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Comprehensive Health Planning and Procedures: The California Experience

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Much public and governmental attention is being focused upon the philosophy, quality, scope, organization and cost of health care delivery systems throughout the nation.¹ In California alone, health care costs gross nearly \$10 billion annually and undoubtedly constitute the largest single industry in the state, exceeding agriculture and aerospace in dollar volume. The complexity of the already complicated quadratic equation of health care delivery system planning, construction and operation is compounded by a plethora of prepaid and insured facilities and programs,

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1. See generally, Comprehensive Health Planning and Public Health Services Amendments of 1966 PL 89-749, amending 42 U.S.C. § 246, S. Rep. No. 1665, 89th Cong., 2d Sess. 9 (1966), H.R. REP. No. 2271, 89th Cong. 2d Sess. 10 (1966); Social Security Amendments of 1972 PL 92-603, amending 42 U.S.C. §§ 1395, 1396, et seq. H.R. REP. No. 92-231, 92d Cong., 1st Sess. 5 (1971). S. REP. No. 92-1230, 92d Cong., 2d Sess. 9 (1972), H.R. CONF. REP. No. 92-1605, 92d Cong., 2d Sess. 10 (1972).

Medicare, Medicaid, and an entire spectrum of still other influential factors, all undergoing rapid change.

Over the last 25 years, much of the health care delivery system in California has engaged in a curious exercise, in concert with facilitating governmental agencies, legislatures and governors, in creating a statutory and administrative illusion in an unaware public that meaningful mandatory comprehensive health planning exists in the State of California.² Except for some very minor qualifications, anyone could, and can today, build or expand and operate a hospital anywhere in the State of California, without any governmental approval as to choice of location or number or types of beds.³ Such minor qualifications include satisfaction of requisite state health and safety standards with regard to construction⁴ and operation,⁵ and appropriate zoning at the local level.⁶

However, it is the initial and most pivotal decision of whether to build or not to build or expand a hospital which totally lacks any mandatory governmental regulation. Instead of mandatory governmental approval to build or expand, other significantly less effective inducements to obtain governmental approval exist by virtue of state⁷ and federal legislation⁸ in this area.

This carrot, rather than stick, approach has resulted in a multiplicity of profound and unbridled consequences due to overbedding, which have had (and will continue to have for years to come) a tremendous impact upon the consumer public, taxpayers, and existing health care delivery systems, both in terms of availability and costs.⁹ This article deals with the historical evolution of hospital planning and regulation, on the one hand, and the unique

2. See, e.g., CAL. HEALTH & SAFETY CODE § 432 *et seq.*, 435 *et seq.*, 436 *et seq.* (West 1970); CAL. HEALTH & SAFETY CODE § 437-438.7 (West Supp. 1973).

3. *Id.*; cf., 17 CAL. ADM. CODE § 251, *et seq.* (1970). This assumes that no governmental funds are used in such construction.

4. CAL. HEALTH & SAFETY CODE § 1265 (West Supp. 1974). Cf., 24 CAL. ADM. CODE § T17-001, *et seq.* (1972).

5. CAL. HEALTH & SAFETY CODE § 1278 *et seq.* (West 1973).

6. CAL. HEALTH & SAFETY CODE § 438.5 (West 1970); cf., Hagman, *Accessory and Specialized Uses*, §§ 8.32-8.36, CALIFORNIA ZONING PRACTICE, CONT. ED. BAR (1969).

7. See, e.g., CAL. HEALTH & SAFETY CODE §§ 436.45 [public loan eligibility] and 1265.5 [no waiting period] (West Supp. 1974); CAL. WELFARE & INSTITUTIONS CODE § 14105.5 [ineligibility under Medi-Cal Program] (West Supp. 1974).

8. See, e.g., 42 U.S.C. § 291, *et seq.* (1970); 42 U.S.C. § 1122 (1970).

9. The simple fact is that unused private and non-profit hospital beds are paid for by patients, *pro rata*, in direct charges or increased insurance premiums, and unused publicly-funded hospital beds are paid for with tax revenues, as a result of fixed overhead costs.

procedural aspects of obtaining voluntary governmental comprehensive health planning approval of a hospital or hospital addition, on the other.

HISTORICAL ORIGINS AND DEVELOPMENT OF
COMPREHENSIVE HEALTH PLANNING

Conceptually, a dichotomy first must be noted between hospital "planning" on the one hand, and "licensing" on the other, for the two are mutually exclusive, at least for the present. Illustratively, a hospital may be licensed with or without comprehensive health planning approval.¹⁰ However, the known and yet to be determined ramifications of being licensed without benefit of comprehensive health planning approval are such that most hospital license applicants also proceed through voluntary comprehensive health planning.

Curiously enough, these ramifications are not entirely legal in consequence, but may be dictated by economics, public relations both within and outside of the health care system constituent professions, and other motivational factors implicit in seeking to establish a hospital or addition within a preexisting health care delivery system.¹¹ Moreover, not all of the future legal consequences of failing to obtain comprehensive health planning approval are known at the present time.¹²

Governmentally funded hospital in-patient programs such as Medicare¹³ and Medicaid¹⁴ (the latter in California having been designated "Medi-Cal"¹⁵) are undergoing constant scrutiny and revision both at state and federal levels. Indeed, no one can pres-

10. CAL. HEALTH & SAFETY CODE § 1265 *et seq.* (West Supp. 1974), specifically subdivision (e) of § 1265.5. See generally, Dorsey, *Certification of Need Laws*, 106 ARCHIVES OF SURGERY 765 (1973).

11. It is frequently a delicate matter to establish a new hospital with concomitant staff in a community with pre-existing facilities. Costs to patients will rise as competition for qualified nurses and technical personnel increase. Moreover, hospitals, particularly non-profit hospitals, need the support of the medical profession to maintain their levels of efficiency, by patient referrals.

12. See, e.g., 42 U.S.C. §§ 1395(11), 1396(a) (1970); H.R. REP. No. 92-231, 92d Cong., 2d Sess. 9 (1972).

13. 42 U.S.C. § 1395, *et seq.* (1970).

14. 42 U.S.C. § 1396, *et seq.* (1970).

