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Ken Wing

A. G. Schneider

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THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974: IMPLICATIONS FOR THE POOR

by Andreas G. Schneider* and Kenneth R. Wing**

I. INTRODUCTION

The National Health Planning and Resources Development Act of 1974,1 was signed into law on January 4, 1975, following a lengthy legislative struggle. During the past 11 months, the fighting among private and public health interests has continued, although the principal arena has shifted from the Congress to the Department of Health, Education and Welfare, which is charged with primary responsibility for implementing the law.2 While the final outcome of this political conflict is still difficult to foresee,3 some informed estimates can already be made concerning the implications of this legislation for the poor.

This article will not summarize the entire Act, since a short, useful discussion of the legislation directed at Legal Services issues is already available.4 Instead, this article will focus on those few provisions which directly affect the poor. From this analysis, suggestions will be made to assist Legal Services attorneys and their clients in devising local strategies to protect and advance the interests of the poor.

II. OVERVIEW

The thrust of the Act, which adds new titles to the Public Health Service Act, is twofold. Title XV mandates an expansion and restructuring of the existing health planning apparatus.5 Title XVI seeks to integrate the Hill-Burton health facilities construction and modernization program,6 which had been administered autonomously, into a more comprehensive national health planning process. At the same time, it redirects the flow of construction and modernization funds from inpatient to outpatient facilities. These modifications hold some promise of making health care services somewhat more available to the poor.

Roughly speaking, federal health planning efforts have heretofore focused on three programs: Comprehensive Health

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2. At this stage in the implementation process, interest groups such as the American Hospital Association and the National Association of Counties are exerting considerable pressure on HEW to shape the content of the regulations. Nine days after the Act was signed, the American Medical Association announced its intention to file suit to enjoin implementation of the law; however, as of December 1, 1975, no such litigation has been initiated. See generally, Iglehart, Health Report/State, county governments with key roles in new program, 7 NAT'L J. 1533 (1975).
3. Regardless of other outcomes, the Act clearly represents a windfall for one group: the lawyers, planners, bureaucrats, and consultants who comprise the professional constituency of the "social pork barrel."
5. For a description of the existing health planning apparatus, see Herzog, Participation by the Poor in Federal Health Programs, 1970 WISC. L. REV. 682, 683-708 (1970).
7. Enacted in 1966, Pub. L. No. 89-749, and codified at 4 U.S.C. §246, the Comprehensive Health Planning Program established a network of state ("A") and local ("B") agencies throughout most of the country which were expected to develop and implement state and areawide plans for the national distribution of health care resources. The state and areawide CHP agencies were also given "review and comment" responsibility on requests for federal health funds in their jurisdictions. However, the agencies were given no authority to implement their plans and their comments on applications for federal funds were generally ignored. Other factors associated with the failure of CHP "A" and "B" agencies to accomplish comprehensive health planning were: resistance to planning by the medical care industry; lack of effective consumer participation; and inadequate federal financing for "B" agencies, necessitating reliance on local — i.e., medical care industry — sources. O'Connor, Comprehensive Health Planning: Dreams and Realities, 52 MILBANK MEM. FUND Q. 391, 400-5 (1974).

8. Enacted in 1946, Pub. L. No. 60, Stat. 1041, the Hill-Burton Program was the first federal planning effort. Under this program, states received federal funds to survey the need for hospital construction. Based on this survey, the state Hill-Burton agency was to prepare a yearly plan. Federal grants and loans for construction (and, beginning in 1964, modernization) of public or private nonprofit hospitals were to be allocated in accordance with this plan. During the first 20 years of the program, construction projects assisted with Hill-Burton funds accounted for an estimated 30 percent of the hospital beds in the county. Rose, Hospital Admissions of the Poor and the Hill-Burton Act, 3 CLEARINGHOUSE REV. 185, 191 (Dec. 1969).

9. Authorized by the Heart Disease, Cancer, and Stroke Amendments of 1965, Pub. L. No. 89-239, codified at 42 U.S.C. §§299 et seq., Regional Medical Programs were intended to coordinate medical research relating to these disease categories and to disseminate research through the health care system. HEW designated medically-related public or nonprofit private institutions as the regional agencies for areas within a state or several states. The RMPs then received federal funds with which to finance research, training, data exchange, direct patient care, or construction projects. Over $1 billion in federal funds were expended on RMPs and their projects without any significant impact on the organization of the health care delivery system. See Bodenheimer, Regional Medical Programs: No Road to Regionalization, 26 MED. CARE REV. 1125 (1969).


12. In the 16 months following the expiration of wage-price controls under the Economic Stabilization Program in April, 1974, the medical care component of the consumer price index increased at an annual rate of 13.1 percent; during this same period, prices for all goods and services rose at a 10.1 percent annual rate. Under existing health care delivery and financing arrangements, a slacking in this cost spiral is not likely in the foreseeable future. See Igeharti, Health Report/Explosive rise in medical costs puts government in quandary, 7 NAT'L J. 1319, 1321 (1975).


15. The functions of the National Council, which is internal to HEW, are to "advise, consult with, and make recommendations to" the Secretary regarding (1) the development of national planning guidelines, (2) the implementation and administration of the Act, and (3) the implications of new medical technology. Section 1503(a) of the Act, 42 U.S.C. §300k-3(a). A HEW Departmental Committee charged with developing the guidelines has solicited public input, 40 Fed. Reg. 25080 (June 12, 1975). HEW's goal is to establish the National Council by June, 1976.

16. Section 1521, 42 U.S.C. §300m.

17. These functions include: preparation of a preliminary State Health plan; implementation of relevant portions of the final State health plan; administration of a State certificate of need program; serving as the designated planning agency for purposes of Section 1122 of the Social Security Act, 42 U.S.C. §1320A-1; and periodic review of the "appropriateness" of all existing institutional health services, Section 1523(a) of the Act, 42 U.S.C. §§300-n-2(a). The SHPDA is also given the responsibility of administering the State Medical Facilities Plan, in accordance with which construction and modernization grants and loans will be distributed, Section 1603(a)(1) of the Act, 42 U.S.C. §§300o-2(a)(1). The SHPDA also sets priorities among projects under the State Medical Facilities Plan, §1602(1) of the Act, 42 U.S.C. §300o-1.

