Chapter III

PRIORITY ISSUES FOR STATE HEALTH POLICY
CURRENT PRIORITY ISSUES

A priority issue for purposes of statewide health planning is a problem that cuts across the entire health system, thus achieving statewide significance. Six such issues were selected for this Plan by the OSHPD, in consultation with its Advisory Committee on the State Health Plan. They are:

- improving health status
- encouraging cost effectiveness in health care delivery
- supply and regulation of health personnel
- the future of publicly financed health services
- planning for health systems with statewide impact
- coordination of existing State health policies and programs.

Issue #1: Improving Health Status

Statement of Problem: Health planning is concerned with improving the health of individuals and groups. Planning thus begins with some understanding of what "health" is, what "causes" good health, what steps can be taken to improve it and how to measure whether investment of additional resources is "buying" more health—or only more jobs, more facilities, more services, more procedures, more technology. However, evidence is lacking concerning the beneficial impact of many health services on health status, and there is some evidence of negative impact. This problem underlies current doubts about the effectiveness of health care services.

Background and Analysis: The closest approximation to a widely accepted definition of "health" is that proposed in 1946 by the World Health Organization:

"Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Although many have criticized its "impracticality," no one in government or in research has proposed any more acceptable or often quoted substitute.
The major virtue of the W.H.O. definition is that it goes beyond mere "absence of disease" and invokes a positive state of being. This progressive and active implication has great appeal, whether as a reachable goal or inspirational ideal. Additionally, the definition is consistent with an assumption of multiple origins of poor health and therefore multiple interventions for its improvement.

In addition to problems of definition, the pursuit of "health" is complicated by its causal complexity, as illustrated in Blum's model (Figure II-i). The causal links between health status and a multitude of health reducing or health inducing influences have long been the subject of heated debate.

The beginning of the argument is the indisputable fact that in the last three centuries, three important and related changes occurred in western society: the size of the population grew, mortality rates due to infectious disease declined and life expectancy increased. The question is why. Rene Dubos has long argued that preventive treatment has been more important than curative treatment. Thomas McKeown has argued that the changes are related to advancements in nutrition (quality and quantity), which in turn improved resistance to infectious disease and thus improved chances of living longer and reproducing. He also demonstrated that therapies for controlling infectious disease were introduced and widely distributed only after the decline in death from infectious disease had run most of its course.

McKeown's data consisted of vital statistics from England and Wales since 1837. Although he reviewed similar data from Sweden, France and Hungary, and found no contradictions, he did not include the United States. McKeown's demographic analysis, however, has inspired a number of American researchers to attempt to replicate his findings.

Weinstein has shown that in Massachusetts, despite the presence of supposedly effective treatment, the incidence and prevalence rates of some conditions have increased (subacute bacterial endocarditis, streptococcal pharyngitis, pneumococcal pneumonia, gonorrhea, and syphilis) and mortality for yet other conditions shows improvement in the absence of any treatment (smallpox). McKinlay and McKinlay have argued that a marked decline in overall mortality for the United States has occurred since 1900 but that the improvements since 1930 may not be directly attributable to medical interventions. They use data and methods similar to McKeown's to test their hypothesis.

In an attempt to determine whether specific medical measures had an effect on the decline in age and sex adjusted death rates for ten major infectious diseases in the United States between 1900 and 1973, McKinlay and McKinlay compared disease specific mortality trends with data on the introduction of specific therapies commonly thought to be effective. Disregarding smallpox (since the only effective measure had been introduced about 1800) only influenza, whooping cough and poliomyelitis show what can be considered substantial declines of 25 percent or more after the date of medical intervention. The death rates of the remaining six infectious diseases (tuberculosis, scarlet fever, pneumonia, diphtheria, measles and typhoid) showed negligible declines subsequent to the date of medical intervention.
These interpretations of historical trends are complemented by recent studies of the direct impact of behavioral and environmental factors on health status. Lester Breslow and his associates have demonstrated that personal health practices minimize four major health risk factors (smoking, obesity, hyperlipidemia and alcoholism) and, consequently, are the most statistically significant predictors of life expectancy. There is some epidemiological evidence of association between levels of air pollution and death rates from respiratory and heart diseases, as well as evidence that malignant neoplasms are induced, maintained or promoted by specific environmental factors. There was an interesting drop in mortality in the Chicago area of 21 percent during 1970-1975 following enactment of a low sulfur fuel ordinance and ban on leaf burning in 1969. Finally, a relatively new line of epidemiological investigation is beginning to show significant correlations between "social networks," i.e., a person's sociocultural resources, and cancer mortality.

The strongest challenge to the role of health services, specifically medical services, comes from some evidence of lack of scientific basis and real potential for harm. The federal Office of Technology Assessment states that "only 10 to 20 percent of all procedures used in present medical practice have been proven by clinical trial". There are data showing differential mortality (controlled for all the obvious factors) by hospital, by type of hospital and by volume of surgery performed. One reaction, perhaps an extreme one, to such findings is theories of "medical nemesis" that picture medical care as a modern institution of social control, which functions to deflect attention from economic sources of death and disease in industrialized society. Health care services as traditionally conceived (and funded) are thus empirically and theoretically suspect for many observers: at best, ineffective, at worst, oppressive and, ultimately lethal.

Further, doubt concerning health services and associated expenditures is conveyed by studies showing the effect of hypothetical reduction of cardiac, cancer and vehicular accident mortality on life expectancy. The results are surprisingly insignificant, suggesting a biological limit that no amount of cure, care or compensation can overcome.

Frequently, public policy issues relating to health have been characterized as a trade off between medical quality and the cost of services. A preoccupation with the quality cost trade off in light of skepticism regarding the effectiveness of many medical interventions, creates more confusion than consensus in developing solutions to the many health issues confronting us. Shifting the focus to effectiveness and efficiency may facilitate public policy development. Efficiency is defined, in an economic context, in terms of cost per "unit of output." On the other hand, effectiveness measures the impact of the "unit of output" on health status. In this context, alternative methods for improving health (medical and nonmedical) are evaluated in terms of their relative costs and impact on health.
In sum, investigation and debate concerning the origins and determinants of health status are widespread, growing and increasingly irreverent about traditional medical intervention. It appears well accepted that a comprehensive model, such as Figure II-1, must replace the mechanistic, disease agent medical intervention model of nineteenth century epidemiology. Improvement in health services alone cannot be expected to improve health status on any large or permanent scale.

At the same time, the relative roles of other, more complex causes are by no means established, nor are the priorities among possible interventions. It is therefore reasonable to assume that deprivation or withdrawal of access to health care services on the grounds that they are ineffective is not warranted by the facts. It is also certain that statements concerning self responsibility for health are not substitutes for identifying and lessening environmental sources of disease, e.g., tobacco, weapons testing, unsafe cars, carcinogenic pollutants. Economic pressure on publicly funded programs should not be allowed to distort the fact that they have achieved some dramatic improvements in health status\textsuperscript{19} or oversimplify the intricate mystery of good health.

Cochrane\textsuperscript{20} has demonstrated how norms of effectiveness and efficiency can be integrated with sound epidemiological research to create decision making in health policy and program formulation. Epidemiological research currently is used as a foundation for health policy in Canada. A similar effort in California is not beyond the range of the possible.
POLICY RECOMMENDATIONS FOR IMPROVING HEALTH STATUS

Health-1: The basis for determination of health policy and for the allocation of health resources in California should be a framework that views health care, behavior, environment and human biology as the four determinants of health and the major interventions for its improvement.

Such a model best explains the current state of knowledge concerning the origins of health and the ways to influence the health status of individuals and groups. It also recognizes that each of these broad factors can have both positive and negative impact on health status.

Health-2: Existing state epidemiological and other research resources should be coordinated and used to conduct basic research in the determinants of health, to evaluate research in the field and to advise the governor, the legislature, the health and welfare agency, the health systems agencies and interested others concerning effective medical and nonmedical interventions and relative resource allocation priorities among them.

An authoritative State source of epidemiological data, research, theory and advice would go far to promote consensus concerning resource allocation and system change. The Resource for Cancer Epidemiology and the Epidemiological Studies Laboratory Sections in the Department of Health Services represent a structural nucleus for implementing this recommendation. Coordination with the University of California would be valuable in order to take full advantage of existing publicly funded resources.
Statement of Problem: Health expenditures have been absorbing an increasing proportion of the nation's resources since 1966 when Medicare and Medicaid were implemented. Government payments for health care have shown an even greater increase, accounting for much of the increase in total health expenditures. In 1960, 5.3 percent of the Gross National Product (GNP) was expended for health care. By 1978, this grew to 9.1 percent of GNP and amounted to $192.4 billion. Over this same period, government's involvement went from 24.7 percent to 40.6 percent--$78.1 billion.

As a growing share of this country's resources is expended on health care and as the involvement of public funds increases, pressures mount for control. Sound public policy to encourage cost effective health care delivery must address the source of the problem, namely, incentives in the health system. Existing incentives encourage spending.

Background and Analysis: The competitive forces of supply and demand do not operate freely in the health sector. In a competitive industry, if excess supply develops, competition forces market price down. As price falls, less efficient firms leave the industry, other firms may curtail production and the excess supply eventually disappears. On the other hand, if excess demand develops, prices are bid up, new firms enter the industry, other firms find it profitable to increase production, and the excess demand is eventually satisfied. In competitive industries, market pressures discourage inefficient production processes and unwarranted high cost technology.

The health industry operates quite differently. First, most care is not directly paid for by the consumer. In the case of hospital care, approximately 90 percent of hospital revenue is received from third party payors--government (50 percent) and private health insurance (40 percent). Thus, the consumer has little, if any, incentive to be cost conscious in his health care consumption decisions.

Second, the consumer has insufficient knowledge concerning the health care product he is purchasing. The consumer thus places faith in the physician to prescribe proper treatment for a given condition. Due to widespread insurance coverage for health expenditures, the physician has little incentive to be cost conscious in prescribing treatment. On the contrary, the physician has an economic incentive, through fee-for-service remuneration, to be on the "safe side" and prescribe additional tests, provided these tests do not have a significantly high probability of causing the patient harm. (Fee-for-service remuneration, besides providing incentives for high utilization and provision of costly services, often encourages physicians to establish high fees, since many insurance companies reimburse physicians according to "usual, customary and reasonable" [UCR] payment schedules. UCR provides an incentive for all physicians to charge higher fees, since each physician is paid in relation to both his/her own "usual" fee and the prevailing fee in the particular locality.)
Third, health care has strong moral implications. Where death or disability may be a potential outcome, economic considerations are not paramount.