15. CAL. WELFARE & INSTITUTIONS CODE §§ 14003, 14020, 14063 (1970).

ently safely envision the governmental programs which will affect, if not control, health care delivery in the next decade.¹⁶ One can readily conclude, however, that the effects of these programs will be profound in their impacts, and it remains to be determined legislatively, administratively, and perhaps even judicially, whether those hospitals which have failed to proceed through and obtain approval from voluntary comprehensive health planning will qualify for participation in the governmental programs which will be ultimately developed.¹⁷

Moreover, medical insurance carriers and prepaid medical plan associations have representation on the various voluntary comprehensive health planning agencies and could exert substantial economic influence over non-approved hospitals by not contracting with them for services.¹⁸ Thus, a hospital may well be assuming a significant risk at the onset by failing to obtain voluntary comprehensive health planning approval.

Of course, such a generalization does not necessarily apply universally and some hospital applications which are integrated with prepaid medical plans, such as the Kaiser-Permanente Foundation, may feel warranted in ignoring comprehensive health planning, as they do. But even here, there may well be wisdom in qualifying hospitals as broadly as possible, if only to acquire options which are not yet known. This is particularly true in light of the tremendous recent emphasis being placed upon health maintenance organizations.¹⁹ Similarly, it remains to be determined, both at the state and federal levels, whether so-called "grandfathered" hospitals, which did not proceed through voluntary comprehensive health planning,²⁰ will qualify for governmentally funded health care programs.

16. See, e.g., 42 U.S.C. § 222 (1970).

17. Compare note 20 & note 21 *infra*. See 22 CAL. ADM. CODE § 51207(e) (1971); CAL. WELFARE & INSTITUTIONS CODE § 14105.5 (West Supp. 1973). See also, 42 C.F.R. §§ 51, 100 (1973); 38 FED. REG. 31380 (1973).

18. For example, Blue Cross of Southern California, by resolution of January 26, 1963, resolved "that effective as of the 1st day of February, 1963, the management of Hospital Service of Southern California will not execute a contract with a hospital whose actual construction commenced after February 1, 1963, without taking into consideration the recommendations of a duly constituted area of regional hospital planning body." This action was repealed effective December 30, 1973. However, Blue Cross of Illinois adopted a similar approach on May 22, 1973.

19. CAL. HEALTH & SAFETY CODE § 1175, *et seq.* (West Supp. 1973). Compare, 42 U.S.C. § 1876 (1970); 42 C.F.R. § 51 (1973). See, e.g., The Health Maintenance Organization Act of 1973 P.L. 93-222, 87 Stat. 914, 42 U.S.C. —.

20. Calif. Stats. 1969, ch. 1451, §§ 1, 15. Calif. Health Care Providers Assn. v. Saylor, 4 Civil 12237 [4th D.C.A. unpub. op.] (1973).

Another phenomenon, somewhat peculiar to California, is the proliferation of doctor-owned hospitals, which frequently results in another discernible exception to proceeding with and through voluntary comprehensive health planning.²¹ The compulsion for some doctors to own hospitals may, in some instances, be due to their belief that they can administrate hospitals better than professional administrators.²² In some instances, it may be due to a desire to make more money as investors in their own hospitals, relying in whole or in part upon their being in a unique position to determine when and for how long their patient should be hospitalized in their hospital.²³ But in still other instances, it may be even more fundamental to a doctor's ability to practice his profession fully, which brings us to the question of hospital privileges.

Some doctors are simply not qualified, in the opinions of some hospitals in their communities, to perform various kinds of surgical procedures, whether by virtue of peer review or otherwise. Depending upon the existence and composition of the health care delivery systems in any given community, these doctors may or may not be able to perform significant surgery which requires hospital facilities or hospitalization. In order to avoid stigma among their peers or economic detriment through denial of access to the far more lucrative aspects of medical practice, such as surgery, some of these doctors may feel compelled to establish their own

21. See, e.g., 42 U.S.C. § 1122 (1970), 42 C.F.R. §§ 51, 100 (1972), 38 FED. REG. 31380 (1973); and CAL. WELFARE INSTITUTIONS CODE § 14110, subparagraph (e) (West 1972). But see, CAL. WELFARE & INSTITUTIONS CODE § 14105.5 (West Supp. 1973); 22 CAL. ADM. CODE § 51207(e) (1971).

22. In this context, "doctor-owned hospitals" means those hospitals owned by doctors located in the immediate community wherein the doctor-owner practices. It also includes some chain hospital operations which are frequently publicly owned profit operations, but may enter into contractual arrangements with local doctors whereby the doctor shares in the hospital's profits or gross receipts. Typically, such arrangements are created as a result of a sale by doctor-owners to chains where final purchase prices are to be determined by future receipts, or where a joint venture variation or sale leaseback emerges. But see CAL. BUS. & PROF. CODE §§ 650, 652 (precluding unearned consideration for referral of patients).

23. Ironically, physicians are precluded from owning any interest in pharmacies (other than hospital pharmacies) because of the potential evils inherent in such a conflict of interest. CAL. BUS. & PROF. CODE § 654 (West Supp. 1973). *Magan Medical Clinic v. State Bd. of Medical Examiners*, 249 Cal. App. 2d 124, 135, 57 Cal. Rptr. 256, 263 (1967). But physicians may own hospitals without any restrictions whatsoever.

hospitals wherein they may determine for themselves what types of surgical procedures they are qualified to handle. (It is a recognized fact that many "hospitals" throughout the state lack operating and emergency facilities and personnel, as many an unfortunate has learned, or learned too late.²⁴)

The economic and social impacts, and indeed they are multiplicitous, of the decision to construct or expand a hospital are cumulative and profoundly affect all other present and future health care delivery systems within the confines of any given community.²⁵ To demonstrate the *cumulative* impacts, one can analyze the nature of a component of a health care delivery system, the acute general hospital.

