
E000610

REVIEW OF PROGRAMS AND ORGANIZATION OF THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

A REPORT PREPARED FOR

THE ASSISTANT SECRETARY FOR HEALTH

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I. STUDY PERSPECTIVE

On February 21, 1973, a special work group was convened by the Assistant Secretary for Health who delivered the following charge:

"... undertake a broad review of HSMHA's programs and organization, and their interrelationships with the other health agencies."

"...submit to the Secretary, by April 15, 1973, an organization plan which will:

(1) reflect recent and projected changes in the programs administered by HSMHA

(2) be designed to help achieve the Department's goals in the field of health services with maximum management effectiveness and efficiency."

1. EXTENSIVE INTERVIEWS WERE CONDUCTED.

Also explicit in the charge was the desire to achieve broad input into the study through extensive interviews. During the course of the study, more than 80 officials and staff inside and outside HSMHA were interviewed by the task force. The list of interviewees is shown in Appendix A.

2. THE APPROPRIATE FEDERAL ROLE IN HEALTH PROVIDED THE BASIS FOR THE ORGANIZATIONAL ANALYSIS.

The appropriate federal role in health has been summarized in recent statements by Secretary Weinberger and Under Secretary Carlucci. This role is:

(1) Financing of Health Services to reduce financial barriers affecting access to health care. The current vehicles for accomplishing this are Medicare and Medicaid. A more comprehensive approach to national health insurance is likely.

(2) Health and Medical Research activities that have broad national benefits but whose high investment costs make it difficult for the private sector or State and local governments to make an adequate annual investment.

(3) Preventive Health and Consumer Protection activities that can be achieved best through collective action, such as regulation of the manufacture and sale of foods, drugs, and medical products; and preventive health and safety activities, such as the control of communicable diseases.

(4) Limited Technical Assistance and Special Start-Up Funding for Demonstration of structural changes in

the system, to introduce new types of facilities or manpower, or to demonstrate new types of delivery systems.

(5) Health Manpower Education Programs as part of a general educational initiative that will place principal reliance for accomplishing this role on the institutions of higher education with Federal support through general student assistance programs administered by the Office of Education. Limited Federal assistance may be needed to overcome especially difficult supply and geographic distribution problems, or to demonstrate the validity of new types of health professionals.

(6) Direct Provision of Health Care Only as a Last Resort. The Federal government's responsibilities to provide health and medical services directly to certain population groups, such as reservation Indians and merchant seamen, will continue until these groups are provided for adequately under other mechanisms.

3. THE STUDY HAD TO BE BROADENED BEYOND JUST THE HEALTH SECTOR OF DHEW.

With the study requirements to reflect actual and projected program changes and achieve the Department's goals in the field of health services with maximum management effective-

ness and efficiency, the scope of the study could not be limited to programs within the NIH, FDA, and HSMHA. Major decisions have been made by the Administration that have widespread impact and implications beyond the present health services organizational structure. Therefore the issues identified and recommendations developed cut across agency lines.

II. STUDY FINDINGS

The findings in this study fall into three general categories: those impacting health services across agency lines; those dealing with the HSMHA organization as presently structured and those pertaining to regional operations.

1. HEALTH CARE FINANCING PROGRAMS NEED TO BE DEVELOPED AND ADMINISTERED IN THE CONTEXT OF A TOTAL HEALTH STRATEGY.

Medicare and Medicaid together represent the largest single Federal influence on the nation's health care delivery system. Together they pay for almost one third of the inpatient hospital bills in the U.S. Expenditures for these programs are estimated at $17.4 billion in 1974, or almost 80% of the HEW health budget. Because of their uncontrollable nature, outlays for health financing and their share of Federal health outlays can be expected to increase.

An important factor in the rapid rise in health care expenditures is the failure to achieve changes in the supply and organization of health services that are consistent with the increased demand generated by the availability of financing. Because of the impact financing programs have had on inflation in health care costs, new methods are being devised to attempt to utilize Federal financing programs to contain these rising costs. In line with these efforts, increased attention

needs to be paid to problems and inefficiencies of providers and to financing decisions that affect provider activities and costs. In addition, plans and programs that affect the financing of health services need to be integrally related to activities aimed at the development and modification of systems of health care delivery resources.

Currently, the major Federal health financing programs are operated by agencies whose concerns are not the substantive issues of financing insurance programs' impact upon health care delivery, but rather managing large scale payment programs and determining eligibility of beneficiaries. Although some HSMHA programs are attempting to capture third party reimbursement for services, and have provided professional advice regarding standards for participation in financing programs, the health agencies of HEW have not been in a position to significantly influence Medicaid and Medicare. Moreover, the Assistant Secretary for Health, even with nominal "policy guidance" responsibility for health financing, has not been able to affect the financing programs in an appreciable way.

The effect of a broad national health insurance program upon the nation's health care delivery system will be even more profound than that of Medicaid and Medicare.

It is critically important that the present and future health financing programs be integrated with other Federal health activities.

The following are examples of the integral relationships between future health activities and the financing programs that can be achieved most successfully through single leadership:

-- The benefit package for national health insurance should be designed with a view toward medical necessity and efficacy of services covered rather than their similarity to other insurance plans.

-- The continuing supply and distribution of health care resources need to be integrated with the demands for services generated through financing.

-- The development and administration of national health insurance should embody the experience gained from Medicare, Medicaid, HSMHA, and NIH biomedical research in a whole range of activities such as treatments for specific diseases, and efficacy of medical care.

-- The determination of what constitutes the essential mental health services to be covered under national health insurance should be based on the expertise of NIMH.

-- The effective development of preventive health activities should consider whether prevention would be accomplished more effectively through coverage of preventive services under financing or through collective action.

-- Coverage of preventive health services under national health insurance should be based on the experience of HSMHA as to their efficacy.

-- Reimbursement of Federal service projects through national health insurance can be accomplished much more easily and quickly under single leadership that could mandate, for instance, reimbursement of free-standing clinics under Medicaid or reimbursement of NHSC personnel by Medicare. There is presently no single focus to effect this integration.

-- Research priorities for both health services and biomedical research should be developed with a view towards the health problems encountered through the financing system.

-- Economic considerations of providing and influencing distribution of health resources through reimbursement policies need to be fully explored.

These examples illustrate major issues in Federal health programs that can only be fully explored and resolved if all health programs are considered integrally and if the

financing programs are fully utilized to determine the outcomes. Such issues can most successfully be resolved by consolidation of all HEW health programs, including financing programs, under single leadership and responsibility.

The present operations of health financing programs are not integrally related to the other program activities within SRS and SSA. Both MSA and BHI receive administrative support and overall policy direction from their parent organizations. Eligibility determination for Medicare is the only function that would have to be maintained within the current context of the income maintenance programs, but it could be performed on a service basis by SSA, with reimbursement from the operating health agencies as appropriate for the services provided.

In the case of Medicare, eligibility for all social security benefits is determined uniformly by SSA staff, and records of eligibility are maintained centrally in SSA for each beneficiary. Records on utilization of Medicare are maintained by the carriers and intermediaries. Records on beneficiaries' payment of the required Medicare deductible are kept centrally in SSA, but are not a part of the larger record system on social security beneficiaries'

utilization of other social security benefits. These activities are routine and do not impact significantly on the health delivery system and could, therefore, be continued in the current fashion and paid for by BHI on a service basis.

The operation of the Medicare program and its payment system are relatively self-contained within BHI. The activities conducted in BHI -- the certification of providers for participation in Medicare, contracting with the fiscal intermediaries and State health agencies, and determination of reimbursement policies in terms of reasonableness of cost and appropriateness of care received -- are the ones that have a major influence on the health care delivery system. The removal of BHI from SSA would not seriously disrupt either these activities or the other ongoing operations of SSA.

For Medicaid, both eligibility determinations and the payment of individual claims are the responsibility of the States. The Federal functions with respect to both eligibility and reimbursement policy are limited to developing regulations and guidelines. Federal payments to the States for Medicaid are made centrally in SRS, but the operation is a relatively simple one of determining the allowable Federal share of the total States'

Medicaid costs. The part of the payment operation in SRS that relates to Medicaid could easily be identified and run by MSA. Although Medicaid admittedly has less influence on the health care delivery system than Medicare, it is the development by MSA of Federal guidelines to the States for reimbursement policy that is critical to influencing the system. In addition, these guidelines need to be consistent with Medicare reimbursement policy in order to achieve the maximum impact on the health care delivery system. MSA could be removed from SRS without disrupting either the Medicaid program or the other operating programs in SRS.

2. THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH WILL REQUIRE STRENGTHENING AND REALIGNING TO EFFECTIVELY ASSUME ITS ROLE AS A FOCAL POINT FOR ESTABLISHING AND DIRECTING HEALTH POLICY.

Although the Assistant Secretary for Health has been identified as the principal official responsible for the Department's health policies since April 1968, his office has never been staffed or aligned to carry out this responsibility effectively. Furthermore, he has not been in a position to direct or to be held accountable for the implementation of established policies. The Assistant Secretary, for instance, has budgetary responsibility for only about 20% of the HEW health budget. The

result has been lack of an integrated health strategy. The authorities and capabilities of the Assistant Secretary for Health must be enhanced to resolve these problems.

There has been increasing overlap and duplication of staffs and activities between the various health programs of the Department especially in the areas of research, statistics, and financing standards. The current fragmentation of leadership and accountability means duplication and waste of staff as well as lack of any effective focus for activities that bridge the financing and service programs, such as PSRO's. This lack of focus has resulted in considerable confusion of responsibility and activity not only within HEW but also throughout the private sector which must relate to the federal health financing programs. The Assistant Secretary's responsibilities should be defined so that he can be held accountable for the planning and implementation of all the Department's health programs.