Fourth, there are few limits to advancements in medical science and technology and to consumer expectations. As long as dollars are available, devices and services for their expenditure are likely to be introduced. Changing style of care brought about by advancements in medical science is often cited as the major reason the health sector is absorbing a continually increasing proportion of GNP. For example, since 1960, one-third to one-half of the increased cost of a day of hospitalization is attributed to changing style of care. The remainder is due to economy wide inflation.

Fifth, incentives in the health industry promote increasing capacity, services and technology. While physicians typically are paid on a fee-for-service basis, hospitals have primarily been reimbursed on a cost (plus or minus) basis, providing incentives to expand services. Hospitals compete for physicians. Physicians are attracted by a well equipped workshop, having all the services or equipment they might find useful. Physicians are also attracted by the prestige of the institution, which is related to its size and breadth of services and equipment. Hospitals compete for customers (physicians) not through lower prices, as in other sectors of the economy, but through expanding services, which result in increased prices. Finally, the community, and the hospital trustees, place value on the institution's prestige. Prestige is also a major factor in attracting philanthropic funds. Consumers, many of whom are insulated by insurance from the direct consequences of increasing prices, place a high priority on ready accessibility of high quality hospital services. Since they do not see the added costs of having a full service hospital within a 10-minute versus a 20-minute drive, they naturally prefer the former.

In summary, incentives in the health industry encourage expansion of capacity and services, virtually regardless of the economic consequences. Widespread third party coverage combined with fee-for-service reimbursement, consumer expectations and cost reimbursement create an industry that can apparently expand indefinitely.

In California, these incentives have resulted in extreme excess hospital capacity. In 1978, average occupancy was below 60 percent, while national planning guidelines recommend an 80 percent occupancy rate. In addition to excess beds, there is excess capacity of services and facilities. Recent research has suggested that California hospitals, on the average are smaller than hospitals in the remainder of the United States, and have more ancillary service capability per bed than the average hospital in the United States. This high service capability has resulted in a competitive disadvantage for California hospitals in general when compared nationally according to bed size, such as required under current Medicare reimbursement regulations and suggested under proposals to reform Medicare and Medicaid reimbursement.
Encouraging Cost Effectiveness

Priority Issues for State Health Policy

The product resulting from increasing health expenditures is difficult to define. There is some evidence that major advancements in improving health status do not come from medical care, as discussed under Issue #1. Where benefits to health do result, there is no ready method to correlate a given expenditure to a given benefit.

Even with the relatively large proportion of resources devoted to health, major gaps exist in accessibility and availability of health care for some population groups. In California, approximately six million people reside in areas designated as medically underserved by the State Health Manpower Policy Commission. Nearly 20 percent of California's population is not covered by health insurance. At the same time, there is evidence of overutilization of health services among groups covered by government programs or private health insurance.

In addition to high and growing overall health expenditures, gaps in availability of care and diminishing returns from additional investments in health services, a growing proportion of health expenditures are borne by public funds. Government's share is likely to increase when and if a national health insurance plan is implemented. A wide variety of national health insurance proposals are before Congress, including: (1) a proposal by Congressman Dellums that would essentially nationalize the health industry; (2) the Kennedy-Waxman bill calling for mandated employer provided comprehensive health insurance with hospital and physician payment limits; (3) President Carter's proposal to phase in comprehensive health insurance; (4) Senator Long's catastrophic health insurance plan; and (5) a series of "pro-competition" approaches inspired by Alain Enthoven, a Stanford economist.

At this time, the competitive approaches are gaining in support, while the Dellums and Kennedy-Waxman proposals are seen as more government at a time the public is apparently expressing a desire for less government. When this attitude is combined with high general inflation and a major slackening in economic growth, proposals for increased government expenditures are not greeted enthusiastically. The Enthoven approach, which is riding a wave of support due to public attitudes about government involvement in general and the health industry's desire to avoid regulation, is an attempt to introduce economic incentive into consumer decision making with respect to selection of health insurance coverage. In brief, consumers would be given a wide choice of qualified health insurance options, with incentives for cost conscious selection. The employer would pay a fixed premium contribution, with the employee responsible for the premium differential for the option he or she selects. Moreover, the employer's premium contribution would no longer be tax exempt. This tax deduction has provided an incentive for the offering of high cost/high option insurance plans which, according to many economists, encourage high utilization and discourage price conscious consumer or provider behavior.

With this mechanism in place, certificate of need and rate controls would not be necessary, according to the advocates of the "competitive" approach since health insurance carriers, which are competing for the consumer's dollar on the basis of premiums incentives would encourage growth of HMOs. Effective implementation of such
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A system would negotiate rates with providers. In addition, the consumer's premium incentive would encourage growth of HMOs. Effective implementation of such a system would require further "deregulation", including major relaxation of professional licensure restrictions and elimination of California's prohibition against the corporate practice of medicine, to enable health facilities and alternative types of health providers to effectively compete.

This approach may warrant serious consideration on the consumer side (i.e., competitive health insurance options) although it is important to make clear that consumer decisions which are entirely "cost conscious selections" may shortchange the public. It is important that consumer decisions be based on appropriately weighted efficiency and effectiveness considerations and that the desirable alternative programs of the future should place at the consumers' disposal the full spectrum of health services, including where possible those provided in settings devoted to the care of complex cases and that involve the education of future health professionals. Moreover, the proposed wholesale scrapping of existing control mechanisms, such as certificate of need and professional licensure restrictions while not providing for public rate controls and medical quality assurance may be premature. The anticipation of growth in HMOs may be overly optimistic, as may be the expectation of their relative effectiveness. Provider consortiums would still be possible, inhibiting HMO growth and inhibiting the effectiveness of insurance carrier/provider rate negotiations. Mechanisms to phase in reforms on both sides of the equation should be studied. At this time, the compatibility of this approach with goals of achieving "mainstream" health care for the indigent is not apparent. The growing share of government funds coupled with increasing public concern over growing government in general, calls for major reforms in the health delivery and financing system. Health care is a major component of government expenditures; if the latter are to be controlled, it is essential that control be exercised over the health portion. This control must be implemented in a manner which does not simply result in cost shifts from public to private payors and which provides incentives for effective health care delivery.

There are several approaches to moderating the current incentives, with or without national health insurance, including:

- mandatory hospital revenue limits imposed at the federal level
- mandatory revenue limits imposed at the State level either through rate setting or budget review mechanisms
- voluntary self-regulation
- economic guidelines for health planning
- changes in physician reimbursement mechanisms, including Health Maintenance Organization (HMO) development
- introduction of competitive elements.

These approaches are not mutually exclusive. In fact, their application in concert could comprise a highly effective program.
In 1977, 1978 and 1979, national efforts were made to enact cost containment laws that would place across-the-board revenue limits on hospitals. These attempts all failed in Congress. It is likely new initiatives will be introduced in an effort to balance the federal budget. Such proposals, which would exempt states that have their own mandatory programs, envision a national cost containment strategy with broad, aggregate goals which could be applied on a state-by-state basis. National guidelines will be essential in the operation of any kind of national health insurance program.

While rate setting and budget review and approval programs differ across states, they have one common characteristic: reimbursement levels are determined prospectively, rather than retrospectively. At least ten states have rate control programs, six of them mandatory. Maryland, Massachusetts, Connecticut, New Jersey, Washington and New York have mandatory programs. Arizona, Minnesota, Western Pennsylvania and Indiana have voluntary programs. Recent results suggest that mandatory programs can be effective in restraining hospital cost increases. For example, the program in Maryland has reduced the rate of inflation in hospital cost per patient day from 15.1 in 1975 to 8.7 percent in 1978 and per inpatient stay from 15.1 percent in 1975 to 7.9 percent in 1978 while at the same time improving the financial position of hospitals. The New Jersey system is now using some innovative techniques to establish rates according to diagnosis related categories. While New York's program has had success in containing costs, it has been accused by many of being overly restrictive, resulting in severe financial problems for some hospitals. However, the experience in some state programs strongly suggests that they can work if developed and administered properly. To cite unsuccessful programs as justification for not moving ahead in California is shortsighted.

While these programs may not be panaceas, if coordinated with health planning, they have significant potential for cost containment through providing incentives to hospitals and reinforcing the planning process. Coordination of rate control and planning is addressed in Section 1526 of P.L. 93-641. In 1978, the California Legislature recognized the need to incorporate economic guidelines in the planning process through enactment of SB 1903, which requires the California Health Facilities Commission to develop such guidelines. For four consecutive years beginning in 1977, budget review legislation in California has failed.

In 1978, the hospital industry developed a national voluntary cost containment program in an effort to diffuse public pressures for mandatory programs. Initiated after a declining trend in the rate of increase in hospital costs had appeared, this Voluntary Effort is claiming success. Without changing the current payment system or addressing individual economic incentives, the program anticipated successful results due to industry wide opposition to mandatory controls.

Voluntary efforts could be made part of a mandatory budget review system, where hospitals could collectively share data and ideas, jointly plan and implement productivity enhancing programs. A "peer review" mechanism to assist hospitals in preparation of budget submissions could also be implemented.
Encouraging Cost Effectiveness

Economic guidelines for health planning require planning and certificate of need to take into account cost effectiveness measures and aggregate economic constraints. Economic guidelines range from standards for individual hospital performance to areawide expenditure targets to aggregate limits on capital expenditures requiring a certificate of need. In fact, a local health plan could eventually be viewed as a program budget. Unless health plans and the administration of certificate of need are based on economic standards, fragmentation will result, as cost containment and planning processes work at cross purposes. Then, rather than the health plan establishing the priorities for reforming the health system, the plan will be viewed as a wish list to be arbitrarily cut by the economic regulators.

Changes in physician remuneration mechanisms would do much to change current incentives which encourage excessive utilization, high technology, specialty care and maldistribution of physicians among specialties and areas. In addition to fee-for-service encouraging this type of behavior, "usual, customary and reasonable" (UCR) payment schedules used by many third party payors encourage physicians to set high customary fees, which become the basis for reimbursement. The greatest departure from current practice in remedying these deficiencies would be major expansion of prepaid group practice arrangements and Health Maintenance Organizations (HMOs). An intermediate step would involve revisions in fee-for-service reimbursement schedules to increase fees for primary care and delivery of services to medically underserved groups, and to decrease fees for unwarranted, highly specialized, high technology care.

