Partnership for Health and Medicare

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THE WORDS "fragmentation," "overlap," "waste," "duplication," and "gaps" have increasingly crept into the jargon of persons concerned with improving the delivery of health care in the United States. It appears that this terminology will be with us as long as medical care remains a collection of bits and pieces or until we can transform the "nonsystem" of health care into an integrated system in which needs and efforts are closely related.

As those of us in the Federal Government strive to overcome these obstacles to providing the American public with the most efficient and economical care, we should be acutely aware of the parallel challenge we face in carrying out our own organizational missions. We cannot allow fragmentation in Federal health programs if we are going to progress toward integration of the total health picture. Last fall, the opportunity to meet this type of challenge head-on emerged with the formation of the Community Health Service. This new organization, one of the nine major components comprising the Health Services and Mental Health Administration, includes programs and activities formerly in the Division of Medical Care Administration (DMCA) and the Office of Comprehensive Health Planning (OCHP). Among its many responsibilities, DMCA was charged with developing, evaluating, and recommending minimum standards for health care providers under Title XVIII, the Medicare Program. OCHP had the responsibility of administering the Partnership for Health Program.

Current Separation of Programs

Medicare and Partnership for Health share a philosophy and, as time goes on, they can develop effective operational linkages. The emphasis has to be on the word "can": "can build," "can develop," and "can interrelate." At present, the two programs tend toward splendid isolation, which is not surprising. They were conceived in response to different problems, and interested and involved different groups during their legislative development and implementation.

Problems. Medicare grew out of the need to find better mechanisms to assist the aged in financing their health care costs. Incidentally, or maybe not quite so incidentally, hospitals and other providers of services were helped with some of their touchy money problems.

Initial agitation for the Partnership for Health legislation came principally from State health departments. They were tired of the frustrations caused by multiple, rigid formula grant programs and set about to revise one of the basic laws governing the activities of the Public Health Service.

Since a major piece of legislation was being overhauled, there was time and opportunity to resolve another problem: namely, the need to encourage a more orderly review of the health scene on a nationwide basis. So planning and support for public health-oriented activities were coupled in the revised legislative package. Then as the shape of the final law became more apparent, the legislation was seen as a vehicle for molding intergovernmental as well as governmental-nongovernmental relationships.

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In its final form, the law and its regulations blended three separate and distinct interests.

1. Planning to expose the health problems of the nation.
2. A partnership to work on the problems.
3. Money, a goodly portion of which is allocated to State health and mental health departments, to help reduce identified health problems.

Persons involved. Early development of each program delineated its specific functions. So too did the fact that different people were involved in implementing each program.

To some extent, this fact is logical. Medicare has involved an unprecedented number of agencies, institutions, associations, and personnel in its operations. At least during its early stages, the Partnership for Health Program is involving fewer and less diverse people, most of whom are in governmental positions or with areawide hospital or health and welfare councils.

Even if one agency participates in both programs, different people are involved. For example, many State health departments have responsibilities to both programs, but most frequently one group in the department carries out Medicare certification activities, another group works in health planning, and too rarely do the two groups get together. Similarly, many hospital associations probably have separate committees appointed for the two programs.

The observation about diverse personnel is not offered as criticism. People absorbed in the implementation of each program had to meet rigid deadlines, and they worked to capacity resolving the operational difficulties entailed by each program. The necessity for total concentration on a single program was a fact of life. Nevertheless, a second fact of life has become the tendency to perpetuate the narrow focuses of concentration; to encourage development of an individual momentum for each program; in short, to consider each program as a separate entity.

Factors Precluding Program Isolation

This tendency toward separatism may be expedient, but too many factors are at work which will discourage if not preclude it.

The programs share a philosophy. Medicare and the Partnership for Health Program have compatible conceptual bases. Each, in its own way, emphasizes the importance of comprehensive health services.

Of the two, the Partnership for Health legislation speaks out most explicitly on comprehensive health services. Familiarity with the words of the preamble has not reduced their challenge. "The Congress declares that the fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living. . . ." As if to remove all doubt, the preamble continues ". . . that the Federal financial assistance must be directed to support the marshalling of all health resources—national, State and local—to assure comprehensive health services of high quality for every person. . . ."

