 objectives (about 75 percent) were unmeasurable;

--94 of the 216 objectives (about 43 percent) were improper because they concerned plan development activities rather than changes in health status or the health care system;

--22 of the 216 objectives (about 10 percent) had no recommended actions, and 24 of 54 measurable objectives (about 44 percent) had poorly developed recommended actions in that their achievement would not substantially accomplish the objective; and

--378 of the 384 recommended actions (about 98 percent) had no resource requirements.

The HSA's director agreed the HSP was unrealistic. He said that the various groups and individuals that participated in developing the plan wanted their interests and concerns specifically addressed in terms of goals and objectives. He characterized the plan as a "wish list" in that it describes the health system that the HSA would like to see created in the area if everything desirable could be accomplished. At the conclusion of our work, the director said that the HSA had no plans to significantly reduce the number of goals, objectives, and recommended actions because of the many pressures that operated against large reductions, such as the desire (1) not to "turn off" those who have done the work and (2) to appease those who strongly believed their projects should appear in the plan.

HHS CITES IMPROVEMENTS IN PLANS

The Bureau of Health Planning reviewed HSPs during 1978 and identified a number of problems--most of which were discussed above in our assessment. The Bureau found, among other things, that the plans often had not:

--Clearly identified the health status and health systems problems or the goals, objectives, and resources required to resolve these problems.

--Limited the number of objectives as plans included more objectives than could be achieved and frequently failed to identify their priority objectives.

--Expressed objectives in quantifiable terms, thereby precluding measurement of progress toward their achievement.

--Clearly specified resource requirements to achieve goals and objectives.

--Effectively used available data, eliminated technical jargon, and limited the length of plans.

In response to these problems, the Bureau revised its plan development guidelines in February 1979, highlighting the need for improvements in these areas. A Bureau official told us in April 1980 that he believed the plans currently being reviewed have made substantial progress in addressing the problems.

The Bureau has given HSAs until March 1982 to develop revised HSPs, which will be revised every 3 years rather than annually. The Bureau expects that, once these first triennial plans are established, subsequent revisions will reflect a more careful and thoughtful analysis of the health care system. The Bureau believes, however, that a field as embryonic as health planning must be given more than a decade to develop.

HHS NEEDS GREATER INVOLVEMENT WITH HSAs DURING PLAN DEVELOPMENT

In the preceding section we discussed the deficiencies that resulted from plans not being developed in accordance with HHS guidance. However, we believe that many of the deficiencies could have been identified early and dealt with if HHS had greater involvement with the HSAs during the plan development process.

The Bureau of Health Planning is responsible for issuing plan development guidance and assessing the adequacy of HSPs. The 10

HHS regional offices are responsible for monitoring HSAs' day-to-day performance in carrying out their functions under the act--including developing HSPs. Although the Bureau issued adequate and timely guidelines for developing the plans, the regional offices generally did not monitor that development.

For the six HSPs included in our review, HHS' monitoring consisted of reviewing the final HSA approved plan or a completed draft, rather than working continually with the HSA during the development stages to assure that the plan met HHS requirements. Many HSA officials said HHS never stressed the importance of developing plans in conformance with the guidance. Further, they said HHS visits were infrequent and concentrated on subjects other than developing the HSP. The planning director at one HSA said that, although a draft of each chapter was submitted separately to HHS, the HSA never received a single comment on the drafts. Yet we found that this HSP deviated significantly from HHS guidance.

We believe that plan deficiencies could have been reduced if HHS (1) had greater involvement with the HSAs during the plan development process and (2) required conformance with its guidance. As discussed in chapter 1, HSPs were developed through a lengthy, dynamic process that involved many competing interests and extensive community participation by citizens, local governments, professional organizations, and consumer and other interest groups--as well as efforts by the professional staff. As a result of the lack of involvement during the process, HHS first commented after the plans were fully developed--too late to effect meaningful changes.

Officials at three HHS regional offices told us that monitoring has been hindered by staffing problems and lack of headquarters guidance. One region's program director said that, because of insufficient staff, monitoring has concentrated on planning agencies with serious problems. In another region, the program director said inadequate headquarters guidance and lack of regional staff expertise in health planning hindered monitoring efforts; in the third region, the program director cited the lack of headquarters guidance on the expected extent and scope of regional office monitoring.

IMPLEMENTATION OF PLANS HAS BEEN SLOW

HSAs are responsible for developing an annual implementation plan which shows the short-term (1 year or less) objectives for achieving, or moving toward achieving, the HSP objectives. The HSAs that we visited had placed little emphasis on implementation, and most HSAs had accomplished few AIP objectives. HSA officials said their major effort has been revising and expanding the HSPs rather than implementing them.

As mentioned earlier (see p. 17), the health planning amendments of 1979 amended the act by requiring that HSPs be revised every 3 years rather than annually. The new 3-year planning cycle is expected to enable HSAs to devote more time to implementing the HSP rather than continually revising it. We believe that the AIP has little meaning until the HSP is sufficiently developed to provide an adequate basis for implementation. Once the HSP becomes an effective document, HSAs should then actively participate in implementation.

HSA officials believe that the HSAs cannot be held responsible if the objectives in their plans are not implemented. They said the act gave HSAs significant responsibilities, but very little authority to carry them out. For example, one HSA director said a cost-containment objective in his HSP requires reducing a specific number of hospital acute care beds by 1983. However, the HSA has no authority to require hospitals to close unnecessary beds--it can only encourage them to do so. For this reason, the director believes the HSA cannot be held accountable if the desired reduction in acute care beds does not occur. HSA officials told us that, because the HSP is a community document, it is the community's responsibility--not the HSA's--to implement the plan.

CONCLUSIONS

Despite substantial resources and extensive community effort, the HSPs that have been developed to date by HSAs are not adequate. Substantive deficiencies existed in the plans' stated objectives, the recommended actions for accomplishing those objectives, and the resource requirements for carrying out those actions. As a result, the plans did not represent a well-developed framework for making needed improvements in the health care system. Specifically, often we found that:

--Plan objectives lacked measurability, which limited the ability to assess the progress being made toward accomplishing them.

--Plan objectives were not limited to priority goals, and there were many more objectives than could be accomplished within a reasonable time frame.

--Recommended actions for accomplishing the objectives were nonexistent or poorly developed.

--Resource requirements (personnel, facility, and financing costs) for implementing each recommended action were unspecified or inadequate.

Also, many of the objectives were questionable because they (1) concerned further planning, which was not appropriate according

to HHS' definition of an objective, and (2) were unattainable or unrealistic in what they sought to achieve through local community resources.

The plans' inadequacies are attributable to HSAs' failure to follow HHS guidance when developing plans, some HSAs' inclination to satisfy the perceived needs of those who participated in the plan development process, and insufficient HHS involvement with HSAs during the plan development process.

HHS has taken some steps to improve the guidelines for developing plans, and the frequency with which plans will have to be developed has been reduced from annually to every 3 years. We believe this is a step in the right direction. However, we also believe that greater recognition must be given to the fact that developing an HSP is a lengthy, dynamic process that attempts to meet the needs of many organizations with diverse interests and involves the participation of many individuals and groups. We believe that, if HHS is to provide meaningful input to the plan, it must actively work with the HSAs during the plan development process (i.e., before the results of the community process are solidified into a written document).

Finally, we believe that, when the plans have been adequately developed, HSAs should actively pursue plan implementation through appropriate public and private health organizations.

RECOMMENDATIONS TO
THE SECRETARY OF HHS

To improve the quality of health systems plans, we recommend that the Secretary:

--Assess the adequacy of the latest health systems plan at each HSA.