It is, fundamentally, a service system. As such, it is impossible to predetermine, with any accuracy, the volume of use to which the hospital will be put. As a service system, it is readily apparent that there are fixed costs necessary to maintain such a facility. Personnel, material, plant facility and equipment are the most obvious. These must be maintained with consistency, irrespective of the ebb and flow of patient use. By applying the state guidelines, if an acute care hospital were not realizing at least 85% bed occupancy, it would be operating at a deficit.²⁶

What factors would precipitate an under-utilization of 85% bed occupancy? Of course, there is the simple possibility that the population to hospital bed ratio is not properly synchronized, in the first instance, *i.e.*, that there are already too many beds to the existing population. This is a purely quantitative analysis. But a closer inquiry may be justified, in a qualitative sense. Are the beds of a special nature, *e.g.*, intensive care units, cardiac care units, teaching, obstetrical, pediatric? Are the beds situated in a hospital with ancillary facilities which distinguish them from being merely operative and post operative? For example, are there radiological, nuclear or other capabilities being maintained by the hospital? If so, what ratio of such qualitatively qualified beds are desirable in ratio to the population within a defined area? The number of needed or justified teaching hospital acute care beds,

24. The term "hospital" applies without distinction to health facilities lacking emergency facilities or personnel. CAL. HEALTH & SAFETY CODE § 1265. *But see* CAL. HEALTH & SAFETY CODE § 1250(a). In many instances, emergency patients *in extremis* have been rushed to "hospitals" lacking facilities and personnel, to their detriment. See, for example, Nelson, *Some Hospitals Don't Give Care in Emergencies*, Los Angeles Times, April 30, 1973, § II, at 1, col. 5.

25. See, *e.g.*, Herman Smith Associates, *University of California, Irvine; Teaching Hospital Feasibility Study—Phase I* (Dec. 20, 1971).

26. *California Community Health Systems Evaluation & Analysis—Model* (Sept. 1972).

or the number of obstetrical beds, or the number of intensive care unit beds, per thousand population, is demonstrably distinguishable.

Here, then, one begins to see the emergence of a pyramidal and symbiotic relationship between various components and subcomponents of health care delivery systems themselves and the need for meaningful planning and coordination between them. Statutorily at least, both federal and state legislatures have provided some criteria as to how such planning and coordination should be achieved, such as comprehensive health planning, even though merely voluntary at present.

Federal Legislative History

In 1966, Public Law 89-749 (42 U.S.C. § 246) commonly known as "Comprehensive Health Planning and Public Health Services Amendments of 1966", was enacted.

Its accompanying House Report analyzed the Act, in pertinent part, as follows:

Section 2. Findings and declaration of purpose

In this section the Congress recognizes the need for an effective partnership between Federal, State and local governments, and nonprofit private groups for promoting personal and environmental health that Federal financial assistance must be directed to the marshaling of all health resources to assure comprehensive health services for every person; and that the foregoing requires increased leadership capacity in State health agencies and at the community level. This section also states that the Congress finds that Federal financial assistance must be directed to support the marshaling of all health resources to insure health services for every person, but without interference with existing patterns of private practice of medicine, dentistry, and related healing arts.

. . .

Section 3. Subsection (a). Grants to States for comprehensive State Health Planning

(1) Authorization. This paragraph authorizes the Surgeon General . . . to make grants to States which have submitted and had approved by the Surgeon General, State plans for comprehensive State health planning.

(2) State plans for comprehensive State health planning. This paragraph sets forth the prerequisites for acceptance of a State plan for comprehensive State health planning. Such a plan must designate or establish a single State agency (which may be an existing agency) as the sole agency for administering the State's

health planning functions under the plan and a State health planning council (which shall include representatives of State and local and nonprofit private agencies and groups concerned with health, and of consumers) to advise such State agency. A majority of the membership of this agency must consist of representatives of consumers. In addition, the plan must set forth policies and procedures for the expenditure of funds under the plan for comprehensive State planning for health services (both public and private) including health facilities and manpower; and it must provide for cooperative efforts among governmental or nongovernmental health agencies and groups and also for cooperative efforts between them and similar agencies and groups in the fields of education, welfare, and rehabilitation. Each plan must contain or be supported by assurances that the funds paid will not diminish the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning. Provisions must be made in the plan for adequate methods of administration, fiscal control, and recordkeeping. The State agency must give assurances in the plan that it will review its approved State plan not less often than once annually and submit appropriate modifications.²⁷

In 1972, Public Law 92-603 (amending 42 U.S.C. § 1395, *et seq.*, 1396 *et seq.*) commonly known as "Social Security Amendments of 1972", was enacted.

Its accompanying House Report analyzed the initial Act, in pertinent part, as follows:

2. Improvements in operating effectiveness

(a) Limitation on Federal participation for capital expenditures. Under Title XVIII (medicare) depreciation on buildings and equipment, and interest on loans used to acquire them, are reimbursable as part of the cost of providing services to medicare beneficiaries. Such reimbursement is paid without regard to whether the items were constructed or purchased in conformity with any type of health facility planning requirement. Similarly, reimbursement on a cost basis for inpatient hospital services provided under titles V (maternal and child health) and XIX (medicaid) of the Social Security Act includes a recognition of certain capital costs without regard to conformance to planning requirements.

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive area wide planning for the development and utilization of all types of health care facilities. But the acceptance of the purposes of State and area wide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end result of such planning. Thus, while a significant amount of Federal money is currently being expended under the comprehensive health planning provisions of the Public Health Service Act in the interest of furthering health facility planning at the State and local levels, Federal funds are

27. H.R. REP. NO. 2271, 89th Cong., 2d Sess. 10 (1966), 1966 U.S. CODE CONG. & ADM. NEWS 3830, 3839-3840. Cf., 42 C.F.R. §§ 100.105, 100.106 (1972). See also DPA [Designated Planning Agency] Manual, U.S. Dept. of HEW Comp. Health Planning Service (Nov., 1973).

being expended for health services provided under medicare, medicaid, and the maternal and child health programs without regard to whether the facilities providing the services are cooperating in such health facility planning. Your committee believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, your committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts, in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State, and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health care planning agencies. On the areawide level, 125 planning agencies are receiving Federal grants: 72 of such agencies are operational. It is estimated that 140 areawide planning agencies will be receiving grants by the end of June 1971 and that more than 90 such agencies will be operational.

To avoid the use of Federal funds to support unjustified capital expenditures and to support health facility and health services planning activities in the various States, your committee's bill authorizes the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement amounts to providers of services and health maintenance organizations under title XVIII for depreciation, interest, and in the case of proprietary providers, a return on equity capital, related to certain capital expenditures that are determined to be inconsistent with State or local health facility plans. (Similar authority would be provided with respect to the Federal share of payment for inpatient hospital care under titles V and XIX.) Capital expenditures for the purposes of this provision include expenditures (1) for plant and equipment in excess of \$100,000; (2) which change the bed capacity of the institution; or (3) which substantially change the services provided by the institution. The Secretary would take such action on the basis of findings and recommendations submitted to him by various qualified planning agencies. If he determines, however, after consultation with an appropriate national advisory council, that a disallowance of capital expenses would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he would be authorized to allow such expenses.