Admittedly, the term "comprehensive health" is subject to many definitions, depending upon the person speaking and the context within which the phrase is being used. Within the context of this legislation, however, the term unquestionably is used to embrace both environmental and personal health needs.

As to personal health, the preamble carries two connotations. One relates to the potential need of persons for preventive, diagnostic, therapeutic, and rehabilitative services—a series of words easy to recite, but such services are not always given. The second connotation relates to the resources required to meet these individual needs. These resources include hospitals, extended care facilities, home health agencies, laboratories, personnel, and so forth. Obviously, these resources must be available if Medicare benefits are to be more than a paper promise.

Medicare's involvement in comprehensive health care stems as much from economic and political concerns as from philosophical convictions. Insuring only hospital care easily could lead to heavy reliance on hospitals as a dominant location in which to care for the aged.

Acknowledging this potential reliance, the designers of Medicare accepted the idea of including posthospital extended care and home health services as benefits. Then, in the political climate of the time, the argument about the cost of physicians' services quickly led to the addi-

tion of Part B benefits. Influential as these political and economic arguments were, the expansion of benefits would not have occurred if it had been contrary to the philosophy of the program's supporters.

So, in a very real sense, Medicare is the practical application of the charge in the preamble to the Partnership for Health Act. Medicare excludes preventive care and some diagnostic services, but it provides other diagnostic as well as therapeutic and rehabilitative opportunities. Further, through various administrative devices, Medicare encourages provision of these services in the most appropriate setting. Providing services leads to focusing on the availability and interrelationships between resources which, in turn, are concerns of comprehensive health planning.

Programs cannot realize full potential independently. By sharing interests and problems, the two programs can gravitate naturally toward each other. This gravitation will accelerate because neither program can reach its full potential independently.

Medicare is basically an action-oriented program. This orientation creates the program's strengths and weaknesses. Based on patterns established by voluntary insurance, Medicare covered selected health care costs for selected groups of people. Medicare was never intended to serve simply as a collection and redistribution mechanism or to maintain a neutral role in health care. From the beginning, through congressional sanction of standards, Medicare began influencing quality of services.

In addition to causing positive changes, Medicare has highlighted problem areas including the (*a*) power of a financing program which aggravated personnel shortages, (*b*) potential for disrupting organizational patterns even while fostering some improvements, (*c*) poor health practices, (*d*) dilemma of quality versus availability of health services, and (*e*) a legion of other difficulties. Because it is such a massive and therefore influential financing program, Medicare has the potential for supporting improvements in the organization of care. However, Medicare does not provide the framework to encourage simultaneous attention to the interlocking problems. This lack can be remedied by comprehensive health planning.

In contrast to Medicare, which has a well-defined task, the Partnership for Health Program is more theoretical and encompassing. This orientation gives the Partnership for Health Program strength ever while saddling it with handicaps.

The Partnership for Health Program begins with a loose confederation of ideas. The first several sections relate to planning. Only a general charge is issued to the planning agencies under the guidelines for this program.

1. Make the scope of planning broad.
2. Consider the whole State and all its residdents.
3. Be concerned with all health and associated problems that affect the well-being of people.
4. Consider all types of health services, facilities, and manpower available or to be developed.
5. Undertake a variety of informational, consultative, and promotional activities including recommendations for actions by public and voluntary agencies, public and private institutions, and persons from all sectors.

The planning sections of the act are followed by those authorizing formula and project grants. In concept, the two sections are viewed as interrelated, with the first laying out problems and the second part serving as a tangible, financial commitment to help meet the problems. In practice, considerable portions of the formula grant funds necessarily must be devoted to supporting usual public health activities.

The guidelines in the Partnership for Health Program provide unusual (and, to some people, frustrating) leeway, but their generality was essential. The program is not directed toward solving specific, delimited conditions. It is intended to establish a framework and mechanisms for cooperative efforts. The program concentrates on structure and process, properly leaving to States and localities responsibility for spelling out specific topics to be considered.

Although the generality leaves room for adaptation to local need, it also can contain pitfalls. Possible objectives for the planning activity can become overwhelming. For example, one agency listed 22 objectives (*1*). All these objectives were reasonable; but their number alone, not to mention their complexity, could well intimidate the best of planners.