--Require HSAs to revise inadequate plans so that such plans (1) concentrate on a few significant objectives that can be achieved in a reasonable time frame, (2) specify a strategy for and organizations for accomplishing the objectives, and (3) identify the resources needed to carry out the objectives.

--Actively work with HSAs during the development of future health systems plans to ensure that future plans do not contain the deficiencies currently existing.

--Require HSAs to actively pursue the implementation of health systems plans and annual implementation plans after plans are determined to be consistent with HHS guidance.

AGENCY COMMENTS AND OUR EVALUATION

In a draft of this report, we proposed that HHS clarify guidance to HSAs regarding the time period covered by HSPs. HHS did not concur and responded that past and present guidance clearly indicates that plans are to cover a 5-year period. (See app. I.)

Our reexamination of the HHS guidance showed that its language directed that plans cover at least a 5-year period. Also, as discussed on page 11, of the plans examined during our review, only one stated it pertained to a 5-year period, two implied a 5-year period, and three gave no indication of the time period covered. Our main purpose in making our proposal was to minimize the extent to which open-ended HHS guidance was contributing to the large number of objectives in the plans we reviewed. Because HHS has concurred in our recommendations that it assess the adequacy of the latest HSPs and require HSAs to revise inadequate plans, we have deleted our proposal regarding the time period from our final report.

HHS concurred in our first two recommendations, stating that current Department policies require the continuous assessment and monitoring of HSPs and the revision of inadequate ones. Further, HHS commented that HSAs are required to revise their plans on an accelerated schedule when serious deficiencies are found. While HHS policies require assessment and monitoring of HSPs and revision of inadequate plans, we found little evidence during our review that these policies where being carried out. Therefore, our recommendation to review and monitor HSPs and expedite correction of deficiencies needs to be implemented.

HHS did not concur in our recommendation that it actively work with HSAs during the development of future HSPs. HHS commented that the Congress clearly intended for these plans to reflect local choices about the desired form of their health care systems made through an open process in which national priorities are considered. We are not recommending that HHS make decisions about the content of the plan, but only that HHS monitor the development of plans to assure that HSAs follow prescribed guidance. We believe that (1) HHS involvement with HSAs during plan development would better ensure that future plans do not contain the deficiencies currently existing and (2) such involvement need not preclude the plans from reflecting local needs and choices. In our opinion, in the current process, when HHS comments after plans are fully developed, it is too late to effect meaningful changes. Once the HSA has demonstrated the ability to develop a meaningful plan, HHS' role during plan development could be minimal.

HHS also agreed with our recommendation regarding HSAs pursuing implementation of their plans but disagreed with the contention that implementation needs to await substantial additional plan development efforts. HHS stated that agencies have begun to seek implementation, that this effort needs to be increased, and that current funding levels make it difficult to accomplish broad scale plan development activities and plan implementation. Consequently, HHS seeks those improvements that relate to high-priority goals and objectives but does not stress great detail. HHS contends that this approach allows agencies to concentrate their scarce resources on implementation activities. We believe that the AIP cannot be a meaningful document unless it is based on an adequately developed HSP. This report shows that many HSPs do not provide an adequate basis for implementation. We believe that it is of questionable value for HSAs to expend time and resources to implement programs or initiate activities that address objectives that may not be of a high priority. For this reason, we continue to believe that HSAs should not pursue plan implementation until their HSPs are adequately developed.

CHAPTER 3

THE CONGRESS AND HHS NEED TO CLARIFY

PLANNING RESPONSIBILITIES IN STATEWIDE HSAs

The process the act established for developing health plans is inappropriate for the 13 States that have established a single health systems agency for the State (statewide HSA). Normally, the State agency and statewide council have the role of consolidating various HSPs of the State into a State health plan. Since there is only one HSA in these States (and only one HSP), the consolidation role does not exist. Therefore, as a practical matter, the act's provisions result in HSAs and statewide councils (assisted by State agencies) duplicating the plan development process by each preparing a health plan for the same geographic area--the entire State.

Although the statewide HSA situation has been an issue of considerable attention, HHS has provided little guidance addressing the special problems in developing health plans in these States. In four of five States visited, the health planning agencies had not established arrangements to deal with the situation, and the roles assumed by HSAs and State agencies varied widely.

We believe that the health planning program could be improved if the Congress would amend the act to permit one health plan in these States and if HHS would take aggressive action to clarify planning responsibilities.

THE EXISTING HEALTH PLANNING PROCESS IS INAPPROPRIATE FOR STATEWIDE HSAs

The process specified in the act for developing health plans is not appropriate in the 13 States with statewide HSAs. The HSA is required to prepare and implement an HSP for its geographic area. The statewide council develops a State health plan based on the various HSPs developed within the State. The State agency assists the statewide council by consolidating the various HSPs into a preliminary State health plan. In States with a statewide HSA, the consolidation role for the State agency and statewide council does not exist, and except for the addition of programs specifically relating to State government, the two plans--the HSP and the State health plan--should be similar. In short, HSAs and the statewide council (assisted by the State agency) prepare health plans for the same geographic area--the entire State.

Inherent problems in defining roles and relationships of the HSA, State agencies, and the statewide council in States with statewide HSAs have been an issue of considerable attention over

the past 3 years. An earlier GAO report 1/ and an HHS consultant's report evaluated the statewide HSA situation and made specific recommendations for improving it. In addition, two national associations representing health planning agencies testified before the Congress on the problems in States with statewide HSAs and presented possible corrective actions.

GAO report identifies statewide HSA issue

Between November 1976 and June 1977, we reviewed the progress being made in implementing the health planning legislation in several statewide HSAs and found that the roles of HSAs and State agencies needed to be clarified. Some statewide HSA and State agency officials were concerned about potential conflicts and duplication because of similar responsibilities. HHS had done little to help statewide HSAs and State agencies deal with the situation. In our earlier report, we recommended that the Congress amend the act to allow States with statewide HSAs to have only a State agency (section 1536 option) and require all other States to have at least two HSAs. If the Congress chose not to amend the act, we recommended that it clarify the responsibilities of HSAs and State agencies in these States. In commenting on our report, HHS agreed that these States were having problems and said that it was reviewing a consultant's report on the issue.

Consultant affirms statewide HSA concept

A consultant reviewed the implementation of the act in statewide HSAs and section 1536 States. The consultant's report, issued in January 1978, strongly suggested that the statewide HSA structure was workable, even though the HSP and State health plan were very similar documents focusing on the same statewide area. The consultant reported that the health planning agencies did not clearly perceive the distinctions between the two documents. The consultant believed that the situation could be improved by HHS guidance requiring written agreements for plan development between the HSAs and State agencies. Without such agreements, the consultant believed that duplication of effort was possible and that confusion would remain about differences between these documents.

Two private associations testify on statewide HSA issue

The National Association of Single State Agencies, an organization representing health planning agencies in States with statewide

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1/ "Status of the Implementation of the National Health Planning and Resources Development Act of 1974" (HRD-77-157, Nov. 2, 1978).

HSAs, was organized to support the statewide HSA concept and to help member agencies implement the act. During testimony in February 1978, this organization urged the Congress to continue the act's flexibility and to discourage the standardization of the health planning agencies in States with statewide HSAs. It was believed that these agencies should be given the opportunity to develop relationships to fit each State's unique needs. In October 1979, the head of this organization told us that HHS had done little to resolve the problems of statewide HSAs and that the need still existed to clarify the respective roles and responsibilities of the health planning organizations.

During congressional testimony in March 1979, the American Health Planning Association presented a proposal for resolving the statewide HSA situation. Among other things, the Association proposed that the statewide council, in consultation with the Governor, define specific roles for the HSA and the State agency--provided the roles involved functions already authorized by the act. The Association opposed amending section 1536, which would allow more States the option of having only a section 1536 State agency. The Association wanted to avoid disrupting existing working relationships, to encourage cooperative planning, and most importantly, to allow the HSA, State agency, and statewide council to determine roles that best fit each State's needs.

