HRSA's Role in Primary Care and Public Health in the 1990s

ROBERT G. HARMON, MD, MPH
RONALD H. CARLSON

Dr. Harmon is Administrator and Mr. Carlson is Associate Administrator for Planning, Evaluation, and Legislation of the Health Resources and Services Administration (HRSA) of the Public Health Service.

Tearsheet requests to Mr. Carlson, Room 14–33, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD, 20857.

Synopsis

The principal responsibility of the Health Resources and Services Administration (HRSA) is to see to it that primary health care services and qualified health personnel and facilities are available to all Americans, particularly the disadvantaged and the underserved.

HRSA's resources are directed toward not only the most financially, functionally, and culturally vulnerable segments of the population but also to those who have significant clinical needs such as pregnant women, children, those infected with HIV.

The Agency seeks to carry out its mission in many ways. The central approach, however, is to assure the availability of services to its constituencies directly or indirectly through the more than 50 programs it administers.

This article explains HRSA's role in detail and cites its many ramifications for the nation's health in the 1990s.

PUBLIC HEALTH in the United States can be defined by its mission, substance, and organizational framework as outlined in the National Academy of Science's Institute of Medicine (IOM) Report, "The Future of Public Health" (*1*). This definition addresses the following questions:

1. What are the common goals of public health?
2. What areas of concern does public health address? and
3. How does public health differ from what public health agencies do?

The picture of public health in America presented in the IOM report encompasses functions specific to the role of public agencies, recognizing at the same time that responsibility for assuring basic health services is shared by the public and private sectors. The report emphasizes that the goals and concerns of public health can and should be addressed not only by governmental health departments but also by private organizations and practitioners, other public agencies, and the community at large (*1*).

HRSA's Mission

The mission of the Health Resources and Services Administration (HRSA) can be framed by the three key public health agency functions identified in the IOM report—assessment, policy development, and assurance.

Assessment: monitoring the health of the public. Effective assessment of the public health includes the regular and systematic collection, assembly, analysis, and use of information on the state of the community's health. It also includes dissemination of that information. Assessment provides the framework for policy development.

Policy development: promoting scientifically sound health policy. The development of comprehensive public health policies requires that decision-making and priority-setting be based on the best scientific knowledge. Priorities are established not only by the size of health needs but also by how existing technology or investment in research can meet those needs. Policy development provides the framework for assurance.

Assurance: guaranteeing the benefits of public health for all. The third function of the HRSA mission is to assure the public that the services necessary to achieve agreed-on goals are in place, either by providing services directly or by encouraging and regulating public sector actions that provide them.

In the 1990s, HRSA's principal responsibility is still to assure that primary health care services and qualified health professionals and facilities are available to meet

the health needs of all Americans, particularly the disadvantaged and the underserved. The nation's racial and ethnic minorities, the poor, people in rural areas, and other at-risk groups are broadly and profoundly affected by gaps in the health care system. It is essential that HRSA identify major weaknesses in the system and assist in correcting them.

Filling the gaps in the health care infrastructure, or "assuring the availability of health care," is a responsibility unique to HRSA. HRSA's resources are directed toward, but not exclusive to, serving those who are not only the most financially, functionally, and culturally vulnerable but also a broader segment of the population that demonstrates significant clinical needs—whether they be pregnant women, or children, or those infected with HIV.

The Agency seeks to carry out its mission along many and varied paths. The central approach, however, is to assure the availability of services to its target populations directly and indirectly in the following ways:

- developing the capacity for coordinated, community-based systems of primary care for vulnerable persons in locations of unmet need,
- providing grants for the delivery of health services which are not being financed through other means, and
- supporting the education and training of health professionals and the placement of primary care personnel in underserved areas.

HRSA's Role in Primary Care

HRSA characterizes the functions of primary care as (*a*) to cure or alleviate common illnesses and disabilities; (*b*) to serve as an initial entry, screening, and referral point for the rest of the health care system; (*c*) to identify other human support systems necessary for the effective utilization of health services; and (*d*) to provide guidance and counseling to individuals regarding personal health practices.

HRSA's role in primary care can be defined by the three components of mission, substance, and organizational framework as described in the IOM report (*1*).