18. Intended to assure that SHPDAs function effectively, the State Administrative Program requires, inter alia, that the SHPDA "(A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public." Section 1522(b)(6) of the Act, 42 U.S.C. §300m-l(b) (6).

bursed to states under the Public Health Service Act.\footnote{20} The bottom tier, which will probably prove to be the most powerful, will consist of a network of Health Systems Agencies (HSAs).\footnote{21} One HSA will operate in each of the approximately 200 Health Service Areas designated by the Secretary of HEW in September 1975.\footnote{22} The SHA may be a nonprofit private corporation,\footnote{23} a public regional planning body,\footnote{24} or a single unit of local government,\footnote{25} but regardless of its legal form, its governing body must have a majority of consumers.\footnote{26} Within its health service area, each HSA is responsible for collecting data concerning the health status of residents,\footnote{27} inventorying health care resources and needs,\footnote{28} and developing and implementing long- and short-term plans to meet those needs.\footnote{29} The HSA will also have some direct and indirect authority to secure compliance with these plans.\footnote{30}

In addition, the Act authorizes funds to assist in the modernization or construction of medical facilities.\footnote{31} Allocation of these funds will occur under the terms of a State Medical Facilities Plan (to be distinguished from the State Plan), in the development and implementation of which the HSAs, SHCCs, and SHPDAs all play a role.\footnote{32} The amounts at stake are potentially large: Fiscal Year 1975-1977 resource development authorizations total $610 million.\footnote{33} However, whether such monies are actually appropriated and obligated is another matter altogether. The Labor-HEW appropriations measure for F.Y. 1976 strongly suggests that such funds will be limited: only $74.26 million of the $205 million authorized for that period was appropriated in the bill (H.R. 8096) approved
by the House-Senate conference committee.\textsuperscript{34} (None of the $150 million in resources development authorization for F.Y. 1975 was even appropriated, much less obligated.)

In assessing the implications of the Act for the poor, it is important to understand what it does \textit{not} do. This legislation does not contain any entitlements or subsidies to assist the poor in purchasing health care services.\textsuperscript{35} It does not provide either the regulatory authority or funding necessary to alleviate the shortage of primary care physicians in medically underserved areas where the poor reside.\textsuperscript{36} Further, notwithstanding the lofty national priorities it articulates,\textsuperscript{37} the Act is unlikely to have much impact on inflation in the price of health care services.\textsuperscript{38}

Nonetheless, Legal Services attorneys and other consumer advocates cannot afford to ignore this legislation. It contains several benefits, some concrete, others merely potential, of which the poor can and should take advantage. Moreover, if a decent national health program is ever enacted, and if, as many observers believe, \textsuperscript{39} those billions of health care service dollars will be channelled through the planning and regulatory apparatus established under the Act, then gaining a foothold in this administrative structure will assist low-income consumers in assuring that any future financing program benefits them as well as the organized provider interests. In addition, some of the Act's provisions pose a clear and present threat to the poor which can and must be met.

\textbf{A. Benefits for the Poor}

Several provisions of the Act hold some promise of (1) improving the access of poor people to inpatient and emergency services at private nonprofit hospitals, (2) improving the quality of care in public hospitals, (3) making some new outpatient facilities available to the poor in medically underserved areas, and (4) generating information about the unmet health needs of low income communities. However, these benefits will only be realized, if at all, to the extent that adequate funds are appropriated and obligated, and only to the extent that broad-based consumer health organizations are developed at the community level to hold the new health planning bureaucracy accountable for its performance.

\textit{1. Access to Private Nonprofit Hospital Services}

Despite massive public subsidies, many nonprofit "community" hospitals maintain their long tradition of refusing to serve the poor.\textsuperscript{40} Since private nonprofit hospitals are the only source of needed emergency and inpatient services in many communities, access to those facilities is often essential. The Act offers two possible handles on this problem.

The first concerns the "free services"\textsuperscript{41} and "community

\textit{34}. The eventual appropriation may prove to be even lower than $74.6 million, for on December 18, 1975, President Ford vetoed H.R. 8096. Although the veto appears to have been prompted by other items in the bill, the Administration has made no secret of its opposition to direct federal subsidies for health facility construction and modernization. In his Fiscal Year 1976 Budget, President Ford proposed to end all funding for CHP, RMP, and Hill-Burton and to fund the Act at a level of $175 million, some $256 million less than the total F.Y. 1976 authorization for planning and regulation under Title XV ($176 million) and resources development under Title XVI ($225 million). See Ford makes personal effort to curb HEW in asking changes in law to cut growth, 7 NAT'L J. 199 (1975). Since the resource development dollars cannot be spent until Title XV planning apparatus is in place, most of the $175 million requested by the President is intended to finance planning and regulation activities under Title XV.

\textit{35}. Even under its discretionary Area Health Services Development Fund, Section 1640 of the Act, 42 U.S.C. §300h, an HSA is expressly precluded from using the moneys, if any, "to pay the costs incurred by an entity or individual in the delivery of health services," Section 1513(e)(3) of the Act, 42 U.S.C. §300f-2(e)(3).

\textit{36}. The Health Subcommittees in the Senate and the House with appropriate jurisdiction over both planning and manpower issues have decided to address the maldistribution issues in separate legislation. See Iglehart, \textit{Health Report/Kennedy effort to revise health manpower carries over to '75}, 6 NAT'L J. 1949 (1974). For a discussion of the linkages between planning and distribution of health care personnel, see Navarro, \textit{A critique of the Present and Proposed Strategies for Redistributing Resources in the Health Sector and a Discussion of Alternatives}, 12 MED. CARE 721 (1974).

