The Health Care Financing Administration: Unlocking Resources

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AMERICANS are a humanitarian and pragmatic people who harbor strong national impulses to help others and to take action when faced with a difficult problem. Within these impulses, I believe, can be found both the source of our present health care cost dilemma and the promise of a solution.

The "do something" impulses have led to great industrial and technological accomplishments and to legislation designed to solve a variety of social problems. One example is the Social Security Act of 1935. The two major programs of the Health Care Financing Administration—Medicare and Medicaid —are embodied in today's version of this landmark law.

Medicare supports medical and hospital care for the elderly and disabled, and Medicaid provides for health care for many low income individuals and families. No one would argue today against the provision of this kind of help for the most vulnerable and needy in our society—the aged, the disabled, the poor. But problems arise when those basic impulses of humanitarianism and pragmatism encounter a changing reality. And that is our situation today: We are in the midst of a health care funding crisis and a growing skepticism about Government's ability to solve problems—problems that can be attributed in part to a national decision to be compassionate to those in need and to act on their behalf.

The growth in spending for health care has been dramatic. Between 1960 and 1979, total spending for health increased from $27 billion a year to more than $180 billion, an increase of almost 700 percent. In 1960, less than 6 percent of the gross national product went for health care; today, the total is nearly 9 percent. Almost 13 cents of every Federal dollar goes to the health industry. The elderly, who account for a large share of this spending, are the fastest-growing segment of the population. Today, 23 million people, 1 in every 10 Americans, are 65 and older. In a generation or so, their total will be upward of 50 million—by 2030, 1 in 5 members of our society will be elderly. In fiscal year 1977, the aged incurred $41.3 billion for health care, 29 percent of the total personal health care bill of $142.6 billion. Federal funds accounted for a large portion of the spending for the aged, totaling $23.4 billion.

The population explosion of the elderly is aggravated by two trends —increased demand and growing costs associated with modern health care. Demand for quality health care is increasing at the same time that sophisticated technology and scientific advances are making that care increasingly expensive. Beyond this "localized" cost expansion within the health care system is the wider national economic context of general inflation. Inflation is the number one domestic problem, and health care inflation fuels that condition. The problem is especially troubling for the health care industry because it is highly visible. Today's hospital bill is always shock-

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ing, and scarcely a family has not received one in recent years. Health care costs stand out, and the industry is a ready target for criticism, justified or not.

Set against these rising trend lines is the reality of limits on fiscal and human resources that can be devoted to health care needs. There is also increasing public skepticism about Government's ability to solve problems. Government agencies concerned with health care are often perceived as overgrown, inefficient, and unable to manage effectively. We are entering an era of limited Government resources, in which a conservative "Proposition 13" attitude is widespread, at a time when high inflation makes health care more and more costly.

But care for those in need—the elderly, poor, and disabled—cannot be denied. Yet, spending cannot be allowed to escalate unchecked. Thus, management of public programs must be improved in order to use those resources we have in the most efficient manner.

As the largest single purchaser of services within this system, the Health Care Financing Administration (HCFA) is under intense scrutiny—a clear target for criticism when any failure of the health system becomes apparent. At the same time, HCFA has enormous opportunities to improve the system. To contribute to the solution of our nation's health care problems, we must apply the highest management skills within the agency and in the health system itself. Every available resource must be used to maximum efficiency and effectiveness. As former Health, Education, and Welfare Secretary Joseph A. Califano, Jr., put it: "Efficient management is, in itself, an act of compassion—for it unlocks resources to be used for human ends." That must be the end product of HCFA efforts—to make every dollar count, to "unlock resources" for the use of Medicare and Medicaid beneficiaries, in a manner which contributes to the productive use of resources throughout the entire health system. Behind every statistic and budget table, at the end of every chain of funding, are people in need. They are the reason for the existence of HCFA.

Our duty is to perform that management task in the most efficient and effective manner possible, managing the funds that drive the health care system in such a way that it will satisfy present needs and accommodate new demands and new directions. Management in this sense is "an act of compassion."