The complexity of present health issues also can stymie efforts. It automatically invites the collection and analysis of vast data and stimulates study after study. The complexity can lead to members of advisory councils grappling at meeting after meeting with seemingly unmanageable problems. No one will be satisfied unless the process will lead to visible results. Medicare can help comprehensive health planning avoid pitfalls by providing tangible, well-defined problems.

National concerns will force cooperative activity. Combining the theoretical and practical can be beneficial to both programs. The cooperative approach will be given a strong incentive by nationwide concerns which cannot be quieted or ignored any longer.

Rising health care costs continue to be a headline issue. Admittedly this is not a new issue. Nor are the rising costs totally unwelcome, since they reflect many beneficial changes. Better pay for hospital personnel, improved technology, and more people receiving services are only a few of the advantages. Nevertheless, the commonplace prediction of $100 per day costs for hospital care cannot be accepted complacently.

Furthermore, concerns over costs are coming into perspective. In the past, the impact of costs affected the population in a scattered fashion. Some patients felt it when they were discharged from the hospital; management and labor experienced it during collective bargaining; Blue Cross, when requesting a rate increase; and hospitals when they heard from Blue Cross.

This diffusion of impact is a phenomenon of the past, however. Medicare, the largest payment program in the country, changed this. When Medicare is affected by rising costs, Government officials must take cognizance of the fact. When, as the law requires, the Secretary of Health, Education, and Welfare announces an increase in the deductible, aged citizens, hospitals, and many others soon feel the impact.

The natural response to the coalesced reaction is to look hard at the reasons for the rise to sort out the justifiable causes from those which are evidence of ineffective use of the health dollar. From there it is only a short step to seeing a potential relationship between Medicare and comprehensive health planning.

Mutual Interests and Support

Circumstances and a natural compatibility create an active relationship between the two programs. Medicare engenders problems for attention and comprehensive health planning provides the environment for dealing with them. Then Medicare, in turn, can provide tools and information to reinforce the planning process. As a starting point for collaborative effort, two questions might well be asked: "What services are needed?" and "How good are they?"

What services are needed? Traditionally the question about needed services has been answered in terms of number of hospital beds, number of nursing home beds, and on down the list of requirements. The result too frequently was a disjointed recitation.

Both Medicare and the Partnership for Health legislation are forcing changes to be introduced in methods used to calculate need. Partnership for Health stresses the broad overview on an areawide as well as State basis. Medicare supports this view through its broad benefit structure, and it emphasizes that the continuum of care desired for aged persons depends upon a range of services. Medicare emphasizes extended care and home health services as desirable complements and alternatives to hospital care. In effect, a payment program is breathing life into the concept of progressive patient care.

Patient requirements should be the dominant factor in spelling out community and State needs for services and facilities. Nevertheless, legislative and administrative requirements can exert their influence. For instance, Medicaid (not Medicare) now requires that a beneficiary entitled to skilled nursing home services also be entitled to home health services. In other words, home health services are being further emphasized, and State health authorities would do well to recognize it. These developments are not remote from hospital associations or individual hospitals. To the contrary, they have a vital role to play.

It is one thing to say that refined measures for determining facility requirements are badly needed; it is another to acquire the data and techniques to make the determination. Medicare

provides data which can be used to profile health facilities in a community and permit evaluation of their interrelationships.

Hospitals can add to the data. Hospitals' utilization review committees are noting people who do not need to be in hospitals but cannot be discharged because there is no adequate way to continue their care. Frequency of these instances suggests the need for out-of-hospital services. Data on needed outpatient services are not a scientific basis for planning, but they are a practical beginning and should be brought to the attention of State and areawide planning agencies.

Medicare and Partnership for Health Programs can foster comprehensive health and progressive patient care; they can build administrative mechanisms into their programs to encourage adoption of the concepts. In the final analysis, however, patients, physicians, and hospitals have to apply the concepts in established practice.

Hospitals can demonstrate their acceptance of these concepts—and the concepts will become the prevailing ideas—in numerous ways. For example, hospitals can introduce extended care and home health services. There is some movement in this direction. Approximately 650 hospitals have extended care units, providing a little less than 15 percent of the beds. Some 160 have home health programs.