3. THE CHARACTER OF HSMHA MUST UNDERGO DRASTIC REVISION TO ACCOMMODATE THE NEW FEDERAL ROLE IN HEALTH.

The present character of HSMHA reflects the development of a variety of categorical grant programs during the 1960's. It is composed of 16 categorical programs with narrowly defined missions, each operating relatively independently

and largely without a clear definition of their relationship to an overall health strategy. These programs and functions must be reorganized and redirected to contribute more effectively to the Department's health leadership responsibilities. New relationships must be established to relate HSMHA programs more effectively with the current health financing programs and to a future program of national health insurance.

4. THE RESPECTIVE ROLES OF THE HEALTH AGENCIES, ESPECIALLY IN APPLIED RESEARCH AND CONTROL ACTIVITIES, ARE NOT CLEAR.

Since the establishment of HSMHA and the realignment of the other health agencies in 1968, the major trend in health services programs has been toward the delivery of health services in a comprehensive manner. Biomedical or disease-oriented research has been maintained in a categorical setting. The Cancer and Heart and Lung Disease Acts of 1971 and 1972, however, call for initiation of categorical "control" programs in community settings to expedite the translation of the results of research into medical practice. The re-introduction of categorical service activities in a research setting has confused both the role of research programs with respect to delivery of health services and the role of service programs with respect to comprehensive approaches to service delivery.

In addition, applied research that is ostensibly relevant to many health activities has grown up in virtually every health agency of HEW. The question arises, then, of whether this research is more effectively carried out in an independent research setting, or whether it should be integrally related to the programs it supports.

5. THE ROLE AND ORGANIZATIONAL PLACEMENT OF THE HEALTH MANPOWER PROGRAMS NEEDS TO BE REDEFINED.

The health manpower development activities of the Department were organized in a Bureau of the Public Health Service in January 1967. The organization provided policy focus for manpower education; unified management of a number of special educational support programs for health professionals; and a focus for developing innovative methods in health manpower education. The Bureau was moved to the NIH in 1968 in recognition of the overall impact of research and educational support programs on medical schools and institutions of higher education.

Until recently, the programs in the BHME have been concerned primarily with the education of health manpower and have therefore focused on academic institutions. Questions of utilization, distribution, and payment for manpower were considered by health services and financing programs. Most of the health service programs have therefore established separate manpower development activities to

address these issues as they relate to their particular health service mission.

Federal support for education will be provided primarily through general student assistance rather than categorical support for educational institutions. The budget request for 1974 phases out many of the institutional support programs of the Bureau, while increasing special programs to stimulate development of new and flexible methods to train and utilize personnel.

These activities and the manpower efforts that have proliferated among HSMHA programs need to be combined to eliminate the duplication and confusion which currently exist. A focal point is needed that views the provision of trained manpower for the delivery of health care services as a form of resource development to be undertaken with a view towards its ultimate utilization and reimbursement.

6. HSMHA IS A CONGLOMERATE OF SPECIALIZED CATEGORICAL PROGRAMS WITHOUT A CENTRAL PURPOSE SUPPORTIVE OF OVERALL HEALTH POLICY. INTERPROGRAM COMMUNICATION AND COORDINATION IS MINIMAL AND CLUSTERING OF PROGRAMS HAS BEEN MARGINALLY EFFECTIVE IN CORRECTING THIS PROBLEM.

HSMHA was created in 1968 primarily to bring together all programs concerned with the provision of health care. It currently consists of 16 separate operating programs,

most of which have a separate and unique legislative mandate to address a narrowly defined problem within the health care delivery system.

Viewing HSMHA as a whole, there is a broad range of diverse activities that has evolved as each program established separate components designed to meet its unique objectives. These range from direct delivery of care to technical assistance and basic research. Many of the functions established in the separate programs are similar. Most programs have developed a technical assistance and grants management capability, for instance, and half of the programs have specialized training and research activities.

There have been attempts, through special projects and committees in such areas as data management, third party financing, and services integration to involve appropriate programs and combine resources in a HSMHA-wide effort to achieve a coordinated approach to a particular health services delivery issue. These efforts appear to have been limited in scope and effectiveness to blend HSMHA efforts under a broad health services strategy.

HSMHA planning has traditionally been done on a program-by-program basis rather than in support of agency-wide

goals. HSMHA-wide goals have been stated in general terms of improving access, efficiency, quality and effectiveness of health services. This general approach to goals is a best attempt to summarize potential impact of the various programs, but unfortunately these generalized goals have been beyond the aggregate ability of HSMHA to achieve.

In November 1971, HSMHA programs were grouped into four clusters, each under a separate Deputy Administrator. These clusters represented the major areas of activity within HSMHA, namely Prevention and Consumer Services; Health Services Delivery; Development; and Mental Health. (See Appendix B for current HSMHA organization chart.). From interviews with the 16 Program Directors, it appears that where clusters served any purpose it was to improve the interaction among programs, but only those within the cluster. Nevertheless, the interviews also revealed that programs within the cluster still duplicate efforts and maintain separate staffs; that the most effective program interrelationships are still at the operating level; and that there is little joint planning, operation and evaluation. Half of the Program Directors felt the cluster had no effect on their program, and four felt the cluster system had even hindered their efforts.

Interviews revealed a variety of perceptions on the role of the cluster Deputy Administrator. Of the responses from the Program Directors, three considered the cluster deputy to be a line manager, four a coordinator, while eight thought he served as both. There was agreement among the Program Directors that when clusters were originally established, the cluster deputy was intended to coordinate programs and act as a crisis solver; but, in some instances, depending on the deputy's personality, his role gradually became that of a line supervisor.

In summary, the clusters appear to have offered a convenient way to conceptualize the broad array of HSMHA programs and to have reduced the direct span of control of the Administrator; but not to have been effective in coordinating program resources to achieve broader health services goals.

7. THE INTERFACE BETWEEN HEALTH SERVICE AND HEALTH CARE FINANCING PROGRAMS HAS BEEN INADEQUATE.

Discussions with HSMHA Program Directors revealed that only a few steps had been taken at operating levels to assure that adequate relationships exist between HSMHA-financed service activities and SSA and SRS financing programs. In addition, the relationship of the health service and health financing programs in the processes of policy development and program planning is not consistent or adequate. As a result, opportunities for an integrated policy with respect to health services have been foregone. Crucial decisions regarding

the implementation and operation of a national health insurance program deserve a more thorough and substantive input from the Department's health officials.

With increasing dependence on financing programs for health services, many questions arise from the lack of a coordinated health services policy:

-- Should grant programs provide a different benefit package from financing programs?

-- Are some of these services medically desirable, and should they be covered under financing?

-- What needs to be done to bring the Indian Health system up to standards of participation for financing?

-- What is the maximum potential for reimbursement of project grant activities through existing and future financing programs?

Answers to such questions are essential to developing a unified health strategy, and they are possible only through a close integration of all HEW service activities.

8. THE RELATIONSHIP OF MENTAL HEALTH TO OTHER HSMHA ACTIVITIES IS UNCLEAR.

At the time the Public Health Service was reorganized in 1967 and 1968, NIMH had developed sizable service delivery program elements in addition to its basic research activities. It had become a disease-oriented, vertical organization, approaching mental health problems through a variety of activities. The placement of NIMH in HSMHA in 1968 appears to have made sense as organizational housekeeping and because NIMH had many functions in common with other HSMHA programs. Its size, variety of activities, and single focus, however, make it unique. As NIMH is divested of its responsibilities to finance the operation of community mental health centers and other mental health training and services, it begins to assume the characteristics of the other research institutes at NIH.

9. THE NEW ORGANIZATION MUST PROVIDE FOR THE PHASE OUT OF MAJOR HEALTH SERVICE ACTIVITIES.

The 1974 budget calls for the termination and redirection of several major programs and activities in line with a redefinition of the Federal role in health. A reorganization that looks toward the future roles in health must at the same time provide for the orderly transition of ongoing operations.

Within HSMHA, the Regional Medical Program, the Hill-Burton Construction Program and the Emergency Health Program will

be terminated by the end of FY 1974. Support for community mental health centers, alcohol abuse projects and long term training will be gradually phased out beginning in FY 1974. St. Elizabeth's Hospital will be transferred to the District of Columbia, and contracts with community hospitals and other Federal facilities will replace direct provision of inpatient care in PHS hospitals. Project grant support for Maternal and Child Health Service will be replaced by formula grant funding. Although no specific action was requested in the budget, several of the remaining HSMHA programs anticipate significant changes in response to the move toward health services financing and the discontinuance of activities best supported at the State and local level.

In the Bureau of Health Manpower Education, the budget calls for termination of categorical support in allied and public health, and for schools of nursing, veterinary medicine, podiatry, pharmacy and optometry. Funding is increased for special projects and educational initiative awards in order to focus health manpower training support in areas of special need.

10. THE CURRENT ROLE OF THE REGIONAL OFFICES AND THEIR RELATIONSHIP TO NATIONAL PROGRAMS HAVE NOT BEEN ADEQUATELY DEFINED AND IMPLEMENTED TO REFLECT THE INCREASED EMPHASIS ON DECENTRALIZATION.

Tensions exist between the regional offices and

national categorical programs. The regional offices are generally concerned with helping develop integrated health service systems to meet State and local needs and priorities. On the other hand, national programs are generally concerned with specific objectives under more narrow categorical missions specified in legislation and appropriations.

The integration of these categorical programs in supporting comprehensive health service development has been defined as a responsibility of the regional offices. Recent decisions to accelerate the decentralization of programs to the regions stress the need to place decision-making authority closest to the point of program implementation in order to improve the effectiveness of programs and the coordinated use of all resources in meeting local health care needs.

Decentralization of HSMHA grant programs to the regions has proceeded to the point where 25 grant programs have been decentralized, representing 60% of the total HSMHA grant dollars. Additional grant programs have been partially decentralized while another 20 remain centralized. Most of this latter group have been determined appropriate for centralized operation. Alcohol and drug abuse service grant programs are presently centralized, although decentralization plans are now being developed.

While considerable progress has been made in the decentralization of grant programs, the regions have expressed difficulties in achieving program integration. During interviews the Regional Health Directors stated the following common problems:

-- There are serious differences between regional offices and headquarters staff with respect to the manner of achieving objectives. Headquarters programs have viewed some efforts at integration as obstacles to the achievement of national programmatic objectives.