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit their findings and recommendations (along with those of other

qualified planning agencies) with respect to proposed capital expenditures that are inconsistent with the plans developed by such agencies. (All such health facility and health services planning agencies must have governing bodies or advisory bodies at least half of whose members represent consumer interests.) An adverse decision by a State planning agency may be appealed to an appropriate agency or individual at the State level.²⁸

From the foregoing, two things become readily apparent. First, the Secretary of the United States Department of Health, Education and Welfare has been delegated broad and extensive interpretive and discretionary powers with regard to the promulgation of Federal regulations and policies regarding which health services providers will qualify for federally funded health care programs and the negotiation of compacts with the States.²⁹ Second, the Secretary has been empowered to investigate and explore alternative approaches with regard to ultimately achieving meaningful comprehensive health planning throughout the nation.

Thus, the Comprehensive Health Planning and Public Service Amendments of 1966 constitute a significant, but initial effort to achieve meaningful comprehensive health planning, and the Social Security Amendments of 1972 admittedly are only an intermediate, transitory extension of the initial legislation. In other words, the genesis of legislation in this area is far from concluded, and it is reasonable to anticipate still further, and perhaps even more dramatic, federal legislation. These, then, are the federal initiatives made in this area to which the respective states have had to respond.

California Legislative History

The California legislature was quick to respond in seeking compliance with the federal Comprehensive Health Planning and Public Health Services Amendments of 1966 (42 U.S.C. § 246). In 1967, the legislature enacted into law Part 1.5 of the Health and Safety Code, California Health and Safety Code § 437, *et seq.*³⁰ Indeed, the California legislation recited that it was in direct response to the enactment of Public Law 89-749.³¹

28. H.R. REP. No. 92-231, 92d Cong., 1st Sess. 5 (1971), 1972 U.S. CODE CONG. & ADM. NEWS 4948, 5065-5066. Cf., 42 C.F.R. Part 100 (1972).

29. Compare, 42 C.F.R. §§ 51.4(a) and (d), 53.11 and 53.122 (1972).

30. Cal. Stats. 1967, ch. 1597 p. 3826 § 1. For a review of other state responses, see Curran, *National Survey and Analysis of State Certificate of Need Legislation for Health Care Facilities*, Conf. on Health Planning, Certificates of Need, and Market Entry (1973).

31. CAL. HEALTH & SAFETY CODE §§ 437.5, 437.6 (West Supp. 1973).

This responsive California legislation expressly acknowledges and accedes to federal supremacy, paramount authority, and pre-emption, both legislatively and administratively, by the following:

If any provision of this part is found to be in conflict with federal rules and regulations pertaining to the administration of Public Law 89-749, such provision shall be of no force or effect to the extent of such conflict.³²

Some provisions of the California statutes which are involved were not codified. In 1969, California enacted such a law, the purposes of which are set forth in its initial section, as follows:

Section 1. This act establishes a permanent basis for voluntary area planning to guide communities in developing hospitals and other health facilities of a desirable size and location and commitment to community service purposes. Through continued coordinated development of hospitals and related health facilities and services, including facilities licensed by the Department of Mental Hygiene, the people of the State of California can obtain more effective service and can save substantial sums in capital costs and operating expenses.

Area planning for hospitals and related health facilities and services is complex and includes sensitive relationships between consumers, professional groups, institutions, and governments.

The purpose of this act is to establish a public policy that each hospital and related health facility including facilities licensed by the Department of Mental Hygiene, proposed to be constructed, expanded, or altered for the purpose of increasing bed capacity or changing license category shall in good faith review its plans and program with an approved voluntary area health planning agency or voluntary local health planning agency and obtain its objective reviews and recommendations before proceeding to licensure. It shall also be a purpose of this act that all state and local governmental zoning and planning agencies shall, within the limits of statutory authority, give consideration to, but not be bound by, the actions, recommendations and decisions of such approved voluntary area health planning agency or voluntary local health planning agency.³³

Other sections of the enactment provided for modification and amendments to § 437, *et seq.*, of the Health and Safety Code. Also included were several new provisions, in order to comply with the federal Comprehensive Health Planning and Public Health Services Amendments of 1966. Among these new provisions, which have since been amended, are those which set forth the voluntary

32. CAL. HEALTH & SAFETY CODE § 436.7 (West 1970).

33. Cal. Stats. 1969, ch. 1451, p. 2969 § 1.

comprehensive health planning organization³⁴ and the criteria which they are to follow.³⁵

Of particular significance are the criteria to be applied:

The Advisory Health Council shall develop general principles to guide voluntary area and local area health planning agencies in the performance of their responsibilities under Section 437.7. These principles shall provide for consideration of the following factors and may provide other guidelines not inconsistent herewith:

(a) The need for health care services in the area and the requirements of the population to be served by the applicant;

(b) The availability and adequacy of health care services in the area's existing facilities which currently conform to federal and state standards;

(c) The availability and adequacy of other services in the area such as preadmission, ambulatory or home care services which may serve as alternatives or substitutes for the whole or any part of the services to be provided by the proposed facility;

(d) The possible economies and improvement in service that may be derived from operation of joint, cooperative, or shared health care resources;

(e) The development of comprehensive services for the community to be served. Such services may be either direct or indirect through formal affiliation with other health programs in the area, and include preventive, diagnostic treatment and rehabilitation services. Preference shall be given to health facilities which will provide the most comprehensive health services and include outpatient and other integrated services useful and convenient to the operation of the facility and the community.³⁶

California Administrative History

It is noteworthy that for several years prior to January 1, 1970, voluntary comprehensive health planning was available to any applicant seeking either the establishment of a new hospital facility or the alteration or modification of an existing one, and such voluntary planning was frequently utilized as an avenue.