HHS HAS PROVIDED MINIMAL GUIDANCE TO STATEWIDE HSAs

In implementing the act, HHS developed regulations and issued guidelines to help HSAs and State agencies perform their functions properly. These regulations and guidelines have not adequately addressed the statewide HSA issue. The only reference to the issue is in the State health plan guidelines, which say that health planning organizations (HSAs, State agencies, and statewide councils) should work out their individual roles and responsibilities.

As mentioned in chapter 2, HHS issued guidelines for developing HSPs in December 1976 and revised them in February 1979. Regarding coordination in developing health plans, the guidelines state that the HSA shall comply with the statewide council's guidance for preparing the HSP to assure the feasibility of aggregating the various HSPs within the State into the State health plan. The roles and responsibilities of the HSAs, State agencies, and statewide councils in States with a statewide HSA are not mentioned.

Guidelines for developing the State health plan, issued by HHS in August 1978, recognized the need for modifying the plan development process in statewide HSAs. The guidelines provided that the process should initially focus on establishing appropriate roles and responsibilities and on resolving coordination problems in statewide HSAs. However, specific roles were not provided. The guidelines state that:

"Without effective coordination among the SHCC [statewide council], SHPDA [State agency], and HSA, an overlapping of planning efforts is probable.

"In general the HSA should provide a greater focus on regional and non-state program planning while the SHPDA concentrates principally on areas of State Government activity and support in the health sector.

"Each State agency in a single HSA State should design its State health planning process in conformance with the principles set forth in Federal guidelines concerning the development of the HSP/AIP taking into account the needs of various areas within the State. There should be coordination throughout the planning process to avoid duplication and ensure consistency and compatibility."

In the States that we visited, HHS monitoring and technical assistance efforts did not clarify the various roles and responsibilities. The HHS regional offices neither addressed the statewide HSA issue nor assured a coordinated program for developing health plans in these States. Instead, HHS dealt with the HSA and State agency as separate entities when reviewing health plans. In one region, an HHS official said that the regional office has attempted to assist these organizations, but that they are seeking specific written guidance on how the program should work in statewide HSAs; the law specified two separate health plans and did not distinguish between statewide HSAs and multi-HSA States.

PLANNING IN FIVE STATEWIDE HSAs VARIED WIDELY

Without specific guidance, HSAs and State agencies in the five States with statewide HSAs visited have developed their own roles. In one State, the HSA and State agency succeeded in establishing a cooperative program, while in four other States, no lasting coordinated program emerged. In three of these four States, the HSA and State agency initially established agreements for joint preparation of one health plan for the State, but joint planning did not last because HHS wanted these organizations to separately meet their own requirements. While HSAs and State agencies met the act's requirements by developing separate health plans (the State health plan was often based on the HSP), the roles assumed by HSAs and State agencies varied widely.

HSA and State agency officials cited a need to better define roles of health planning organizations in States with statewide HSAs. In fact, two States believed it was pointless to develop two separate plans and specifically requested HHS to allow them

reverse the roles and responsibilities of the HSA and the SHPDA. * * * Also, the format of the plans is not the same. Each planning entity developed plans which are difficult, if not impossible, for the SHCC to coordinate."

The statewide council decided to review the feasibility of altering the plan development functions of the HSA and State agency. The decision was made primarily because of the statewide HSA situation--including the political environment, organizational structure, and duplication of efforts between the two agencies. At the statewide council's direction, the State agency submitted a proposal to HHS calling for the development of a single, or "master," health plan for the State. The proposal specified that, after the master health plan was completed, separate summaries would be developed to meet each agency's requirements under the act. In October 1979, HHS had serious problems with the concept of a single health plan and wrote the State agency:

"The law is specific on the requirements for two plans, i.e., HSP/AIP and SHP. The recategorization of these into summary documents culminating in the 'Master Health Plan' does not alleviate our concerns. We would strongly recommend that this be clarified and the clarification insures consistency with legislative intent."

In summary, the State had an uncoordinated health planning program, and HHS, because of the act's requirements, opposed the State's efforts to resolve the problem.

Statewide HSA 2

The Governor originally requested HHS to designate it a section 1536 State; however, HHS determined that it did not qualify. Subsequently, the State legislature created, by statute, a nonprofit public benefit corporation to be the HSA and designated the agency of human services as the State agency. These two agencies (which are closely linked because the HSA's board of directors also serve as the statewide council) have done an effective job in cooperatively implementing the health planning act.

Although no written agreements were developed, HSA and State agency directors believe that the intent of the State legislature and Governor was that the two planning agencies cooperate with one another. Consequently, the HSP was developed jointly by the agencies. Two of the State agency's planning staff work in the HSA's office space, and the planning staffs of both the HSA and State agency participated in developing the HSP. The preliminary State health plan consisted of the HSP with additions concerning State health programs and policies. HHS reviewed and accepted the HSP and preliminary State health plan in the summer of 1979.

to prepare one health plan for the State to satisfy the act's requirements. HHS denied these requests, noting that the act specifically requires both an HSP and a State health plan.

Our review of the adequacy of HSPs (see ch. 2) included two plans prepared by statewide HSAs. Whether the statewide HSA situation has had a significant negative impact on developing adequate health plans is difficult to determine. We found that HSPs, whether prepared by statewide HSAs or HSAs in multi-HSA States, have substantive deficiencies; as a result, they are difficult to use as a guide for improving the health care system.

Following is a summary of how health planning has been carried out in three of the five States we visited. These examples illustrate the wide variance in the roles assumed by HSAs and State agencies. In the first example, the HSA's HSP was basically oriented toward health facilities, while the State agency's State health plan emphasized health status--and the statewide council believed coordinating the documents was impossible. In the second example, the HSA and State agency appear to have effectively coordinated the development of their health plans, while in the last example, the HSA had performed most of the State's health planning activities.

Statewide HSA 1

In February 1977, the HSA and State agency agreed to develop a single plan to meet the requirements of an HSP and a State health plan. The HSA and State agency believed that close coordination was needed to avoid duplication. The staffs of both agencies participated in drafting and revising the various components of the single plan, which was considered to be the original HSP. After its completion, the joint planning ceased because HHS would not accept a single plan to meet the needs of both agencies. The HSA revised the HSP, while the State agency began to prepare a preliminary State health plan. According to the State agency director, the State agency also wanted to establish its own identity since the HSA had created the image that it was the health planner for the State. Because the HSP dealt with facilities, the State agency developed a State health plan that emphasized health status.

In October 1979, the State agency summarized the above evolution of the plan development process as follows:

> "First, it was determined that the HSA and the SHPDA would collaborate in developing a HSP which was basically systems (health facilities) oriented.
>
> "Second, the SHPDA developed a SHP [State health plan] which emphasized health status. The evolution of this plan development process proved to

HSA and State agency officials said that issuing two separate health plans for the State is pointless. Further, the public becomes confused about differences between the two documents. In October 1979, the State agency requested HHS approval to develop and issue a single health plan for the State. HHS denied the request in December 1979, noting that the law is very specific in defining and describing the functions of the HSA and State agency. Although HHS agreed that coordination and cooperation could avoid unnecessary duplication, it said there must be some leeway to allow the HSA to produce independent recommendations.

Statewide HSA 3

Since July 1976, this HSA has developed three HSPs with little or no assistance from the State agency, while the State agency independently developed the preliminary State health plan. The preliminary State health plan consisted simply of the HSP with some limited data on various State health programs and budgets. HHS found the preliminary State health plan unacceptable.