-- Inadequate integration of programs at headquarters leaves too much responsibility for coordination at the regional level.

-- The fact that regional offices receive separate allocations tied to individual appropriations instead of a consolidated operating budget is viewed as a constraint to their ability to integrate activities.

-- There is inadequate structured regional office input into national policy and budget development.

-- Relations with Medicaid and Medicare staff are generally episodic and unstructured.

11. THE ROLE OF THE REGIONAL OFFICE NEEDS TO REFLECT THE FUTURE FEDERAL ROLES IN HEALTH.

At present, the primary role of the HSMHA regional health staff is to implement and integrate HSMHA's various categorical grant programs within the HEW region. Organization at the regional level is a reflection of Headquarters organization along cluster and categorical program lines. Coordination with the health activities of other agencies is limited in the regions just as it is in headquarters. As the HEW health agencies respond to changes in the federal roles in health, the RO health staff will be expected to assume the following responsibilities:

-- Awarding funds to and monitoring performance of organizations established to maintain surveillance of professional standards.

-- Monitoring performance of agencies which have roles in health insurance financing systems.

-- Certifying facilities for participation as providers in health financing programs.

-- Providing technical assistance to prepare community-level health care delivery projects for financing through reimbursements.

-- Providing technical assistance to community or State-level authorities for the prevention of communicable diseases.

-- Coordinating and assisting in collection of data on health care resources and health status.

-- Awarding funds for State-wide and community level planning and coordination efforts.

-- Assisting in the implementation of programs to provide care for beneficiaries through direct delivery activities.

-- Assisting programs for safeguarding health through enforcement of laws governing the manufacture and sale of food, drugs, and other substances.

III. RECOMMENDATIONS

The recommended agency structure for the health services activities of HEW contains three new agencies organized around the functions of providing and financing health services, development of health resources, and prevention and control of health problems. Within each of these functions, the federal role varies from one of direct action to one of serving as a focus for information and advice. Four other organizational options which were considered are discussed in Appendix C.

Implementing these three agencies would result in a health structure consisting of five agencies, each functioning under a specific health mission:

Food and Drug Administration - consumer protection

National Institutes of Health - biomedical research

Center for Disease Control - preventive and public health

Health Resources Administration - health care resources

Health Services Administration - health services

The purpose of this study has been to create a structure that facilitates the development and implementation of consistent HEW health policy. The functions of the three new agencies provide a continuing focus on the elements that will have to be considered in the development of overall health policy.

Since the establishment of CDC as a separate agency requires very little change, the primary elements of this recommendation are to consolidate into two agencies major HEW activities that support the provision of health services and the development of health resources.

Within a new agency for health services, all programs now financing or directly supporting the delivery of health care would be consolidated. The need to bring the major financing programs of Medicare and Medicaid under health policy direction has been discussed earlier in this report. In addition, the current HSMHA health service programs would be consolidated to facilitate a coordinated approach in redirecting these activities toward support through the financing system rather than direct Federal assistance. These current HSMHA service programs are supported through a variety of mechanisms, including formula and project grants, contracts, and direct federal assistance for beneficiary care.

It is recognized that the effective operation, consolidation, and redirection of these activities will place extensive administrative burdens on a new agency that is also charged with operating and integrating the health service financing activities. Nevertheless, it is strongly recommended that these functions be in a single agency to provide a strong policy focus for health services, to meet the need for more effective interaction between

direct service and financing programs, and to eliminate costly and at times conflicting duplication of efforts between them.

The consolidation of activities supporting the development of health care resources is the second major provision. The proposed new HRA will require immediate and extensive redirection and integration of ongoing programs. A greater degree of competence must be developed to provide the surveillance and research activities necessary for development of a coordinated resources strategy. In addition, this agency will require immediate integration of ongoing resource development programs within a coordinated resources strategy. The long term focus of this agency must be the provision of information, analysis and advice on the overall supply, demand, and effective utilization of health care resources.

Resource development has been articulated as a Federal responsibility in the past, and has been the general goal of numerous, scattered efforts. Consolidation of these activities will facilitate more effective utilization of limited Federal funding through greater targeting of activities. Problems should be identified in a broader context of the overall view of health resources in the U.S. The impact of this agency will not depend as much on the operation of direct programs, as on their indirect role in influencing the policies and programs of other agencies.

1. THE HEALTH SERVICES ADMINISTRATION WILL BE THE FOCUS FOR ALL HEW HEALTH SERVICES ACTIVITIES.

The primary mission of the Health Services Administration will be to provide and finance the delivery of health services through Medicare, Medicaid, grants and contracts, direct delivery, and ultimately, national health insurance. Major functions include administering the health care financing programs (Medicare and Medicaid); developing and monitoring compliance with standards for participation of providers in financing; reviewing the appropriateness of care received in terms of cost, quality, and effectiveness; preparing existing health service programs for support through third party financing by strengthening their management capability and ensuring they meet acceptable standards for reimbursement; and providing health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs.

The Health Services Administration would include all HEW health care financing activities: the Bureau of Health Insurance (BHI) from the Social Security Administration (SSA); the Medical Services Administration (MSA) from the Social and Rehabilitation Service (SRS); the Professional Standards Review Organization (PSRO) and Nursing Home Affairs activities from the Office of the Assistant Secretary for Health (OASH); and Medical Care Standards activities from the Community Health

Service. In addition, HSA would include all service project activities: family planning projects; neighborhood health centers, family health centers, and migrant health projects; formula grants: Maternal and Child Health (MCH) and 314(d); and direct care activities: Indian Health Service (IHS) and Federal Health Programs Service (FHPS).

Within this agency, the financing activities might be integrated and organized into 3 major components modeled after the BHI substructure. These three financing components would be policy development, program implementation, and program monitoring. The service and formula grant activities might comprise a fourth self-contained component of HSA that has within it functions comparable to the financing substructure. The grant services component could contain a unit for policy and regulations, one for technical assistance and program implementation, and a third for program monitoring. (Training of grantee staffs is considered a form of technical assistance.) The direct care activities might comprise the fifth component of HSA. These activities are relatively self-contained administratively because of their distinct operating requirements, and could retain much of their present organizational structure.

The administrative structure for program direction and staff support in HSA would be derived from SSA, SRS, and HSMHA. In addition to the integral BHI and MSA components, certain administrative support functions, such as personnel and financial management, are now carried out centrally in SRS and SSA, and a proportion of those staffs should be identified and transferred to HSA. There are, as well, some policy support activities in SSA that relate to Medicare. The relevant portions of these activities -- i.e. sub-units of the Office of the Actuary, Office of Research and Statistics, Office of Program Evaluation and Planning, and the Bureau of Hearings and Appeals -- should be identified and transferred to OASH and HSA.

The Health Services Administration will serve as a policy resource for issues concerning the delivery of health services. Information on utilization of all federally-financed health services will be collected through HSA, although all other data-gathering activities will be conducted in HRA. These operational data will include utilization of services through reimbursement, grant, and direct service programs and will need to be closely related to baseline and other data developed in HRA. All research will be conducted in HRA, including research and experiments with the financing system. HSA staff will identify problems with the financing system that have policy implications, and they will work closely with HRA research and surveillance staff to develop experiments that help resolve these policy questions.

2. THE HEALTH RESOURCES ADMINISTRATION WILL PROVIDE NATIONAL LEADERSHIP WITH RESPECT TO THE REQUIREMENTS FOR AND DISTRIBUTION OF HEALTH RESOURCES.

The functions of the Health Resources Administration will be: providing overall surveillance of the status of health care in the nation through State and local health planning activities as well as collection and analysis of data on resource supply and demand, vital statistics, and disease incidence; developing and testing (in coordination with Federal health service activities) new approaches to the provision, distribution, and utilization of health manpower, health facilities, and health care systems; providing limited special support for development of resources that are not effectively provided through health service financing or general education support mechanisms.

This agency brings together the entire set of HSMHA organizations now located within the Development cluster -- National Center for Health Services Research and Development, Health Care Facilities Service, Comprehensive Health Planning Service, Regional Medical Programs Service, and Health Maintenance Organization Service -- and the Emergency Medical Services and National Center for Health Statistics from the HSMHA Office of the Administrator. The Bureau of

Health Manpower Education from NIH, the National Health Service Corps, and other health service research and training activities that are now located in various HSMHA programs are also brought together in HRA. The Health Resources Administration will require a thoughtful and carefully planned integration of ongoing programs. In addition, a new program dimension needs to be developed to provide a national policy focus with respect to health resources and health data. Consolidating these several major programs will be the first step in creating a strong, continuing organizational capability for health resources activities.

The substructure of the Agency should clearly reflect the continuum of health resource programming: from surveillance of what is happening in the health system and its components; to research and evaluation of specific segments and issues related to the health system; to development and operation of well-defined demonstrations and limited resource development activities.

The surveillance component is envisioned to include the current activities of the Comprehensive Health Planning Service, the National Center for Health Statistics, the manpower intelligence unit in BHME, and current HSMHA

activities related to the definition of health scarcity areas. The research and evaluation component includes the National Center for Health Services Research and Development and the research elements of the BHME and other HSMHA programs. The development and operations component includes the demonstration and developmental programs of the BHME, the National Health Service Corps, Health Maintenance Organization Service, and Emergency Medical Services; and the operational programs of BHME, the Regional Medical Programs Service, and the Health Care Facilities Service.

It is important to emphasize the need for consolidating ongoing research and training activities. Where such ongoing work goes beyond answering the needs of specific grant or contract operated programs, they should be included in HRA. Program direction and management support for this new agency should be obtained primarily from BHME and HSMHA.

3. THE CENTER FOR DISEASE CONTROL WILL BE THE FOCUS FOR PREVENTIVE HEALTH ACTIVITIES CURRENTLY BEING CARRIED OUT WITHIN HSMHA.