\textit{37}. Section 2(a)(1) of the Act, 42 U.S.C. §300k(a)(1), provides, "[t]he achievement of equal access to quality health care at a reasonable cost is a priority of the Federal government" [emphasis added].

\textit{38}. The principal cost control mechanisms in the Act are: the requirement that the SHPDA perform certificate of need and §1122 review functions, §§1523(a)(4)(A), (B), 42 U.S.C. §§300m-2(a)(4)(A), (B); the requirement that HEW develop uniform systems for accounting for costs, calculating volume of services and rates, and classifying institutional providers so as to permit cost and reimbursement rate comparisons, §1533(d), 42 U.S.C. §300n-2(d); and the authorization for federal support of demonstration rate regulation projects in up to six states, §1526, 42 U.S.C. §300n-5. To the extent that health care costs increases are attributable to excess capacity, the certificate of need and Section 1122 review requirements should enable states to avoid further wasteful subsidies; however, the capacity of these review mechanisms to eliminate subsidies of existing surplus capacity is extreme-
service obligations undertaken by recipients of Hill-Burton construction and modernization grants under the old Title VI of the Public Health Service Act, 42 U.S.C. §§291c et seq. These obligations are continued in the Act under Title XVI and will apply to grantees under both titles. Recognizing the massive failure of the states to enforce these obligations under Title VI, the Act shifts many (but not all) enforcement responsibilities to the federal government, and explicitly recognizes a private right of action in federal court to promote compliance with these obligations. Enforcement of the "free services" and "community service" obligations will promote low income consumers' access only to hospital services provided by Title VI or Title XVI grantees. Final regulations implementing this new enforcement scheme are not even scheduled for publication until June 2, 1976, one and one-half years after the Act was signed. When they will actually take effect, and whether they will actually be enforced, is anyone's guess.

The second handle to assure access is potentially of much broader scope: the Act's mandate that states establish a certificate of need program to be administered by the SHPDA. Certificate of need programs, which are now in

43. See Rose, Legislative Developments in Providing Free Hospital Services to the Poor, 8 CLEARINGHOUSE REV. 720 (Feb. 1975).
45. Section 1612(c) of the Act, 42 U.S.C. §300p-2(c), requires the Secretary of HEW to investigate periodically the extent of compliance with "free services" and "community service" assurances by Title XVI grantees. Both Title VI and Title XVI grantees must submit compliance data directly to the Secretary, Section 1602(6), 42 U.S.C. §300o-1(6). At the same time, the SHPDAs remain responsible for enforcing such assurances; failure on the part of the SHPDA to do so may result in withholding of Title XVI construction and modernization funds for specific projects or for all projects, Section 1612(a)(2), 42 U.S.C. §300p-2(a)(2).
46. This private right of action lies if, after six months have elapsed from the filing of a complaint with the Secretary, the Secretary has dismissed the complaint or the Attorney General has not brought an action for compliance, Section 1612(c), 42 U.S.C. §300p-2(c). Until final regulations implementing Title XVI emerge, actions seeking to enforce "free services" assurances against Hill-Burton grantees may still be filed in federal court under Title VI. While such actions are not subject to the six month waiting period under Title XVI, the issue of primary jurisdiction may pose some problems. See Corum v. Beth Israel Medical Center, 373 F. Supp. 558 (1974). Yet even when final regulation emerge under Title XVI, complaints concerning the administration of the Hill-Burton program by either HEW or the States will not be subject to the six month waiting period, since Section 1612(c) speaks only to noncompliance by "entities" which are receiving or have in the past received assistance under Titles VI or XVI.
47. Sections 1523(a)(4)(B), (a)(5) of the Act, 42 U.S.C. §§300m-2(a)(4)(B), (a)(5). States which fail to enact certificate of need authority within four fiscal years after calendar year 1975 are precluded from receiving any health resource dollars under Title XVI or any other Public Health Service Act funds until such a law is adopted, §1521(d) of the Act, 42 U.S.C. §300m(d).


The regulatory scope of some of the existing certificate of need legislation extends beyond facilities to additions of high-technology equipment or expansion of services offered, changes which can have substantial effects on hospital costs. See Ensminger, supra note 11, at 49-61.

The Act mandates that the certificate of need program "provide for review and determination of need prior to the time such services, facilities, and organizations found to be needed shall be offered or developed in the State, "Section 1523(a)(4)(B), 42 U.S.C. §300m-2(c)(4)(B). Neither this language, nor that of Section 1532, 42 U.S.C. §300n-1, precludes a state from undertaking a more ambitious regulatory program, although some state courts may erect constitutional barriers. See, e.g., In the Matter of: Certificate of Need for Ashton Park Hospital, 282 N.C. 542, 193 S.E. 2d 729 (1973).

The precise contours of the Act's certificate of need mandate will presumably be set forth in regulations promulgated by the Secretary of HEW pursuant to Section 1532(a), 42 U.S.C. §300n-1(a). In May, 1975, a coalition of consumer organizations led by Nader's Public Citizen, Inc., formally petitioned HEW to mandate the inclusion of stringent federal review criteria for new hospital construction in state certificate of need laws; as of December, 1975, no proposed rulemaking on this subject had been published.


2. Quality of Care in Public Hospitals

In jurisdictions where the states or their political subdivisions continue to operate hospitals, these facilities usually constitute the primary, if not exclusive, source of health care for the poor. Years of inadequate financing for both operating and capital costs have left many public hospitals incapable of providing care of adequate quality. The central problem facing consumer advocates who seek to strengthen public hospitals is the inability and/or unwillingness of the states, counties, and localities to commit effect in only 29 states, tend to focus on the construction and modernization of health facilities, conditioning approval of such undertakings on an administrative finding of "necessity" for the proposed facility." However, the Act by no means restricts states to this conventional format. Thus, consistent with legislative intent, states could establish and administer certificate of need programs which would condition approval for continuing operation (as well as construction or modernization) upon a periodic showing by each nonprofit "community" hospital that it had met its share of the needs of the low income consumers in its service area for access to emergency and inpatient care.