Mission. HRSA's primary care mission is twofold: assuring the availability of basic primary and preventive care services, particularly to mothers and children, minorities, the homeless, the poor, drug users, migrant workers, people with AIDS or HIV, those with Hansen's disease, and those who need organ transplants; and providing quality educational opportunities for students and residents in primary care.

With respect to the second phase of its mission, HRSA has a responsibility to assist in training adequate numbers of primary care providers and placing them in the areas most in need of health services. HRSA also assumes a role in training primary care faculty in the skills that will assure their success in the academic environment so that they can successfully serve as role models for potential primary care practitioners.

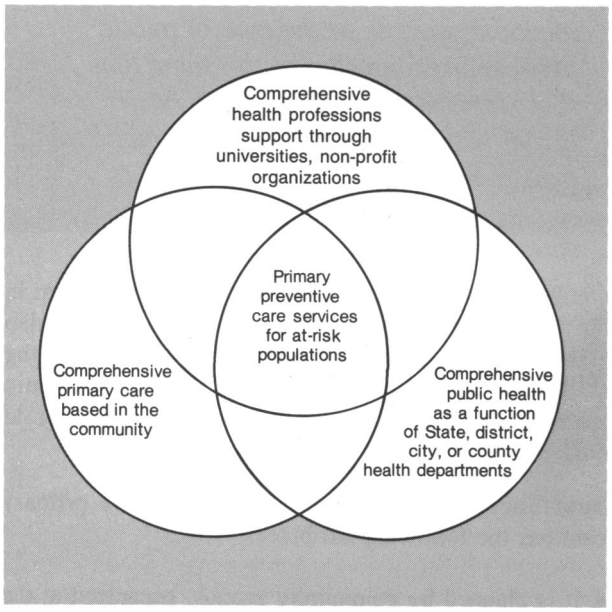
'The picture of public health in America presented in the IOM report encompasses functions specific to the role of public agencies, recognizing at the same time that responsibility for assuring basic health services is shared by the public and private sectors.'

Substance. The substance of comprehensive primary care has the following attributes:

- It is planned by community groups, organized at the local level, and facilitated by collaboration among community providers. It is provided to the extent possible near families needing it.
- It views family members, particularly parents, as partners of the professionals providing care, shares information with the family, assesses and addresses family needs, and recognizes and respects family strengths and ways of coping.
- It recognizes that different cultures have different concepts and practices with regard to health care. It respects these differences, and adapts approaches with these differences in mind.
- It promotes the effective and efficient organization and use of resources to assure access to necessary comprehensive services.
- It relates to physical, mental, and oral health, nutrition, health promotion-disease prevention, emergency medical services, social services, and other necessary supportive and supplementary services.
- It provides continuity of care, assures necessary followup and avoids gaps, redundancies, and incompatible approaches.
- It is available at times that make it fully accessible to all families being served.
- It is available regardless of the family's ability to pay.

HRSA seeks to improve the substance of care by encouraging delivery in the context of 'Community-Oriented Primary Care' (COPC), an approach to primary care practice that combines primary care skills and the

Interrelationship of HRSA primary care programs and public health



principles of epidemiology (*2*). Such capacity building strengthens existing approaches to primary care delivery and incorporates three essential elements of the basic COPC model, each of which must be represented in some form—a primary care program or practice, a defined target population, and a process by which the major health problems of the community are addressed. Of critical importance is that the practice meets the basic characteristics of primary care as mentioned previously.

Organizational framework. The optimal organizational framework of primary care employs closely integrated working relationships at the community level. The relationships involve local public health agencies in collaborative partnerships of public and private entities. As efforts to improve access to primary care for the underserved increasingly require a multi-faceted approach, the need for service coordination and integration becomes increasingly desirable for the following reasons. First, coordinated programs are better able to meet the full range of health care needs of the medically underserved. Second, and equally important, coordinated efforts allow individual programs to maximize their limited resources and provide a broader array of services to more people.

HRSA's role of supporting the primary care infrastructure manifests itself in many forms, with each approach to coordination fitting the unique circumstances and problems of local communities. Some illustrative patterns of coordination are consortia-networks and targeted approaches (*3*). Consortia and networks link multiple agencies in a common organizational structure whose purpose is to address a generic issue, such as improving perinatal care or reducing fragmentation in primary health services. These partnerships incorporate executive-level agency involvement and the commitment by all parties to address their problems through the coordinating structure.