The primary mission will be to provide national leadership for the prevention and control of communicable and vector-borne diseases and other preventable conditions. Major functions will include preventing and controlling communicable diseases by stimulating State and community

action, providing technical assistance, and demonstrating effective techniques; developing occupational safety and health standards and other related activities to assure safe and healthful working conditions; administering programs relating to childhood lead-based paint poisoning and urban rat control; directing foreign and interstate quarantine activities; and improving performance of clinical laboratories.

This agency would contain the programs in the Prevention and Consumer Services cluster -- Center for Disease Control (CDC), Bureau of Community Environmental Management (BCEM), and National Institute for Occupational Safety and Health (NIOSH). The agency would retain the designation of Center for Disease Control, since the primary agency emphasis will continue to be on the current CDC activities. The lead-based paint and rodent control programs and associated staff which remain in the FY 1974 BCEM budget should be incorporated into the CDC structure, rather than be retained as a free-standing organization. NIOSH, however, should retain its independent organizational status in anticipation of its transfer to the Department of Economic Affairs under the President's Departmental Reorganizational Plan. A careful review should be made of all NIOSH activities prior to transfer to DEA, to determine appropriate activities to be

transferred and to establish future program linkages between DHEW programs and NIOSH.

During implementation, special administrative arrangements may need to be made if NIOSH central office staff continues to be located in the Parklawn Building, while looking to the CDC in Atlanta for overall program direction and management support. The remaining BCEM operations could also be accommodated under these special administrative arrangements, if it appears desirable to maintain their present location at Parklawn. It is expected that the combined staffing available for this agency in 1974 will be sufficient to manage the new organization.

4. OTHER ORGANIZATIONAL AREAS WILL REQUIRE SPECIAL ATTENTION.

Preventive Health Activities

In addition to health services and health resources, the third broad complementary component of an overall health strategy is the function of preventing and controlling health problems. Activities of this type include the consumer protection activities of the Food and Drug Administration, the communicable disease prevention and control activities of CDC, and the occupational and environmental safety and health activities of NIOSH and BCEM.

Consideration was given to grouping all preventive health activities under single leadership in a health protection agency, as envisioned for the Department of Human Resources by the President's Departmental Reorganization Plan. This single agency approach would provide the third aspect of an overall health strategy and would consider broad questions of how to prevent health problems from both a personal health and a public health aspect. Such an agency would serve as a source of expertise regarding the efficacy of various preventive health services that are proposed for coverage under health financing programs. It would also weigh the relative merits of conducting preventive health activities through a public health or collective action approach rather than a personal health services approach.

It was generally felt that consolidating preventive health activities under single leadership would clarify the definition of preventive activities; however it was also recognized that the merger of an enforcement agency with an agency which has relied with significant success on cooperative and technical assistance approaches would not strengthen either agency's ability to perform. Thus, a move to consolidate FDA and CDC is not recommended in this report. The recommendation groups all clearly preventive activities that are currently in HSMHA under CDC leadership, and maintains the separation of FDA.

It is important, in lieu of consolidating enforcement and other preventive activities, to distinguish their functions from those of other health services and health resources. Preventive health activities should be specifically targeted efforts designed to determine and reduce the impact of or avoid exposure to infectious or unsafe agents or conditions that may have a detrimental affect on health. They should not overlap with other more general efforts to increase the effectiveness of the entire health care system, nor should they overlap with efforts to improve delivery of general (as opposed to preventive) services by State Health Departments. Without a clear demarcation of this nature, activities carried out for prevention may become indistinguishable from other health care services.

National Institutes of Mental Health

Deliberations concerning the appropriate organizational placement of the National Institutes of Mental Health in the restructuring gave consideration to several factors. Primary among these were: budget actions consistent with the new Federal role in health which de-emphasize service delivery and manpower training programs; the resulting emphasis on research as the predominant future role of NIMH; and the functional integration being achieved in the recommended five-agency approach reflecting resources, services, prevention, research, and [illegible].

There are distinct advantages in considering a functional integration of NIMH, i.e., moving manpower training and statistical activities to HRA and service delivery project and formula grants to HSA. This would achieve a clear consolidation of the health service and manpower programs and facilitate the necessary conversion to other financing mechanisms along with similar activities in the new HSA. It would simplify policy development and implementation for such programs. In addition, the NIMH expertise would facilitate the inclusion of coverage for essential mental health services in the financing programs. Under this approach, the basic research and research training activities would be moved to the NIH.

The NIMH alcohol and drug abuse service activities, however, require legislation to be separated from NIMH. Since feasibility of short-term implementation was an important consideration, the separation of alcohol and drug abuse services from NIMH was not recommended. This decision implies the retention of at least some service activities within what will become primarily a research program.

At the same time, there is merit to placing primary emphasis by organizational placement on the future role of NIMH as a research-oriented organization without limiting its activities to research. This

would result in a minimum of disruption within mental health activities, with the possible risk of complicating the future conversion of service and manpower programs.

Given these considerations, it is recommended that NIMH be retained as a free-standing Institute and be placed within NIH. Placement of NIMH in NIH makes it even more important to give attention to resolution of the issues concerning relationships among the health service delivery aspects of NIH programs -- particularly those in the National Cancer Institute and the National Heart and Lung Institute -- and the proposed Health Services Administration and Health Resources Administration.

Health Service Delivery Aspects of NIH Programs

The interfaces between basic biomedical research, demonstration, and direct delivery are complex. In the specific area of demonstration and direct delivery of services, the most obvious area of concern is the re-introduction of control programs in the National Cancer Institute and the National Heart and Lung Institute.

It was not possible in this study to give full consideration to defining appropriate relationships and operational patterns between health service delivery and biomedical

research. Control programs and other health service related activities of NIH with their categorical focus would attempt to bridge from research to services through the establishment of disease-oriented community systems of health care. It was the general assumption of this study that these services must, in the long run, be tied to health financing programs. While no recommendation is being made for organizational changes to address the relationship of service delivery and research programs, the area requires further study and resolution. Legislative, programmatic, and pragmatic concerns should be incorporated into an analysis of alternative steps the Assistant Secretary for Health could take to clarify these relationships. These considerations will have substantial impac on the HSA service delivery program policy and implementation, decentralization actions, regional office program responsibiliti and the future role of research programs.

Applied Health Research

During the study, it was evident that applied research is being carried out in virtually every HEW health agency. Applied research -- both biomedical and health services research -- is needed to develop means of improving the health service delivery system and preventive health services and to provide a sound scientific basis for regulatory action by FDA. This research was initially the responsibility of NIH,

but has grown up elsewhere largely because the NIH research has been unresponsive to other program needs.

Environmental health research is probably the most diffuse area of applied health research. Within HEW, environmental health research is carried out in NIH by the National Cancer Institute, the National Institute for Environmental Health Sciences, the National Institute of Child Health and Human Development; in FDA at the National Center for Toxicological Research; and in HSMHA by BCEM, NIOSH, and CDC. The primary need for this research is as a scientific basis for FDA's regulatory decisions, yet most of the research other than that at NCTR is not influenced appreciably by FDA's needs.

In addition, the applied research problem includes much research that falls into the "gap" between NIH and HSMHA. This research would be useful both to the financing and delivery of health services and to the development of health resources, but NIH considers it too service-or technology-oriented and HSMHA considers it too biomedical-oriented. This research could be made more responsive to the program needs either by placing it organizationally within the program that would use the research results, or by establish a mechanism for the program that needs the results of the resear to influence the priorities for and the ways the research is carried out.

It was recognized that neither of the two possible solutions to the applied research problem was happening in HSMHA. It was also recognized that the solution to the environmental health research problem probably did not lie in HSMHA, since the problem concerned primarily FDA and NIH. To attempt to address that problem through an applied health research organization in HSMHA would tend to complicate rather than simplify it. While the problem requires early attention, it was considered more appropriate for study and resolution outside the context of this study.

In general, the applied research problem arises because NIH, the agency whose primary mission is research, has often been unresponsive to other program needs for this research. The solution lies either in devising ways to make this research responsive while leaving it in its present research setting or to place the research activities in the respective program settings where it can be responsive. The former alternative appeared more attractive because the direction and setting of research priorities, including applied research, is considered an appropriate and a necessary activity for the Assistant Secretary for Health.

5. THE REGIONAL HEALTH DIRECTOR SHOULD BE THE TOP HEALTH OFFICIAL IN THE REGION AND REPORT TO THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH.

The major future responsiblities of the regional office (RO) health staff will be to help administer and monitor national health insurance activities, provide surveillance of the health delivery system, and assist in resource development and public health activities at the State and local level. The overall mission includes the following major functions.

Standards Compliance. This will be a major activity in the administration of Medicare and Medicaid and in future national health insurance and revenue sharing programs. Standard setting and compliance activities relating to health provider participation influences the manner in which those services are organized and delivered. This function must be conducted in close cooperation with the designated State and local agencies.

Surveillance. Regional Offices will play an important role in the health intelligence network. Information on health care needs, conditions, and program effectiveness must be gathered and analyzed on a State and regional basis to monitor programs and problems; to predict trends; to assess resource utilization and to provide the basis for developing strategies for change i health financing and resource development programs.

Resource Development. As an outgrowth of surveillance and assessment activities, the RO could target technical assistan

and demonstration support to States and communities and provide means for channeling new health services knowledge and new developments in science and technology as a result of research.

Technical assistance activities should utilize capacities available within the RO's, within the five central agencies, and elsewhere in the Department, as well as in other specialized resources throughout the nation. Technical assistance resources must be enhanced and expanded as appropriate. Support of this type will need to be provided to community groups and agencies, as well as health institutions and official agencies.

Preventive and Public Health Activities. The Department's health activities have traditionally been especially concerned with helping the development of State and local public health services. This focus should continue through the RO's, although it should be developed in a context of concern for a total health strategy. Effective assistance in this area will require a clearer definition of preventive health activities that should be focused on problems of disease control through epidemiology and immunization.