We manage five basic programs: Medicare; Medicaid; Standards and Certification, through which we establish the conditions of participation for institutions serving our beneficiaries; Professional Standards Review Organizations (PSROs), through which quality of services is assured; and the Quality Control Programs, which are working to eliminate fraud and abuse within and outside the programs.

The Medicare and Medicaid programs are administered by the Federal Government through States, intermediaries, and fiscal agents. Funds flow through these agents to providers of services. Through the providers, services are delivered to beneficiaries of the program—the elderly, disabled, and poor.

Our total budget for fiscal year 1980 is more than $44 billion in Federal funds to be used to support health care services for our beneficiaries. This is, indeed, big business, but because of our unique administrative structure, HCFA is not a "big Government." It is a relatively small agency, having less than 4,600 Federal employees to oversee annual spending of more than $44 billion. Total administrative costs are less than 5 percent of its budget. About four-tenths of 1 percent—less than $170 million—is spent on direct Federal administration by HCFA. Another $790 million in Federal funds supports the Medicare and Medicaid program operations through the Social Security Administration. Some $820 million goes to State and local governments for administration of the Medicaid program and $660 million to intermediaries and carriers. Total administrative costs, including PSRO funding and research and demonstration activities, are about $2 billion. The remaining $42 billion, or more than 95 percent of the HCFA budget allocation, is paid out in benefits. Hospitals receive the lion's share of that amount, about $26 billion or almost 62 percent of the HCFA budget in fiscal year 1980. Nearly $8 billion will be spent on physicians' services and another $5 billion on long-term care services.

Thus, the Medicare and Medicaid programs involve a network of actors, the vast majority of whom are not Federal employees. Private insurance carriers and intermediaries and State and local agencies employ another 65,000 full-time equivalent employees. More than 350,000 health care providers are involved in providing services to our beneficiaries.

When the American public says big Government does not work, it is saying in our case that the entire health care network does not work. It is not just HEW or HCFA that is perceived as a bloated bureaucracy, but the entire system that uses Government funding for health. I believe, therefore, that all of us in the health care network have a responsibility to counter that criticism and the current lack of confidence in our ability to solve health care problems by establishing a new record of competence. Competence in terms of our ability to provide quality care, and in HCFA's case, confidence in our ability to manage our programs. Given the prevailing attitude of austerity, our programs are already at risk. Unless we establish our ability to manage effectively, there will be restrictions in the future. The end result would be a reduction of benefits for those who need them most. Our challenge is to do our job better.

We must improve the efficiency of our programs by making certain that every possible dollar is turned into service delivery. We must eliminate abuse and waste anywhere they may occur. We must achieve these ends in order to use the funds we have to the greatest effect and, additionally, to nurture public confidence in our programs.

In July 1979, HCFA completed a massive reorganization designed to help us manage our programs more efficiently. We first defined our agency's mission, the major functions which we perform, and our priorities for the coming year. We then restructured HCFA in a manner which enables us to fulfill these objectives.

The three basic elements of HCFA's mission are:

- To promote the timely delivery of appropriate, quality health care to HCFA beneficiaries—the aged, the disabled, and the poor.
- To make certain that beneficiaries are aware of the services for which they are eligible and that those services are accessible to them and provided in the most effective manner.
- To ensure that HCFA policies and actions promote efficiency and quality within the total health delivery system which serves all Americans. This requires a constructive relationship with providers and third parties involved in that system.

To accomplish that mission, HCFA must carry out three basic functions—setting policy, contracting for administration, and monitoring performance. Everything else HCFA does as an organization relates to these three functions and to trying to improve our performance in carrying them out.

In addition to these three critical functions, our key priorities for the next year include:

- Improving access to care and quality of services for our beneficiaries.
- Improving management control, including tighter performance standards, improved quality and financial control, and stronger internal audit capability.
- Ensuring appropriate use of health care services through the PSROs, as well as our own efforts, and ensuring that our standards of quality are met by all providers.
- Reducing fraud and abuse to ensure public confidence in our programs and guarantee that those eligible for benefits through our programs receive them.
- Simplifying our programs, particularly through the integration of the administration of Medicare and Medicaid where practicable. This streamlining can lead to increased provider participation and improved access to health care for our beneficiaries.