The HSA's director believed that HHS should provide guidance defining the roles of the planning agencies in statewide HSAs, but also believed the State agency's negative attitude toward health planning was the major cause for delaying the progress of health planning in the State. He claimed the State agency has provided little or no assistance in developing the three HSPs. For example, the HSA depends on the State agency for basic data (such as hospital financial information and utilization of services) necessary for health planning. The State agency has shown little enthusiasm for providing necessary data, especially in a timely manner; as a result, the HSA's progress has been delayed.

State officials said HHS needs to define the roles and responsibilities of the health planning organizations in the State. According to them, neither the statewide council nor HHS has informed the State agency about its proper role in implementing the act. In addition, the statewide council members also serve as the HSA's executive committee and have trouble distinguishing between the two functions. They also have difficulty advising the State agency on its functions. One State official told us that HHS believed it was inappropriate for it to identify the specific tasks the State agency should be performing. Further, he believes the State has received inadequate guidance, and he was confused about how the Federal Government wanted the health planning act implemented in the State.

The HHS regional program director said that little assistance has been provided to the State agency because the region has limited staff and it decided to help the agencies that wanted and used the assistance. According to him, the State agency has little initiative and wants HHS to tell it precisely what to do. He added

that the State agency is understaffed, even though annually it does not spend about $150,000 of the HHS grant.

CONCLUSIONS

The process established in the act for developing health plans is inappropriate in statewide HSAs. The process results in two organizations (the HSA and State agency) duplicating the plan development process by each preparing separate health plans for the same geographic area--the entire State. Neither the act nor HHS has clearly defined the respective roles and responsibilities of these organizations in preparing health plans.

We believe there are two alternatives for streamlining this process and making it simpler and more useful for the States, HSAs, and the public:

1. Permit States with statewide HSAs to eliminate them and adopt the section 1536 approach.

2. Permit the development of a single health plan and clearly define the roles of the statewide HSA and the State agency in preparing that plan.

The first alternative would eliminate the existing confusion about the roles and responsibilities of the statewide HSA and the State agency. However, it would also largely eliminate the community involvement in health planning and might further disrupt the health planning program in these States.

The essence of the second alternative (single plan, clearly defined roles, cooperative effort) would also eliminate the existing confusion and would be more consistent with the spirit of the act, which calls for cooperative planning.

Therefore, we believe that the current structure of the health planning program in these States should be maintained. In our opinion, the benefits derived from eliminating statewide HSAs would not offset the negative effects caused by further disrupting the health planning program.

RECOMMENDATION TO THE CONGRESS

If the Congress decides to continue the health planning program under the same or a similar structure, we recommend that the National Health Planning and Resources Development Act be amended to allow the health planning organizations (HSAs, State agencies, and statewide councils) in States with statewide HSAs to jointly develop one health plan for the State.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary issue regulations and guidelines concerning the implementation of the health planning program in statewide HSAs that would include requiring written agreements between the statewide HSA and the State agency which set forth their respective roles in carrying out the joint planning process.

AGENCY COMMENTS AND OUR EVALUATION

HHS concurred with the intent of our recommendation and stated that forthcoming plan development guidance will require that statewide council planning guidance define HSA and State agency planning roles carefully, and that these roles be reflected in agency work programs and budgets and, where appropriate, in formal written agreements. (See app. I.) In this manner, HHS commented, unnecessary duplication of effort can be avoided without putting these policies into Federal regulations and without requiring the same division of responsibilities in each of these States. However, HHS noted that issuing new Federal regulations may be inappropriate until the President's proposal to phase out the health planning program is acted on. We believe our recommendation is appropriate and should be implemented if the health planning program continues under the same or a similar structure.

CHAPTER 4

PROGRAM IMPACT DIFFICULT TO ASSESS

Health systems agencies were established to improve the health of residents; increase the accessibility, acceptability, continuity, and quality of health services; and prevent unnecessary duplication of health resources. HHS has several completed, ongoing, and planned efforts to assess various functions of HSAs and the impact of the health planning agencies in meeting program goals. HHS officials recognize several significant problems in assessing program impact. The most significant is distinguishing the impact of the health planning agencies from the impact of other organizations, such as professional standards review organizations and State and local governments, which are simultaneously attempting to influence the health care system. Despite the problems, HHS believes that it will be able to assess program impact. We believe that evaluating the impact of the health planning program will be very dificult and may not produce clear and dramatic evidence concerning the effectiveness of health planning organizations.

The results of one evaluation of program impact were presented to the Congress in March 1980. In early 1979, the American Health Planning Association completed a survey that examined one HSA and State agency function--the review of proposed new institutional health services submitted under State certificate-of-need legislation or section 1122 of the Social Security Act. The Association reported that the health planning agencies had disapproved or discouraged proposed capital investment projects totaling $3.4 billion between August 1976 and August 1978. It also estimated that planning agencies had saved the health care system at least $8 for every $1 spent on health planning. Our analysis showed that the $3.4 billion savings estimate was unreliable and, therefore, not an accurate measure of the health planning program's impact.

HHS EFFORTS TO ASSESS PROGRAM IMPACT

In fiscal year 1979, HHS began to assess the health planning program from two viewpoints--performance evaluation and impact evaluation. Performance evaluation assesses how well the planning agencies have progressed in conducting required functions (such as developing an HSP), while impact evaluation measures how well health planning agencies have affected the health care system or health status of the population. Because HSAs and State agencies can carry out their functions effectively without any demonstrable effect on the health care system, assessing program impact is important.

HHS is attempting to evaluate the impact of the health planning program in several ways, such as (1) developing measurable objectives at the national level, (2) developing standards that

address program impact at the individual HSA and State agency level, (3) initiating a performance evaluation program, and (4) contracting for special evaluation studies.

Measurable objectives

HHS is establishing for the health planning program an initial set of measurable objectives, which will be quantitative statements of what should be achieved at the national level within a specified time frame. For example, one objective involves increasing the number of health service areas having attained "acceptable" hospital-bed-to-population ratios. An acceptable ratio is lower than four hospital beds per 1,000 population (as specified in the national health planning guidelines) or a greater amount based on an analysis of the area's unique needs. For this and other objectives, HHS will establish target figures and target dates. As of November 1980, HHS was analyzing comments it had solicited on the objectives. Baseline data will be obtained and updated annually to indicate progress toward meeting the objectives.

Impact standards

The act requires HHS to review the performance of each HSA and State agency at least every 3 years. This review is accomplished mainly by on-site assessments conducted by teams comprised of HHS regional and headquarters staff. Existing standards only assess agency performance--how well the agency has progressed in conducting the functions and requirements of the act. HHS is developing a second set of standards that will address agency impact. Once the new standards are developed, the on-site assessments will include the collection and validation of information relating to the agency's impact.

Performance evaluation program

HHS is implementing a performance evaluation program, which consists of conducting telephone surveys, making site visits to HSAs and State agencies, and developing case studies. A private contractor is training HHS staff on evaluation skills (survey methods, data analysis, case study development) needed to carry out the program. The contractor will help prepare case studies that will address HSA and State agency activities in (1) availability and accessibility of primary care, (2) cost containment, (3) health promotion and disease prevention, and (4) long-term care. HHS plans to make additional studies without contractor assistance. A policy group, consisting of HHS and health planning agency officials, identifies subjects for studies, defines information needs, reviews study results, and develops actions to be taken.

Special evaluation studies

HHS has funded several studies and has planned additional studies by private consultants that will contribute toward an initial national assessment of HSAs. Ongoing or planned studies include such topics as the effects of certificate-of-need programs, the relationship between physical and mental health planning, the ability of health planning agencies to provide information on progress toward national guidelines and national health priorities, the role of HSAs and State agencies in health personnel planning, the review of proposed use of Federal funds, and the role of HSAs in fostering competition in the health care system.