Competitive approaches were discussed above in reference to the Enthoven proposal. Without major reforms in private health insurance, "competition" could be introduced by major governmental purchasers (i.e., Medicare and Medi-Cal) exercising their market leverage on individual providers. Use of their "monopsony" power could be quite effective in controlling expenditures in these programs often at the expense of purchasers with less market leverage. The effect on the health care delivery system would be less favorable in terms of accessibility, equity and quality considerations.

In September 1978, Governor Brown appointed a committee composed of representatives of the health care providers, health insurance, business, government and other interests to develop recommendations for health care cost control. Its report, submitted in January 1979, recommends a comprehensive program involving strengthened health planning and certificate of need, excess hospital capacity reduction, reform of ineffective, redundant health care regulations and introduction of strong economic incentives to the health industry. These incentives would be obtained from increasing health insurance options for consumers and implementation of a hospital rate control program. These recommendations formed the basis for health care cost control legislation introduced in the 1979-80 session.

In summary, solutions must deal with restructuring economic incentives in the health industry. While the growth and development of HMOs would be the most direct approach
through changing both physician and hospital incentives (see Issue #5), simply instituting prospective hospital reimbursement systems would be a major and important step. To assure that these reforms result in a health delivery system consistent with community needs and priorities, coordination with health planning, certificate of need and licensure is essential. While altering consumer incentives in the purchase of health insurance plans has promise, its full potential will require action on the national level, including tax law changes.
POLICY RECOMMENDATIONS FOR ENCOURAGING COST EFFECTIVENESS
IN HEALTH CARE DELIVERY

Cost-1: AN ECONOMIC CONTROL PROGRAM FOR HEALTH FACILITIES IN CALIFORNIA SHOULD BE BASED ON BUDGET REVIEW AND APPROVAL INCORPORATING THE FOLLOWING ELEMENTS:

- ADEQUATE DATA BASE
- GUIDELINES DEVELOPED THROUGH HEALTH PLANNING AND STATED IN HSPS AND THE STATE HEALTH PLAN
- PRESERVATION OF INDIVIDUAL HEALTH FACILITY MANAGERIAL DISCRETION
- ALL PAYORS COVERED, WITH PAYMENT RATES FOR ALL PAYORS BASED ON APPROVED BUDGETS TO ACHIEVE INTER-PAYOR EQUITY
- PHASED ELIMINATION OF UNREASONABLE CROSS SUBSIDY AMONG REVENUE PRODUCING COST CENTERS
- ASSURANCE OF FINANCIAL STABILITY OF NEEDED, EFFICIENT AND EFFECTIVE INSTITUTIONS
- PREESTABLISHED STATEMENTS OF FINANCIAL REQUIREMENTS AS A BASIS FOR BUDGET SUBMISSIONS
- PROSPECTIVE PAYMENT DETERMINATION AS AN INCENTIVE FOR EFFICIENT MANAGEMENT
- COORDINATION WITH LICENSING AND QUALITY ASSURANCE PROGRAMS
- DETAILED BUDGET REVIEW BY EXCEPTION
- COORDINATION WITH FEDERAL ECONOMIC CONTROLS, WITH MAXIMUM DELEGATION TO THE STATE, UNDER BROAD FEDERAL GUIDELINES.

Existing reimbursement incentives discourage cost effective health facility management, encourage cost shifting among health care purchasers and encourage hospital expansion without regard to community need. Coordination of budget review and planning is essential to assure that the payment system supports the resource allocation objectives of the local and State health plans, recognizing special circumstances facing certain areas and individual institutions, including university based teaching hospitals.
Cost-2: ANY PROGRAM TO ENCOURAGE COST EFFECTIVENESS ON THE PART OF HEALTH FACILITIES SHOULD INCLUDE POSITIVE INCENTIVES FOR BOTH MANAGEMENT AND MEDICAL STAFF TO ACHIEVE GREATER EFFICIENCY AND EFFECTIVENESS.

To the extent health care providers can take an active role in promoting cost effective health delivery, the need for forceful sanctions is diminished.

Cost-3: HEALTH MAINTENANCE ORGANIZATIONS SHOULD BE RECOGNIZED AS HAVING DEMONSTRATED SUBSTANTIAL COST EFFECTIVE HEALTH CARE DELIVERY AND THUS SHOULD BE ENCOURAGED.

HMOs, in particular large prepaid group practice arrangements, provide an integrated, private sector approach consistent with cost containment objectives.

Cost-4: MAJOR ENVIRONMENTAL INTERVENTIONS AND PERSONAL RESPONSIBILITY FOR HEALTH SHOULD BE RECOGNIZED AS NECESSARY, LONG-TERM STRATEGIES FOR CONTROLLING HEALTH CARE COSTS.

Behavioral change and reduction of environmental risks diminish need for health services, and more importantly, have significant long run potential for improving the health status of the population.

Cost-5: PHYSICIAN REIMBURSEMENT MECHANISMS UNDER PUBLIC AND PRIVATE PROGRAMS SHOULD BE REDESIGNED TO ELIMINATE INCENTIVES FOR INAPPROPRIATE LEVELS AND TYPES OF CARE AND PROVIDE INCENTIVES FOR APPROPRIATE AND COST EFFECTIVE TYPES OF CARE.

To a considerable degree, financial incentives determine physician behavior, i.e., reimbursement is not neutral vis-a-vis medical practice. Current reimbursement patterns reward surgical and subspecialty medical practice, use of hospital and ancillary services and settlement in areas of high physician supply. Incentives are inherent in any payment pattern and for physicians in California, these should be redirected. While expansion of prepaid group practice plans is a possible remedy, development of alternative reimbursement methods would be a useful step.


The intent of licensure and certification regulations is generally to protect public safety and welfare. The impact on costs is not always considered. Under current conditions, such inattention cannot continue.
Cost-7: A PROGRAM OF EXCESS HOSPITAL CAPACITY REDUCTION SHOULD BE IMPLEMENTED, EMPHASIZING INCENTIVES AND MECHANISMS FOR CLOSURE OR CONVERSION OF ENTIRE INSTITUTIONS, BASED ON A PUBLICLY ADOPTED PLAN AND CONSISTENT WITH CONSTITUTIONAL GUARANTEES OF DUE PROCESS.

Excess capacity reduction through closure of entire institutions and major services is widely recognized as having potential for significant long-term savings. Closing of entire institutions, based on a sound health plan, could enable the orderly development of new, needed and appropriate facilities and services. This approach also has quality enhancing aspects through encouraging utilization in appropriate settings.

Cost-8: LEGISLATION SHOULD BE ENACTED TO REQUIRE THE OSHPD TO SET ECONOMIC PLANNING GOALS FOR HEALTH SYSTEMS PLANS AND ADOPT CEILINGS ON AGGREGATE HOSPITAL CAPITAL EXPENDITURES APPROVED THROUGH CERTIFICATE OF NEED.

To be effective, tools for containing aggregate health care costs, planning and certificate of need decisions should be based on aggregate, areawide economic goals addressing budgetary constraints. Operating within aggregate budgetary constraints will require local and statewide priority setting and evaluation of tradeoffs between alternative proposals for capital expenditures. Aggregate economic goals and limits are the foundation for cost effective resource allocation and fiscally responsible health planning. Budget review activities should be coordinated with economic goal development to assure compatibility.
Issue #3: Supply and Regulation of Health Personnel

Statement of Problem: Health personnel issues are closely connected to Issue #2 and to numerous issues, in particular health services (Chapters VI-X). Nevertheless, it is useful to identify broad personnel issues calling for attention at a policy level. The central position and high cost of this resource call for the development of relevant policy from a comprehensive perspective that is consistent with the Principles and Recommendations elsewhere in this Plan. Issues include: overall physician supply in California; physician maldistribution within the state; the impact of reimbursement patterns on physician choice of specialty, location of practice and productivity; supply and utilization of nurses; role and regulation of "midlevel practitioners" (MLPs); and underlying all, opportunities for and support of minority groups to enter the health professions and to apply their cultural and linguistic skills where they are most needed.

Background and Analysis: Health care is a labor intensive industry: health care services are delivered by people and a large part of health care expenditures go to pay people. Health personnel costs accounted for approximately 48 percent of the total national health care expenditures of $139 billion in 1976.

Compared to the rest of the nation, California has relatively high numbers of health care personnel. For example, while in the United States there are about 175 active physicians for each 100,000 population, California has 225. In the 1977 California Health Manpower Plan, statewide supplies of nurses were found to be adequate to meet most estimates of current need, and the growing state supply also seemed likely to be sufficient for projected future needs. California has five dental schools and two of the nation's twelve schools of optometry. Fourteen regulatory boards license nearly 400,000 health care personnel and others are regulated through the State Department of Health Services. As many as 600,000 persons in total are employed in the state in various health occupations. Provider category specific data regarding California supply and distribution can be found in the 1977 Health Manpower Plan as well as the 1979 update to that Plan.

Co-existing with abundant numbers of most categories of health personnel are shortages of certain types in various areas and institutions in the state. One type of shortage is the geographic and specialty maldistribution of physicians. Another is chronic shortages and high turnover rates for nurses in many hospitals and nursing homes and on evening and night shifts. Current State policy respecting physician maldistribution is to increase the supply of family physicians and midlevel practitioners and to encourage and support their location in medically underserved areas. Primary care nurse practitioners and primary care physician's assistants can work in teams with the doctors, and to some extent, substitute for the more expensive physician in providing primary care.
It must be stressed that increasing the number of physicians in the state, regardless of specialty, does not reduce physician fees (see Issue #2, above), does not necessarily improve access to or quality of care, creates a potential for unnecessary care and has significant financial implications. As noted, the California physician-population ratio is well above the national average already. It has been estimated that in addition to his/her own income, a physician generates $250,000 annually in health care costs: tests, drugs, hospitalization, etc., totaling more than $9 million in a 30-year productive lifetime. Each physician thus represents a long term cost to society far exceeding individual earnings. At current rates of increase, the number of medical doctors in California will continue to grow faster than the state's population, yielding a ratio of 277 per 100,000 in 1990. Continuing increases in physician supply, whether purposefully through State programs, through unplanned output from the State's eight medical schools or from unregulated immigration from other States and countries, must be viewed with concern.