Given the stated mission of the regional health staff and the related functions, the recommendations on the RO's are:

-- The Regional Health Director (RHD) should be the principal health official in the RO. This role should include a

broad mandate encompassing program leadership, planning, implementation and direction of day-to-day operations. It also should include a relationship with the Regional Director as principal health advisor, making unnecessary the position of Associate Regional Director for Health. The RHD should be responsible for all health programs in his region.

-- The RHD's should report to the Assistant Secretary for Health through the Deputy Assistant Secretary for Program Operations.

-- The capacity of RO staff to provide technical assistance should be increased as appropriate.

-- Grant decentralization should be completed promptly.

-- The RHD should develop mechanisms for the full integration of the efforts of the regional health staff such as consolidated work plans; consolidated operating budget for salaries and expenses; and flexibility in utilization of personnel.

IV. NEXT STEPS

Several factors need to be considered carefully in the development of an implementation strategy.

- There is presently a high degree of momentum associated with the new leadership in DHEW which could be supportive of reorganization.

- New agency heads will be designated in the near future. Reorganization activities should begin as soon as possible to avoid territorial disputes that may develop with delayed action.

- The overall impact of the new health leadership to effect the proposed organizational changes will diminish with prolonged delay.

- The current uncertainty and restlessness that permeates HSMHA demands immediate action and strong leadership.

- The abolishment of HSMHA and creation of two new agencies (Health Services Administration and Health Resources Administration) could be done internally under the direction of an acting Administrator of HSMHA. The outward appearance of this approach, however, could well be construed

as procrastination, with no intention of carrying out the reorganization. The need to avoid prolonged organizational chaos would argue strongly for an immediate break of HSMHA into HRA and HSA, with each agency reporting directly to OASH.

- Since all of the recommended actions can be effected within the authority of the Secretary, concurrence in the overall concept at that level will be sufficient to begin implementation under the leadership and direction of the Assistant Secretary for Health.

- The development and approval of a complete organizational plan containing detailed mission and function statements for all units is a time-consuming process. Effective reorganization will be seriously jeopardized if this process must be completed before implementation begins.

- Immediate implementation will require management flexibility for making operating decisions within the overall framework of the recommended plan.

- Details of the organizational structure can be developed as implementation proceeds.

Considering these factors, it is recommended that implementation proceed under the leadership of a management team assembled by

the Assistant Secretary for Health. The team should include:

- Deputy Assistant Secretary for Administration and Management
- Deputy Assistant Secretary for Medical and Scientific Affairs
- Deputy Assistant Secretary for Program Operations
- Administrator of HSA
- Administrator of HRA
- Director of NIH
- Director of CDC
- A nucleus of three or four managers that can direct day-to-day activities in specific areas of the reorganization

There are two principal issues regarding the makeup of the management team. The first involves the integration of BHI and MSA and their ultimate transfer to HSA. The responsibility for this merger could be assigned to the Administrator of HSA along with the realignment of the service programs from HSMHA. Because of the magnitude of both tasks, the Assistant Secretary could elect to retain in his office the BHI/MSA responsibility until such time as the administrative details are finalized, thereby ensuring an orderly integration of these programs into HSA.

The second issue involves the agency heads' direct participation in this undertaking. Effective implementation will require a

close working relationship that might not otherwise occur if each agency is left on its own to implement respective portions of the recommendations. It is quite important, therefore, that the entire team be held accountable for the total reorganization.

The following steps should be taken to implement the reorganization:

Step 1 - Obtain Secretary and Under Secretary concurrence in overall concept. With this concurrence, delegate implementation authority and responsibility to the Assistant Secretary for Health.

Step 2 - Brief appropriate Congressional and Executive Offices. It is essential that these briefings be completed before details of the reorganization become general knowledge.

Step 3 - Appoint the management team and develop an implementation strategy and plan.

Step 4 - Transfer NIMH to NIH and initiate further study of its internal organizational and programmatic inter-relationships.

Step 5 - Establish CDC as an agency and transfer BCEM and NIOSH.

Step 6 - Establish two new agencies (HRA and HSA) and abolish HSMHA.

Step 7 - Transfer BHME from NIH to HRA.

Step 8 - Establish Regional Office liaison staff under the Deputy Assistant Secretary for Program Operations and begin to implement other recommendations relating to the Regional Offices.

Step 9 - On a predetermined date to be established by the Secretary, preferably not later than July 1, 1973, transfer BHI (SSA) and MSA (SRS) to the direction of the Assistant Secretary for Health. Within 90 days of this action, the OASH and the management of BHI and MSA will determine and implement the necessary administrative actions to integrate appropriate functions and establish their staffs in HSA.

If implementation is undertaken immediately along the general steps outlined above, the reorganization could reasonably be completed by October 1, 1973.

Time is of the essence and the degree of success will in large measure depend upon the speed with which implementation can proceed in an orderly manner. To this end, an early commitment from the Secretary is imperative.

PERSONS INTERVIEWED DURING STUDY OF HSMHA PROGRAMS AND ORGANIZATION

Health Services and Mental Health Administration

Acting Administrator:

David J. Sencer

Deputy, Associate and Assistant Administrators:

Frederick L. Stone, Interim Deputy Administrator and Acting Deputy Administrator for Development

Beverlee A. Myers, Associate Administrator for Program Planning and Evaluation

John H. Kelso, Associate Administrator for Management

David W. Johnson, Associate Administrator for Regional Offices

Gerald N. Kurtz, Associate Administrator for Communications and Public Affairs

Joan F. Bushnell, Assistant Administrator for Legislation

Robert J. Laur, Deputy Administrator for Prevention and Consumer Services

Emery A. Johnson, Acting Deputy Administrator for Health Services Delivery

Bertram S. Brown, Deputy Administrator for Mental Health

Program Directors and Staff:

David J. Sencer, Center for Disease Control

Marcus M. Key, National Institute for Occupational Safety and Heal

Robert E. Novick, Bureau of Community Environmental Management

Marjorie A. Costa, National Center for Family Planning Services
Albert B. Lauderbaugh

Arthur J. Lesser, Maternal and Child Health Service
Grace M. Angle and Ralph R. Pardee

Paul B. Batalden, Community Health Service
Michael J. Goran

Emery A. Johnson, Indian Health Service

Robert E. Streicher, Federal Health Programs Service
Roland D. McRae

H. McDonald Rimple, National Health Service Corps
Howard G. Hilton and Alexander Montgomery

Robert van Hoek, National Center for Health Services
Research and Development

Harald M. Graning, Health Care Facilities Service
Ruth E. Dunham

Robert P. James, Comprehensive Health Planning Service
John Caponiti, Jr.

Harold Margulies, Regional Medical Programs Service

Gordon K. MacLeod, Health Maintenance Organization Service

Bertram S. Brown, National Institute of Mental Health
James D. Isbister and James D. Lawrence

Morris E. Chafetz, National Institute on Alcohol Abuse and Alcoholis
Kenneth L. Eaton and John A. Deering

William E. Bunney, Division of Narcotic Addiction and Drug Abuse
Karst Besteman

Theodore D. Woolsey, National Center for Health Statistics
Edward B. Perrin

Regional Health Directors:

Gertrude T. Hunter, Region I

C. Robert Dean (Acting), Region II

George C. Gardiner, Region III

Eddie J. Sessions (Acting), Region IV

E. Frank Ellis, Region V

Holman E. Wherritt, Region VII

Abel G. Ossorio, Region VIII

Donald P. MacDonald (Deputy), Region IX

David W. Johnson, Region X

Other HSMHA Staff:

Eugene W. Veverka and Alvin E. Harvel, Office of the Associate Administrator for Regional Offices

Donald E. Goldstone, Office of the Associate Administrator for Program Planning and Evaluation

Other Agencies, HEW

Morris R. Cranmer, Director, National Center for Toxicological Research, Food and Drug Administration

Joseph P. Hile, Director, Executive Director of Regional Operations, FDA
Ronald T. Ottes

John F. Sherman, Acting Director, National Institutes of Health
Robert Berliner, Thomas J. Kennedy, Leonard D. Fenninger and Leon Schwartz

Kenneth M. Endicott, Director, Bureau of Health Manpower Education, NIH
Daniel F. Whiteside and Charles H. Boettner

Calvin B. Baldwin, Jr., Executive Officer, National Cancer Institute, NIH
John C. Bailar, III and John W. Yarbro

Theodore Cooper, Director, National Heart and Lung Institute, NIH

David P. Rall, Director, National Institute of Environmental Health Services, NIH

William W. Payne, Deputy Director, National Institute of Environmen Health Services, NIH, and Scientific Coordinator of Frederick Cancer Research Center

Howard N. Newman, Commissioner, Medical Services Administration, Social and Rehabilitation Services

Thomas M. Tierney, Director, Bureau of Health Insurance, Social Security Administration
Irwin Wolkstein and Morris B. Levy

Office of the Assistant Secretary for Health, HEW

Richard L. Seggel, Deputy Assistant Secretary for Program Operatio

Wade H. Coleman, Special Assistant for Drug Abuse Prevention

Rupert F. Moure, Acting Deputy Assistant Secretary for Administration and Management

Office of the Secretary, HEW

Bernard F. Kelly, Office of the Under Secretary

Eugene Rubel, Executive Secretariat (Health)

Peter B. Hutt, Office of the General Counsel

Keith Weikel, Office of the Assistant Secretary for Planning and Evaluation

Peter Fox, Office of the Assistant Secretary for Planning and Evaluation

Thomas S. McFee, Office of the Assistant Secretary for Administration and Management

