

Civil Rights, HSAs, CON, and Public Health

By John Steen

The following is the transcript (with minor editing) of a presentation in a webinar presented by the Community Health Planning and Policy Development Section of the American Public Health Association on June 26, 2008.

The topic of today's webinar, "New Opportunities to use Civil Rights as a basis for Public Accountability in Health Care Delivery," introduces the question of how civil rights principles bear upon our efforts to meet the full range of healthcare needs of communities. For a broad look at this, I'm going to start with a look back to the beginnings of community health planning 40 years ago, and then consider what states are able to regulate through Certificate of Need today.

The period 1964-66 saw the establishment of Comprehensive Health Planning Agencies and of Certificate of Need. The model for each came out of community planning in Rochester, NY and bore its greatest fruit with the establishment of Health Systems Agencies nationally in 1975-76. Within a few years, there were 205 HSAs and every state but Louisiana had established a CON Program. It was the HSAs that made greatest use of CON in their efforts to assure the accessibility, acceptability, affordability, and appropriateness of healthcare delivery for communities. They achieved this best by staffing the active participation of community representatives in creating Health Systems Plans as well as in CON review.

The applicable CON review criteria were derived from federal regulatory documents and became common to all state CON regulatory programs and HSA review processes. They survive today in the criteria being applied by the 36 states (and the District of Columbia) that still operate these programs. I'll quote three typical paragraphs of criteria from these programs:

"Document the manner in which access of low income persons, racial and ethnic minorities, women and mentally handicapped persons and other underserved groups to the services proposed is commensurate with such persons' need for the health services (particularly those needs identified in the applicable Health Systems Plan as deserving of priority)."

"Discuss the extent to which medically underserved populations (low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly) currently use your services in comparison to the percentage of the population in your service area which is in these categories. Discuss the extent to which the proposed project will affect the extent to which medically underserved populations can be expected to use your services if your application is approved."

“Discuss your past performance in meeting your obligations, if any, under applicable federal and state regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to health programs, facilities and services (including the existence of any civil rights access complaints against you).”

As for the HSAs themselves, most went out of existence with the termination of federal funding after 1986, but two states still maintain their original sets of agencies, Florida and Virginia. Only in Virginia do they maintain their original functions. In New York State, there were originally eight HSAs; today only two remain because they are supported by the communities for which they plan and advocate – Rochester and Syracuse.

Before its demise in 1996, the HSA of NYC’s best work was in information and advocacy for the health of the city’s neighborhoods. It analyzed health status trends for all its neighborhoods using population health indicators, and then assessed resource capacity and use trends for those neighborhoods. Its findings were then disseminated to health plans, major providers, consumer groups, and other interested parties. It then focused on neighborhoods with the most severe problems in order to develop strategies in concert with those parties for improving service delivery and health status. Finally, it assisted state and local agencies in developing appropriate incentives for implementing the strategies. Those included CON review in which the HSA/NYC criteria for measuring access consumed nine pages encompassing 27 questions designed to identify barriers and determine whether the services were accessible or would actually be accessible to those in need. This included provider obligations for uncompensated care under Hill-Burton Act (1946) funding, and how well providers satisfied such obligations by prominently posting and publicizing them to eligible people. The Agency also routinely prepared applications for designation of such neighborhoods as Medically Underserved Areas and Health Manpower Shortage Areas, and assisted community health centers to become federally qualified.

The fullest example today of an HSA promoting the health of its community across the “invisible wall” separating medicine and public health is to be found in Rochester’s Finger Lakes Health Systems Agency (FLHSA). It carries on the function of preparing Health Professional Shortage Area applications to the Bureau of Primary Care. FLHSA also staffs partnerships of government, insurers, and healthcare providers to ensure that residents are covered by an affordable health insurance plan and able to access appropriate health care services when needed.

Going back to the states, I think that their function of issuing report cards on the performance of their healthcare providers and insurers should also be seen as contributing to the improvement of healthcare delivery. The Commonwealth of Pennsylvania was the first to do so, and is still the most dedicated to it. The Pennsylvania Health Care Cost Containment Council (commonly known as PHC4) was established to carry out that function as an independent state agency by the legislature in 1986, and it embodies the belief that “information about healthcare is a civil right.”

Conclusion

The essential problem in attempting to use civil rights principles in state regulation in order to get the health care delivery system to function “as a system” at the community level is the

fragmentation found everywhere in the delivery of healthcare. **We don't have a healthcare system in America because we never planned for one.** Consider –

- No one agency has responsibility for, nor regulatory authority over, the entire community.
- Progressive state health departments have taken initiatives on behalf of their communities when their governors and state legislatures were supportive of it, but state regulatory agencies are never given the mandate to regulate on behalf of the needs of their communities.
- The role of Certificate of Need is that of maintaining some degree of order among the state's institutional healthcare providers, and it only reacts to their initiatives. Licensure too establishes standards for a more orderly system of providers, but it is not used prescriptively to shape the system. State health regulation here is reactive, not proactive.
- Local public health agencies are always trying to better match resources to community needs, but their powers and funding are extremely limited.
- These problems are reflective of the “invisible wall” that separates medicine and public health, a political barrier that prevents an adequate solution to the fragmentation of healthcare delivery.

And so the upshot of all this historical background is that if only we would better empower and fund public health, it would soon achieve the benefits being sought here through regulation. Even were we to achieve Universal Health Insurance, only public health would have the mission of ensuring equitable results in the health status of all communities.

Public health is committed to providing **Ten Essential Health Services**, including:

1. Monitor health status to identify community health problems.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when not otherwise available.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

In 2002, on behalf of the entire public health community, the Public Health Leadership Society (www.phls.org) adopted “12 Principles of the Ethical Practice of Public Health” which includes:

4. **Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.**

So what we require to meet the full range of healthcare needs of our communities is nothing less than a new, better informed consensus of public support for the rationalization of healthcare delivery, one that embodies a population health approach. To begin, we must educate the public about the mission and the vision of public health! It must be the vision of public health in the 21st century **to ensure human rights for all in the interests of social justice.**