Chapter II
A FRAMEWORK FOR STATE HEALTH POLICY
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TOWARD A SOLUTION

The problems and paradoxes in the health care system are neither new nor, in theory, insoluble. They have been the subject of innumerable laws, reports, studies and plans since the 1930s. They have even been mitigated in many instances. What has been missing is consensus sufficient to implement comprehensive, significant change.

The last decade, however, has produced an unprecedented rise in public consciousness of several fundamental and underlying realities:

- Individual behavior, choice and attitude play a major role in the etiology, management and cure of disease, not to mention the promotion of health.
- Resources of the earth are finite—which is not necessarily to say in short supply but simply not infinite.
- The health care system, in its organization, financing and philosophy, has not been concerned with promotion of health.
- Incentives in that system are creating a service too expensive to be universally available in desired amounts.

This Plan is both a product and a herald of such perceptions. Its proposed solutions are not new—but their time is coming.

HEALTH PLANNING: ROLE AND ASSUMPTIONS

The role of health planning in California is to articulate:

- How to protect and improve the health status of all people living and working in the State.
- How to increase the efficiency and effectiveness of health resources in the State.

The California State Health Plan, and any other health plan, must therefore be concerned both with the health status of people and with the production, distribution, organization and financing of health care resources.

Although health status and the health system are usually thought to be related, the connections are in fact complex and for many health problems, not yet demonstrated. This means that effective health planning must be based on four assumptions, which together provide the analytical framework for this Plan.
First, the Plan assumes that health status, or the level of health experienced by an individual or a population, is the product of four related but distinct factors:

- human biology
- environment
- behavior
- health care services.

Figure II-1 shows these factors as a model explaining the origins of health status. This model, which fits contemporary understanding of the etiology and management of highly prevalent, noninfectious disease (heart disease, cancer, diabetes, etc.), has been developing for over 50 years, particularly in the last 20. It was formalized for health planning by Dr. Henrik Blum of the School of Public Health, University of California Berkeley and is currently the basis of health care policy in Canada.

Of these four factors, it is demonstrable that health care services are not the most important (see Chapter III, Issue #1). At the same time, Blum's model implies that an enormous range of social actions has an impact on health status. As this understanding grows, the notion of a "health service" expands. Where "health care" was once synonymous with "medical care," it now encompasses many services and activities unrelated to traditional providers like physicians or hospitals (see Chapter VI, Promotion and Prevention, and Chapter VIII, Long Term Care). The "health resources" of concern to health planning expand similarly as the roles of biology, environment and behavior in influencing health status become clearer.

Having recognized the multiple origins of health status, a second assumption is necessary to facilitate focus on a "manageable" set of phenomena and problems. For purposes of health planning, State policy development and constructive action, the Plan assumes the existence of a "health system," shown in Figure II-2. The elements of the system include the resources needed to produce health services, the variety of services and the results or "outcomes" of having services available.

There are two key points concerning Figure II-2. First is that the health system is itself a subset of human services, including jobs, housing, education, utilities, recreational opportunities and social services, all of which are part of the environment that influences health status and all of which compete for resources used by the health system. Second is that the health system itself produces many outcomes unrelated to health status. Attention to these other outcomes is part of health policy.

The third assumption is that the ultimate task of health planning is to develop a set of policies and actions to influence the character of health care in California over a
FIGURE II-1. Determinants of Health

Adapted from H. Blum... Planning for Health: Development and Application of Social Change Theory, Human Sciences Press, New York, 1974, p. 3.
FIGURE II-2
THE HEALTH CARE SYSTEM

Resources
- Capital
- Operating revenue
- Personnel
- Medical technology
- Education
- Research
- Management
- Legislation

Services/Facilities
- Physicians
- Nurses
- Other health personnel
- Hospitals
- Clinics
- Ambulances
- Skilled nursing facilities
- Other health facilities
- Specialized services
- Other health services

Outcomes
- Utilization of services/facilities
- Employment/provider income
- Expenditure of government funds
- Health Status: improved, no change, worse
- Expenditure of personal funds
- Challenges to racial, sexual, and other cultural behaviors
- Educational opportunities

Note: No service relationships or resource categories are shown in this Figure. For alternative ways to establish categories and relationship among health services, see L. Johns, "Resource Allocation Schemes: Uses and Problems in Plan Development" (MS.), 1976.

