Mission of the HEALTH SERVICES and MENTAL HEALTH ADMINISTRATION

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AMERICAN medicine is doing more things well, for the benefit of more people, than ever before in our history. Its scientific capability has heightened dramatically in recent years. Many factors, especially a series of legislative acts in the health and social welfare fields, have brought good medical care within financial reach of additional millions of Americans.

At the same time, however, readily accessible medical care of high quality remains outside the experience of other millions of the nation's urban and rural poor. Indeed, and for a variety of reasons, many who are not poor find health care difficult to obtain, excessively costly, or below the standards of quality of which our society is scientifically capable. The enormous needs for better health care have now become as manifest as the heightened expectation of all our people that these needs shall be met. This combination of need and expectation has generated overwhelming pressure on the capacity of the American health enterprise.

For this reason, I consider the mission of the Health Services and Mental Health Administration to be one of the most challenging in all of Government. For, as I view its mission, HSMHA is designed and intended to enhance, in every appropriate way, the capacity of American medicine to meet the needs of the people for health care. And I have unlimited confidence in our will and desire to respond to this challenge.

HSMHA's aim is to work toward good health care for every American. Its function is to strengthen each component involved in the delivery of care. To this end, we are involved in partnerships with every element of the purveyor system—the physicians, the hospitals and the other community institutions and agencies, the State and regional authorities, and voluntary groups. We are also in partnership with the consumers of health care, who have an important role to play in assuring that they are well served.

Medical care is an individual and family af-

fair. It takes place in the community and is dependent upon local resources, acting locally—the health worker in the neighborhood, the physician and nurse in the office or clinic, the surgical team in the hospital. Thus, because of the particularly personal and local nature of health care, whatever we do in the Federal Government, in Washington and across the nation, must ultimately be responsive to community problems and community needs. Ours are national resources which, to be useful, must be relevant to local needs and made available in ways that encourage local adaptation and synthesis. I am confident that in their new organizational setting, HSMHA's component elements can use these resources to make a total impact that is greater than the sum of the parts. Let's look more closely at this new structure and its resources.

Components of HSMHA

The Health Services and Mental Health Administration was established on April 1, 1968, as a part of the general reorganization of health activities in the Department of Health, Education, and Welfare. It became one of the Department's three major health agencies.

The largest single component within HSMHA is the National Institute of Mental Health, which has as its basic mission the improvement of the mental health of the American people. NIMH activities strengthen the capacity of the American health enterprise in many ways. The institute conducts extensive programs designed to develop new knowledge through research, to train manpower, and to support mental health services. It is also involved in the prevention and treatment of mental illness and in the promotion of mental health.

Next in size is the Community Health Service. This service administers the broad range of programs authorized by the Partnership for Health Act of 1965, as amended, including comprehensive health planning at State and local levels and the formula and project grants for health services. It is responsible for the grant program to support improved health services for domestic agricultural migrant workers—one of our most vital programs in terms of response to acute human needs. The Community Health Service also performs continuing activities of technical assistance and support in medical care administration, such as those related to standards for health resources participating in Medicare and Medicaid.

The Hospital Facilities Planning and Construction Service administers the Hill-Burton Program which has been a major force for more than two decades in making hospital care geographically accessible. The program is now being reoriented to respond to changing priorities in the health facilities field.

The Regional Medical Programs Service conducts the program authorized by the Heart Disease, Cancer and Stroke Amendments of 1965. In 55 regions across the nation it is stimulating effective cooperation among providers of health services so that the results of research in prevention, diagnosis, and treatment can be brought rapidly to the aid of patients suffering from these and related diseases. It thereby plays an important part in upgrading the general level of care available to the American people. Through these efforts, the RMP Service acts as a bridge between biomedical research and the application of the growing store of knowledge throughout the health service system.

The Indian Health Service and Federal Health Programs Service are responsible for the direct delivery of medical care to specified groups—American Indians and Alaska Natives, merchant seamen, and other Federal beneficiaries. These operations contribute significantly to the total capacity of American medicine in two ways. They provide services to groups not otherwise reached, and they can serve as proving grounds for innovative approaches to the delivery of care.

The National Center for Health Services Research and Development, formally established on July 1, 1968, stimulates and supports experimentation with new methods of delivering health care. It seeks to apply scientific methodology in the social and behavioral sciences to the organization and delivery of medical care in the community setting. The Center is giving high priority to devising new approaches to the delivery of medical care for the poor and to testing methods which show promise of controlling and reducing health care costs.

Two well-known and long-established public health programs are integral parts of HSMHA. The National Center for Health Statistics, a ranking statistical agency of Government, collects and provides data which define and describe the changing state of health of the American people. These data, in turn, furnish the basis for setting priorities, both nationally and locally, and constitute baselines against which progress can be measured.