Regarding the shortage of nurses, the problem again is not one of numbers, but of availability and distribution. Current and projected statewide supplies of registered nurses exceed all but the very highest recommendations as to numbers needed and it is forecast that the supply of active RNs will continue to grow until 1990 at a much higher rate than the population of the State. Yet, survey data from the California Hospital Association show that their membership is experiencing a "chronic and nagging shortage of registered nurses." In the third quarter of 1978, a reported 17 percent of full time and budgeted nursing staff positions in hospitals went unfilled and turnover rates were reported to range from 38 to 63 percent. Hospitals in central and southern areas of the State, jobs for certain nurse specialties and evening and night shifts are particularly hard hit. This imbalance, which is chronic and much studied, both nationally and in California, is attributed to numerous factors in the educational and work environments, including salary levels which are viewed by nurses as incommensurate with their responsibilities. The Biennial Update of the State Health Manpower Plan includes a variety of proposals to resolve the problem while rejecting any "State initiatives" to increase overall supply.

One attempt to balance types of providers involves the development of mid-level practitioners. MLPs include nurse practitioners (NP), physician's assistants (PA), certified nurse midwives (CNM), clinical pharmacists (CP) and expanded duty dental auxiliaries (EDDA). Four of these categories are expanded roles for previously licensed or registered professionals: NP, CNM, CP and EDDA. Physician's assistant is a certified category created in the late 1960s to provide an entry point to the profession for returning medical corpsmen from Vietnam. All of these new or expanded categories have been developed within the past ten years in California, three of them (NP, CNM and EDDA) prepared and utilized in training projects under the umbrella of the Health Manpower Pilot Projects Program, administered by OSHPD.

However, despite recognition of the need for them, the roles of the NP and CNMs vis-à-vis physicians are not yet completely defined or understood, and the appropriate basis on which to reimburse physician associated MLPs remains a controversial problem. An integrated approach to the appropriate roles, numbers and relationships of all types of health personnel is needed.
The need for integration is highlighted by current State regulation of over 400,000 Californians who provide some form of health care subject to some form of State control. Planning for these practitioners—their training, roles, numbers, interrelationships, reimbursement, accountability—is virtually nonexistent. One result is the haphazard accumulation of State manpower regulatory mechanisms, a structure termed MESS (Multiple-Entity Standard Setting) by the Governor’s Committee on Health Care Costs. MESS includes ten healing arts boards in the Department of Consumer Affairs regulating 31 categories of personnel, one of which (Board of Medical Quality Assurance) regulates ten; the Department of Health Services, which licenses, certifies, mentions in regulation, sets standards or otherwise accounts for 52 categories; and at least 50 categories that are unregulated in any way.

Beginning in the late 1960s an effort was begun to accept and train significant numbers of minorities in health professional schools in California and throughout the nation. In general, both nationally and in California, the numbers reached a high point in 1974, and have stabilized or decreased since then. Trends in admissions of underrepresented minority persons to medical schools for California and the United States are depicted in Tables III-1, III-2, and III-3. The 1977 California Health Manpower Plan reported that, based on enrollment data through the 1976-77 school year, "...recently the pace of change has been reduced and there are indications that upward trends have been reversed." Table III-3 shows that data on recent enrollments in medical schools increasingly confirm these indications. Although even at the highest levels achieved, underrepresented minority admissions (except for Blacks in the early 1970s) were generally far short of population parity. Admissions of underrepresented minority students to California’s medical schools have decreased dramatically between 1974 and 1978, dropping from 156 in 1974 to only 120 in 1978 (a decrease of 23 percent). The proportion of minorities in the entering classes in all California medical schools decreased from 16.5 percent in 1974 to only 12.2 percent in 1978 (a proportional decrease of 23.0 percent).

The integration of health personnel planning with overall HSA and OSHPD health planning will require time and thoughtful cooperation. HSAs which have not addressed health manpower planning significantly should begin to contribute realistic policies responsive to local conditions. State law (Chapter 600, Statutes of 1976) mandates a separate State Health Manpower Plan biennially. Now that OSHPD includes a Division of Health Professions Development, there is an opportunity to integrate personnel policy with other State health and HSA planning and to coordinate the activities of the Health Manpower Policy Commission and the Advisory Health Council or (future) SHCC.
Table III-1
First Year Enrollment - University of California Medical Schools
1970-71 to 1978-79

<table>
<thead>
<tr>
<th>Year</th>
<th>Total First Year Enrollment</th>
<th>Mexican-American</th>
<th>Black</th>
<th>Native American</th>
<th>Puerto Rican</th>
<th>Total Underrepresented Minorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-71</td>
<td>442</td>
<td>25 5.6%</td>
<td>50 11.2%</td>
<td>1 0.2%</td>
<td>0 .0%</td>
<td>76 17.2%</td>
</tr>
<tr>
<td>1971-72</td>
<td>493</td>
<td>37 7.5%</td>
<td>49 10.0%</td>
<td>1 0.2%</td>
<td>0 .0%</td>
<td>87 17.6%</td>
</tr>
<tr>
<td>1973-74</td>
<td>555</td>
<td>41 7.4%</td>
<td>41 7.4%</td>
<td>5 0.9%</td>
<td>5 0.9%</td>
<td>92 16.5%</td>
</tr>
<tr>
<td>1974-75</td>
<td>560</td>
<td>54 9.6%</td>
<td>47 8.4%</td>
<td>5 0.9%</td>
<td>3 0.5%</td>
<td>109 19.5%</td>
</tr>
<tr>
<td>1975-76</td>
<td>559</td>
<td>47 8.4%</td>
<td>36 6.4%</td>
<td>3 0.5%</td>
<td>2 0.3%</td>
<td>88 15.7%</td>
</tr>
<tr>
<td>1976-77</td>
<td>557</td>
<td>48 8.6%</td>
<td>34 6.1%</td>
<td>2 0.4%</td>
<td>4 0.7%</td>
<td>88 15.8%</td>
</tr>
<tr>
<td>1977-78</td>
<td>558</td>
<td>55 9.8%</td>
<td>35 6.2%</td>
<td>4 0.7%</td>
<td>2 0.4%</td>
<td>96 17.2%</td>
</tr>
<tr>
<td>1978-79</td>
<td>614</td>
<td>47 7.7%</td>
<td>36 5.9%</td>
<td>2 0.3%</td>
<td>4 0.6%</td>
<td>89 14.5%</td>
</tr>
</tbody>
</table>

Source: Association of American Medical Colleges, Medical School Admission Requirements 1980-81, 1979
### Table III-2
First Year Enrollment - All California Medical Schools
1970-71 to 1978-79

<table>
<thead>
<tr>
<th>Year</th>
<th>Total First Year Enrollment</th>
<th>Mexican-American</th>
<th>Black</th>
<th>Native American</th>
<th>Puerto Rican</th>
<th>Total Underrepresented Minorities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>1970-71</td>
<td>747</td>
<td>4.9%</td>
<td>70</td>
<td>9.4%</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>1971-72</td>
<td>823</td>
<td>6.1%</td>
<td>66</td>
<td>8.0%</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td>1973-74</td>
<td>921</td>
<td>6.1%</td>
<td>52</td>
<td>5.6%</td>
<td>6</td>
<td>0.7%</td>
</tr>
<tr>
<td>1974-75</td>
<td>944</td>
<td>7.7%</td>
<td>72</td>
<td>7.6%</td>
<td>8</td>
<td>0.8%</td>
</tr>
<tr>
<td>1975-76</td>
<td>943</td>
<td>7.5%</td>
<td>66</td>
<td>7.0%</td>
<td>6</td>
<td>0.6%</td>
</tr>
<tr>
<td>1976-77</td>
<td>946</td>
<td>7.2%</td>
<td>60</td>
<td>6.3%</td>
<td>6</td>
<td>0.6%</td>
</tr>
<tr>
<td>1977-78</td>
<td>943</td>
<td>7.5%</td>
<td>48</td>
<td>5.1%</td>
<td>6</td>
<td>0.6%</td>
</tr>
<tr>
<td>1978-79</td>
<td>983</td>
<td>6.0%</td>
<td>53</td>
<td>5.4%</td>
<td>3</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Source: Association of American Medical Colleges, *Medical School Admission Requirements 1980-81*, 1979
### TABLE III-3

Selected Minority Group Enrollment in First-Year Classes in U.S. Medical Schools 1971-1978

<table>
<thead>
<tr>
<th>Year</th>
<th>Black American</th>
<th></th>
<th>American Indian</th>
<th></th>
<th>Mexican-American</th>
<th></th>
<th>Mainland Puerto Rican</th>
<th></th>
<th>Total First-Year Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number Enrolled</td>
<td></td>
<td>Percent Of Total</td>
<td></td>
<td>Number Enrolled</td>
<td></td>
<td>Percent Of Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1971-72</td>
<td>882</td>
<td>7.1</td>
<td>23</td>
<td>0.2</td>
<td>118</td>
<td>1.0</td>
<td>40</td>
<td>0.3</td>
<td>12,361</td>
</tr>
<tr>
<td>1972-73</td>
<td>957</td>
<td>7.0</td>
<td>34</td>
<td>0.3</td>
<td>137</td>
<td>1.0</td>
<td>44</td>
<td>0.3</td>
<td>13,677</td>
</tr>
<tr>
<td>1973-74</td>
<td>1,027</td>
<td>7.3</td>
<td>44</td>
<td>0.3</td>
<td>174</td>
<td>1.2</td>
<td>56</td>
<td>0.4</td>
<td>14,154</td>
</tr>
<tr>
<td>1974-75</td>
<td>1,106</td>
<td>7.5</td>
<td>71</td>
<td>0.5</td>
<td>227</td>
<td>1.5</td>
<td>69</td>
<td>0.5</td>
<td>14,763</td>
</tr>
<tr>
<td>1975-76</td>
<td>1,036</td>
<td>6.8</td>
<td>60</td>
<td>0.4</td>
<td>224</td>
<td>1.5</td>
<td>71</td>
<td>0.5</td>
<td>15,295</td>
</tr>
<tr>
<td>1976-77</td>
<td>1,040</td>
<td>6.7</td>
<td>43</td>
<td>0.3</td>
<td>245</td>
<td>1.6</td>
<td>72</td>
<td>0.5</td>
<td>15,613</td>
</tr>
<tr>
<td>1977-78</td>
<td>1,085</td>
<td>6.7</td>
<td>51</td>
<td>0.3</td>
<td>246</td>
<td>1.5</td>
<td>68</td>
<td>0.4</td>
<td>16,136</td>
</tr>
<tr>
<td>1978-79</td>
<td>1,061</td>
<td>6.4</td>
<td>47</td>
<td>0.3</td>
<td>260</td>
<td>1.6</td>
<td>75</td>
<td>0.5</td>
<td>16,501</td>
</tr>
</tbody>
</table>

Source: Association of American Medical Colleges, Medical School Admission Requirements 1980-81, 1979.
POLICY RECOMMENDATIONS FOR SUPPLY AND REGULATION OF HEALTH PERSONNEL

Personnel-1: THE TASKS, FUNCTIONS AND ROLES OF MANY HEALTH CARE PRACTITIONERS SHOULD BE RECOGNIZED AS FREQUENTLY OVERLAPPING AND POTENTIALLY INTERCHANGEABLE FOR MANY PURPOSES.