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particular time period. The resulting prescriptions are intended to provide direction, inspiration and justification for decisions by consumers, providers, payors and government--county and State, legislative and executive--to resolve problems and achieve results.

Finally, this Plan assumes that health policy is rooted in deeply held cultural values concerning the nature of life, the meaning of death, the reality of individual choice, the proper role of government, the relationships among rights, responsibilities and power. Such values, which vary widely among individuals and groups, introduce a measure of nonrationality and a strong dose of controversy to much discussion of health policy. They may be changed by new research results, new theories, new technology, but they may not be. The process of planning and the production of the Plan are one mechanism for revealing and resolving divergent opinions on these matters. The result is State health policy--or at least one source of it.

The Principles that follow and the Policy Recommendations throughout the Plan are consistent with these assumptions, and future planning should include their continual evaluation.

STATE HEALTH POLICY FOR CALIFORNIA: GUIDING PRINCIPLES

State health policy begins with a statement of principles. The following four principles express the basic values underlying the Plan and establish a fundamental direction for State policy concerning health resources, facilities, services and results (outcomes).

Principle 1: Behavioral, biological and environmental factors are the major determinants of health status, requiring transfer of resources to study and affect them.

Medical science has not been fully effective in preventing or curing many current health problems, e.g., cancer, heart disease, diabetes and hypertension. The sources of such disease in behavior, environment and human biology must be investigated and appropriate interventions supported. As such interventions are demonstrated to be effective, resources now used for medical care can be diverted to problems elsewhere.

Principle 2: The most humane and cost effective approach to health care is promotion of health and prevention of disease.

Society's response to disease and disability can take several forms:

- promote good health
- prevent disease and disability
- diagnose and treat disease and disability
- rehabilitate and then care for ("maintain") a sick or disabled person.
Diagnosis and treatment of health problems are essential. But health promotion and disease/disability prevention are intuitively and economically more rational, followed closely by rehabilitation and maintenance at some acceptable level of personal functioning. Promotion and prevention have a role in health care for all age groups: the unborn, the newborn, children, young adults, the middle aged and the elderly.

**Principle 3:**  **MAKE THE MOST OF WHAT WE HAVE.**

Competition for resources now going to health services is increasing and total health care expenses are a national issue. This strongly suggests that future improvements in health services must come not from increases in amounts of resources but from changes in their use. Where resources are already available in excess, this will not lead to rationing but rather to a heightened concern for efficiency. Many resources can be put to other uses and most can be used more effectively, no matter how superficially specialized they appear to be. Similarly, licensure regulations to improve quality and expenditures for modernization and enhanced skills must be of demonstrable benefit.

**Principle 4:** REMAINING BARRIERS TO HEALTH SERVICES, WHERE THEY HARM THE QUALITY AND EFFECTIVENESS OF CARE, MUST BE ELIMINATED.

If cultural, racial, linguistic, geographical and financial barriers to health services inhibit access, where such services are known (or reasonably assumed) to improve health status, such barriers must be eliminated, or at least minimized.

These principles provide the organizing philosophy for this Plan, and are intended as basic guidelines for future allocation of health care resources and development of health care services.

A final element of any policy, grand or focused, is leadership. Without the willingness to take risks, to act despite uncertainty, to change direction and counter resistance, to manage long lead times and sustain commitment to the end, no solution will prevail. The health care system, often maligned as a "nonsystem," is nevertheless remarkably resistant to change. System or not, it is complicated, tightly constructed and so dense even seasoned observers rarely understand it all. But decisions must be made, money channeled and results documented and assessed. This Plan is a catalyst for that effort over the next five years.
NOTES