PROBLEMS IN ASSESSING PROGRAM IMPACT

HHS officials recognize the serious problems inherent in attempting to evaluate the impact of a program as complex as the health planning program. They identified a series of factors that severely constrain evaluation efforts, as summarized in the following:

1. Measuring the impact of health planning agencies, apart from the impact due to other entities, is the most severe problem. Professional standards review organizations, State and local governments, health care insurers, Federal agencies, and others are also attempting to influence the health care system.

2. Changes in health status occur relatively slowly (over 5 to 10 years or more) and are difficult to attribute to any action, or series of actions, by a health planning agency or the health planning program. For example, changes in infant mortality may be due to infant and maternal health programs, improved nutrition, better education and housing, or other factors.

3. Health planning agencies have few means of directly affecting the health care system. The agencies do not deliver health care services and thus are unable to add or subtract services. In reviewing applications for certificates-of-need and proposals for use of Federal funds, the agencies must assume a reactive posture in that they can only respond to applications submitted by health care providers. On appropriateness reviews, the agencies have no sanctions or other means of enforcing their recommendations.

4. Health planning agencies have little or no control over the many variables that strongly influence the health care system or the health status of the population--such as individual life styles, developments in the technology of health care, and reimbursement policies by Federal and State government and health care insurers.

5. The data to measure changes in the health care system and health status of the population are not always readily available or accessible to health planning agencies.

6. Wide variations exist in local and State philosophies, priorities, geographic settings, and health care needs. These variations make it difficult to devise a system for measuring program impact.

Despite these difficulties, HHS officials believe that the impact of the planning program can be evaluated, recognizing the limitations inherent in their approaches. They said it may be necessary to infer from limited evidence that the health planning program has contributed to certain effects, rather than to prove that it was responsible for those effects. On certificate-of-need reviews, the officials believe that the direct effects can be measured, because the decisions will directly affect the characteristics and operation of the health care system. However, the ultimate impact of the certificate-of-need decisions on health status often cannot be determined until well after the change in the health care system has occurred.

HHS officials further believe that the key to assessing the impact of the health planning program is identifying realistic objectives and expectations for health planning agency activities and appropriate measures for assessing progress. HHS believes that it has made substantial progress, and it will be placing heavy emphasis on the continued development and implementation of the various efforts as a basis for program monitoring and evaluation.

AMERICAN HEALTH PLANNING ASSOCIATION'S UNRELIABLE SAVINGS ESTIMATE

In early 1979, the Association completed a survey of the impact of the health planning program. The Association reported that planning agencies had disapproved or discouraged proposed capital investment projects totaling $3.4 billion between August 1976 and August 1978. It also estimated that health planning agencies had saved the health care system at least $8 for every $1 spent on health planning. About $2.2 billion of the $3.4 billion related to data developed from responses to a questionnaire that the Association sent to HSAs and State agencies throughout the United States. The other $1.2 billion related to data shown in a consultant's study for Los Angeles County. The Association further estimated that disapproval of the capital investment projects would save at least another $10 billion in related operating costs during the 1980s. The Association's February 1979 report was supplied to Members of Congress and was highlighted by both the Association and HHS during congressional hearings. At the same hearings, HHS officials testified that the Association's survey represents tangible evidence of the impact of these agencies.

We found that the Association's $3.4 billion savings estimate was unreliable and, therefore, not an accurate measure of the health planning program's impact. Specifically, the data supporting the estimate were unreliable because:

--The questionnaire responses from HSAs did not support a conclusion that their actions had actually prevented an unnecessary capital investment of $1 billion in health care facilities.

--The questionnaire was not properly developed, making $1.2 billion of the savings estimate questionable.

--The estimated $1.2 billion savings for Los Angeles County was based on unreliable data from a consultant's study, which were inconsistent with other survey data used by the Association in computing its savings estimate.

Because most survey respondents did not provide useful operating cost data, the Association computed the $10 billion operating cost savings using a ratio of $3 of operating cost savings for every $1 of capital investment saved. Because the Association's capital cost savings estimate was unreliable, we believed the Association's estimate of operating cost savings was also unreliable.

On March 13, 1980, we reported the results of our analysis of the Association's supporting data to the Secretary of HHS (HRD-80-40).

In commenting on our report, the Association took strong exception to our conclusions; however, our analysis of those comments did not change our position. Below is a discussion of 6 of 23 case studies we developed which provide further evidence of the unreliability of the Association's savings estimate.

Case studies

We reviewed 23 projects included in the Association's $3.4 billion savings estimate to further analyze the validity of the claimed savings. For each project, we analyzed whether the health planning agencies had prevented the construction or purchase of unneeded facilities or equipment. The projects were selected to obtain a variety of hospital and nursing home projects that were generally representative of the type included in the Association's savings estimate. The 23 projects represented about $127 million of the $2.2 billion portion of the estimate, which excludes the $1.2 billion covering Los Angeles County.

Our analysis showed that the estimated savings for 17 of the 23 proposals (about 74 percent) were either invalid or greatly overstated. The estimated savings for the 17 projects were overstated

by about $78 million. Our work showed that a project disapproval or withdrawal, in itself, is insufficient evidence for including a proposed project in the savings estimate because various factors influence such decisions and many of these projects reappear in the same or revised form.

The following 6 case studies highlight the nature of the conditions and problems we observed in analyzing the 23 projects.

Project A: Invalid savings of $2.8 million

An application was submitted in January 1977 to build a 120-bed nursing home at an estimated cost of $1.4 million, but it was later withdrawn after the HSA recommended disapproval. In June 1977, the applicant withdrew an amended version of the original application (estimated construction cost of $1,420,000) after the HSA's subarea council had recommended disapproval. The HSA recommendations were based on its policy to follow the State agencies' projected need for long-term care beds developed under the Hill-Burton program.

In July 1977, the applicant submitted a third application for this 120-bed facility also estimated to cost about $1,420,000. The HSA recommended approval of the project based on the area's unique needs--specifically, the high occupancy rates of existing facilities and transportation problems involved in moving patients long distances from their place of residence or other facilities. The State approved the project, and in April 1979 the applicant agreed to build the nursing home.

The Association included the estimated construction cost of the first and second proposals, a total of $2,820,000, in its savings estimate. Since both disapprovals were for a project that was finally approved, we believe that the health planning program did not prevent the construction of a facility, and that the savings estimate was overstated by $2,820,000.

Project B: Valid savings of $465,000

In August 1976, hospital officials applied to lease and install a whole-body computerized axial tomography scanner--commonly called a CAT scanner. The CAT scanner, a complex X-ray machine able to better detect medical problems than standard X-ray equipment, had an estimated cost of about $465,000. The HSA and State agency both denied the application because they believed that the demand would be insufficient to justify it. One CAT scanner had been recently approved for a hospital about 12 miles away. Another CAT scanner, operated by a group of private physicians in

their office, was soon to be operational in an adjacent town. Our analysis supported including the project in the estimate since the CAT scanner was not installed.

Project C: Overstated savings of $9.1 million

In June 1976, an application was submitted to renovate and expand a 190-bed hospital at an estimated cost of about $10.9 million. Ancillary service areas--such as laboratory and pharmacy---needed modernization and expansion. In reviewing the application, the HSA found that the hospital patient load did not conform to the HSA's obstetrical care guidelines. The guidelines recommended 1,100 births per year, while the hospital had only about 300. Additionally, the 24-bed obstetrical unit had an occupancy rate of about 22 percent, while the pediatric unit had a rate of about 50 percent. The HSA believed that the additional ancillary service space appeared to be justified, but that, by eliminating the underutilized obstetrical and pediatric units, the amount of new construction would be decreased. The HSA recommended disapproving the project but encouraged a revised proposal. In January 1977, the hospital withdrew its application before State agency action.