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48. 8 CLEARINGHOUSE REV. 720 (Feb. 1975).
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the necessary funds.53 Depending on the amounts appropriated for resource development, the Act may provide some of the needed financing.

The Act authorizes project grants to assist state, county, or municipally owned or operated facilities in undertaking construction or modernization projects designed to avoid noncompliance with licensure or accreditation standards.54 Of the resource development money allotted to each state — the total authorization for the rest of F.Y. 1976 and F.Y. 1977 is $265 million55 — at least 22 percent must be allocated for such grants.56 Noncompliance with licensure or accreditation standards constitutes cause for termination of reimbursement under Medicaid57 and Medicare.58 Although many public hospitals are in clear violation of licensure and, particularly, accreditation standards, few efforts have heretofore been made to invoke this sanction, primarily because a disruption of the stream of federal and state dollars under Medicare and Medicaid would further impoverish the facility and jeopardize the poor.59 Again, if adequate funds are appropriated, a quality enforcement strategy along these lines60 may become viable.

3. Availability of Outpatient Facilities

It is now widely recognized that the United States has far too many hospital beds.61 This surplus of inpatient facilities is partly attributable to the Hill-Burton program; which has funneled more than $2.7 billion into the construction of general hospital beds since 1947.62 As resources have been allocated to inpatient capacity, the development of outpatient facilities has lagged badly, particularly in urban and rural poverty areas.63 In amendments to the Hill-Burton Act in 1970, Congress attempted to modify the flow of federal construction and modernization funds by mandating "special consideration" for outpatient facilities serving rural or urban poverty areas.64 However, the states, charged with the principal responsibility for administering the program, flouted this clear legislative intent and granted millions of dollars for hospital construction, leaving the rural and urban poor without badly needed outpatient facilities. This matter is currently in litigation.65

In an effort to avoid a recurrence of this situation, Congress set as one of the goals of Title XVI the provision of grant and loan assistance for the construction of new outpatient medical facilities.66 In addition, it directed the Secretary of HEW to accord "special consideration" to projects located in and providing services for residents of rural or urban poverty areas.67 The Act specifically requires that a minimum of 25 percent of the amount actually appropriated each fiscal year for allotment to the states for all eligible construction and modernization projects under Title XVI be expended on "projects for outpatient facilities which will serve


43. Section 1625(a)(2) of the Act, 42 U.S.C. §300a-2. If the public facility is located in an urban or rural poverty area, federal funds are available for the entire project cost; otherwise, the federal grants can cover only 75 percent of the cost. Section 1625(c), 42 U.S.C. §300a(c). As defined in Section 1633(10), 42 U.S.C. §300s-1(10), the term "cost" excludes any amounts attributable to expansion of bed capacity. Thus, while public hospitals in urban or rural poverty areas can improve their existing facilities entirely at federal expense, they cannot obtain any federal funds for expansion of their inpatient bed service capability.


52. Section 1625(d), 42 U.S.C. §300r(d).

57. 42 U.S.C. §1396a(a)(2).


59. One such effort was Self-Help for the Elderly v. San Francisco General Hospital (Joint Comm. on Accreditation of Hospitals, filed Apr. 14, 1971); Self-Help for the Elderly et al. v. Richardson, Civil Action No. 2016-71. (D. D.C., filed Jan. 1974). The record in this case establishes that of $135 million appropriated for outpatient facilities for the 50 states and the District of Columbia for F.Y. 1971 and 1972, over $120 million were spent for projects not designed to serve the disadvantaged. In 12 states the funds were transferred to hospital construction projects in violation of the transfer restrictions in the Hill-Burton Act. In over 40 states, no funds whatsoever were allocated to projects designed to serve "residents of urban or rural poverty areas." See Statement of Marilyn G. Rose in Hearings on Implementation of the Hill-Burton Amendments Before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, 93rd Cong., 2d Sess. 100-143 (Nov. 25, 1974).


61. The Senate Committee on Labor and Public Welfare found "a continuing and growing need for outpatient facilities." Id. at 7864. The Comptroller General recently concluded a study of outpatient care in urban poverty areas with the observation that "[t]he demand for outpatient care will increase if the trend toward fewer physicians practicing in inner city poverty areas continues." COMPTROLLER GENERAL, OUTPATIENT HEALTH CARE IN INNER CITIES: ITS USERS, SERVICES, AND PROBLEMS, B-164031(3) at 3 (June 6, 1975). There is no reason to believe that this trend will not continue.

62. Section 110 of Pub. L. No. 91-296 added subsection (4) to 603(a) of the Public Health Service Act, 42 U.S.C. §291a(a).

63. National Association of Neighborhood Health Centers v. Mathews, Civil Action No. 74-52 (D. D.C., filed Jan. 1975). The record in this case establishes that of $135 million appropriated for outpatient facilities for the 50 states and the District of Columbia for F.Y. 1971 and 1972, over $120 million were spent for projects not designed to serve the disadvantaged. In 12 states the funds were transferred to hospital construction projects in violation of the transfer restrictions in the Hill-Burton Act. In over 40 states, no funds whatsoever were allocated to projects designed to serve "residents of urban or rural poverty areas." See Statement of Marilyn G. Rose in Hearings on Implementation of the Hill-Burton Amendments Before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, 93rd Cong., 2d Sess. 100-143 (Nov. 25, 1974).

64. Section 1601(2), 42 U.S.C. §3000(2).

medically underserved populations.” At least half of these projects must be located in rural areas. Presumably, health maintenance organizations, and Migrant Health Centers could qualify for such funding under the Act’s definition of “outpatient medical facility.” The amounts at stake may be substantial: if all funds authorized are appropriated, at least $66 million would be available for this purpose during F.Y. 1976 and 1977.