Indeed, the introduction to the regulations adopted by the California Department of Health, as contained in Title 17 of the California Administrative Code, sets forth these observations:

34. CAL. HEALTH & SAFETY CODE §§ 437.5, 437.7 (West Supp. 1973). The latter divides the state into 12 defined voluntary comprehensive health planning *areas*. With Advisory Health Council approval, these *areas* may further subdivide into *local areas*. The propriety of state creation of these quasi-public bodies to perform this comprehensive health planning function has been ratified by at least one federal court. *Simon v. Cameron*, 337 F. Supp. 1380 (C.D. Cal. 1970). Cf., Jaffe, *Law Making by Private Groups*, 51 HARV. L. REV. 201 (1937).

35. CAL. HEALTH & SAFETY CODE §§ 437.7, 437.8 (West Supp. 1973); CAL. HEALTH & SAFETY CODE § 437.9 (West 1970).

36. CAL. HEALTH & SAFETY CODE § 437.8 (West Supp. 1973).

Several years of experience in voluntary health planning have been augmented by recently enacted Federal and State legislation. The purpose of the legislation is to enhance, encourage and support the voluntary action of consumers and health professionals in the health planning process.

Most recently the State of California through Chapter 1451, 1969 Statutes, has expressed a need for coordination in order that capital expenditures, operating funds and manpower utilization for health facilities will be made primarily in the best interest of the community. The State Health Planning Council has the responsibility of establishing guiding principles to assist voluntary area and local health planning agencies in the performance of their responsibilities for health facility planning.

The responsibilities of voluntary area and local health planning agencies are to assist in the coordinated development of hospitals and other health facilities of desirable size, location and commitment to community service purpose. The statute establishes a process for review of health facility applications to construct, expand or alter bed capacity or licensure category. Hearings and appeals are provided in the law.³⁷

Health facility planning regulations were adopted on October 24, 1970, and amended on January 23, 1971, by the State Department of Health and appear in 17 Cal. Adm. C. § 40500, *et seq.*

The California Health Planning Council was created in 1967 as an advisory unit of the State Department of Health to carry out the intent of the Federal Comprehensive Health Planning Law and Public Health Services Amendments of 1966. The California Health Planning Council, whose name was changed to the Advisory Health Council effective July 1, 1973,³⁸ consists of twenty-five members representing a cross section of consumers and providers of health care services.³⁹ The Council is empowered to establish standing committees,⁴⁰ approve the State Health Plan which is submitted to the Federal Government,⁴¹ recommend approval of the State Health Planning budget,⁴² require state and other agencies to submit data on publicly administered health programs pertinent to effective planning,⁴³ adopt guidelines in health planning to be followed by areawide and local health planning agen-

37. *Id.* Cf., 17 CAL. ADM. CODE § 40518 (1970).

38. CAL. HEALTH & SAFETY CODE § 437, *et seq.* (West Supp. 1973).

39. CAL. HEALTH & SAFETY CODE § 437.05 (West Supp. 1973).

40. CAL. HEALTH & SAFETY CODE § 437 (West Supp. 1973).

41. CAL. HEALTH & SAFETY CODE § 437.4 (West 1970).

42. CAL. HEALTH & SAFETY CODE § 437.5 (West Supp. 1973).

43. *Id.*

cies,⁴⁴ approve the existence of a voluntary area health planning agency for each of twelve designated geographical areas,⁴⁵ promulgate regulations setting forth general principles for planning,⁴⁶ promulgate regulations setting forth administrative procedures for voluntary area and voluntary local health planning agencies,⁴⁷ and consider appeals from voluntary area health planning decisions and make a determination following consideration of such appeals.⁴⁸

The Advisory Health Council has adopted extensive regulations which govern the activities and operations of all area, local and state health planning organizations⁴⁹ and has established five standing statewide committees to facilitate the planning concept: Health Services, Environmental Health, Health Manpower, Health Facilities and Health Information Services.⁵⁰ These standing committees are composed of designated Council members and representatives of organizations, agencies and other groups interested and active in the respective fields of health. All Council and committee meetings are open to the public with notices of the meetings distributed to a wide variety of public and private organizations through state representatives, providers, consumers, official agencies and other groups concerned with health.⁵¹ In accordance with the intent of the Comprehensive Health Planning legislation, the governing boards of the state, areawide and local planning councils consist of a majority of members who are not providers of health services but consumers of such services.⁵² By definition, no person whose major occupation is the administration of health care activities or the performance of health care services can be considered a consumer representative.⁵³

One of the underlying purposes of the Health Planning Law was to stimulate and encourage local and areawide groups in the improvement and extension of Comprehensive Health Planning in

44. *Id.*

45. CAL. HEALTH & SAFETY CODE § 437.8 (West Supp. 1973).

46. CAL. HEALTH & SAFETY CODE § 437.7 (West Supp. 1973). These areawide agencies constitute the so-called "B" agencies because they were established by and under Section 314b of PL 89-749. Due to the size of California, however, some of these area-wide "B" agencies have been further subdivided into "local" agencies. See, note 55 *infra*.

47. CAL. HEALTH & SAFETY CODE § 437.7 (West Supp. 1973).

48. *Id.*

49. CAL. HEALTH & SAFETY CODE § 437.4 (West Supp. 1973).

50. 17 CAL. ADM. CODE § 40500, *et seq.* (1970).

51. CAL. HEALTH & SAFETY CODE § 437.4 (West 1970).

52. It would appear that any citizen may request notice of any and all hearings. See CAL. GOV'T CODE § 54952.3 (West Supp. 1973). Cf., 42 C.F.R. § 100.106(c) (2) (i).

53. CAL. HEALTH & SAFETY CODE § 437.7(a) (West Supp. 1973).

order to promote the development and improved utilization of available and potential health resources. Therefore, the voluntary area and local health planning agencies have been designated the basic and primary units in the comprehensive health planning scheme.⁵⁴ In this regard, the Advisory Health Council has authorized voluntary area health planning agencies in 12 geographical regions to permit inclusion of all counties within the state in the planning organization. Each of these 12 areawide agencies must comply with certain statutory criteria before they can be recognized as authorized planning units, including the requirements that these agencies be incorporated as nonprofit corporations and controlled by a board of directors of health consumers with the balance of the directors being representatives of providers of health services and the health professions.⁵⁵ While there can be but one voluntary area health planning agency in each of the 12 designated regions, each of the 12 area agencies may approve the creation of one or more voluntary local health planning agencies within its geographical region, subject to final approval of the Advisory Health Council.⁵⁶

California Administrative Health Facility Application Procedures

The basic and primary responsibility for the approval or denial of applications for new health facilities or the expansion of existing health facilities rests with the area voluntary health planning agencies.⁵⁷ This is true even when an application is filed originally with, and the hearing is held by, a voluntary local agency. The voluntary area agency in such instances reviews the recommendations of the voluntary local agency and renders a final decision.⁵⁸

In their review of facility applications, voluntary local or volun-

54. CAL. HEALTH & SAFETY CODE § 437 (West Supp. 1973).

55. CAL. HEALTH & SAFETY CODE § 437.7 (West Supp. 1973). However, the State Advisory Health Council arguably possesses supervisory administrative powers over its constituent voluntary area planning agency infrastructure. See 56 OP. ATTY GEN. 239 (1973).