The hospital submitted a revised application in April 1977 with estimated costs of $11.2 million. This proposal called for modernizing and expanding the ancillary services (and included a phase of the project excluded from the original proposal), reducing obstetrical and pediatric services, and reducing the number of hospital beds to 175. The HSA recommended approval of the revised proposal in May 1977, and the State agency approved it in July 1977.

The Association included $10.9 million in the savings estimate representing the disapproved project. Since the revised project was approved, the health planning program did not prevent the expansion of a facility. Since the HSA estimated that the revised project saved about $1.8 million, we believe the savings estimate was overstated by $9.1 million. The hospital's director said that the HSA served the community by disapproving the original proposal because it was not financially feasible for the hospital to provide competent obstetrical services at the existing level of activity.

Project D: Invalid savings of $3 million

In March 1976, an applicant submitted a letter-of-intent to construct a 200-bed nursing home--consisting of 80 skilled and 120 intermediate care beds. The applicant specified only that the proposed nursing home would cost $3 million and have an estimated completion date of March 1978. Having not received any further information, the HSA contacted the applicant in November 1977--about

19 months after receiving of the letter-of-intent--to determine whether he still planned to submit the proposal. The applicant informed the HSA that he no longer intended to submit it, and the project was removed from further review.

In responding to the Association's questionnaire, the HSA listed this project as a withdrawal, and the Association included $3 million in the savings estimate. We did not consider the letter-of-intent to be a valid proposal; thus, we do not believe that the health planning program prevented the facility. Further, HSA officials told us that the proposed nursing home was needed.

Project E: Invalid savings of $2.9 million

In January 1978, this hospital applied to replace its existing 60-bed hospital with a 40-bed facility at a cost of about $3 million. The hospital's architect had concluded that modernization would cost almost as much as a new hospital, while providing fewer improvements. The hospital's decision to build only a 40-bed facility was influenced by the HSP, which showed a need for 40 beds in the county.

After the application was reviewed by HSA staff and three committees, the HSA in April 1978 recommended disapproving the project. The HSA staff believed that the existing hospital should be remodeled because a new facility would be marginally feasible economically. Nevertheless, the subarea advisory council voted by a wide margin to approve the application. However, the program review committee and executive committee separately voted to overturn the subarea advisory council's approval recommendation on technical grounds. Contrary to the HSA's regulations, at the subarea advisory council hearing, the applicant provided certain information not included in the original application. The program review and executive committees did not consider the need for the facility in making their decisions.

On May 25, 1978, the State agency approved the application despite the HSA's recommendation. The State agency informed the HSA that the vote by the subarea advisory council--the committee that had an opportunity to study the application, tour the facility, and hear the public testimony--was heavily considered in making the approval decision. Further, a State agency official told us that the existing hospital was obsolete and that a new hospital clearly was needed. The new facility is under construction and is expected to be completed in January 1981.

Although the HSA's response to the questionnaire indicated that the State agency had approved this project, the Association included the proposed cost of about $3 million in the savings

estimate. Since the project is under construction, we believe there is no justification for claiming a savings.

Project F: Overstated savings of $26.8 million

In November 1976, an applicant proposed to replace an existing hospital and construct an alcoholic and drug rehabilitation center and a primary care-ambulatory care center. The proposed facility, projected to cost about $26 million, included 120 medical/surgical beds, 10 intensive care unit beds, 40 adult psychiatry beds, and 10 adolescent psychiatry beds. An HSA review committee recommended disapproving the project because there was insufficient need to replace the medical/surgical and intensive care unit beds. Underutilized resources at nearby institutions, declining trends in hospital patient days, and the declining population could affect the hospital's ability to attain the projected occupancy rates without reducing other institutions' utilization. In January 1977, the HSA board disapproved the application, and the applicant later withdrew the proposal.

In October 1977, the hospital submitted a $650,000 proposal that would enable it to bring the facility up to the accreditation and life safety code standards. The proposal specified such improvements as installing self-closing fire doors, providing emergency electric power for certain areas, and providing for direct observation of patients in special care areas. Although the HSA wanted to develop long-range plans analyzing alternative roles among the various hospitals in the area, it recommended approval in order to continue services at this hospital. The State agency approved the project in February 1978.

The Association included $52.3 million in its savings estimate for this project--the $26.15 million withdrawal was included in two savings categories. Although the HSA has not precisely defined the hospital needs for the area, we do not believe that it is unreasonable to include about $25.5 million in the savings estimate for this project. This amount represents the difference between the cost of the original proposal ($26.15 million) and the approved renovations ($650,000). Thus, we believe the Association overstated the savings estimate by about $26.8 million for this project.

LIMITATIONS IN USING PROJECT REVIEWS TO MEASURE PROGRAM SAVINGS

Officials at HSAs, State agencies, and HHS regional offices we talked to said that project reviews under section 1122 of the Social Security Act and State certificate-of-need programs could result in savings to the health care system by preventing unneeded projects. However, capital costs represent a simplistic approach to measuring program impact. Through discussions with HHS officials in four regional offices, as well as health planning

officials at eight HSAs and seven State agencies, the following four significant factors were identified which show the limitations of using project reviews to measure program impact or savings.

Operating costs--The most significant factor in reducing health care costs relates to the operating costs of the health facilities. Savings may be greater than the amount of prevented capital investment because operating costs are not incurred on denied facilities. In contrast, over a long period, capital costs of an approved new facility may be more than offset by the difference between operating costs of a new facility and higher operating costs of an older and inefficient facility.

Systemwide costs--The use of capital costs only measures the spending that does not occur directly because of the disapproval decisions. The systemwide costs, such as the cost of alternative forms of care that must be used because of the disapproved project, are not considered. For example, in one State, reducing or restricting the number of nursing home beds is based on the funding and development of alternative forms of care--home health, adult day care, and congregate elderly housing. A State agency official said the State's strategy is to shift resources from institutional to noninstitutional care. He said that this may not result in any savings to the health care system, but will increase the quality of care for the elderly. In summary, although systemwide costs are difficult to measure, an accurate measure of savings requires considering such costs, particularly the expenditures for alternative forms of care.

Deterrent effect--Projects are deterred and savings result by the mere existence of the section 1122 of the Social Security Act and certificate-of-need programs. Such savings are unmeasurable and undocumentable because many applications are never submitted. An effective project review program may experience few project disapprovals--providers would only submit proposals that are consistent with health needs of the area, knowing that unneeded projects will not be approved.

Program costs--Savings estimates do not consider offsetting costs incurred for administering the program and having facilities subject to the review process. In addition to the staff and other costs of HSAs and State agencies to review applications, facilities incur costs in applying for section 1122 and certificate-of-need approval--including in some cases the hiring of consultants to prepare applications. Also, delays in beginning of construction, because facilities are subject to the review process, may also increase a facility's capital cost.

CONCLUSIONS

HHS has several completed, ongoing, and planned efforts to assess various functions of HSAs and the impact of HSAs and State agencies in meeting goals specified in the act. HHS officials

recognize the considerable difficulties in assessing program impact. Despite the problems, HHS believes that it will be able to evaluate the impact of HSAs and State agencies.