The Primary Health Care Consortium of Dade County, FL, for example, is a network of five federally funded community health centers, State and county primary care programs, the county health department, and a local hospital. The network promotes and strengthens an integrated system of primary care for the medically underserved in the county. Major activities include improving the use of the local hospital through expansion of bed units for health center patients and developing procedures for nonurgent inpatient care; sharing specialty services among centers, and using private physicians to supplement center services when needed; sharing of clinical equipment; and participation in educational placement of trainees and residents to provide additional care.

A targeted or joint funding approach to coordination involves two or more agencies in a joint endeavor to develop and implement a program that addresses a specific problem. Frequently, one or more agencies contribute resources to another agency responsible for the services. Beaufort-Jasper Comprehensive Health Services of South Carolina is a HRSA-funded community health center with effective coordination of funding and resources that support a wide variety of health programs. In addition to HRSA funding, this center receives funding from Medicaid, county and State special project funds, Federal and State funds for environmental health projects and, to a lesser extent, private foundation support. The center contracts with State and local health departments to serve as the principal provider of perinatal care, Early and Periodic Screening, Diagnosis, and Treatment and immunization services, and staffs the local Women's, Infants, and Children program clinics. Furthermore, the center receives local funding to support indigent care, works with the schools to provide a wide range of school-based health programs, and has initiated environmental improvement projects to address sanitation and housing conditions that contribute to disease.

HRSA's role in supporting the organizational framework for primary care is also expressed in coordinating medical education with delivery of service. The aim is to improve the education, distribution, retention, supply, and quality of the nation's health personnel. The essence of the national Area Health Education Centers (AHEC) program, for example, is built on partnerships

among medical schools, residency programs, practice sites in rural and urban underserved areas, and community hospitals, private practices, State and Federal Community Health Centers, and other clinical centers. AHECs, often in collaboration with State primary care associations and State offices of rural health, promote training rotations of medical students and residents from university hospitals to community hospitals and clinics. Faculty development opportunities for full-time and volunteer faculty at these clinics are also supported by HRSA programs. This bridge between academia and the practice community not only helps to improve the quality of personnel through appropriate training and education, but it also serves to improve access to health services for the underserved by focusing on well-defined geographic areas or target populations.

Primary Care and Public Health as Partners

As stated previously, HRSA's role is not to provide directly, but rather to help to assure the availability of services. HRSA's programs are designed to complement existing resources. Therefore, coalition building with other providers of health and social services and other levels of health agencies is a requirement. State and local health departments, universities, and others serve as major players in carrying out the broader goals of HRSA primary care programs.

Building stronger relationships. On the national level, stronger linkages through formal agreements among public health agencies, professional interest groups, and HRSA-supported efforts will facilitate improved coordination of all programs affecting primary care for the underserved. These agreements build on existing relationships with health departments and continue to assist in planning, developing, and implementing primary care services within the State and with the coordination of Federal, State, and local resources. HRSA's goal is to expand the existing 41 primary care cooperative agreements to all States and Territories over the next few years. Such endeavors will require better communication and coordination among State health officials, primary care associations, and the regional offices of the Public Health Service.

Likewise, on the local level, stronger linkages need to be established between county and local health department activities and HRSA-supported programs in primary care, such as community and migrant health centers, services for special populations, and the National Health Service Corps. These programs provide prevention-oriented, comprehensive case-managed primary health care services to those who would otherwise lack access to care, particularly the poor, low-income minorities, pregnant women, and children, the homeless, uninsured, substance abusers, HIV-infected persons, the elderly, migrant and seasonal farm workers, and other high-risk groups.

Coordinating programs between primary care and public health. HRSA programs are closely related to the broader sphere of public health programs. The figure shows the optimal relationship shared by the spectrum of comprehensive public health and comprehensive primary care.

First, the circle encompassing comprehensive public health represents all public health responsibilities, such as disease control, maternal and child health, environmental health, vital statistics, primary care, and others. These activities are assured through State, district, city, or county health departments, although other entities (academic medical centers or private practitioners) may deliver these services as well.

Next, the circle containing comprehensive primary care represents responsibilities such as treatment of common illnesses and injuries and preventive public health services, including maternal and child health, immunizations, and routine screening activities. These services are provided in community-based primary care units such as Community and Migrant Health Centers, staffed in part by professionals recruited through the National Health Service Corps or through linked education and service programs. Other providers, such as private practitioners, teaching clinics, and HMOs, also offer these services.