The National Communicable Disease Center, in Atlanta, Ga., provides leadership and expertise to States and communities in preventing and controlling infectious diseases. NCDC leadership has been responsible, in large part, for the virtual eradication of poliomyelitis and the dramatic reduction in measles over the past few years. It is currently spearheading a national immunization program to reduce drastically the tragic congenital defects resulting from the effects of rubella on unborn children.

In addition, HSMHA is now administering the maternal and child health programs authorized under title V of the Social Security Act. These programs include a range of vital health services, not the least of which is family planning. The National Center for Family Planning Services, established in October 1969, will develop family planning programs for the Department of Health, Education, and Welfare, mesh them with other Federal efforts in this area, and function, additionally, as a clearinghouse for the collection, organization, and dissemination of family planning information.

This quick description of HSMHA programs indicates the very broad sweep of its responsibilities. Now I should like to illustrate briefly how these programs relate to each other and to the broad mission of HSMHA—strengthening the capacity of U.S. medicine to provide high-quality health care to all Americans.

HSMHA's Unity of Purpose

For a long time, it was widely believed that the predominant barrier to good health care was financial—that given sufficient money, anyone would receive the care he needed. Acting on this assumption, the Federal Government invested heavily in financing medical care through enactment by the Congress of the Social Security Amendments authorizing Medicare and Medicaid in 1965. This essential and enlightened action has enabled millions to pay for care they urgently need and could not otherwise afford.

Meanwhile, the greatly heightened demand for medical care has placed enormous stress on the capacity of the American health enterprise. Increased patient loads have made it extremely difficult for physicians and health care institutions to maintain high standards of quality. The increased demand, imposed on a relatively static and limited supply of health resources, has produced strong inflationary pressures, and costs have shot upward. In short, we have found that issuing money tickets into the health system, while necessary, is by no means the whole solution to the problem but has, in fact, contributed to a chain of events that has brought the health system to a point of crisis.

On July 10, 1969, Secretary Robert H. Finch and Assistant Secretary Roger O. Egeberg of the Department of Health, Education, and Welfare delivered to the President a "Report on the Health of the Nation's Health Care System" which opened with these words:

> This Nation is faced with a breakdown in the delivery of health care unless immediate and concerted action is taken by government and the private sector.

Later in the same document they issued this call to action:

> Our task now as a Nation is to acknowledge the extreme urgency of the situation, to take certain steps to arrest the inflation that is paralyzing us, and to put in motion initiatives that ultimately will reshape the system. This task is obviously not one for government alone, although government has a major role to play. Much of the burden must be taken up by the private sector since it has the primary responsibility for the delivery of health care.

The Secretary and Assistant Secretary then listed a number of specific responses to this crisis. Among these initiatives were a number of actions designed to build the capacity of our national health resources so that they can respond to the scale of the challenge. These responses recognize the central fact that governmental action in the health care field must, because of the particularly local and personal character of medical care, have its impact in the community. For it is there that physicians and hospitals face, every day, the demands of serving more people better than ever before.

The Federal Government in the past few years has initiated a number of programs aimed at strengthening health care capacity, programs with payoff at the local level. Most, though not all, of these programs have been pulled together in HSMHA, and it is this mission that gives HSMHA its unity of purpose. Let me mention a few programs on the "capacity" side of the health care equation.

The first, historically, is the Hill-Burton Program. It has added 300,000 beds to the physical facilities of the American health enterprise over more than two decades. It has pioneered in planning procedures to help assure that these additions to the system truly strengthen capacity rather than needlessly duplicating it. Now it is giving primary emphasis to modernization of existing facilities which have been allowed to become obsolete.

In the manpower field—the second basic building block of capacity—somewhat different kinds of Federal approaches have evolved in the past few years, notably through the programs of the Bureau of Health Professions Education and Manpower Training of the National Institutes of Health and the Department of Labor. These approaches are designed to augment the total national supply of manpower upon which communities ultimately draw. Within HSMHA, the National Insitute of Mental Health has primary responsibility for training a broad range of personnel urgently needed in mental health. In addition, NIMH is supporting innovative approaches to the development of new kinds of health professionals, taking advantage of such untapped resources as returning military medical corpsmen.

Perhaps above all else, we need to make better use of the resources already available in communities across the nation. Several programs, mostly of very recent origin, are now underway with the purpose of strengthening capacity by improving the ways in which health care is organized and delivered in the community.

Focusing on the Community

One of these is the neighborhood health centers effort of the Office of Economic Opportunity. This program is aimed at the target of immediate accessibility of health care at the neighborhood level. It has involved deployment of existing resources in new patterns and the creation of new resources. Community response has made it dramatically clear that these efforts can fulfill needs that are deeply felt by health consumers.

Within HSMHA several programs operate as levers for raising the capacity of community health resources. The community mental health centers program is bringing treatment of mental illness out of remote isolation and into the environs of the community. It is also thereby advancing the prevention of mental illness in highly significant ways.