The work that we have done in analyzing the Association's savings estimate and in developing information on how HHS is planning to evaluate program impact suggests that making impact evaluations of health planning is very difficult and may not produce clear evidence concerning the successes or shortcomings of health planning organizations.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

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, "Improvements Needed in Developing Health Systems Plans and in Clarifying Planning Roles." 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,

Bryan B. Mitchell
Acting Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED
"IMPROVEMENTS NEEDED IN DEVELOPING HEALTH SYSTEMS PLANS
AND IN CLARIFYING PLANNING ROLES"

GAO Recommendation

To improve the quality of health systems plans, we recommend that the Secretary:

--Clarify the guidance to HSA's pertaining to the time period to be covered by health systems plans so that it is reasonable and specific. GAO's work did not enable it to determine exactly what the time period should be, however, the large numbers of objectives that have flowed from the existing criteria suggest the time period should be limited to a few years.

Department Comment

We do not concur. Past and present Department's planning guidance clearly indicates that Health Systems Plans (HSPs) are to cover a 5 year period. An examination of the Plans' objectives shows that they do adhere to this guidance.

GAO Recommendation

--Assess the adequacy of the latest health systems plan at each HSA,

--Require HSAs to revise inadequate plans so that such plans (1) concentrate on a few significant objectives which can be achieved in a reasonable timeframe; (2) specify strategy for and organization for accomplishing the objectives; and (3) identify the resources needed to carry out the objectives,

--Actively interact with HSA's during the development of future health systems plans.

Department Comment

We concur with the first two parts of this recommendation in that current Department policies require the continuous assessment and monitoring of HSPs and the revision of inadequate plans. In this connection, the Health Systems Agency's (HSAs) are required to revise their plans on an accelerated schedule when serious deficiencies are found.

We do not concur with the third part of this recommendation. We believe that the Congress clearly intended for these health plans to reflect local choices about the desired form of their health care systems made through an open process in which national priorities are considered.

GAO Recommendation

--Stress the importance of HSAs actively pursuing the implementation of health systems plans and annual implementation plans through appropriate public and private health organizations.

Department Comment

We concur with the recommendation in that it is already being carried out as the central theme in all of the Department's policy guidance for the health planning program. However, we disagree with the contention that implementation needs to await substantial additional plan development efforts. The agencies have begun to seek implementation of their plans, and this implementation effort needs to be increased now rather than reduced pending further plan improvements.

The Department's planning development policies are founded on the belief that implementation flows best from a sound plan. If the resources available to the planning agencies are sufficient, we would expect agencies to make substantial broad scale efforts over the next few years in both plan development and plan implementation. But current funding levels for the program, which represent a sizable reduction from prior levels, make this approach not feasible. Consequently, we will continue to seek those improvements which are critical for successful implementation--thorough development of high priority goals and objectives in the plans and development of sound action-oriented Annual Implementation Plans for high priority plan objectives--but not necessarily press for great detail. This approach will allow agencies to take advantage of the less frequent plan revisions permitted by the 1979 amendments to the health planning act (revisions of plans at least every 3 years rather than annually) to concentrate more of their scarce resources on implementation activities.

GAO Recommendation

We recommend that the Secretary of HHS issue regulations and guidelines concerning the implementation of the health planning program in a statewide-HSAs, and require written agreements between the statewide HSA and the state agency which set forth the respective roles of the health planning organizations in carrying out the planning process.

Department Comment

We concur with the intent of this recommendation and forthcoming DHHS plan development guidance will stipulate that Statewide Health Coordinating Council planning guidance should define HSA and State Health Planning and Development Agency planning roles carefully, and that these roles should be reflected in agency work programs and budgets and, where appropriate, in formal written agreements. In this manner, unnecessary duplication of effort can be avoided without putting these policies into Federal regulations and without requiring that the same demarcation of responsibilities be made in each of these states. However, the planning program is scheduled for a major structural change as a result of new budget policies. Therefore, it may be inappropriate to issue new Federal regulations.

SUMMARY OF FEDERAL HEALTH PLANNING EFFORTS

Congressional interest in effective health planning and resources development began in 1946 with the enactment of the Hospital Survey and Construction Act (Public Law 79-725). This act, which established what was commonly known as the Hill-Burton program, authorized grants to States for (1) surveying their needs and developing plans for constructing 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 areawide voluntary health facilities planning agencies. The act expired in June 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 Comprehensive Health Planning programs. The Regional Medical program's purpose was to establish regional cooperative agreements among health care facilities, medical schools, and research institutions. The agreements were intended to educate health care providers about advances in the diagnosis and treatment of heart disease, cancer, and strokes. The Comprehensive Health Planning program provided for grants to (1) States for statewide health planning programs, (2) public or nonprofit private agencies for health planning at the areawide level, and (3) public and other organizations for training, studies, or demonstration projects to plan improvements in the health area. The Regional Medical and Comprehensive Health Planning programs expired upon passage of the National Health Planning and Resource Development Act.

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. Section 1122 of the Social Security Act, as added by the amendments, provided that these agencies approve capital expenditure projects exceeding $100,000. Otherwise, health care facilities and health maintenance organizations would not be reimbursed by Medicare, Medicaid, and Maternal and Child Health programs for depreciation, interest, or return on equity capital. State participation in the section 1122 review program is voluntary.

The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) replaced the Hill-Burton, Regional Medical, and Comprehensive Health Planning programs with a new

national health planning and resources development effort. In October 1979, the President signed into law the Health Planning and Resources Development Amendments of 1979 (Public Law 96-79). These amendments made some changes in the act, but did not make significant changes in the structure or functions of the health planning organizations.

STATISTICAL SAMPLE OF HEALTH SYSTEMS PLANS

METHODOLOGY AND RESULTS

We selected a statistical sample of 200 goals drawn from the latest health systems plan of the 193 health systems agencies that were fully approved as of August 1, 1979. The sample of goals was selected on the basis of a three-part random number--the first part represented the plan, the second represented the chapter within the plan, and the third represented the goal within the chapter. The three-part random number was obtained from a random numbers table. We reviewed the goals as well as the objectives, recommended actions, and resource requirements specified for each of the 200 goals in the sample. Using stratified cluster sample formulas, we computed the results at the 95-percent confidence level.

Our estimates with sampling errors follow for four characteristics of HSPs discussed in this report.

1. HHS guidance requires measurable objectives. Our analysis of HHS guidance showed that an objective is measurable if it is (1) specific--it must identify what should be achieved, (2) quantified--the desirable achievements must be in numerical form, and (3) time oriented--time frames are established for accomplishing it. Is the objective measurable?

	Estimate	Sampling error
	(percent)	
Yes	44.4	6.7
No	55.6	6.7

2. HHS guidance requires that objectives must seek specific changes in health status or the health care system. Objectives that concern plan development activities, such as conducting a study or gathering data, do not qualify as an objective. Does the objective concern a change in health status of people or the health care system?

	Estimate	Sampling error
	(percent)	
Yes	80.7	6.5
No	19.3	6.5

3. HHS guidance requires that each objective have one or more recommended actions--the proposed strategies for achieving the objective. Recommended actions are often poorly developed in that their achievement will not accomplish the objective. Will accomplishing the recommended actions substantially achieve the objective?

	Estimate	Sampling error
	(percent)	
Objectives with no recommended actions	26.2	6.1
Yes	14.1	4.4
No	27.1	6.4
Can't determine	32.7	6.5

4. HHS guidance requires each recommended action to have estimated resource requirements--the personnel, facility, equipment, and financing costs--necessary to achieve the recommended action. Without resource requirements, it is questionable whether the recommended action is feasible. Are resource requirements adequately developed?