There is, of course, no assurance that any amounts approaching these figures will actually be appropriated. And even if such sums are appropriated — and not subsequently deferred or rescinded — they may not be spent until the planning apparatus prescribed by Title XV is in place and operating. The mere construction of new outpatient facilities in urban or rural poverty areas does not mean that they will be staffed with the necessary numbers of primary care physicians and physician extenders, but having such facilities in place greatly increases a community’s chances of attracting and retaining such health personnel.

Past experience indicates that community-based organizations may not learn that funds are available, or may not be capable of putting together an application and guiding it through the review and approval process. Recognizing this problem, Congress has expressly required HEW to “make every effort” to inform eligible applicants of the availability of technical assistance. In addition, nonprofit community organizations are among those entitled to “all necessary technical and other non-financial assistance” with the development of applications for construction and/or modernization funds. Since HEW is unlikely to have the administrative resources to comply literally with this requirement, requests for such information and assistance should be made as early and as forcefully as possible.

In addition to the problems of obtaining subsidies for new facilities, poor people also face the continual problem of preserving existing facilities. A creatively drafted certificate of need law could afford some protection to low income consumers against the termination of existing outpatient medical services. Throughout the country, private and public hospitals located in poverty areas are closing or reducing their outpatient facilities, often citing fiscal reasons as justification. In many underserved communities, such closures leave residents without access to outpatient care in their neighborhoods, forcing them to travel elsewhere for treatment. By requiring any hospital which currently operates an outpatient clinic to demonstrate the lack of need in the community before approving any reduction or termination of service, a certificate of need program would force the hospital either to maintain the

68. Section 1611(d)(2) of the Act, 42 U.S.C. §300p-1(d)(2). Note that “medically underserved populations,” §1633(16) of the Act, 42 U.S.C. §300s-3(16), are not necessarily residents of “urban or rural poverty areas,” Section 1633(15), 42 U.S.C. §300s-3(15).

69. Id.


71. See National Health Law Program, Neighborhood Health Centers: Changing Their Name (and Some of Their Stripes), 9 CLEARINGHOUSE REV. 316 (Sept. 1975).


73. Section 1633(6), 42 U.S.C. §300s-3(6).

74. 25 percent of $265 million, Section 1613 of the Act, 42 U.S.C. §300p-3.

75. Under Title X of the Budget and Impoundment Control Act of 1974 (Pub. L. No. 93-344), only two types of impoundment actions by the Executive Branch are recognized: deferrals and rescissions. Whenever any executive action or inaction precludes the expenditure or obligation of authorized funds, the President must submit a special message to Congress recommending deferral; if at any time after receipt of the special message either House of Congress passes an “impoundment resolution” disapproving the proposed deferral, the authorized funds must immediately be made available for obligation. 31 U.S.C. §1403. Recissions also require a special message to Congress; unless both Houses complete action on the recession request within 45 days of its submission, the authorized funds must be made available for obligation. 31 U.S.C. §1402. It is the responsibility of the General Accounting Office to monitor compliance with these requirements. 31 U.S.C. §§1405, 1406. Thus, while it is unlikely that the impoundments of Hill-Burton funds which occurred in F.Y. 1973 and 1974 will be repeated under Title XVI, the Administration still has substantial latitude to delay the expenditure of moneys appropriated under Title XVI through the deferral mechanism.

76. With the exception of funds to assist publicly owned or operated facilities in avoiding noncompliance with licensure or accreditation standards, no funds will be available in any state until the State Medical Facilities Plan has been approved, Section 1603(a), 42 U.S.C. §300s-2(a); approval of this plan in turn requires the establishment of HSAs, the SHCC, and the designation of a SHPDA.

77. Among the constraints on the availability of physician extenders are restrictive state licensure laws. See generally SIMPSON & MERRIT, PHYSICIAN’S ASSISTANTS AND NURSE PRACTITIONERS: AN ANNOTATED BIBLIOGRAPHY, (September 1974), National Health Law Program.

78. The failure of HEW to develop an effective outreach effort to encourage applications for assistance from poverty areas played a significant role in frustrating the 1970 Congressional mandate that “special consideration” be given to outpatient facility projects serving such areas, National Association.

79. Section 1635 of the Act, 42 U.S.C. §300s-5. Although the primary function of the multidisciplinary Centers for Health Planning authorized under Title XV is to provide “technical and consulting” assistance to HEW, SHPDAs, and HSAs, Section 1534(a) of the Act, 42 U.S.C. §300n-3, the Centers are by no means precluded from providing technical assistance to community groups. Up to 10 Centers will be established throughout the country; they are likely to be based at educational institutions and may require direction from the community to fulfill their potential.


81. For a concise discussion of nonprofit hospital economics, see Freshback, The Economics of Hospital Expansion, 64 HEALTH PAC BULL. 1 (May/June 1975).
services or to develop or cause to be developed a substitute acceptable to the community.\textsuperscript{82}

4. Access to Information

In order to carry out its health planning and resource development functions, each HSA is required to "assemble and analyze" information about the health status of the residents of the area, the nature of the health care delivery system in the area, and the way in which people utilize those health resources available to them.\textsuperscript{83} The data should show which "community" hospitals, physicians, and nursing homes are serving the poor, and which are not. They might even indicate which of these providers serve the poor well and which do not. In addition, SHCC comparisons of the data gathered by different HSAs in the same state should show the allocation on health resources among different areas of the state, and the impact of this allocation on the health status of citizens in the "have not" areas.\textsuperscript{84}

In and of itself, such information will not solve the health problems of poor people. However, it can help consumers and their advocates identify workable solutions and buttress their judicial, administrative, or legislative strategies with facts. If the HSA is unsympathetic,\textsuperscript{85} consumers may find it necessary to pry loose the information. This should not be difficult, since the Act expressly requires the HSA to make its "records and data" available to the public on request. No category of information collected by the HSA is exempt from this requirement.\textsuperscript{86} Moreover, this disclosure mandate arguably applies to whatever information the HSA has obtained relating to the quality of care provided by hospitals, nursing homes, and physicians participating in Medicare and Medicaid, including JCAH survey reports\textsuperscript{87} and PSRO reviews.\textsuperscript{88} An identical obligation to disclose "records and data" attaches to the SHPD,\textsuperscript{89} giving consumers potential access to information an agency from improperly withholding information lies in federal district court, 5 U.S.C. §552(a)(4)(B). The agency must answer within 30 days of service, such complaints take precedence over all other cases on the docket, and complainants who "substantially prevail" may be awarded costs and reasonable attorneys' fees, 5 U.S.C. §552(a)(4)(C), (D), (E).