John Pinney, Office of the Assistant Secretary for Administration and Management

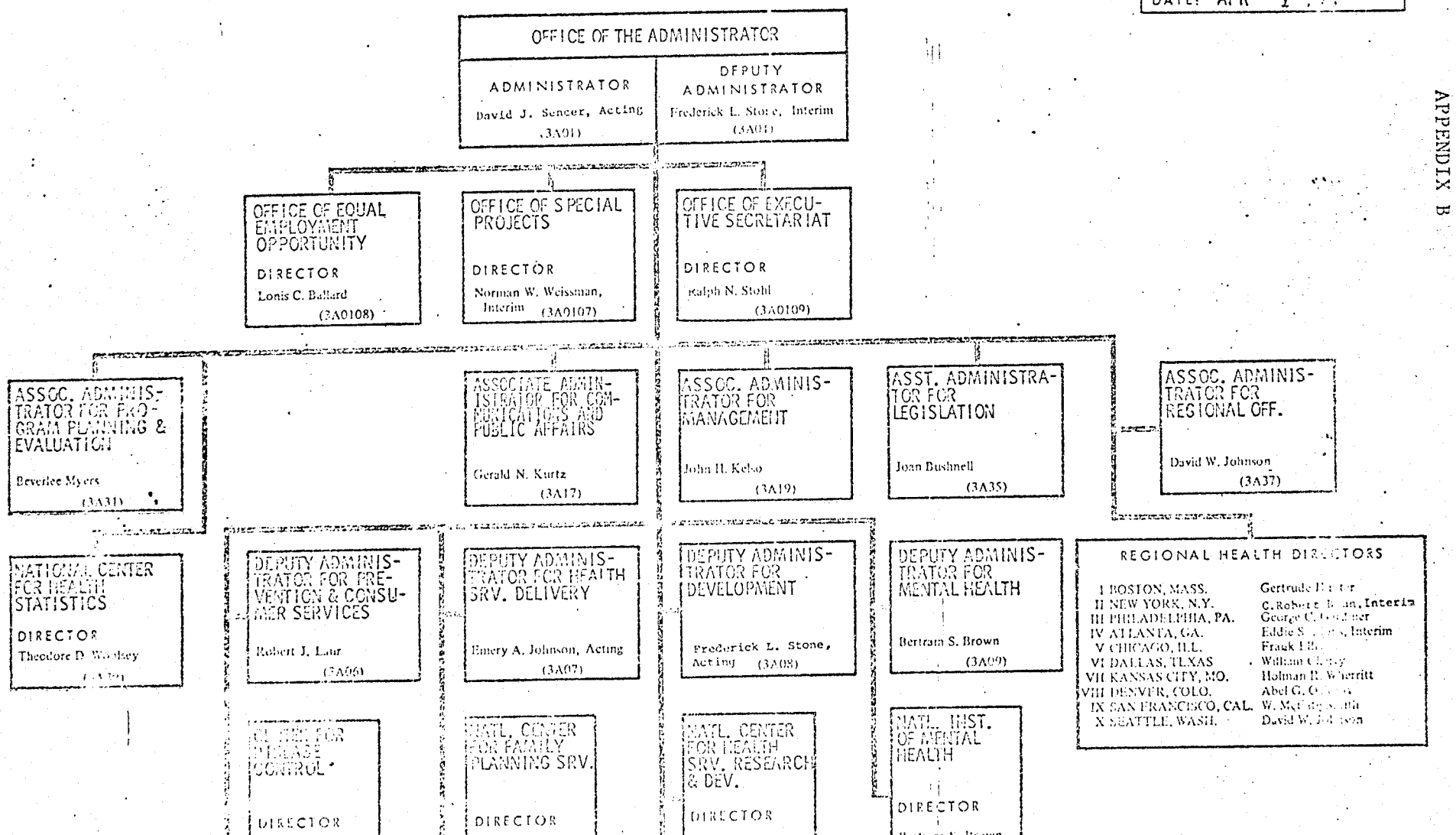
APPENDIX B

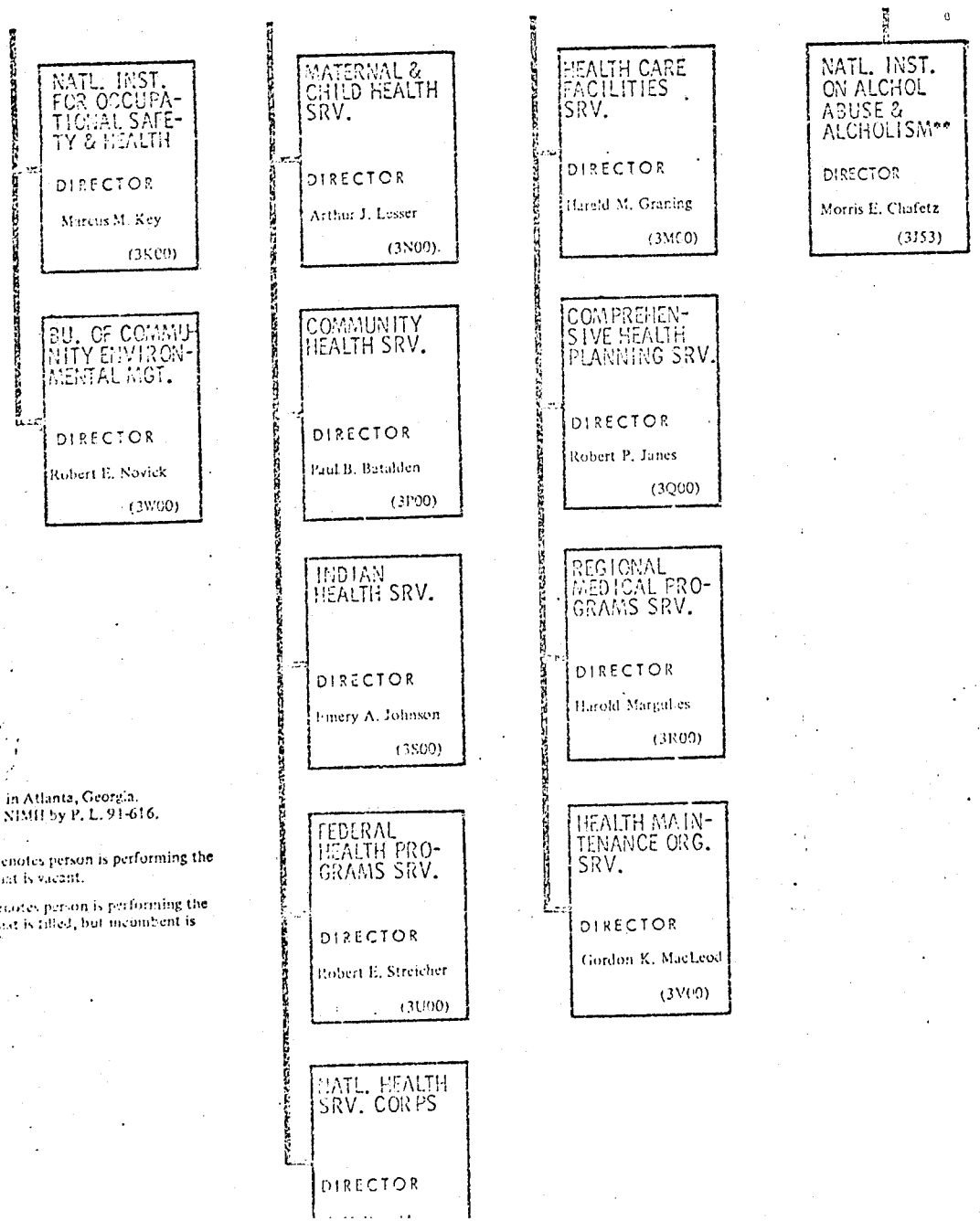
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

APPROVED: HS

DATE: APR 1





* CDC is headquartered in Atlanta, Georgia.
** Established as part of NIMH by P. L. 91-616.

Note: Lower case designation denotes person is performing the duties of a position that is vacant.

Asterisk designation denotes person is performing the duties of a position that is filled, but incumbent is absent.

Appendix C

ANALYSIS OF ORGANIZATIONAL ALTERNATIVES

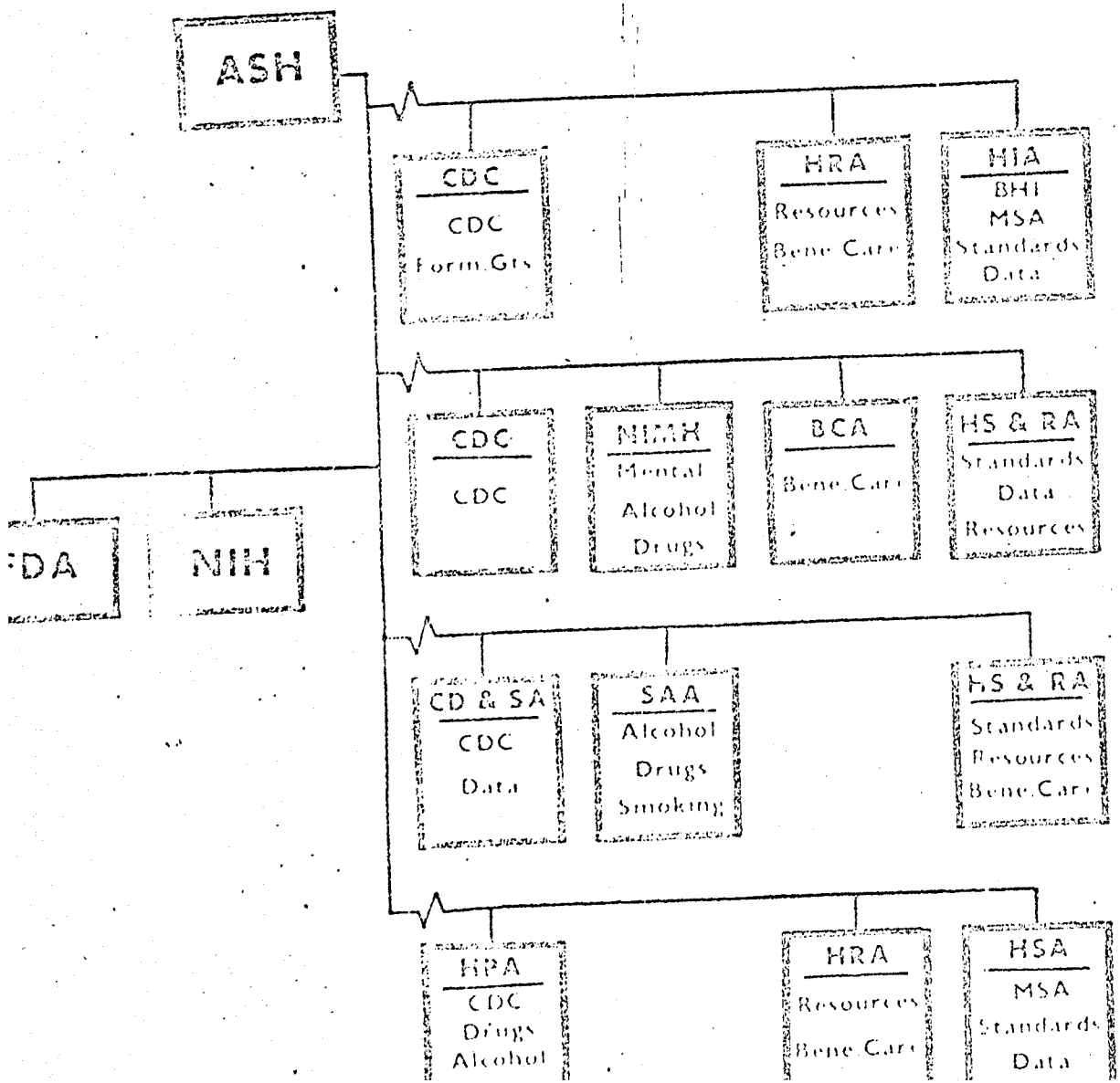
Once the broad federal roles in health were defined, a common problem throughout the major issues as described was that the current organizational structure was inconsistent with these roles and therefore inhibited carrying them out. Four organizational options were developed which had as their core the need for an organizational framework based on an articulated federal health mission. The particular options were developed to isolate issues and contrast alternative ways of addressing them organizationally. They were not intended as "either-or" proposals since there are innumerable variations and combinations possible.