	Estimate	Sampling error
	(percent)	
Objectives with no recommended actions	26.2	6.1
Recommended actions with no resource requirements	36.5	6.1
Yes	19.6	6.2
No	15.7	6.8
Can't determine	2.0	1.8

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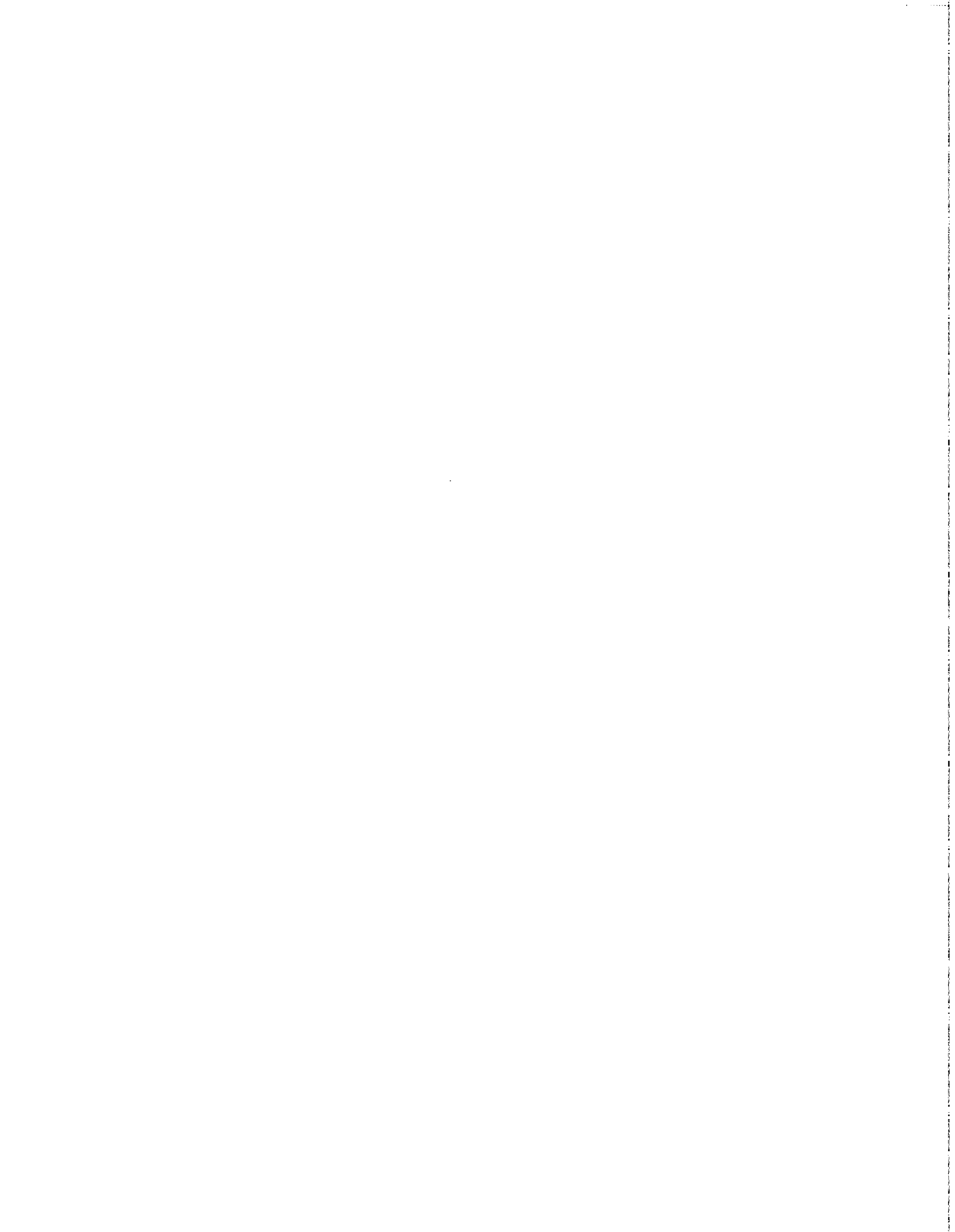

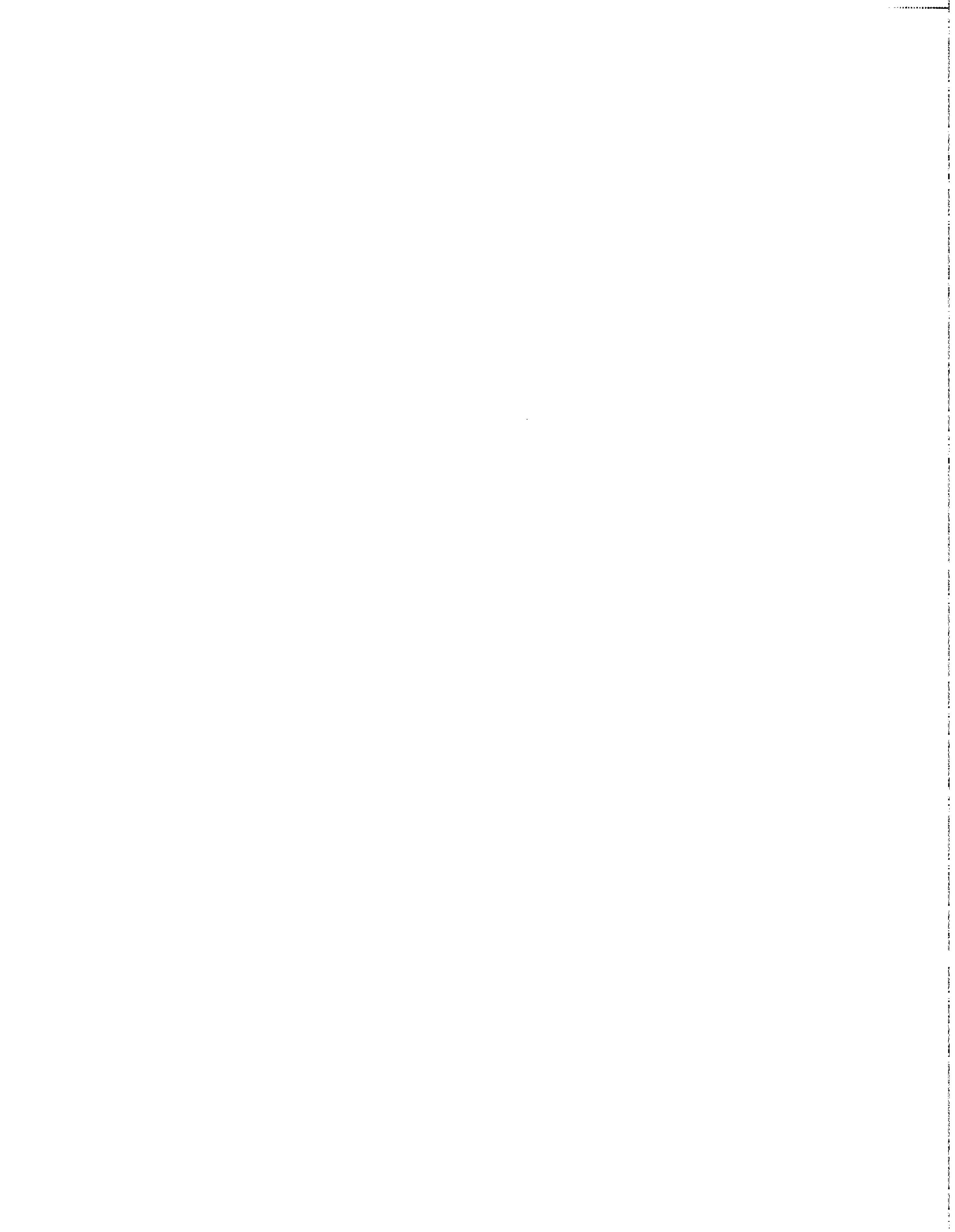

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