\textsuperscript{87} Section 1513(b), 42 U.S.C. §300-2(b), requires that in assembling and analyzing data concerning the effect of the area's health care delivery system on the health of the residents in the area, the HSA "shall to the maximum extent practicable use existing data (including data developed under Federal Health programs)." Among the data collected under Federal Health programs are the accreditation survey reports prepared by the Joint Commission on Accreditation of Hospitals, a private, health industry-dominated organization. A hospital accredited by JCAH is "deemed" to have met the conditions of participation under Medicare, 42 U.S.C. §1395 bb(a), in effect making JCAH the principal quality control mechanism for hospital services received by Medicare beneficiaries. Heretofor, consumers have been barred from access to the JCAH survey reports by longstanding JCAH policy and by 42 U.S.C. §1395bb(a)(2).

\textsuperscript{88} Section 1513(d)(1) of the Act, 42 U.S.C. §3001-2(d)(2), requires that each HSA "coordinate its activities" with each Professional Standards Review Organization designated pursuant to 42 U.S.C. §1320c-1. The Act further requires that the HSA, "as appropriate, secure data from [the PSRO] for use in the agency's planning and development activities." PSROs, which are responsible for reviewing the quality of services provided to Medicare and Medicaid eligibles, 42 U.S.C. §1320c-4(a)(1)(B), will collect an enormous amount of data critical to low-income consumers. See Kirsch, ALTMAN, FRAZIER, KAVET AND MANNIS, PSRO INFORMATION AND CONSUMER CHOICE: THE CASE FOR PUBLIC DISCLOSURE OF HEALTH SERVICES DATA, (February 1975), Harvard Center for Community Health and Medical Care. The disclosure of PSRO data is prohibited except "under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care," 42 U.S.C. §1320c-15. (As of December, 1975, no notice of proposed rulemaking on this subject, much less final regulation, has emerged; however, there is some reason to believe that such regulations, when issued, will be unduly restrictive.) It may well be too much to expect that, in reconciling these two statutory mandates, HEW will allow access by the HSA to the PSRO data it needs to discharge its own functions, even though the boundaries of designated PSROs should be "appropriately coordinated" with the boundaries of the health service areas of HSA, Section 1511(a)(4), 42 U.S.C. §3001(a)(4).

\textsuperscript{89} Section 1522(b)(6)(C), 42 U.S.C. §300f-1(b)(6)(C).
now internal to the state health bureaucracy.90

B. Disadvantages for the Poor

Notwithstanding the provisions discussed above, there is a real possibility that the health planning and resource development activities mandated by the Act could hurt the poor. The greatest threat lies in the potential loss of community health resources gained through past development efforts. Consider the following examples.

Throughout the country, millions of low income families and individuals are dependent upon Community Health Centers (formerly known as neighborhood health centers) and migrant health centers for their care. These community-based outpatient facilities are funded under Public Health Service Act titles.91 The Act confers on each HSA review and approval power over the distribution of these formula grants within its health service area.92 An HSA dominated by providers and "consumers" hostile to such facilities could deny them construction and modernization funds under Title XVI to improve their operations and could reduce or eliminate entirely their operating subsidies, leaving the project enrollees to fend for themselves.93

Another potential source of trouble is the mandated certificate of need program. As argued earlier, a creative certificate of need program can work to the benefit of the poor by enabling them to hold on to existing community resources.

Yet a certificate of need program can also be distorted into a tool for the protection of established provider interests, particularly since the SHPDA, which must administer the program, is not subject to the consumer participation requirements applicable to HSAs and SHCCs. Thus, a proposal to construct or expand a community-controlled outpatient facility could be blocked by a voluntary hospital purporting to offer outpatient services to the same community on the grounds that continuation or expansion of the hospital's facilities would more appropriately meet community needs.94

III. DEVISING CONSUMER STRATEGIES

Health planning and resources development have always been political processes. Considering the stakes, implementation of this Act will not be any different. Organized provider groups — the hospital, physician, and nursing home associations — will probably seek to protect and consolidate their control over health care delivery. State and local governments can be expected to seek control of the flow of federal health dollars into their jurisdictions and perhaps to influence decisions in the private health sector.

To protect their interests, consumers will have to accept the invitation of Congress to participate in this process. Whether a client group is interested in securing some of the Act's benefits or merely in preserving past gains, a coherent political and organizing strategy, perhaps supplemented with litigation, will be required. The following suggestions are intended to assist Legal Services attorneys and their clients in devising ways to shape the implementation of the Act in their communities. Because health politics differ from place to place, only consumer advocates familiar with local conditions can develop and carry out effective organizing strategies.

A. Access to Private Hospital Services

In addition to a legislative effort to secure the enactment of progressive certificate of need legislation, community groups and their advocates should consider efforts to enforce the "free services" and "community service" provisions under Title XVI. While the provisions apply only to Hill-Burton grantees, this emphasis has the advantage of requiring far less political muscle than the push for a consumer-oriented certificate of need law, since the basic obligations have already been established. However, widespread compliance with these

90. State freedom of information laws offer another source of access to SHPDA records and data. However, state health bureaucracies have sometimes proven unresponsive to such laws, and time-consuming litigation has been required to obtain information clearly subject to disclosure mandates. See, e.g., Los Angeles County Health Rights Organization v. Mayer, Civil Action No. C 252035 (Cal. Super. Ct., Sacramento County, dismissed pursuant to stipulation by the parties, May 9, 1975), an action by Medi-Cal recipients to obtain aggregate Prepaid Health Plan utilization data under the California Public Records Act, GOV'T CODE §§6250 et seq. (Supp. 1975).

