A New National Strategy to Make Health Services Flexible and Responsive

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MAKING HIGH QUALITY health services available to the American people is a tremendous undertaking, one in which local, State, and Federal Government enterprises have vital roles, in partnership with the private health sector.

We are now in a period of great and significant change in the way in which we view and deal with these respective governmental roles. It is in this light that I would like to review where we are now in the health service picture, and how we happen to be here. I should like first to go over the new Federal thinking about health services.

I will not try to argue that everything that has happened is a rational progression to our present stance, but I will suggest that what we are now doing is in response to the partial failure of some strongly held assumptions of the recent past and the consequent need to base new policies on new suppositions.

One clear example of those assumptions was the notion that we could drape a national solution over a diffuse assortment of differing local health problems. Federal policies seemed to imply that by addressing problems surfacing in Bridgeport, Conn., we would somehow also rectify the problems which existed in Pocatello, Idaho. To this end, we erected a huge health edifice at the national level, which dispensed many millions of dollars for purposes determined in Washington. Some of this money did a lot of good. Some, it must be acknowledged, was wasted.

This strategy was categorical programing, and it worked just often enough so that we could point with pride to separate instances of improved health care. It is now very evident, however, that this strategy has not solved the health problems of the United States. Consider that:

- In a decade, the average daily hospital room charge for a patient increased 165 percent,
- Millions of Americans still live in areas that are medically underserved,
- Local planning for comprehensive health care services still leaves much to be accomplished,
- Millions of Americans still live in the shadow of potentially disastrous major medical bills which could wipe out their savings and leave their families destitute.

The lesson is clear. The medical marketplace operates under unique, complicated, and outdated ground rules, and there is no real uniformity of need from one community to the next. We have not solved the bedrock problems of health care with fragmented national programs based upon federally established priorities. Indeed, these have led to further fragmented efforts at the community level where health problems occur and where health care must be delivered.

Developing New Strategies

The change this Administration has perceived as necessary is not ideological, but rather realistic and pragmatic. It is based upon a hard look at

real need. We are developing a new national health strategy, based upon a realistic appraisal of what Government can and should do in the health care partnership. We are reorganizing the health functions of the Department of Health, Education, and Welfare in order to meet the changing responsibilities that our new outlook brings.

Federal health responsibilities have expanded and diversified rapidly in the past few years. The history of what was known as the Health Services and Mental Health Administration illustrates this rapid growth. During its 5-year lifespan, HSMHA doubled the number of programs for which it was responsible, reaching by 1972 the unprecedented level of 17 major congressionally mandated programs.

This growth combined with other problems, including those I have mentioned of basic outlook, poses a formidable administrative challenge: How can limited Federal health resources be deployed, managed, and utilized to produce the best possible results—results measured in terms of support to the health care system and ultimately in better health services for the American people? This is the question to which we address ourselves in the current reorganization.

The New Structure

The first step is to develop a workable structure capable of being administered effectively by the Assistant Secretary for Health. The new structure provides for six major agencies, each corresponding to a primary element of the Federal health strategy:

- The National Institutes of Health for the research mission,
- The Center for Disease Control for preventive medicine and public health responsibilities,
- The Food and Drug Administration for consumer protection,
- The Alcohol, Drug Abuse, and Mental Health Administration, to deal with the sociomedical problems of alcohol abuse, drug abuse, and mental health and illness.
- The Health Services Administration (HSA) for responsibilities relating to the delivery of health care and the quality of care,
- And the Health Resources Administration (HRA) to help develop health services resources and to improve the use of those resources.

These last two are the new agencies now in the process of formation. HRA includes three major Bureaus: Health Statistics, Health Services Research and Evaluation, and Health Resources Development.

HSA consists of four Bureaus: Federal Health Programs Service, Indian Health Service, Community Health Services, and a significant new element, the Bureau of Quality Assurance.

In view of the emphasis on health maintenance organizations (HMOs), I would like to focus some attention on the Bureau of Community Health Services in HSA, where the responsibility for HMOs is housed.

The Bureau combines a number of programs whose target is the delivery of care at the community level. These include such longstanding activities as the maternal and child health and migrant health programs, family planning activities, the neighborhood health centers, and two more recent activities, the National Health Service Corps and HMOs.

In the past, these programs, which operated essentially independently of each other, have presented to communities a confusing mixture of often incompatible guidelines and regulations. The new structure will encourage the development of common procedures as well as more effective use of tax dollars and manpower because these programs contain many common elements. Thus, the pooling of program planning, clinical concerns, technical assistance, and the like will make possible considerable Federal efficiencies and savings in manpower, time, and money. An even more important result will be to strengthen the ability of city and county health officials to organize and function according to their local needs without federally imposed categorical dictate or interference.

The Health Services Administration will make every possible effort within the limits of the law to enhance and streamline decision making to insure more effective use of time and money. In this process, we will strive to allow all savings from any mergers of previously categorical activities to remain in the community for reprogramming. The managers of these scarce local health resources should seek the optimum cost-benefit effects for the protection of their communities. The new structure does not in any way represent an attempt to diminish the impact of these important Federal functions. Rather it is designed to bring about the better use of these resources to more effectively accomplish their missions.

The Potential of HMOs

It is within this structure that the Health Maintenance Organization Service is housed. I would like to talk a little about what that Service proposes and how the health maintenance organization idea can help to solve some of the most challenging of our health care problems.