Effective planning for and use of health personnel must begin with the acknowledgement that many distinctions among types of personnel are barriers to flexibility, mobility and innovation.

Personnel-2: IMPROVEMENTS IN ACCESS TO HEALTH CARE SERVICES SHOULD BE ACHIEVED IN THE FUTURE THROUGH BETTER ORGANIZATION OF SERVICES, CHANGED REIMBURSEMENT PATTERNS, IMPROVED PHYSICIAN PRODUCTIVITY AND INNOVATIVE USE OF NONPHYSICIAN MANPOWER, RATHER THAN THROUGH INCREASES IN THE TOTAL SUPPLY OF PHYSICIANS.

There are many ways to overcome remaining problems of access to health care. Physicians are more expensive to educate, remunerate and back up than any other health professional. Physicians are not needed for many tasks that could be and have been delegated.

Personnel-3: NUMBERS OF ENROLLEES IN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION SHOULD BE PLANNED TO REFLECT NUMBERS OF PHYSICIANS NEEDED AS DETERMINED BY THE OSHPD IN CONSULTATION WITH HSAS, GRADUATE MEDICAL EDUCATION INSTITUTIONS AND RELEVANT PROVIDER ORGANIZATIONS.

Effective voluntary planning and successful incentive programs to effect a desirable geographical distribution and specialty balance may make it unnecessary for the State to consider regulatory measures to affect physician supply. Such planning should be based on need for physicians established by a State source taking into consideration demographic factors, migration patterns of physicians and changes in the health care delivery system.

Personnel-4: RATIONAL ECONOMIC INCENTIVES AND COOPERATIVE EFFORTS SHOULD BE VIEWED AS PREFERABLE TO STATE REGULATION OF PHYSICIAN NUMBERS AND PRACTICE LOCATION FOR PROTECTING THE PUBLIC'S INTEREST IN AN ADEQUATE, BUT NOT EXCESSIVE, SUPPLY OF PHYSICIANS.

An ever increasing number of physicians entails significant economic consequences and creates a potential for provision of unnecessary care. If rationalized economic incentives fail to moderate growth (see Cost-2, 3 and 5), more direct controls may be required.
Personnel-5: THE STATE SHOULD SUPPORT THE PREPARATION OF MIDLEVEL PRACTITIONERS TO ASSUME APPROPRIATE ROLES IN PRIMARY HEALTH CARE TEAMS, AND IDENTIFY AND EMPLOY ALL FEASIBLE METHODS TO REMOVE REMAINING BARRIERS.

Physician's assistants, nurse practitioners, certified nurse midwives and expanded duty dental auxiliaries have demonstrated that they effectively perform many health care tasks. Their acceptability by the public has been high, they have tended to locate in need areas and work well in collaboration with their associated professionals. At the same time, attitudes, practice regulations, third party reimbursement and other barriers continue to impede the maximum use of these health professionals.

Personnel-6: STEPS TAKEN BY THE STATE, BY SCHOOLS OF NURSING AND BY HOSPITALS TO IMPROVE THE DISTRIBUTION OF NURSES SHOULD BE DIRECTED TOWARD CHANGES IN RECRUITMENT, TRAINING AND WORKING CONDITIONS, RATHER THAN TOWARD INCREASES IN OVERALL SUPPLY.

The lack of nurses is due to problems "in the pipeline" following entry into school and practice. Additional numbers alone will not improve current, specific shortages.

Personnel-7: DILIGENT RECRUITMENT OF MINORITY STUDENTS INTO ALL THE HEALTH PROFESSIONS, AND STRONG SUPPORT OF MINORITY HEALTH CARE PRACTITIONERS WHO SERVE MINORITY GROUPS, SHOULD BE A SECURE PART OF ANY STATE HEALTH PERSONNEL PROGRAM, PARTICULARLY WHERE NUMBERS OF PLACES, POSITIONS OR REIMBURSEMENTS ARE TO BE HELD CONSTANT OR DIMINISHED.

The primary route for minority advancement in the health care professions has been through increasing the supply. Commitment to opportunity and rewards to minority students and practitioners must be maintained within overall, necessary, societal limits.

Personnel-8: LEGISLATION SHOULD BE ENACTED TO ENABLE A GRADUAL AND RATIONAL INTEGRATION OF VARIOUS PERSONNEL PRACTICE ACTS, STATE RECOGNIZED ROLES AND QUALITY MONITORING.

Legislation is necessary to achieve a full scale, long-term rationalization of personnel resources consistent with related State policies concerning financing and organization of health services.
Personnel-9: All health professions' education programs should incorporate processes for student selection and training such that those selected and trained are those most likely to practice actively and to work in locations where most needed.

Many current problems of personnel maldistribution and unavailability can be traced to inadequate selection and training procedures. Selection and training should anticipate actual conditions of practice (some of which, of course, need to be changed) and reflect state health care policy.

Personnel-10: Planning methods used by the OSHPD and the HSAS should integrate analyses and need projections among different types of manpower and between manpower and other health resources.

Fragmented planning for particular types of manpower resources is not conducive to consideration of broad cost effective approaches, alternatives or trade offs.
Issue #4: The Future of Publicly Financed Health Services

Statement of Problem: The future of publicly financed health programs in California is in jeopardy. A decline in county public health services and medical care for the indigent is well documented. This trend has been accelerated by the effects of Proposition 13 and by high inflation in health services costs.

The general problem of publicly financed health care has three related aspects: the future of county health services, cost containment in Medi-Cal and provision of health services to California's increasing immigrant population, both documented and undocumented. The major problems facing county health programs are: uncertain sources and levels of continued financing; inequities in the scope, level and quality of services among counties; need for stronger working relationships among the State, counties and local health planning agencies, and inadequate information on needs, resources and utilization. The essence of the Medi-Cal problem is reconciliation of cost control with minimum adverse effects on beneficiaries. The heart of the immigrant problem is location of financial responsibility to pay for those unable to pay for themselves. Resolution of these problems will determine whether publicly financed health services will survive and in what form.

The Future of County Health Services—Background and Analysis: California's counties historically have been major providers of health services. Counties provide an extensive array of health programs, including public health, medical care for indigents, mental health, alcohol and drug abuse, emergency medical services and many others.

Public health and medical care for indigents are mandated by the California Welfare and Institutions (W&I) Code and the Health and Safety (H&S) Code. Section 17000 of the W&I Code requires counties to relieve and support all incompetent, poor, indigent persons who are incapacitated by age, disease or accident. This makes counties the providers of last resort for persons who do not have health insurance and who do not otherwise have the ability to pay. The H&S Code mandates counties to provide public health services and authorizes county boards of supervisors to establish and maintain a county hospital, to prescribe rules for its governance and management and to appoint a county physician and other necessary staff.

Net county costs for health programs have increased approximately 300 percent from 1966-67 to 1977-78. During 1977-78, counties allocated slightly over $404 million out of local tax revenues to support county health programs. In addition, counties paid approximately $418 million in mandated shares to meet costs of the Medi-Cal (Title XIX) program. Thus, counties expended in excess of $800 million in 1977-78 as net county costs for health programs. This large and increasing burden on local taxpayers has resulted in closure of county hospitals and clinics and in reduction of public health services. Only 29 counties continue to operate hospitals, while others provide medical care for indigents through contracts or direct payments.
The closure of facilities and reductions in services coupled with vague State mandates and inadequate performance standards have resulted in inequities in the scope, level and quality of health services among counties. Some of this variation is predictable, as needs, resources and priorities differ. A significant number of counties have no means of meeting their W&I 17000 responsibility.

As political subdivisions of the State, counties have long argued for a strong State/county partnership in the provision and financing of county health services. Most county health services are mandated or authorized by law, yet the State subvention for county public health programs currently represents only three percent of total expenditures and the State provides no funding for W&I Section 17000 medical care. On the other hand, Medi-Cal has assumed some of the burden. The remaining county hospitals are major providers of Medi-Cal services, receiving some $347 million in Medi-Cal payments for inpatient and outpatient services in 1978.

The future of county health services has been discussed actively during the past several years and some legislation has been enacted. SB 154 (1978), which provided State surplus assistance to local governments, contained "maintenance of effort" provisions concerning county health services. AB 8 (1979) creates an initial fund of $268 million of State monies dedicated to county health programs, establishes the rudiments of a county health information system and provides for some redistribution of State funds to meet special needs and priorities. Counties are required to submit plans and budgets to qualify for these funds.

The observation that county hospitals share some organizational features with HMOs (i.e., salaried physician staff, comprehensive care, etc.) has led to recent proposals for restructuring State/county relationships in the Medi-Cal program and under W & I Code 17000 in order to encourage development of county based organized systems of health care. Through State/county contracts or partnership agreements, which could include high volume, high quality hospitals in the private sector, such organized systems could eventually become the dominant or exclusive provider of care to Medi-Cal eligibles and other indigents in a defined service area. It is argued that such configurations of publicly financed health services would improve care to indigents and, at the same time, control escalating statewide Medi-Cal and county health service costs. Relevant proposed legislation (SB 716 - 1979) which would have allowed the Department of Health Services to limit the number of hospitals participating in the Medi-Cal Program by selective contracting, has stalled because of concerns over a possible negative effect on Medi-Cal eligibles' access to "mainstream care", the amount of necessary developmental subsidies, and a lack of convincing evidence that significant cost savings can be achieved by restricting Medi-Cal provider participation to county operated programs.

However, the Department of Health Services continues to recognize the role of, and support where possible, county hospitals. Future contingencies such as a continued trend
in county hospital closures due to increasing pressures on local tax bases and limits on Medi-Cal program eligibility which increase indigent utilization of county services may operate to create a crisis in county health services and hospital programs in California. Eventually, the State may find it necessary to use Medi-Cal reimbursement as a vehicle to maintain the financial viability of county health systems, particularly hospital components.

The organization and financing of county health services have important implications for HSAs. Public health services are largely preventive; county medical care for indigents often represents the only source of services for the poor; county hospitals frequently serve the entire community through specialized units and health professions training programs. The consequences of reduced county health programs and the implementation of AB 8 provide HSAs with the opportunity and the need to become more actively involved in county health issues.