91. Supra notes 71 and 72.

92. Section 1513(e)(1)(A)(i), 42 U.S.C. §300l-2(e)(1)(A)(i). The SHCC has review and approval authority with respect to state application for federal funds, Section 1524(c)(6), 42 U.S.C. §300m-3(c)(6).

93. The Act does not expressly confer standing on either community or migrant health centers to seek judicial review of administrative actions with respect to HSA disapprovals of operating subsidies or SHPDA disapproval of resource and development funds. With respect to formula grants for community or migrant health center operation, the review and approval authority of the HSA is subject only to administrative review. If an HSA disapproves the use of such funds, the affected health center may appeal this action to the Secretary of HEW, but the funds will not be made available until the Secretary has reviewed the matter and reversed the determination of the HSA, SECTION 1513(e)(2), 42 U.S.C. §300l-2(e)(2). No provision is made for judicial review of the Secretary's determination, whether by the HSA or the applicant health center. With respect to resource and development funds under Title XVI, HSA review and approval power, Section 1513(e)(1)(A)(i), 42 U.S.C. §300l-2(e)(1)(A)(i), is shared with the SHPDA, which must make an affirmative finding of need for all construction or modernization projects proposed under Title XVI, §1604(b)(1)(A), 42 U.S.C. §300o-3(b)(1)(A), and which must approve and recommend each project application, Section 1604(c)(2)(A) (ii). 42 U.S.C. §300o-3(c)(2)(A)(ii). Final approval authority rests with HEW, Section 1604(c), 42 U.S.C. §300o-3(c). The SHPDA (but not the project applicant) is entitled to the "opportunity for a hearing" prior to disapproval of any application by the Secretary, Section 1604(d), 42 U.S.C. §300o-3(d). If HEW disapproves the project, the SHPDA through which the application was submitted (but not the project applicant) may appeal to the U.S. Circuit Court of Appeals, Section 1630(1), 42 U.S.C. §300m(1).

94. On the tendency of hospitals to use certificate of need requirements to project their market positions and their control over new outpatient facilities, see Havighurst, Regulation of Health Facilities and Services by 'Certificate of Need,' 59 VA. L. REV. 1143, 1204-15 (1973).
obligations can only come if those eligible for "free services" and "community service" benefits are informed of their entitlements. The requirement that grantee facilities post notice of their obligations will help, but an outreach effort by community groups is also necessary. Where appropriate, such organizing efforts may be supplemented with litigation, which can take a number of forms: defenses to individual hospital collection actions in state and local courts, actions in federal court for injunctive relief against noncomplying facilities, and an action in federal court to force the states and HEW to discharge their enforcement obligations.

B. Public Hospital Quality

If resource development dollars authorized under Title XVI are appropriated in any significant amount, some public hospitals should be able to obtain money to improve their facilities. Unlike the projects for construction or modernization of outpatient medical facilities, projects to upgrade public hospitals to bring them into conformity with accreditation and licensure standards need not be approved by the HSA or the SHCC. Since these funds flow directly from HEW to the public grantee, they should be available as soon as an appropriations measure is enacted. Unfortunately, HEW has not yet developed regulations to implement this provision and, barring public outcry, is not expected to do so in the near future.

Even if federal funds become available for this purpose, many state and local governments operating hospitals will not be interested in investing these dollars in their facilities. However, a recent federal district court ruling suggests that states, counties and municipalities which operate hospital facilities cannot provide a standard of care lower than that prevailing in the general community. Institution of litigation to extend this precedent and/or to discredit a facility, combined with organized community pressure, may be necessary to prod responsible officials to seek and obtain federal funds.

C. Subsidies for Outpatient Facilities

Since the people appointed to the HSA governing boards and executive committees will determine how construction and operating subsidies for outpatient medical facilities in rural and urban poverty areas will be distributed, organizing for representation of poor people is essential. Whether the HSAs are private or public, the Act clearly requires that consumers constitute a majority of the members of the governing boards and executive committees. Although HEW appears to be deemphasizing this consumer role, particularly in circumstances where a unit of local government is designated as the HSA, this consumer participation man-


96. See, e.g., Newsom v. Professional Adjustment Service Civil Action No. 75-126-NA-CV (N.D. Tenn., filed April 14, 1975) Clearinghouse No. 15,076.

97. Adams v. Richardson, 480 F.2d 1159 (D.C. Cir. 1973), involving the enforcement of Title VI of the Civil Rights Act against schools engaged in racial discrimination, offers a possible model. It is well established that an action to compel HEW to enforce the Hill-Burton Act does lie, Cook v. Ochsner, 61 F.R.D. 354 (E.D. La. 1972).

98. However, even if the full $265 million authorized for construction and modernization is appropriated and 22 percent of this amount, or $58.3 million, is made available for Section 1625 project grants during F.Y. 1976 and 1977, this sum would probably not be sufficient to meet the needs of New York's Health and Hospital Corporation, much less those of all the other undercapitalized public facilities throughout the country.

99. Section 1604(a), 42 U.S.C. §300a-3(a).

100. According to Eugene Rubel, Acting Director, Bureau of Health Planning and Resources Development, HEW, regulations governing such project grants will not be published as a notice of proposed rulemaking until the spring of 1976; in view of HEW's performance to date, this means that final regulations will not be promulgated until the summer of 1976 at the earliest.

101. It does not seem unduly cynical to suggest that many state and local governments will show little interest in upgrading their facilities with Title XVI funds because they, and not the federal government, will have to finance the maintenance and operating costs of the renovated facility, and because those who use these facilities are not a favored political constituency.