Under terms of Administration legislation now before the Congress, we propose to test nationwide the potential and usefulness of HMOs. We believe that the HMO must demonstrate through sound planning that its tailored premium and benefit packages are what the public wants and can afford.

We have reason to believe that this kind of an organization can prove its worth. While the HMO concept is growing and evolving, it is not totally new. Prepaid medical plans on the HMO model have existed in the United States for 40 years or more. Repeated studies have shown desirable cost-benefit ratios and satisfied customers in the HMO model. Today, some 5 million Americans belong to organizations which are true prototypes of HMOs, and another 1 million are in more limited direct service prepayment plans.

Nevertheless, there is no general understanding in this country of what an HMO really is and does. Partly this is true because HMOs can differ significantly, yet retain the fundamental characteristics which make them HMOs.

These characteristics are as follows:

1. An organized system for the provision of care
2. A comprehensive range of services
3. An emphasis on prevention
4. A voluntarily enrolled subscriber population
5. Dual choice
6. Prepayment
7. Provider risk assumption
8. Consumer participation

An examination of these characteristics may help to indicate why we feel that HMOs should have a favorable influence on the effectiveness and efficiency of our medical care system. We do not propose the HMO as a replacement for present fee-for-service health care. The two systems must and will co-exist, because there will always be practitioners and patients who simply prefer the old system. We are confident, however, that many, both professionals and consumers, will be interested in the HMO approach to the provision of and method of payment for health care. Their preference should be available to them.

An organized HMO system is a separate legal entity or a cooperating group of legally recognized organizations working within a contractual framework to bring together the manpower and facilities needed for the provision of comprehensive health services. These comprehensive services, which can be provided either directly or under contract, include, at a minimum, ambulatory and inpatient physician care, inpatient hospital services, emergency care, and preventive medical services. Most HMOs provide more.

Typically, the preventive services include multiphasic health or screening examinations, immunizations, well-baby clinics, and education. Early treatment of disease, before hospitalization becomes necessary, is a major emphasis of HMOs.

The subscriber population consists of persons who have voluntarily chosen to contract with the HMO for its services. Potential subscribers must

be offered an alternative health service plan, such as Blue Cross-Blue Shield, or a commercial indemnity plan.

As I have indicated, HMOs can differ quite markedly. Two basic types are the centralized plan, of which the Kaiser-Permanente organization is a prime example, and the decentralized or foundation model, exemplified by the San Joaquin Foundation for Medical Care.

Whether centralized or on the foundation model, the HMO plan holds great advantages for consumers, providers, and government alike. For the consumer, the plans provide comprehensive one-stop services. The usual cost of HMO membership for a family ranges from $50 to $60 per month. Also, the HMO assumes the responsibility of providing all necessary medical services to the member, making it unnecessary for him to thread his way through the convoluted maze of general physicians, specialists, and facilities which characterizes the fee-for-service system.

For the provider, the HMO offers a working environment in which he can easily make use of auxiliary personnel and laboratory and X-ray services. He need not hospitalize patients unnecessarily so that insurance will cover certain procedures. He also has ready access to specialist consultation. From the point of view of government as a purchaser of services, the HMO model generally provides a wider range of services for less money with less overhead. In general, HMOs have been shown to be less costly because they provide more outpatient services, and they make less use of expensive inpatient hospital services.

It is satisfying to report that in Washington there is now approaching a rather broad agreement that the HMO concept is a viable, compelling one and that enabling legislation is both needed and forthcoming. Currently there are three separate proposals, including one from the Administration, that deal with HMO authorization, and the differences between them are being narrowed. It is not unduly optimistic to forecast that before long we will have authorization. We would oppose mandating specific services. What finally emerges, we hope, will be an HMO measure that permits a flexible approach, in order to provide the HMOs with the opportunity to innovate, thus placing them on a par with alternative forms of health care delivery.

The key then to all that we are trying to do in health services, including HMOs, is to make health care delivery services as flexible as possible—responsive to the needs of the population served.

Decentralizing Authority

This kind of responsiveness has also been the basic motivation for decentralization of our health programs to the fullest possible extent. The 10 Regional Offices of DHEW are now genuine centers of authority to a greater extent than ever before. Their headquarters are located in Boston, New York City, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco, and Seattle. We are now engaged in increasing their staff capacities to enable them to meet their added responsibilities. The regional health administrators—a new title supplanting "regional health director"—now report directly to the Assistant Secretary for Health and act on his behalf across the broad range of health programs. The reorganization of the headquarters components described earlier is designed to be compatible with this decentralization of authority, although it was not directly prompted by it. The regional health administrators will have greater authority and flexibility in the overall management of their responsibilities, particularly in information, planning, evaluation, and the provision of technical assistance relating to third-party reimbursement, management, accountability, pending special health revenue sharing, and Operational Planning System objectives—to name but a few of their increasing functions.

Finally, it is clear enough that these major changes in the Federal health structure are taking place at a time when we are actively engaged in preparing the way for some form of national health insurance. The new organizational structure is intended to be adaptable to changing patterns of health care financing. It is designed to make the Federal component of the total health system more responsive to the needs for care, now and in the future.

The role of the Federal Government in health care is changing rapidly, but it is by no means disappearing. To the contrary, the future demands that the Federal dollar be spent with greater sophistication and precision than has been possible in the past. That is what we are preparing ourselves to do. In doing so, we look forward to closer and continuing partnership with local leaders and their resources in making better health care for all the people of our nation a reality.