As an alternative to being directly responsible for out-of-hospital services, hospitals can work actively with other agencies in the community. There is no record of what really is being done, but there are plenty of opportunities for cooperation. Transfer agreements between hospitals and extended care facilities represent one method of cooperation. There is nothing to prevent hospitals from taking the initiative in using this admittedly minimal requirement as a foundation for encouraging a pattern of cooperative efforts.

How good are the services? The question of what services are needed may well be the most absorbing concern in the immediate future, but it would be foolhardy not to consider the quality of these services at the same time. The certification process of Medicare exposes existing weaknesses. Hospital personnel would do well to urge that proposals for overcoming deficiencies in services be included in the State planning agency's recommendations. Also, these persons might encourage State health departments to arrange, sponsor, and fund from formula grant monies supportive activities which cannot be financed through Medicare.

Among such activities already underway are training programs to upgrade skills of personnel, to make specialists available for consultation, and to encourage shared use of scarce personnel. These activities are beneficial to the public's health and quite appropriately a concern of State health departments.

Form and Effect of Interrelationships

Availability and quality of services are of mutual interest to hospitals, Partnership for Health, and Medicare. Receiving increasing attention is how formal the link between the two Federal programs should be and what effect this relationship will have upon hospitals.

Form of relationship. The link can be tangential, with Medicare simply offering a topic for consideration by comprehensive health planning. The interweaving can occur informally, with persons intimately involved in Medicare serving on advisory councils to State and areawide planning agencies.

There is some suggestion that the links might well be constitued on a more formal basis. One suggestion that has found its way into print (*2*) is that conditions of participation in Medicare be expanded to include a requirement related to planning.

Capital expenditures can be a link. It was proposed, as part of the 1967 social security legislation, that when institutions participating in Medicare make substantial capital expenditures that are not in accordance with statewide health plans, the Department of Health, Education, and Welfare would have authority to reduce the reimbursements to the institutions or to terminate their participation in the program.

Although this idea was adopted by the Senate, it was dropped in conference. That proposal, which would have been the tightest link between the programs, was intended to augment the amendment to comprehensive health planning legislation, enacted in 1967, which requires

State planning agencies to assist each health care facility to develop a program for capital expenditures which is consistent with an overall State plan. Some form of program interrelationship is inevitable because planning, services, and financing for both programs cannot be carried out separately.

Effect of relationships. The most immediate effect of the anticipated interrelationship between the programs is fear. Fear should not be brushed aside lightly; its basis deserves careful thought.

Fear of Government intervention is often expressed. Standing alone, Medicare and comprehensive health planning each can be highly influential forces. Functioning together, they can be more so. It is essential that their influence always is constructive and beneficial. Following the traditions of this country, both programs have built-in protection mechanisms to see that this occurs.

Medicare is far from being a federally dominated program. The active and sometimes vocal participation of fiscal intermediaries, States, and the hospitals themselves assures a tempering effect when it is needed. The protective device in the Partnership for Health Program is provided by the mandatory advisory councils, with the requirement that the majority of the representatives be consumers.

Fear of domination is not a one-sided phenomenon. The Government has much at stake in regard to the health of citizens and also has a responsibility to the public. Government can no more afford to leave the responsibility for the nation's health totally to the private health sector than can the voluntary sector relinquish all its responsibilities to Government.

The fear would be diminished if it were expressed properly. The approach to effective health programs is not "public" or "private," it is "public and private." The problem is how to accomplish a blending of interests effectively and to establish a bona fide partnership for health.

Accompanying fear of domination is fear of loss of autonomy. Planning automatically will raise questions about location of special services, possession of sophisticated equipment, conversion of under-utilized hospitals into extended care facilities, withholding reimbursements from substandard facilities, or constructing new facilities of questionable need.

The questions will cause cries of indignation. Having a hospital is important to a community. Benefactors are willing to donate money for a building but understandably derive little satisfaction in underwriting a transportation system to move patients to a nearby facility. Physicians pressure hospitals to compete with other institutions. Hospitals are reluctant to trust their futures to outside influences.