56. CAL. HEALTH & SAFETY CODE § 437.7 (West Supp. 1973).

57. CAL. HEALTH & SAFETY CODE § 437.7(g) (West Supp. 1973).

58. CAL. HEALTH & SAFETY CODE § 437.7(e) (West Supp. 1973). See generally 56 CAL. ATTY. GEN. OPS. 239 (June 5, 1973); 56 CAL. OP. ATTY. GEN. 128 (March 30, 1973); and 55 CAL. OP. ATTY. GEN. 200 (May 10, 1972).

tary area agencies are required to apply their respective local or area health plans to each application in order to determine whether such application warrants approval or denial.⁵⁹ These local or area health plans which are developed and continually modified with a view toward the particular health resources, requirements and projections of the community or area in issue are required to be consistent with the general planning principles adopted by the Advisory Health Council.⁶⁰ Factors which must be addressed in these health plans are: (a) the need for health care services in the particular area; (b) the availability and adequacy of health care services in the area's existing facilities which currently conform to federal and state standards; (c) the availability and adequacy of nonconforming services in the area; (d) the possible economics and improvements in services which may be derived from the operation of joint, cooperative, or shared health care resources; and (e) a general plan for the development of comprehensive services for the communities to be served.⁶¹

In the event a voluntary local or area agency has failed to create or adopt its particular health plan, or if such health plan does not meet the requisite legislative criteria as determined by the Advisory Health Council, the voluntary local or area agency must construe all facility applications pursuant to the criteria specified in the State Health Plan until such time as a local or area health plan is approved by the Advisory Health Council.⁶²

The State Health Plan which is prepared by the Bureau of Health Facilities Planning and Construction of the State Department of Health contains comprehensive statewide health planning objectives and priorities together with detailed statistical information concerning designated hospital service areas in the state. The State Plan indexes and lists information in each designated health service area relating to its current and projected population; the percentage of population 65 years of age and over, the current industry and potential for economic growth, the present bed capacity, usage, and projected need, the number of conforming and nonconforming facilities, and the extent and nature of services provided by existing facilities. The State Plan thus provides the underlying statistical information and projections necessary for a structured evaluation of health facility applications.

59. CAL. HEALTH & SAFETY CODE § 438.4 (West Supp. 1973).

60. CAL. HEALTH & SAFETY CODE § 437.7(c) (West Supp. 1973).

61. *Id.*

62. CAL. HEALTH & SAFETY CODE § 437.8(a)-(e) (West Supp. 1973).

In conducting its business of approving or disapproving health facilities applications, a voluntary agency must hold one public hearing upon reasonable notice.⁶³ At this public hearing the applicant may be represented by counsel and has the right to present oral and written evidence in support of its application and to cross-examine witnesses.⁶⁴ The public hearing must be held before a minimum of five persons, a majority of whom are required to be consumers.⁶⁵ Once a quorum is established and the composition of the meeting is such as to meet the consumer-provider ratio requirements, a vote by a simple majority of those committee members present is sufficient for a decision on an application.⁶⁶ The written findings of fact and recommendations are considered public record and are placed on file with the Department of Health. The voluntary agency upon request must make available a transcript of the public hearing at the expense of the requesting party.⁶⁷

Subsequent to a public hearing on an application, all persons who presented oral or written statements at the hearing are permitted to file with the voluntary area or local agency their written objections to the submitted findings and recommendations.⁶⁸ The actual decision of a voluntary areawide agency or recommendation of a voluntary local agency must be made at a public meeting.⁶⁹ Public notice of such meeting must be given and a quorum of at least one-third of the agency board membership must be present, a majority of which must be consumers.⁷⁰ The purpose of the

63. The California Advisory Health Council adopted the following policy at its public meeting on October 20, 1971: "That the State Health Planning Council adopt the policy that, in the absence of the voluntary local and area health planning agencies having an approved Health Facilities and Services Plan, the State Plan for Hospitals and Related Health Facilities shall be adopted and utilized by these agencies in their review and decisions on applications submitted in accordance with the provisions of Chapter 1451, Statutes of 1969, which are received by these agencies after December 1, 1971. This policy is to be in effect until such time that the State Health Planning Council has approved the Health Facilities and Services Plan for the individual voluntary local and area health planning agencies to guide them in their responsibilities under Chapter 1451, Statutes of 1969."

64. CAL. HEALTH & SAFETY CODE § 437.7(e) (West Supp. 1973).

65. CAL. HEALTH & SAFETY CODE § 437.7(f) (West Supp. 1973).

66. 17 CAL. ADM. CODE § 40516(b) (1) (1970).

67. 17 CAL. ADM. CODE § 40516(b) (2) (1970).

68. CAL. HEALTH & SAFETY CODE § 437.7(f) (5) (West Supp. 1973).

69. 17 CAL. ADM. CODE § 40516(b) (3) (1970).