Medi-Cal Cost Containment—Background and Analysis: More than two million Californians, including the poor, the aged, the disabled and families with dependent children, receive services through the Medi-Cal program each year.

The Medi-Cal budget has increased at an average rate of 18 percent per year over the last decade, and now represents approximately 16 percent of the total State budget. For FY 1979-80, the budget will be nearly $4 billion. The pressures to contain the relentless increase in Medi-Cal program costs have been intensified by the effects of Proposition 13 and the possibility that further limitations on government spending will be enacted.

High expenditures do not mean the cost of the Medi-Cal program is excessive. A recent analysis indicates that when adjustment is made for change in the purchasing power of the health care dollar, "...the Medi-Cal program has done relatively well at holding expenditures down."47

Four broad cost containment policy options for the Medi-Cal program have been proposed:

- reductions in administrative cost

  (For FY 1979-80, Medi-Cal administrative costs will be approximately $300 million, 7.3 percent of the total program costs, half of which is the cost of eligibility determination in county welfare offices. When the eligibility determination costs are excluded, administrative costs are only 3.6 percent, a low figure compared to large-scale private health insurance programs. Much of this cost is for procedures designed to control costs to the program.)

- limitations on the number of program beneficiaries
(The most direct way to reduce Medi-Cal cost is to change eligibility requirements to reduce the number of beneficiaries. This is contrary to the intent of the program, which is to assure that the poor have adequate access to necessary care. It is also likely to be counterproductive from a cost containment standpoint alone, since those no longer eligible for Medi-Cal would become the direct responsibility of the counties, where State and local tax dollars, without federal financial participation, would bear the entire cost.),

- reductions in utilization rates

(Reorganization of utilization may be effected by elimination of benefits and unnecessary utilization and by substitution of less expensive for more expensive services. Assuming that elimination of benefits would jeopardize the program's intent, the most effective approach to utilization and substitution may be the prepaid capitation contract with an HMO, which creates the financial incentive for the contractor to eliminate unnecessary utilization. The HMO also appears to have the ability to reduce hospital admission rates, in part due to substitution of care in ambulatory settings. Experience has shown that the HMO approach to cost containment offers substantial financial impact—from 10 to 40 percent savings—while retaining a full range of benefits.) and

- reductions in cost per unit of service

(Initially, it would appear that Medi-Cal could control program costs by reducing rates of payment. This prospect however, is constrained by federal law which requires that hospital inpatient care must be paid on a reasonable cost basis. Maximum allowances have been set for hospital outpatient services, but providers allege that payment levels do not cover costs and thereby create incentives to hospitalize or to send patients to county facilities where operating losses are subsidized by the county. Likewise, physician payment rates have been kept low in Medi-Cal, in turn causing many physicians not to accept Medi-Cal patients and creating an incentive for over utilization among those physicians who are highly dependent on Medi-Cal for revenue.)

As noted, some emerging strategies for directing the future of publicly financed health services in California are concerned with strengthening relationships between Medi-Cal, county health services and HMOs through the development of organized systems of care. However, there has been significant opposition to proposals that include elimination of any participating hospitals or associated physicians currently providing services to Medi-Cal patients. An alternative to excluding entire hospitals as providers is the development of approved regionalized centers for certain types of services, particularly those that are quite costly to the program. Centers could be designated as exclusive Medi-Cal providers for a wide array of acute, nonemergency procedures. (The possibility of reducing unit costs while assuring quality and effectiveness by regionalizing obstetrical, cardiovascular surgery and oncological services is also discussed in Chapter VII.)
More recently, proposals for organized systems of nonacute publicly financed health services have been advanced. AFDC families and medically indigent children accounted for 34 percent of Medi-Cal provider payments in 1978 and the disabled accounted for another 34 percent. Such concentration of Medi-Cal eligibles in these categories make attractive the development of regionalized primary care and multidisciplinary (for the disabled) service centers which would be reimbursed through non-fee-for-service mechanisms (e.g., capitation with full or shared risk, fee-for-service up to an annual maximum established contractually, etc.) Such regional centers would have to attract moderate to heavy patient loads in order to take advantage of economies of scale and to minimize the financial risk involved.

Finally, consideration should be given to volume purchasing strategies for reducing the unit costs of medical supplies, drugs, lab, and radiological services through contracting directly with suppliers and joint purchasing for or on behalf of major Medi-Cal providers.

Health Care for Immigrants—Background and Analysis: Increasing numbers of both documented and undocumented immigrants pose a special problem for publicly financed health services, in particular county hospitals. Since documented immigrants create no legal problems associated with care, but merely add to the pressure on public resources described above, this discussion will focus on care for undocumented immigrants.

"Noncitizens" pose a unique problem in that there is a question regarding their absolute right to health services, regardless of assumptions concerning need. State statutes require that all California hospitals provide emergency services to clients who present themselves in a medically emergent condition, regardless of their citizenship status, and further, that California counties provide services that protect the public health. However, some counties and hospitals have adopted restrictive service policies, turning on a finding that no emergent medical condition or threat to public health exists. Inevitably, mistakes will be made and issues of liability raised. Further, undocumented immigrants with "legitimate" health problems may be discouraged from seeking the services and, to the extent that communicable disease control is frustrated, public health problems may emerge.

There is considerable confusion regarding financial responsibility for undocumented immigrants. There are clear prohibitions against the use of federal Medicaid/Medicare funds to subsidize health services to noncitizens. State Medi-Cal law also specifically prohibits use of Medi-Cal funds to purchase services for noncitizens. A recent legal opinion by the State Attorney General concerning county obligations under W&I Code 17000/Title 17 States:50

- counties are not authorized to provide nonemergency (elective) services to undocumented immigrants under W&I 17000
- Counties may provide nonemergency (elective) services to undocumented immigrants if the client applies for Medi-Cal and, in the course of applying, claims that residency status is legal.

- Counties may require proof of citizenship prior to providing nonemergency (elective) services.

- County employees may be personally liable for knowingly authorizing the expenditure of public funds for, or providing health care services to, illegal or undocumented immigrants.

This opinion, which must be tested in court, has encouraged some California counties to institute procedures that screen for citizenship prior to delivery of elective services. To the extent that Spanish surname or language is used as a reason to screen, civil rights violations may be occurring. In addition, some counties and private providers argue that the cost of providing care to undocumented immigrants is excessive and should be subsidized by the State and federal governments.

A proposed change in federal law would require persons who enter the United States under regular immigration quotas under a sponsorship agreement which covers routine health care, to be subject to deportation if the immigrant uses publicly funded medical assistance. The California Department of Health Services would be required to collect information on any medical assistance (as defined in DHHS regulations) received by such persons and provide it to the Attorney General of the United States. In addition, the State, at the request of DHHS, might be required to file a suit either to enforce the sponsorship contract or to seek reimbursement. If this amendment is passed, the State of California and the Department of Health Services would be required to permit the use of the Medi-Cal program as an enforcement arm of the Immigration and Naturalization Service.
POLICY RECOMMENDATIONS FOR PUBLICLY FINANCED HEALTH SERVICES

Publicly Financed Services-1: THE DEPARTMENT OF HEALTH SERVICES, COUNTIES AND HSAS SHOULD FORM A PARTNERSHIP IN IMPLEMENTING AB 8 TO ASSURE THE AVAILABILITY, ACCESSIBILITY AND EFFECTIVENESS OF COUNTY HEALTH PROGRAMS AND FACILITIES.

AB 8 provides an unprecedented opportunity to review and strengthen county public health services and medical care programs for the indigent.

Publicly Financed Services-2: CURRENT INEQUITIES IN THE SCOPE, LEVEL AND QUALITY OF COUNTY HEALTH SERVICES SHOULD BE REDUCED THROUGH LEGISLATION TO CLARIFY EXISTING MANDATES IN THE HEALTH AND SAFETY CODE, AND THROUGH DEVELOPMENT OF NEEDS ASSESSMENT METHODOLOGIES AND PERFORMANCE STANDARDS.

County duties and responsibilities need to be better defined and performance standards developed in order to assure accountability, efficiency and effectiveness.

Publicly Financed Services-3: THE DEPARTMENT OF HEALTH SERVICES AND THE OSHPD, IN CONJUNCTION WITH THE COUNTIES AND HSAS, SHOULD COORDINATE EXISTING STATEWIDE PLANNING ACTIVITIES INVOLVING COUNTY HEALTH SERVICES AND DEVELOP CRITERIA TO ASSESS THE NECESSITY AND APPROPRIATENESS OF THESE SERVICES.

The absence of a statewide plan for county health services has created many problems and uncertainties. The development of such a plan is essential for decisions involving allocation of scarce public resources for human services, particularly under categorical funding programs.
Publicly Financed Services-4: A COMPREHENSIVE COUNTY HEALTH DATA SYSTEM SHOULD BE DEVELOPED THROUGH THE COORDINATION OF EXISTING STATE AND COUNTY PROGRAM INFORMATION RESOURCES.

Data on need for services, resource allocations and utilization of county health services is necessary for county health program development, monitoring and evaluation. The data also should be utilized for studies of the relative cost effectiveness of county health programs and for analysis of the effects of Proposition 13.

Publicly Financed Services-5: THE DEPARTMENT OF HEALTH SERVICES SHOULD PROMOTE COST CONTAINMENT THROUGH STRENGTHENING RELATIONSHIPS BETWEEN MEDI-CAL, COUNTY HEALTH SYSTEMS, AND HMOS, INCLUDING:

- INCREASE MEDI-CAL MEMBERSHIP IN HMOS
- FACILITATE THE DEVELOPMENT OF NEW HMOS AND OTHER FORMS OF ORGANIZED HEALTH CARE
- ASSIST COUNTIES THAT OPERATE HEALTH SYSTEMS TO CONVERT THEM INTO HMO LIKE OPERATIONS
- ASSIST COUNTIES IN MAINTAINING THE FINANCIAL VIABILITY OF COUNTY HOSPITALS THROUGH MEDI-CAL REIMBURSEMENT POLICIES

HMOs offer a sound mechanism for containing the cost of health care and potential exists for increased Medi-Cal participation in them.
Publicly Financed Services-6:  

THE DEPARTMENT OF HEALTH SERVICES SHOULD PROMOTE COST CONTAINMENT THROUGH DEVELOPMENT OF CONTRACTUAL RELATIONSHIPS CONTAINING APPROPRIATE FINANCIAL INCENTIVES AND QUALITY SAFEGUARDS WITH DESIGNATED VOLUME PROVIDERS AND SUPPLIERS OF MEDI-CAL GOODS AND SERVICES.