A review of the current activities of the various health components of HEW suggested that there were three major health program functions -- health services, prevention of health problems, and development of health resources. The organizational options were attempts to "package" various groupings of these program functions into agencies with coherent missions. In addition, the options reflected a pragmatic concern for the impact of any organizational change in ongoing operations in terms of the need to minimize the negative aspects of disruption and to maximize the use of existing administrative capabilities.

1. DESCRIPTION OF ORGANIZATIONAL ALTERNATIVES.

For each alternative creating a new agency, a descriptive organizational title, abbreviated mission statement, and major functions were identified. These four alternatives are shown in chart form on the following page.

ORGANIZATIONAL ALTERNATIVES



OPTION 1
BREAK HSMHA INTO THREE AGENCIES ALONG FUTURE FUNCTIONAL LINES

OPTION 2
BREAK HSMHA INTO FOUR AGENCIES WITH EXISTING ADMINISTRATIVE CAPACITY

OPTION 3
BREAK HSMHA INTO THREE AGENCIES ESTABLISHING SUBSTANCE ABUSE AND BUILDING ON CDC SURVEILLANCE CAPACILITY

OPTION 4
BREAK HSMHA INTO THREE AGENCIES: TWO RELATED TO HEALTH FINANCING INCLUDING MSA; ONE WITH CATEGORICAL [illegible] IMPACT FOCUS

Option 1

Center for Disease Control

Mission: Provide national leadership for the prevention and control of communicable disease and other public health functions.

Major Functions: Develop means to prevent and control communicable diseases; stimulate State and community action through surveillance and education; provide technical assistance and demonstration of effective techniques for control of communicable diseases; enforce foreign quarantine regulations; administer State formula grant programs for drug abuse, alcoholism, public and mental health services, and maternal and child health; and develop standards to assure safe and healthful working environment.

Current organizational elements include the Center for Disease Control, the National Institute for Occupational Safety and Health, and all formula grant programs.

Health Resources Administration

Mission: Prepare existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions: Provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; continue to provide or arrange for health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs; provide student and institutional assistance for the education of manpower to meet special problems which are not effectively covered under general educational support mechanisms; and support demonstrations designed to improve the future production and utilization of health services manpower.

HRA includes all HSMHA demonstration, service, and training project grant programs exclusive of those in CDC; direct care programs; the Bureau of Health Manpower Education exclusive of research and manpower intelligence activities; and the Nursing Home Improvement activities.

Health Insurance Administration

Mission: Administer present Title XVIII (Medicare) and Title XIX (Medicaid) programs, including development, implementation and enforcement of standards, policies and procedures for participation in financing programs; provide HEW focus for the development and implementation of national health insurance; and conduct programs for monitoring, evaluating, and testing new approaches relating to health insurance programs.

Major Functions: Administer Title XVIII and XIX programs; develop standards and certify providers for participation in financing programs; monitor compliance and adequacy of standards; evaluate overall impact of standards and financing for policy implications; review appropriateness of care received in terms of cost, quality and effectiveness; develop and test new approaches to improve the health insurance programs, including financing, delivery systems, and health manpower; collect data on health status and health services resources; analyze data for policy implications and disseminate information to appropriate action agencies.

HIA includes the health financing and related support activities in the Social Security Administration and the Social and Rehabilitation Service; HSMHA activities in medical care standards, research and development, comprehensive health planning, and health statistics; research and manpower intelligence from BHME; and the Professional Standards Review Organization from OASH.

Option 2

Center for Disease Control

Mission: Provide national leadership for the prevention and control of communicable diseases.

Major Functions: Develop means to prevent and control communicable diseases; stimulate State and community action through surveillance and education; provide technical assistance and demonstration of effective techniques for control of communicable diseases; enforce foreign quarantine regulations; and develop standards to assure a safe and healthful working environment.

The CDC includes the present Center for Disease Control and the National Institute for Occupational Safety and Health.

National Institutes of Mental Health

Mission: Provide national leadership in the field of mental health, including intensive efforts directed at such problems as alcoholism and drug abuse.

Major Functions: Conduct and support research, training, and community programs in the areas of general mental health, drug abuse, and alcoholism; provide focus for collection and dissemination of information on drug abuse and alcoholism and other mental health problems; serve as principal focus for behavioral science activities and for cultural and social problems related to mental health.

The NIMH includes the current NIMH activities except for St. Elizabeths Hospital.

Beneficiary Care Administration

Mission: Provide or arrange for health care for Federal beneficiary populations.

Major Functions: Make arrangements for or provide health services to specified federal beneficiaries; facilitate the conversion of beneficiary care programs to financing through national health insurance or other mechanisms.

BCA includes the Indian Health Service, Federal Health Programs Service, and St. Elizabeths Hospital.

Health Standards and Resources Administration

Mission: Facilitate development and implementation of health insurance programs through setting and monitoring of standards for participation in insurance programs; surveillance of health status and system resources; and preparing existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions: Develop standards and certify providers for participation in financing programs; monitor compliance and adequacy of standards; review appropriateness of care received in terms of cost, quality and effectiveness; evaluate overall impact of standards and financing for policy implications; develop and test new approaches to improve the health insurance programs, including financing, delivery systems, and health manpower; collect data on health status and health services resources; analyze data for policy implications and disseminate information to appropriate action agencies; provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; provide student and institutional assistance for the education of manpower to meet special problems which are not effectively covered under general educational support mechanisms; and support demonstrations designed to improve the future production and utilization of health services manpower.

The HSRA includes the Bureau of Health Manpower Education; HSMHA demonstration, service and training project and formula grant programs exclusive of those in NIMH and CDC; HSMHA medical care standards, comprehensive health planning and health statistics activities; and the Professional Standards Review Organization and Nursing Home Affairs activities from OASH.

Option 3

Communicable Disease and Surveillance Administration

Mission: Monitor the health status and health delivery capacity of the nation and provide assistance to meet urgent communicable disease and manpower shortage problems.

Major Functions: Conduct data gathering, monitoring or epidemiological surveillance of health status and of health delivery resources; communicate findings to appropriate action agencies; analyze data for policy implications; control communicable diseases through stimulating action by State Health Departments or selective federal intervention; provide health personnel to critical shortage areas; and develop standards to assure safe and healthful working environment.

CDSA includes the HSMHA components of Center for Disease Control (exclusive of Smoking and Health), National Center for Health Statistics, National Institute for Occupational Safety and Health, and National Health Service Corps; and the manpower intelligence activities from BHME.

Substance Abuse Administration

Mission: Provide assistance for the prevention and control of substance abuse.

Major Functions: Develop the means to prevent, control and treat abuse of substances such as alcohol, drugs, and tobacco; provide training support for health workers in substance abuse; assist States and communities in dealing with these problems through public education, technical assistance and grant assistance to provide for treatment, rehabilitation and other community action programs.

The SAA includes the National Institute for Alcohol Abuse, the Drug Abuse Program, and Smoking and Health activities.

Health Standards and Resources Administration

Mission: Facilitate development and implementation of health insurance programs through setting and monitoring of standards for participation in insurance programs; and preparing existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions: Develop standards and certify providers for participation in financing programs; monitor compliance and adequacy of standards; review appropriateness of care received in terms of cost, quality, and effectiveness; evaluate overall impact of standards and financing for policy implications; develop and test new approaches to improve the health insurance programs, including financing, delivery systems, and health manpower; provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; provide student and institutional assistance for the education of manpower to meet special problems that are not effectively covered under general educational support mechanisms; support demonstrations designed to improve the future production and utilization of health services manpower; and continue to provide or arrange for health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs.

The HSRA includes the Bureau of Health Manpower Education excluding manpower intelligence; all HSMHA demonstration, service, and training project and formula grants exclusive of those related to alcohol, drug abuse, and CDC; direct beneficiary care programs including St. Elizabeths Hospital; HSMHA activities in medical care standards, comprehensive health planning, and research and development; and Professional Standards Review Organization and Nursing Home Affairs activities from OASH.