70. 17 CAL. ADM. CODE § 40516(b) (4) (1970).

public meeting is for the applicable agency board of directors to discuss the submitted findings and recommendations and review any written objections filed thereto. Significantly, the law does not provide for the tendering of any oral testimony or written evidence by anyone at the public meeting, except the above-referenced written objections to the proposed findings and recommendations. This procedure is consistent with the notion that the public hearing is not intended to be a "re-hearing" on the application. Any decision or recommendation of a voluntary agency must be concurred in by a majority of the board of director members present.⁷¹ In the event of a tie vote, the application is deemed denied.⁷² If the application is filed originally with, and the hearing is held by, a voluntary local agency, the voluntary area agency reviews the recommendations of the voluntary local agency and renders a final decision.⁷³

Application Appeals Procedures

The Health Planning Law provides for a variety of administrative appeals. The decision of a voluntary area agency or the lack of a decision of a voluntary area agency are both made subjects for appeal.⁷⁴ The appealable decision may either be the findings of fact and recommendations of a voluntary area agency after it has held a public hearing itself, or it may be the decision of the voluntary area agency after it has rejected the recommendation of a voluntary local agency.⁷⁵

There are two possible appellants in a proceeding where a voluntary area agency acts as its own hearing body. One appellant is the applicant for planning approval, and the other possible appellant is the minority but more than one-third membership of the board of directors of the agency.⁷⁶ Further, in a proceeding where a voluntary local agency was the original hearing body, more than one-third of the members of its board of directors may also appeal a decision of the reviewing voluntary area agency.⁷⁷

An appeal of the more than one-third of the members of the board of directors of a voluntary area agency is made directly to

71. *Id.*

72. *Id.*

73. *Id.*

74. CAL. HEALTH & SAFETY CODE § 438.4 (West Supp. 1973).

75. CAL. HEALTH & SAFETY CODE § 438 (West 1970). *See generally*, 55 OP. ATT'Y. GEN. 200, 204 (1972). *But see* 42 C.F.R. §§ 100.104-100.110 (1973).

76. CAL. HEALTH & SAFETY CODE § 438.1 (West Supp. 1973).

77. *Id.*

the Advisory Health Council.⁷⁸ Similarly, an appeal of the more than one-third of the members of the board of directors of a voluntary local agency is also made directly to the Advisory Health Council.⁷⁹

An appeal by the applicant is made to the consumer members of another voluntary area agency which has been designated by the Advisory Health Council as the appeals body for the original deciding voluntary area agency.⁸⁰ Such an appeal by an applicant must be filed within 30 days after the 90-day period in which the voluntary agency must reach a decision, provided no continuances have been agreed upon by the parties.⁸¹ In the event the applicant is unsuccessful in this appeal, it is granted the opportunity of a second administrative appeal by petition directly to the Advisory Health Council for a hearing on the decision rendered by the voluntary area agency which acted as the original appeals body in the proceeding.⁸² In this regard, there is judicial authority for the proposition that the designated time limit for the filing of an administrative appeal constitutes a jurisdictional limit upon an administrative tribunal's authority to hear the appeal.⁸³

The grounds for administrative appeals from a voluntary agency proceeding either by the applicant or by more than one-third of an agency's board members are as follows: (a) failure of an agency to comply with the procedures required by the Advisory Health Council or its own procedures in considering an application so as to deny the applicant due process and a fair hearing; (b) findings of fact and recommendations not sustained by substantial evidence; (c) action taken arbitrarily, capriciously or with prejudice; (d) action taken not in accordance with the principles for planning adopted by the Advisory Health Council and the voluntary agency in issue; (e) allegation of grounds for disqualification of a director or committee member discovered after the decision was reached.⁸⁴

In accordance with the principle of exhaustion of administrative

78. *Id.*

79. CAL. HEALTH & SAFETY CODE §§ 438.1, 438.3 (West Supp. 1973).

80. CAL. HEALTH & SAFETY CODE § 438.1 (West Supp. 1973).

81. CAL. HEALTH & SAFETY CODE § 438 (West 1970).

82. CAL. HEALTH & SAFETY CODE § 438.3 (West Supp. 1973).

83. *Id.*

84. *Hollywood Circle, Inc. v. The Board of Alcohol Beverage Control*, 153 Cal. App. 2d 523, 526, 314 P.2d 1007, 1009 (1957).

remedies, only a final decision of the Advisory Health Council is reviewable by the courts.⁸⁵ Judicial review of this final administrative decision is available through the appropriate administrative mandamus proceedings.⁸⁶ The administrative record to be lodged with the superior court in such a mandate proceeding would consist of the transcripts, minutes of public meetings, documents, exhibits, and other materials submitted to the Advisory Health Council for its review together with the Advisory Health Council's decision and findings.

Since appeals to the Advisory Health Council and its decisions concern applications for approval of proposals for the construction of new or additional health facilities and such other related applications, all of which involve a determination of whether the applicant qualifies to enter the health care provider field or expand existing health care facilities, judicial review is limited by the substantial evidence rule and the courts will uphold a Council decision unless it is found to lack substantial evidentiary support or infringe upon the applicant's statutory or constitutional rights.⁸⁷

FUTURE DEVELOPMENT OF COMPREHENSIVE HEALTH PLANNING

In California, as elsewhere, comprehensive health planning has been impossible to achieve, inasmuch as hospitals can be constructed or expanded without comprehensive health planning ap-

85. 17 CAL. ADM. CODE § 40522 (1970).

86. CAL. HEALTH & SAFETY CODE § 438.4 (West Supp. 1973). *But see*, 42 C.F.R. § 100.106(c) (1972) prescribing an administrative review by a state agency other than the Advisory Health Council as to qualification for Medicare and MediCal capital expenditure reimbursement, and 42 C.F.R. §§ 100.108, 109 for final review by the Secretary of HEW.

87. CAL. CODE OF CIV. PRO. § 1094.5 (West 1955) provides in part that a writ applies "for the purpose of inquiring into the validity of any final administrative order or decision made as the result of a proceeding in which by law, a hearing is required to be given, evidence is required to be taken and discretion in the determination of facts is vested in the inferior tribunal, corporation, board or officer." The proceeding before a voluntary area health planning agency results in an adjudicatory decision under the health planning law made as a result of a proceeding in which a hearing was required and evidence was taken. Thus, once the administrative appeals are exhausted the decision of the Advisory Health Council becomes reviewable under Section 1094.5 of the Code of Civil Procedure. *Keeler v. Superior Court*, 46 Cal. 2d 596, 267 P.2d 967 (1956). *Cf.*, 55 OP. ATT'Y. GEN. 200, 206, *et seq.* (1972).