Fears engendered by interrelating health programs can be alleviated if voluntary and official health agencies and vendors of services stop thinking in terms of facilities and concentrate instead on patient needs. A patient does not need hospital care alone, he needs a spectrum of services. Most hospitals now cannot meet the total needs of the patient; they already depend upon other agencies and institutions. Community health systems already exist; it is important to make them effective. Independent and isolated efforts cannot be effective; coordinated effort must be substituted.

Once the hesitancy to cooperate is overcome, another fear may well set in. This is the fear of inability to plan well. Planning is a relatively new discipline in the health professions, and its widespread acceptance has been artificially stimulated. Concern is growing that results of planning will not be evident quickly enough.

Most statements about planning to date have been optimistically laudatory. It might be far better to take the realistic approach and listen to the advice of Professor May (*3*).

> Since 1930, planning for optimal health services has been viewed as desirable. First interest on the part of knowledgeable leaders in the health field, later large sums of money, and now a public mandate have been provided in support of the movement. Yet it remains in its adolescence. Whether it matures into a responsible, creative adult, or remains a groping unsure teenager, is a function not of the amount of money poured into it or the number of words poured out by the agencies and others involved, but rather of the wisdom and expertise brought to bear on the problem by the people involved and the intelligence and receptivity of people whom the planning process affects.

Finally, it helps to remember that all health programs are only intended to help achieve better health and better health care. There

can be no quarrel with the desired end. This intention provides incentive for making the programs perform well.

REFERENCES

(*1*) U.S. Public Health Service: Hospital and medical facilities series (under the Hill-Burton Program). Series B—Community planning: Procedures for areawide facility planning. A guide for planning agencies. PHS Publication No. 930–B–3. U.S. Government Printing Office, Washington, D.C., 1963.

(*2*) Somers, A. R.: Medicare: Way to make planning effective. Mod Hosp 108: 100–103, 172, June 1967.

(*3*) May, J. J. P.: Health planning: Its past and potential. Health Administration Perspectives No. A5. Center for Health Administration Studies, Graduate School of Business, University of Chicago, Chicago, Ill., 1967, p. 52.

Tearsheet Requests

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New Program to Finance Nonprofit Hospitals Begins with Illinois Hospital

A hospital construction project to cost $24,853,812 will begin soon in Rock Island, Ill., under a new Federal program that involves both the Department of Housing and Urban Development and the Department of Health, Education, and Welfare. The project is the first to be approved for construction under the Nonprofit Hospital Insurance Program, which was enacted under title XV of the Housing and Urban Development Act of 1968 (Public Law 90–448).

The program provides for mortgage insurance by HUD's Federal Housing Administration to finance new and modernized hospitals, including major movable equipment to be used in operating them. The mortgage amount for a hospital project may not exceed $25 million or 90 percent of the estimated replacement cost of the project and equipment. The mortgage term is 25 years, and the current maximum interest rate is 7½ percent. The hospital must be owned and operated by nonprofit corporations and associations. Plans for expansion or new construction are approved by HEW's Health Facilities Planning and Construction Service, which administers the nationwide Hill-Burton program. No application for mortgage insurance is approved unless the State Hill-Burton agency has certified that a need exists for the facility and that reasonable minimum standards for licensing and operating hospitals are in force.

FHA has issued a commitment to insure a 25-year $21 million loan to replace St. Anthony Hospital, established in 1893, by a large new complex to be renamed the Rock Island Franciscan Hospital. It will have 261 general hospital beds, 50 mental health beds, 40 rehabilitation beds, and full outpatient services. New construction will include an eight-story building, a two-story mental health center, and a total energy plant to supply heat and electricity for both buildings.

In addition to the mortgage loan, the hospital will receive grants from the National Institute of Mental Health, $920,264; the Illinois Mental Health Program (for the hospital's Comprehensive Community Mental Health Center), $332,075; and the Public Health Service's Hill-Burton program (for rehabilitation facilities and the diagnostic and treatment center), $580,200.

Upon completion of the new hospital on a 38-acre site in 1971, it is expected that two wings of the present hospital will be converted to an extended care facility. The existing hospital has 212 beds, only 49 of which conform to Hill-Burton standards. The new complex will serve an area with a population of about 80,000.