Comprehensive primary care and public health could not exist without health personnel, many of whom receive training or education through HRSA programs, represented by the top circle. The primary care team may include physicians, nurses, physician assistants, social workers, technicians, and administrators as well as dentists, podiatrists, optometrists, pharmacists, and others. Since primary care involves the coordination of an array of services, a combination of many or all of these various professionals may be needed.

As emphasized previously, the overlapping area—the common ground—is where public health and primary care share responsibility for assuring sound coordination of activities. HRSA's challenge is to assure that its resources are shared and used through effective and efficient organizations.

Targeting resources effectively to fill significant gaps. Effective targeting of resources to deliver primary care to the nation's most disadvantaged and underserved populations is one of HRSA's critical roles in strengthening cooperative relations between primary care and public health. HRSA's resources provide tech-

nical and financial support to build capacity. Agency funding supports (*a*) public-private health science centers to build provider capacity through health professions education, (*b*) State health agencies to assist States in strengthening their capacity to deliver maternal and child health services, (*c*) community and migrant health centers to deliver direct primary care services to medically indigent populations, and (*d*) the National Health Services Corps to increase the supply of appropriately trained health professionals to serve in areas where these providers are scarce. (It should also be noted that other public programs such as Medicaid and Medicare also fund primary care service delivery, as do private third party payers. Moreover, increases in the proportion of third-party reimbursement is a goal of HRSA's primary care service programs.)

The Agency's resources that are directed at filling gaps in the health system are redirected once the non-Federal parts of the system begin to fill them. Therefore, effective targeting of resources is critical to the Agency's mission in taking important measures to assure that existing weaknesses in the nation's health system are corrected, and that all are assured the benefits of public health.

References

1. The future of public health. The Institute of Medicine. National Academy Press, Washington, DC 1988.
2. Community-oriented primary care: from principle to practice, edited by Nutting, P. A. HRSA Publication No. HRSA PE 86–1, Public Health Service, Rockville, MD, 1987.
3. Lewis-Idema, D., et. al.: HRSA programs and coordinated systems of primary care. Prepared under HRSA contract 89–992(p). Public Health Service, Rockville, MD, 1990.

HRSA's Collaborative Efforts with National Organizations to Expand Primary Care for the Medically Underserved

ANABEL BURGH CRANE, MPA

Ms. Crane is Director, Division of Planning and Evaluation of the Office of Planning, Evaluation, and Legislation, Health Resources and Services Administration. Tearsheet requests to Ms. Anabel Crane, Room 14-36 Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857.

Synopsis

As the Federal agency that provides leadership in expanding access to primary health care, the Health Resources and Services Administration (HRSA) manages some 50 programs directed toward the delivery of services and strengthening the base of national health resources. An enabling element of the agency's strategy is the expansion of partnerships with national associations, private foundations, and other entities that share a concern for the health care of the medically underserved. Cooperative efforts with national organizations are intended to promote the integration of public and private resources and encourage adoption of efficient approaches to organizing and financing health care. Medical education in the primary care specialties, State programs for women and children, involvement of managed care organizations with low-income populations, and programs concerning the uninsured are the foci of some of these collaborative relationships.

ALTHOUGH THE U.S. HEALTH CARE SYSTEM has always been fundamentally private, the Federal Government has provided support for the care of special population groups as defined in law. Since the early 1900s, for example, there have been programs to serve mothers and children. Others eligible for federally supported care have included members of the Armed Forces and their dependents, veterans, and American Indians and Alaska Natives. With the advent of Medicaid and Medicare in 1966, the Federal Government began financing health services for the medically indigent and the elderly, thus affecting significantly larger numbers of the general population nationwide. Beginning at about this same time, the Federal role in health services delivery was expanded, primarily through the direct funding of State and local nonprofit public and private entities that provide primary care to underserved populations.

Since 1980, Federal policy has moved strongly toward strengthening the role of States in designing and implementing health programs for citizens who depend on public support for needed services. During the past several years, the Health Resources and Services Administration (HRSA) has pursued a strategy of expanding partnerships with States, national associations, private foundations, and other entities that share a concern for the underserved in addition to managing