Project grants under the Partnership for Health Program are encouraging new modalities of care, supporting innovative efforts of a variety of health institutions and agencies. Many of these projects, which emphasize primary ambulatory care, are also reaching into neighborhoods and districts where care has been least accessible in the past.

The health program for migrant farmworkers augments community capacity to serve a group whose overwhelming health needs have not been met under the existing system.

New programs with direct community impact are emerging in such critically important fields as narcotics addiction and suicide prevention.

In addition, as I have already noted, our direct medical care programs constitute an important extension of community capacity, nationwide, by serving Indians and others for whom such care has been extremely difficult to obtain.

With the transfer to HSMHA of the maternal and child health programs, the role of our Administration has been greatly strengthened. These include well-established programs with direct community impact that are already exerting effective leverage to strengthen the capacity of health care delivery systems. Their new organizational placement presents an opportunity for us to enhance the total impact of our efforts.

I have been emphasizing the delivery of health care because that represents the central thrust of HSMHA programs. In doing so, however, I should stress also that we are deeply involved in the prevention of disease, in the health implications of malnutrition, in the advancement of family planning in the context of

health services, and in still other activities essential to the maintenance of health. I feel strongly that such programs must increasingly become a part of the basic health system of every community if these programs are to be fully effective. Probably the most complex challenge faced by HSMHA, however, is how to bring these diverse programs together for maximum effectiveness.

Each program should be viewed as a source of strength upon which the community may draw, singly or in combination, according to its own needs and priorities. The synthesis of these community-target efforts must take place in the community itself if it is to be truly meaningful—in terms of real health care delivered to individuals and families. Thus, the task of Federal health services programs, I believe, is to facilitate this synthesis in every possible way.

Our support to the States is one important mechanism. We are fostering comprehensive health planning at the State level and providing formula grants to State agencies for health purposes. The intent of these efforts is to strengthen each State's ability to assist communities in achieving health objectives.

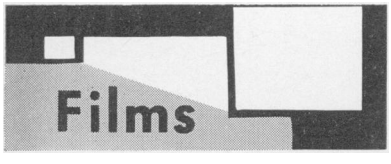
Our support of areawide planning agencies under the Partnership for Health Act is another mechanism designed to achieve synthesis at the community level. The role of the agencies that we see emerging is one of community trusteeship. These planning agencies bring together the consumer and the purveyor of health services to oversee the distribution and use of resources, identify the unmet needs, and set realistic priorities. They represent not an operating agency but rather a focal point for community responsibility in health.

The regional medical programs constitute a powerful resource upon which the community may draw for resolution of health problems. They pull together into an effective functioning alliance the full medical strength of the region, to assure that the best in care can, in fact, be delivered where it is needed.

It is very clear that our administration of these diverse resources must, at all costs, avoid rigidity or the imposition of preconceived patterns upon a community. We cannot view each program's mission fragmentarily or one-dimensionally. Rather we must be flexible enough to respond to the needs of the varied neighborhoods and communities where health care is delivered to individuals and families.

Tearsheet Requests

HSMHA Information Office, Room 17–A–53, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852

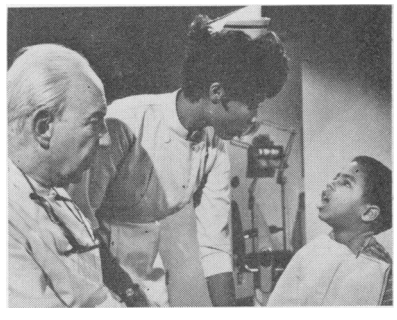


Stop Rubella. *Order No. M–1749. Motion picture, 16 mm., color, sound, 13½ minutes, 1969. Produced by the National Medical Audiovisual Center in Atlanta, Ga. Cleared for television.*

SUMMARY: Features the stars of the television series "Julia," Diahann Carroll, a nurse, and her costar, Lloyd Nolan as her boss, Dr. Chegley. The film begins in an entertaining fashion and ends with an appeal to parents to have their children, 1 year to puberty, vaccinated against rubella.

In a brief interview during the film, Dr. H. Bruce Dull of the National Communicable Disease Center describes how the vaccine is to be used and why it is necessary to protect mothers by immunizing children. The disease, sometimes called "German measles," caused defects in 30,000 babies born to mothers who caught the disease during pregnancy in the 1964 national rubella epidemic.

The film, through stylized animation, shows the rubella virus attacking the unborn child in the womb. It introduces the developers of the vaccine, Dr. Paul D. Parkman and Dr. Harry J. Meyer, Jr., of the Division of Biologics Standards, National Institutes of Health.



AVAILABLE: The film may be purchased from General Services Administration, National Archives and Records Services, Washington, D.C. 20209. Attention: Government Film Sales, price, $48.50.