102. Greater Washington, D.C. Area Council of Senior Citizens v. District of Columbia Government, Civil Action No. 275-71 (D. D.C. Sept. 11, 1975). Clearinghouse No. 6294E. Although the defendants' duty to provide adequate medical care is predicated on local law (Organization Order No. 141, Appendix I, D.C. Code, 215 (1973 ed.)), this decision may be persuasive with courts asked to enforce similar provisions in other localities.


104. Supra notes 92, 93.


106. In the Notice of Proposed Rulemaking implementing the Act's HSA provisions, 40 Fed. Reg. 48802 (Oct. 17, 1975), proposed C.F.R. §122.109(d)(1)(iv), (d)(2), HEW has given units of local government or public regional planning bodies designated as HSAs the ability to control the membership, staff, budget, and actions of the HSA's governing body, even though the Act confers "exclusive" authority on the HSA's governing body, Section 1512(b)(3)(A), 42 U.S.C. §300i(b)(3)(A). This construction of the statute, seemingly inconsistent with Congressional intent, has been attributed to the intense pressure put on HEW by the National Association of Counties. Inglehart, Health Report/State, County Governments Win Key Roles in New Program, 7 NAT'L J. 1533 (1975). The self-interest of county and municipal officials in making the HSAs "accountable" to them is both substantial and obvious. Not only will the HSAs determine the distribution of health funds within the county or municipal jurisdiction (i.e., patronage), but they also threaten to offer consumers and community groups the potential of establishing an independent base of political power financed by federal planning and resource development funds.
date appears to be enforceable in federal court.\textsuperscript{107}

The HSAs are now being formed. According to the HEW timetable, conditional designation\textsuperscript{108} of HSAs for the bulk of the health service areas will be completed by March 1976.\textsuperscript{109} The political maneuvering differs from area to area. For example, in Oklahoma, where the entire state has been designated a health service area, consumer groups which had initially planned to form their own HSA applicant have joined with the CHP “B” agency and some provider interests in opposing the application submitted by the state for designation of a public, gubernatorially-controlled entity.\textsuperscript{110} In Los Angeles, on the other hand, four different groups have submitted letters of intent to apply: The County Board of Supervisors, the CHP “B” agency, and ad hoc Steering Committee on which the hospitals are represented, and a community health corporation from East Los Angeles. Whatever the outcome, the designation process promises to be a lengthy one.\textsuperscript{111}

D. Information

Under the Act, an HSA has the authority to ferret out much useful information that is now exclusively within the provider domain. However, still provider resistance to disclosure of this information is possible in many jurisdictions. Unless the HSA is adequately funded and staffed,\textsuperscript{112} and unless consumers play a meaningful role in its governance, it is unlikely to have either the technical capacity or the political will to exercise this authority effectively. Again, the HSA’s potential as an institutional consumer advocate will not be realized unless broadly-based community pressure is brought to bear, both to secure consumer representation and to keep those representatives accountable.\textsuperscript{113}

\textsuperscript{107} In the one reported case in which community groups attempted to enforce the consumer representation requirements for CHP areawide health planning councils, 42 U.S.C. §300l-4(b)(2), the decision established only that federal courts have jurisdiction to consider such complaints, New York City Coalition for Community Health v. Lindsay 362 F. Supp. 434 (S.D. N.Y. 1973). Cases in which courts have enforced consumer representation requirements in other federal programs include Comprehensive Group Health Services Board of Directors v. Temple University, 363 F. Supp. 1069 (D.C. Pa. 1973); Chacon v. Hodgson, 465 F. 2d 307 (7th Cir. 1972); and Lower East Side Neighborhood Health Council-South v. Richardson, 346 F. Supp. 386 (S.D. N.Y. 1972). Cf. North City Area-Wide Council v. Romney, 469 F.2d (3d Cir. 1972).

\textsuperscript{108} The purpose of conditional designation is to enable HEW to evaluate the ability of entities seeking designation as HSAs to perform their required functions adequately. No entity may be conditionally designated for more than 24 months, Section 1515(b)(2) of the Act, 42 U.S.C. §300l-4(b)(2). As a practical matter, applications submitted by CHP “B” agencies and RMPs will receive priority, Section 1515(b)(4), 42 U.S.C. §300l-4(b)(4).

\textsuperscript{109} In order to designate an entity as an HSA, the Secretary must find, either on the basis of the entity’s performance as conditionally-designated HSA or on the basis of the entity’s application, that it is “capable of fulfilling, in a satisfactory manner,” the requirements and functions of an HSA, Section 1515(c)(1), 42 U.S.C. §300l-4(c)(1). The term of any such designation may not exceed 12 months, and the entity’s performance is subject to review by HEW, Section 1515(c)(3), 42 U.S.C. §300l-4(c)(3), as well as its annual budget, Section 1535(c), 42 U.S.C. §300n-4(a). The Act makes no provision for judicial review of the Secretary’s designation determinations.

\textsuperscript{110} \textit{Alternative to Boren’s Health System Agency South}, Tulsa Daily World, Dec. 4, 1975, at C7, col. 1.

\textsuperscript{111} In addition to challenging conditional and annual designations, supra note 109, consumers may be able to influence HSA policy through Subarea Advisory Councils representing different geographic regions within each HSA’s health service area. Section 1515(c). 42 U.S.C. §300l-1(c). The SACs must be composed of a majority of consumers, but establishment of one or more such bodies is entirely within the discretion of the HSA. \textit{Id.} Proposed 42 C.F.R. §122.112, 40 Fed. Reg. 48809 (Oct. 17, 1975), would permit an HSA to make “financial and other resources” available to any SAC it chooses to establish, but the powers of the SAC remain advisory in nature. There is a danger, of course, that HSAs will attempt to use SACs as surrogates for community participation in health policy-making without any real delegation of authority or responsibility.

\textsuperscript{112} Section 1515(b)(2) of the Act, 42 U.S.C. §300l-1(b)(2) attempts to assure adequate staffing by mandating certain types of expertise and stipulating minimum staffing and salary levels.


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