The substantial evidence test is applied where an application for a license has been denied [*McDonough v. Goodcell*, 13 Cal. 2d 741 (1939)] or welfare benefits are denied [*Bertch v. Social Welfare Department*, 45 Cal. 2d 524, 289 P.2d 485 (1955)]. In *Bixby v. Pierno*, 4 Cal. 3d 130, 146, 481 P.2d P.2d 242, 253, 93 Cal. Rptr. 234, 245 (1971), the Supreme Court stated the rule to be "In a case involving the agency's initial determination whether an individual qualifies to enter a profession or trade the courts uphold the

proval.⁸⁸ The possible penalties of loss of Medi-Cal participation,⁸⁹ full Medicare reimbursement,⁹⁰ possible loss of private insurance coverage,⁹¹ and one year delay for licensing,⁹² apparently do not discourage such non-approved construction.

It seems clear, therefore, that unless and until comprehensive health planning approval is made a mandatory prerequisite to the licensing of a hospital, hospitals will continue to proliferate unabated.

From a legal standpoint, the imposition of comprehensive health planning approval (sometimes referred to as a "certificate of need") as a mandatory prerequisite to licensing presents significant problems. It seems clear that such an approach is available by law under theories which are utilized and applied with regard to public utilities⁹³ and which invoke the utilization and application of the police power.⁹⁴ That is, the concept of public convenience and necessity is a usual prerequisite to public utility monopoly under public utility laws,⁹⁵ and the concept of a business "affected with a public interest" is similar justification for the exercise of police power.⁹⁶ Even where there is a valid determination that hospitals are affected with a public interest, significant constitutional questions remain, where the right to construct a hospital is sought to be regulated.⁹⁷

agency decision upon the applicant's statutory or constitutional rights."

But see, 42 C.F.R. § 100.108(d) (4), providing that such a determination is not binding upon the U.S. Dept. of HEW with regard to Medicare or MediCal reimbursement.

88. CAL. HEALTH & SAFETY CODE § 1265.5(e) (West Supp. 1974).

89. CAL. WELFARE & INSTITUTIONS CODE § 14105.5 (West Supp. 1973); 22 CAL. ADM. CODE § 51207(e) (1972). *But see* 42 C.F.R. § 100 (1972).

90. 42 U.S.C. §§ 701, 1395, 1396 (1970). *But see* 42 C.F.R. § 100 (1972).

91. *See* note 18 *supra*.

92. CAL. HEALTH & SAFETY CODE § 1265.5(e) (West Supp. 1974).

93. *See, e.g.*, CAL. PUBLIC UTILITIES CODE §§ 1011, 1031 *et seq.*, 1051 *et seq.*, 1061 *et seq.* (West 1956).

94. *Engelsher v. Jacobs*, 5 N.Y.2d 370, 184 N.Y.S.2d 640, 157 N.E.2d 626 (1959), *cert. den.* 360 U.S. 902 (1959).

95. *See* note 93 *supra*.

96. *Accord: Simon v. Cameron*, 337 F. Supp. 1380, 1381 (C.D. Cal. 1970); *Attoma v. Dept. of Social Welfare*, 26 A.D.2d 12, 270 N.Y.S.2d 167 (1966); *Engelsher v. Jacobs*, 5 N.Y.2d 370, 184 N.Y.S.2d 640, 157 N.E.2d 626 (1959), *cert. den.* 360 U.S. 902 (1959). *Cf.*, OP. ATT'Y. GEN. 128, 136 (1973). *See generally*, Barron, *Business and Professional Licensing—California, a Representative-Example*, 18 STAN. L. REV. 640 (1966).

97. *See, e.g.*, *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973).

In its 1973 legislative session, a bill was introduced in the California Legislature to completely integrate comprehensive health planning, licensing and rate regulation for hospitals.⁹⁸ Providers of health care delivery services call the approach "franchising". Indeed, the statutory solution as proposed mandates planning approval as a prerequisite to any future hospital construction or expansion. It expressly provides what has been patently obvious but heretofore unimplemented:

1186. (a) The Legislature hereby finds and declares that:

(1) State policy recognizes the vital importance of having a hospital and related health facilities system in California which makes available to the public the highest capabilities of health science in an effective manner. Current rapidly accelerating rates charged for health care services are a matter of serious public concern which require state controls and surveillance of health facilities development, construction, and rates as herein provided.

(2) State policy recognizes the obligation of state government to assure access and availability of high quality, effectively provided, economical health services to all the people of California. Because of the impact of health care services on public funds, the state has a particular interest in the cost of care for those people whose care is paid for at public expense.

(3) State policy declares that health care facilities are affected with the public interest; involved in the distribution of essential services; obliged to furnish services to the general public at fair, equal, and nondiscriminatory rates; and functioning in an area where usual business competition often does not apply.

(4) State policy, therefore, recognizes an obligation of the state government to provide reasonable and appropriate safeguards to insure that the total costs of health facility services are reasonably related to the total service offered by the health facilities, and that the rates charged by hospitals are uniform for all purchasers of health services.

(b) In light of the foregoing, the Legislature declares it is the intent of the state to develop policies and programs designed to (1) assure equitable access to health facilities and services in health facilities; (2) improve the cost effectiveness of health facilities usage; and (3) assure the provision of quality health services in health facilities at reasonable cost.

(c) It is the purpose of this part, in furtherance of the objectives set forth in subdivision (b), to provide for (1) establishment of a system to retard inflationary cost increases for health care in health facilities; (2) establishment of a single approval authority for construction of new health care facilities; (3) reconstitution of areawide health planning agencies; and (4) establishment of a system to license health facilities and approve special services in health facilities with emphasis on quality of care.⁹⁹

98. 1973 Cal. Legis. Sess. Senate Bill 413 to enact the "California Health Facilities Act." Deleted in Senate Finance Committee on August 16, 1973.

99. *Id.*, commencing at p.4 line 16, proposing new CAL. HEALTH & SAFETY CODE § 1186.

This stringent franchising approach was welcomed and supported not only by the consumer sector, but by existing hospitals themselves, the latter being faced with economic disaster as a direct and proximate result of the proliferation of doctor-owned hospitals. Unfortunately, it was deleted in the California Senate Finance Committee on August 16, 1973. Time alone will tell whether such an approach will be too late in materializing. In many areas of California, the magnitude of overbedding has reached such dimensions that no effective comprehensive health planning can be achieved for decades.

In any event, a stringent franchising approach such as that introduced in the California legislature and discussed herein by way of illustration appears to be the only possible approach which would close the loop between planning and licensing. Until then, we will do without comprehensive health planning. It will be interesting to note the machinations of all concerned in seeking to avoid this inevitability.