Such contractual arrangements have the potential for minimizing unit costs and promoting appropriate utilization without disrupting existing patterns of care.

Publicly Financed Services-7:  

UNDOCUMENTED IMMIGRANT PATIENTS SHOULD BE TREATED AS ANY OTHER PATIENTS IN A HEALTH FACILITY, THAT IS, RESIDENCE STATUS SHOULD PLAY NO ROLE IN THE SECURING OF URGENT (I.E., NONELECTIVE, MEDICAL TREATMENT).

This will avoid potential violations of federal and State civil rights laws and help prevent the spread of communicable diseases.
Issue #5: Planning for Health Systems with Statewide Impact

Statement of Problem: Certain distinct health care systems in California pose unique questions for planning because the populations they serve are not confined to a single health service area, and/or they are not subject to the same federal or State laws as other providers. Such systems include:

- health maintenance organizations (HMOs*)
- federal systems: Veterans Administration, Public Health Service, Military, Indian Health Service
- State systems: University of California, State hospitals.

Planning concerns associated with these "Statewide" systems include: whether OSHPD or HSAs should plan for them at all; whether HMOs constitute such a distinctive subsystem of a health service area that they should be treated in a separate plan; whether, if HMOs are planned for separately, their enrolled populations should be subtracted from the total community in projecting needs for future beds and services; whether it is possible, appropriate or worthwhile for the State and HSAs to plan for State or federal health facilities when these facilities lie largely outside HSA jurisdiction.

In essence, the exclusion of HMO's population or the inclusion of federal facilities could increase the measure of current, local excess capacity and absolute capacity respectively, while unanticipated changes in State hospital programs could have unpredictable impact at the local level. These systems thus pose special problems for planning.

In addition, the HMO, as an alternative mode of health care delivery known to be acceptable and cost effective, poses a larger problem of appropriate treatment vis-a-vis State regulations.

HMOs—Background and Analysis: There are 200 HMOs nationally, with 34 in California enrolling more than 3,000,000 people, nearly 14 percent of the State's population.

The structure, philosophy, economics, membership and experience of HMOs have been studied extensively. Key facts include:

- HMOs have an incentive to encourage cost effective health care, since they operate on a fixed budget
- prepaid group practice HMOs use about half the hospital days of either "individual practice association" HMOs or the fee-for-service sector
- this decreased rate of hospital use, rather than lower costs per hospital day, is the principal HMO cost control mechanism

*For definitions of terms associated with HMOs, see the working paper, "Statewide Health Systems," OSHPD, 1979.
the assumption that HMO members are younger, healthier and more affluent than the general population may no longer be valid: the membership is aging, recent evidence suggests that sicker people are more likely to choose an HMO, and many HMOs have enrolled unemployed Medicaid populations. (However, the possible effects of selection factors such as employment status, screening for high risk conditions and a predominantly urban enrollee population need further research.)

- the HMO incentive structure can be abused, as evidenced by the sorry history in California of the Medi-Cal backed "prepaid health plans" (PHPs) in the early 1970s

- national HMO growth is on the increase and California enrollment could reach over five million people, 22 percent of the population, by 1985.

Federal and State policy toward HMOs is generally positive. Federal "qualification" entitles an HMO to marketing opportunities among large (over 25 people) organizations. State policy, influenced by the PHP scandals, is somewhat cautious, as evidenced by Knox-Keene requirements. The 1979 Congressional amendments to P.L. 93-641, and concurrently developed State legislation, have exempted some HMOs from CON review altogether.

A major concern evoked by significant HMO expansion is the possible cost impact on existing hospitals. The following diagram summarizes the effect of various assumptions:

<table>
<thead>
<tr>
<th>If</th>
<th>Direct Cost to HMO Members</th>
<th>Direct Cost to Users/Payors for &quot;Community&quot; resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO builds own hospital</td>
<td>increases to cover capital costs</td>
<td>increases to absorb fixed costs previously spread over more patients; increases to absorb variable costs not eliminated through cutback or closure</td>
</tr>
<tr>
<td>HMO uses existing hospital via contract</td>
<td>little change, assuming reasonable contractual arrangement between HMO and hospitals</td>
<td>increases if use involves existing beds, pt. days/1000 decreases due to HMO incentives, and fixed and variable costs are allocated to other patients</td>
</tr>
<tr>
<td>Hospital closes completely or closes services due to HMO competition</td>
<td>could decrease, insofar as HMO premiums may be influenced by a decrease in other health insurance premiums</td>
<td>decreases, since all fixed costs and some variable costs are eliminated</td>
</tr>
<tr>
<td>HMO buys an existing facility</td>
<td>(same as above)</td>
<td>(same as above)</td>
</tr>
</tbody>
</table>

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It is clear that adverse community impact could be avoided by some degree of closure in the rest of the private sector. It is thus consistent with positive HMO policy to facilitate closure of underutilized hospital facilities and services (see Cost-9).

A positive HMO policy, however, must not simply consist of a "laissez faire" State stance on HMO expansion. California's experience with Medicaid PHPs is sufficient evidence that organizations with similar financing structures can nevertheless vary in the quality and comprehensiveness of service they provide. HMO development must be reevaluated at each stage and include the capacity to redirect or adjust the policy environment to limit HMO expansion to those relatively effective and efficient institutions. Current Knox-Keene HMO licensing authority and associated requirements provide that capacity and should only be "streamlined" with extreme caution.

Finally, HMOs should be viewed as only one of many models for improving the organization of health services delivery. Other models for organized health systems, models not exclusively reliant on prepaid capitation payment, have potential for ensuring quality while controlling costs. For instance, the Individual Practice Association (IPA) model may eventually prove to be an appropriate subject of positive health planning policy. IPAs frequently take the form of an association of primary care physicians who are reimbursed through capitation methods and are responsible for case management and necessary referrals for specialty or acute care. IPAs (in particular, the "SAFECO" model) are based on the principle that primary care physicians can provide continuity, quality assurance and 70-80 percent of most medical services. Redundant care is presumably avoided when physicians take responsibility for individual patients and their care. It has been recently suggested that the State could encourage IPA development through pilot Medi-Cal projects which would reward individual primary care physicians or groups with a "management fee" for each Medi-Cal patient who agreed to be "locked into" the physician's practice. (The participating physicians would have to maintain practice patterns that fall within defined normative practice profiles for physicians of their type.)

A potential State role in expanding the IPA model in the private sector has yet to be sufficiently detailed. Unlike the situation of HMOs where facility expansion and acquisition is crucial, incentives in the State's certificate of need program may not be relevant to IPA development. Possible State sponsored incentives could be created in the Public Employees Retirement System (currently a major purchaser of HMO services in California) and by appropriate tax incentives, but private group health insurance representatives must increase their interest in IPAs before the model's potential viability in this State can be reasonably assured. Also, it should be recognized that IPAs and "classic" HMOs are organized in significantly different ways. The potential cost savings previously attributed to HMOs, may not be similarly achieved in IPAs where, for instance, physicians are not salaried. Thus, caution should be exercised in extrapolating HMO cost savings to IPAs.

Federal Systems—Background and Analysis: Federal hospitals and direct health service programs are a resource for many Californians: active duty and retired military and their
dependents, Native Americans, veterans, merchant seamen and other federal beneficiaries. While some rely exclusively on their federal facilities for health care, others cross over into the community health system for some services, from personal preference or because services are not available in the federal system. Some, like many veterans, have private insurance in addition to their federal eligibility.

Hospitals in the federal system generally provide physician services through salaried physicians, and their costs per day tend to be lower than their civilian counterparts. However, lengths of stay per admission run two to three times the average in general community hospitals. This may be related to characteristics of the service population.

As is the case with all hospital constituencies, the beneficiaries of the federal health services have a strong interest in protecting their hospitals. Veterans, retired military and merchant seamen are effective lobbies against periodic attempts to reduce the number of federal hospitals, such as the Public Health Service Hospital in San Francisco.

Health planning has traditionally ignored, and been ignored by, the federal health system. Lacking either federal or State authority over the federal facilities, planning agencies seldom addressed them. However, some federal laws and regulations are now being revised to encourage more attention to the federal facilities by HSAs, including:

- P.L. 96-79 requires an ex-officio representative of the Veterans Administration hospital, if one exists in the area, to sit on the governing body of the local HSA and SHCC
- the National Guidelines for Health Planning require local and State health planning agencies to take use of federal health facilities by area residents into account and adjust their plans as necessary
- any proposed closure of a Public Health Service hospital must be reviewed and approved by the local HSA
- DHHS recently required all PHS hospitals to develop long range plans jointly with their HSA
- capital expenditures of more than $400,000 by any VA hospital are subject to the review and comment of the local HSA under the "A-95" clearinghouse review process.

DHHS has made it clear that it is not only desirable for local and State health plans to analyze the contribution of federal facilities to the community's health system, but it is mandatory that they do so in all plans adopted after January 1, 1979.

State Systems—Background and Analysis: The State of California maintains two systems of health facilities for the general public:

- State hospitals for the mentally ill and developmentally disabled
University of California hospitals.

(In addition, the University of California operates hospitals and clinics for its students.)

Hospitals for the mentally ill and developmentally disabled are discussed in Chapter IX.

The University of California system includes five teaching hospitals with a total of 2,528 beds, located adjacent to or near the schools of medicine in San Francisco, Davis, Irvine, Los Angeles and San Diego. (The joint UCSF - Berkeley Program and the UCSF Medical School activity in the San Joaquin Valley do not have their own hospitals.) These hospitals provide the full range of general and specialized services in each of the five large facilities to support their teaching and research activities. The hospitals are generally major referral centers for their areas and for out-of-State. The hospitals and their teaching settings can make important contributions to the maximization of effectiveness and efficiency in the entire health care system.

There has been increasing competition in recent years between the University of California hospitals and local community hospitals for the subspecialty referral patient. In part this has been stimulated by the location in the University hospitals' urban and suburban market areas of graduates of the Universities' own teaching programs. Practice in such areas, which is economically and professionally rewarding to the physician, has been a major stimulus to the growth in specialty programs of local hospitals.