Program Notes

Alcoholism Services

The Baltimore (Md.) City Health Department has established a new program of alcoholism services in the city's southern health district. Under the program, Mrs. Alice E. Gracie, alcoholism counselor in the health department, will assist public health nurses with the problems of alcoholism and the care and treatment of alcoholics.

Each week a public health nurse will meet with Mrs. Gracie and present the case of a patient who is, or is suspected of being, an alcoholic. Together they will visit the patient's home. Mrs. Gracie will evaluate the patient and make recommendations. According to Dr. Robert E. Farber, Baltimore City Commissioner of Health, all public health nurses in the southern district will eventually receive such help.

Colorado's High Nurse Ratio

Colorado has 29.4 full-time public health nurses per 100,000 population, compared with an average of 18.8 for the United States. Forty-one percent of all nurses employed in public health in the State are between the ages of 40 and 59; 56 percent are under 40. In the United States, 59 percent of such nurses are between 40 and 59.

Of the 697 nurses engaged in public health work in Colorado, 60 percent have a bachelor's degree or higher, and 58 percent have had public health preparation. Of the 603 working full time, the percentage with a bachelor's degree or higher is 64 percent.—*Colorado's Health*, March–April 1969.

Tough Antipollution Laws

On June 25, 1969, Governor Richard B. Ogilvie of Illinois signed into law several bills giving the attorney general of the State broad new powers to act against water and air polluters. Attorney General William J. Scott, who sponsored the administration-backed bills, commented that the result is "the toughest anti-pollution enforcement laws in the United States."

Two of the bills permit the State to close down sources of pollution anywhere in Illinois by filing mandamus or injunction suits. Two other bills increase maximum penalties of water and air polluters. Fines of $5,000 instead of $500 can be levied; daily fines are increased from $100 to $200; the 30-day maximum jail sentence is increased to 6 months.

Housing Patients' Relatives

After operations or at other times when a patient's condition becomes critical, relatives can stay for short periods on the premises of the Lakeville Hospital of the Massachusetts Department of Public Health at minimal cost and receive their meals in the hospital cafeteria.

Parents of children with cerebral palsy who are admitted for short-term treatment and intensive physiotherapy can also be housed. The parents are permitted to participate in treatment and to learn methods of physiotherapy and occupational therapy applicable to the care of their children. These aspects of treatment can then be carried on more effectively at home.—*THIS WEEK in Public Health* (Massachusetts Department of Public Health), June 23, 1969.

"Brush-Ins" for Dental Health

To try to bring about partial prevention of dental decay among children, the division of dental health of the Montana State Department of Health has initiated a program of "brush-ins" in elementary schools. By the end of the 1968–69 school year, the program had been carried out in two schools in Billings and in the Ravalli County schools.

Conducted in cooperation with local dentists, these brush-ins, or self-application programs, include teaching children to brush their teeth in the proper way while using acidulated phosphate fluoride paste as a vehicle to provide the fluoride ion. An educational program in dental health is included. Mothers serve as volunteers after being trained in the proper method of toothbrushing and other essentials.

Dr. A. Jack Terrill, director of the division of dental health, considers the procedure of self-application effective enough to be carried out empirically in any area of Montana, based on results of the program to date in Montana and the results of laboratory tests in North Dakota. The North Dakota study, he pointed out, indicated that penetration of the acidulated phosphate fluoride by self-application seemed to exceed that from a solution application.—*Treasure State Health*, July 1969.

Screenees and Treatment Lapses

Seventy-two of 505 employees of the Colorado State Department of Highways and the State Patrol who were screened in a recent multiphasic program were found to have at least one abnormal test result. Subsequently, 38 of the 72 were confirmed as having previously unrecognized chronic disease—diabetes, high blood pressure, chronic lung disease—and 28 persons were put on active treatment regimens. One year later only 15 persons remained on their prescribed treatment.

"Evaluation of the educational impact of the screening program showed an increase in the target population's knowledge of chronic diseases but no evidence of favorable effect on behavior," according to Dr. Edward Gilmore, heart disease and stroke control officer, Public Health Service.—*Colorado's Health*, March–April 1969.

Items for this page: Health departments, health agencies, and others are invited to share their program successes with others by contributing items for brief mention on this page. Flag them for "Program Notes" and address as indicated in masthead.