All State hospitals, including those in the University system, were exempt from State certificate of need until the passage of AB 4001 in 1976. Now all are subject to the same planning and CON regulations as any hospital in the community health system. While all HSPs recognize the role of the University hospitals in providing services to Californians outside the boundaries of local health service areas, none of the plans provide special policies or formulas relating to this role.
POLICY RECOMMENDATIONS FOR HEALTH SYSTEMS WITH STATEWIDE IMPACT

Systems-1: THE STATE SHOULD ENCOURAGE THE DEVELOPMENT AND GROWTH OF PUBLIC AND PRIVATE HMOs AND OTHER MODELS FOR ORGANIZED HEALTH SYSTEMS THAT APPROPRIATE STATE STANDARDS PROVIDE AN EFFECTIVE ALTERNATIVE TO THE TRADITIONAL ORGANIZATION OF FEE-FOR-SERVICE MEDICAL CARE.

Some HMOs have demonstrated their ability to attract members, provide high quality care and reduce costs per enrollee. It is reasonable for State policy to single them out for explicit attention; however, it is essential that proper criteria and standards be developed and implemented.

Systems-2: THE STATE SHOULD ENCOURAGE THE AVAILABILITY OF AN HMO OPTION (PUBLIC AND PRIVATE) TO ALL PEOPLE IN THE STATE, PARTICULARLY TO THE MEDI-CAL POPULATION, BUT SET NO NUMERICAL GOALS FOR STATEWIDE HMO MEMBERSHIP.

The State's proper concern is to assure the availability of HMOs in all areas and to all people in the State. It is not to "promote" at the level of individual choice. The setting of a numerical goal would become an incentive to push.

Systems-3: STATE PLANNING METHODS AND HSP GUIDELINES SHOULD INCLUDE DISTINCT PROJECTIONS OF LOCALLY ANTICIPATED HMO MEMBERSHIP AND FACILITY NEEDS AND CONSIDERATION OF THE IMPACT OF FACILITY DEVELOPMENT ALTERNATIVES.

HMOs require attention in all HSPs, not just in those from HSAs where HMOs now exist. However, "separate chapter" status could obscure the strong interactions between HMOs and the fee-for-service sector, interactions that must be analyzed and understood.

Systems-4: ALL FEDERAL HEALTH FACILITIES SHOULD VOLUNTARILY SUBMIT INFORMATION ON THE DELIVERY OF SERVICES AT THE FACILITY TO THE CERTIFICATE OF NEED PROGRAM WHERE A NEED FOR SUCH DATA HAS BEEN DEMONSTRATED.

It is not rational for federal facilities, which can have significant local economic impact, to exclude relevant information from public review for need and other CON considerations. In the case of federal funding for recognized tribes and related Indian health organizations where issues of tribal sovereignty may intrude, a system of coordination of Tribal, Urban specific and HSPs may be preferred.
System-5: All federal health facilities should voluntarily submit their proposed capital and operating budgets for local HSA review and comment.

Since federal facilities are not subject to CON review, some local scrutiny of future intentions is desirable.

System-6: Planning for federal health systems and facilities should proceed as follows at the present time:

- The OSHPD should collect and analyze necessary data.
- The HSAs should identify and analyze salient local issues.

The OSHPD has greater potential than a local HSA to obtain uniform, comparable data from federal systems, while the role and impact of particular federal facilities are best addressed at the local level.

System-7: OSHPD should be involved in the planning process for the University of California hospitals and clinics.

The University of California hospitals and clinics are the legal responsibility of a single body, the University of California Regents, whose perspective on the hospitals is statewide. The SHP is the natural focus for a comprehensive approach to these facilities, balancing statewide and local concerns. OSHPD should take the lead role in integrating into the SHP and HSPs the programs of these facilities and coordinating HSA review and comments on these programs.

System-8: Each service chapter of future state health plans and local health systems plans should include an identifiable component analyzing the University of California hospital(s), in particular chapters relating to specialized services.

Special chapter treatment is not called for, but separate consideration may be.

System-9: The OSHPD should study the impact of competition among HMOS, as well as the utility of an upper limit on membership enrollment in a given area.
It is alleged by some HMO proponents that competition among HMOs, as well as competition between HMOs and the fee-for-service sector, is desirable. Others feel that an "overbalance" of HMO membership is to be avoided. Study of the two views is needed.
Issue #6: Coordination of Existing State Health Policies and Programs

Statement of Problem: Although California spends billions on health care and related social and environmental programs, plans and budgets are often developed and reviewed in a fragmented manner. Mandates overlap; the same target groups are served by multiple, unrelated services; consistency with State and federal priorities and with each other is difficult to assess. The post-Proposition 13 climate strengthens the need for interdepartmental and interagency coordination to avoid cost shifting and to maximize accountability and effectiveness.

Background and Analysis: No comprehensive ongoing mechanism currently exists to guide or assess the total State health effort and its impact on health problems. Examples of coordination problems abound. In mental health, efforts to improve quality of care may be thwarted by dispersion of responsibility among government agencies and between the public and private sector. In long term care, the availability, role and use of residential care facilities is virtually unknown, despite their potential as substitutes for more expensive institutional care. Overlap, duplication and gaps in programs for the handicapped are characteristic. State programs for natural resources and energy management require closer collaboration with concerns for environmental health.

As the health care delivery system becomes complicated with ever increasing legal, moral, ethical, economic and political variables, it is desirable that the Legislature and Departmental policy makers alike receive direction for future legislation, decisions and actions from a single document, based upon a comprehensive health planning act, P.L. 93-641. Concern for coordination is evident in P.L. 93-641's requirement concerning SHCC review of other health related plans. Amendments to the Act proposed in 1979 indicate that the OSHPD should play an explicit coordinating role in the development of State health policy. While a complete review of current policies and programs lies outside the scope of this Plan, the principles and policy recommendations previously stated may be broadly applied.
POLICY RECOMMENDATIONS FOR COORDINATION OF STATE HEALTH POLICY AND PROGRAMS

Coordination-1: THERE SHOULD BE AN EMPHASIS IN STATE PROGRAMS AWAY FROM TRADITIONAL MEDICAL SERVICES AND TOWARD PROMOTION AND PREVENTION SERVICES AND STATE AGENCIES SHOULD DEVELOP WAYS TO SHIFT RESOURCES TO SUCH PROGRAMS.

Legislators and State agencies must begin to act on the fact that traditional medical care services are only one of four major determinants of health status and possibly a less important one.

Coordination-2: "COST CONTAINMENT" FOR GOVERNMENT PROGRAMS SHOULD TIE EXPENDITURE OF HEALTH CARE FUNDS, WHETHER DIRECTLY (AS IN MEDI-CAL) OR INDIRECTLY (AS IN LICENSURE REGULATIONS), TO THE STATE HEALTH PLAN AND ASSOCIATED PLANNING PROCESSES, SPECIFICALLY:

- CHANGE IN REIMBURSEMENT FROM GOVERNMENT PROGRAMS (MEDI-CAL, WORKERS COMPENSATION, CCS, ETC.) SHOULD BE REVIEWED FOR IMPACT ON LOCAL SUPPLY, ORGANIZATION AND UTILIZATION OF SERVICES

- MEDI-CAL REIMBURSEMENT POLICIES SHOULD BE LINKED TO THE STATE HEALTH PLAN

- STATE GRANT PROGRAMS FOR SPECIFIC HEALTH SERVICES SHOULD BE TIED TO APPROPRIATENESS REVIEW AND TO THE STATE HEALTH PLAN

- LICENSURE AND CERTIFICATION REGULATIONS SHOULD BE COORDINATED WITH THE STATE HEALTH PLAN AND RESOURCE PROJECTIONS

- STATE CAPITAL FINANCING FOR HOSPITALS AND OTHER HEALTH FACILITIES SHOULD BE TIED TO THE STATE HEALTH PLAN
* DATA COLLECTION MECHANISMS AND PROTOCOLS SHOULD BE COORDINATED WITH OSHPD DATA NEEDS.

Cost containment, while not an end in itself, has acquired a significance that cannot be overemphasized. Government agencies in particular, sometimes protective of particular programs or unable to phase them out for political reasons, must be cognizant of their responsibility for cost containment and should view the Plan as a major guide to budgeting and funding in specific programs. However, the tying together of these elements to the planning process must be preceded by fact finding, objective evaluation and a full discussion with all affected parties of the options and the potential impacts arising from the proposed linkages.

Coordination-3: PROGRAMS FUNDING MEDICAL CARE SERVICES TO TARGET GROUPS WITH PROMINENT SOCIAL PROBLEMS SHOULD VIEW "SOCIAL SERVICE" EXPENDITURES AS NECESSARY AND LEGITIMATE AND ADVOCATE FOR SOCIAL SOLUTIONS AS APPROPRIATE.

Health problems that are highly associated with social conditions should be confronted directly by health service programs. Housing, jobs, social services and pollution are examples of nonmedical approaches that may do more for the health status of program beneficiaries than health provider services. Since many traditional social service interventions have not demonstrated substantial success in remedying the social problems underlying much of the need for health services, new and innovative approaches must be considered.

Coordination-4: THE SHCC, WHEN ESTABLISHED, SHOULD USE THESE COORDINATION RECOMMENDATIONS (IN ADDITION TO OTHER CHAPTER III POLICIES) AS THE FRAMEWORK FOR REVIEW OF OTHER HEALTH RELATED STATE PLANS, DEVELOPING GUIDELINES BY DEPARTMENT OR PLAN AS APPROPRIATE TO ENSURE UNDERSTANDING AND COMPLIANCE.

The SHCC review responsibility is a key mechanism for developing coordination between this Plan and other health related plans.
Coordination-5: FUTURE STATE PROGRAMS IN HEALTH SERVICES SHOULD ATTEMPT TO COMPLEMENT FEDERAL PROGRAMS, AND TO AVOID COSTLY DUPLICATION AND CONFUSING OVERLAP.

California legislation is not always internally consistent or well integrated with existing federal programs.
NOTES


36. op. cit.


39. Ibid., p. 121.

40. Ibid., p. 122.

41. Ibid., pp. 124-129.


43. Ibid., pp. 8-16


45. Department of Health Services, 1979. Net county costs are the residual costs to counties after revenues from all sources other than local taxes are subtracted from expenditures.
46. A more detailed discussion of the reasons for closure of county hospitals can be found in California Assembly Committee on Health, "Interim Hearing on the Future of County Hospitals--Palo Alto, California, October 13, 1979", California State Assembly Publication No. 600, 1976.

47. Health Policy Program, Background Analysis of Medi-Cal Program Growth (draft), University of California, San Francisco, 1979.


49. Ibid, p. 53.


51. A number of cases are currently being investigated by civil rights staff in both DHS and OSHPD.


54. Derzon, op. cit., p. 47.