Option 4

Health Protection Administration

Mission: Provide national leadership for protection from public health hazards.

Major Functions: Develop the means to prevent, control, and treat diseases and other health problems that pose a threat to public health through infection or safety hazards, such as communicable diseases, alcoholism, drug abuse, smoking, and unsafe working environments; stimulate State and community action to deal with these problems through surveillance, public awareness and education; and direct federal action to provide technical assistance and demonstrate effective techniques.

HPA includes the Center for Disease Control, alcohol and drug abuse activities, and the National Institute for Occupational Safety and Health.

Health Resources Administration

Mission: Prepare existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions: Provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; continue to provide or arrange for health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs; provide student and institutional assistance for the education of manpower to meet special problems which are not effectively covered under general educational support mechanisms; and support demonstrations designed to improve the future production and utilization of health services manpower.

The HRA includes HSMHA demonstration, service, and training project and formula grant programs exclusive of alcohol, drug abuse and CDC; direct care programs including St. Elizabeths Hospital; the Bureau of Health Manpower Education exclusive of research and manpower intelligence; and the Nursing Home Improvement activities.

Health Standards Administration

Mission: Provide professional health guidance for administration of financing programs; administer present Title XIX (Medicaid) Program; facilitate development and implementation of health insurance programs through surveillance of health status and system resources; and set and monitor standards for participation in insurance programs.

Major Functions: Develop standards and certify providers for participation in financing programs; administer Title XIX Program; monitor compliance and adequacy of standards; evaluate the overall impact of standards and financing for policy implications; review appropriateness of care received in terms of cost, quality, and effectiveness; develop and test new approaches to improve the health insurance programs, including financing, delivery system, and health manpower; collect data on health status of disease and health services resources; analyze data for policy implications and disseminate information to appropriate action agencies.

HSA includes the Medical Services Administration and related support activities in the Social and Rehabilitation Service; HSMHA medical care standards, comprehensive health planning, health statistics, and research and development; research and manpower intelligence activities from BHME; and the PSRO activities from OASH.

2. EVALUATION OF ORGANIZATIONAL ALTERNATIVES.

The alternatives were evaluated against six criteria which addressed the study findings, as well as the practical considerations of implementing a new organizational alignment. The ranking of the alternatives within each criteria is shown in the following chart and is discussed in detail below.

Effectiveness of Options in Meeting Organizational Criteria

Criteria	Option 1	Option 2	Option 3	Option
Facilitates development of integrated health policy for a national health mission	MOST	LEAST	LESS	MORE
Facilitates inter-program coordination within a single agency mission	MOST	LEAST	LESS	MORE
Provides flexibility for future change	MOST	LEAST	LESS	MORE
Facilitates regional operations	MOST	LEAST	LESS	MORE
Facilitates implementation by building on existing administrative strengths	MORE	MOST	LESS	LEAS
Minimizes disruption of ongoing activities	LEAST	MOST	MORE	LES

-- How well does the organization facilitate development and implementation of integrated health policy and strategy for a national health mission? This criterion reflects the adequacy of the sum of the agency missions to comprise a total health mission as well as the degree to which organizational placement of activities supports development of national health policy.

a. Option 1 - most effective

This alternative brings together all HEW health programs under single health leadership. All activities related to the financing of health care, the most extensive health program, would be consolidated in a single agency (HIA) along with the policy supporting activities of surveillance and health services research. In addition, the two other agencies (HRA and CDC) most clearly represent the other principal health roles of preventive and public health activities and resources support. The consolidation of activities supporting health care resources will facilitate their redirection toward a more effective relationship to the financing system.

b. Option 4 - more effective

This alternative retains the advantage of providing an agency focus for health care financing activities (HSA) and resources (HRA). The financing role, however, is diminished with the absence of the largest financing program, Medicare, from HSA. In addition, the HPA focus is closer to problem-solving than prevention, and does not represent an articulated national health mission.

c. Option 3 - less effective

The absence of either MSA or BHI further undermines the capacity to address the integration of federal health care financing activities. The existing health agency activities related to standard setting and monitoring are consolidated in HSRA, but their effectiveness would be diminished because of the additional responsibility to administer ongoing resources and direct care programs. The policy support focus is diminished with the separation of surveillance activities in CDSA from health services research in HSRA. The narrow focus of SAA does not reflect a broad federal mission, as do the other agencies.

d. Option 2 - least effective

This alternative does not provide for consolidating the operating health care financing programs, and diminishes the focus of HSRA on policy support related to these programs. In addition, the resource activities remain [illegible] delivery of services are spread across three agencies, namely HSRA, BCA, and NIMH. The latter two agencies do not represent articulated national health missions.

-- How well does the organization facilitate interprogram coordination within a single agency mission? This criterion reflects the importance of a clear mission for each agency that unifies programs within the agency and facilitates coordination in achieving overall health policy.

a. Option 1 - most effective

Under this alternative, each agency would be responsible for a single and distinct health mission. Functions relevant to achieving those missions are contained within each agency. Considerable coordination will be needed between the direct support for health services contained in the HRA with the health care financing agency (HIA). This coordination, however, is not required because of duplicative activities, but to implement overall federal policy in moving from direct to financing support.

b. Option 4 - more effective

This alternative contains many of the advantages of the above option, but the functions within the HPA are not entirely consistent -- i.e. alcohol and drug abuse treatment programs are not as closely related to other preventive activities as they are to the service activities in HRA. The coordination of all resources activities in facilitating their conversion to support through the financing system will thus be more complex.

c. Option 3 - less effective

As with option 4 above, the coordination of ongoing service resources activities is made more complex by housing them in two separate agencies. In addition, two agencies lack a unifying mission and contain divergent functions. CDSA would be responsible for broad health care surveillance and the control of communicable diseases, and the HRSA would be responsible for supporting policy development in health care financing and the administration of health services resources programs.

d. Option 2 - least effective

Resources activities would be distributed across three agencies (NIMH, BCA and HSRA) greatly complicating their coordination and consistent transition to support through the financing systems. Two of the agencies (HSRA and NIMH) contain several duplicative functions relevant to federal health missions.

-- How well does the organization provide flexibility for future change? This criterion reflects the ability of the organizational structure to accommodate changes which may be reasonably predicted at this point in time, without drastic realignment.

a. Option 1 - most effective

This alternative proposes the greatest realignment now of the health programs into agencies that serve future functions. Changes could be accommodated easily within the agencies because their missions are broad yet distinct.

b. Option 4 - more effective

This alternative contains many of the advantages of option 1 above, but is weakened by the addition of the time-limited direct Federal activities in alcoholism and drug abuse to the CDC, and creation of a new health protection agency whose focus will have to be changed as alcohol and drug abuse activities are phased out.

c. Option 3 - less effective

This alternative would create a new agency for substance abuse to house the time-limited activities in alcoholism and drug abuse. As these activities are phased-out, the entire agency would probably be abolished, since its focus is too narrow to accommodate future change. In addition, this agency sets the precedent for establishment and dissolution of entire agencies in response to changing federal priorities for special action in specific problem areas.

d. Option 2 - least effective

Two agencies, namely the NIMH and the BCA will require future realignment since they have a specific, categorical focus and contain time-limited activities.

-- How well does the organization facilitate regional operations? Based on the preliminary findings of this study related to regional office operations, it is assumed that regional offices activities will be integrated and focused on: 1) certification and monitoring of health care financing standards; 2) data gathering and surveillance; 3) developing resources for improved health care delivery; and 4) strengthening the States' public health capacities. This criterion addresses the amount of coordination that will be required of regional staff in implementing the policy and programmatic direction of the national health agencies.

a. Option 1 - most effective

Each regional activity is clearly aligned to one central agency function, requiring the least coordination at the regional level.

b. Option 4 - more effective

Regional offices must coordinate policies from 2 agencies in resources development activities (HPA and HRA) and in health care financing activities (SSA and HSA).

c. Option 3 - less effective

Regional resource activities will have to coordinate policies from two agencies (SAA and HSRA). Regional standards activities must coordinate policies from 3 agencies (HSRA, SRS and SSA).

d. Option 2 - least effective

Regional resource activities must coordinate policies from three agencies (NIMH, BCA, and HSRA) and regional standards activities must coordinate policies from 3 agencies (HSRA, SSA and SRS).

-- How effectively will the organization facilitate implementation by building on existing administrative strengths?

a. Option 2 - most effective

Three of the agencies, namely CDC, NIMH and BCA have substantial independent administrative capacity within them now, and the fourth, HSRA, can be readily created building on the administrative capacity of HSMHA.

b. Option 1 - more effective

One new agency (HRA) would be created without any existing administrative support capacity. CDC is relatively self-sufficient and HIA would pick up administrative capacity with the transfer of BHI and HSA. In addition, legislation would be required to separate alcohol and drug abuse activities from NIMH.

c. Option 3 - less effective

One agency (SAA) would be created without any existing administrative support capacity, and one (CDC) would require additional administrative staff to assume responsibility for all surveillance activities in support of health policy planning. Legislation would be required to separate alcohol and drug abuse activities from NIMH.

d. Option 4 - least effective

Two new agencies would be created without existing administrative support capacities, namely HRA and HSA. This option would also require legislation to separate the drug and alcohol abuse programs from NIMH.

-- How effectively can the organization be implemented without disrupting ongoing activities?

a. Option 2 - most effective

Under this alternative, all existing programs are maintained essentially intact.

b. Option 3 - more effective

The NIMH and BHME programs would be split, with activities assigned to separate agencies. Data gathering activities and drug abuse and alcoholism activities would have to be realigned from their current organizations.

c. Option 4 - less effective

This option is identical to option 3, in addition to which it would require the transfer of HSA from SRS.

d. Option 1 - least effective

This alternative would be the most disruptive since it would distribute the activities of numerous current health services and health manpower programs to several different agencies in order to separate formula from project grant support in resources development; and would separate data gathering and surveillance as well as health services research activities from ongoing grant and contract support. In addition, it would require the transfer of both MSA and BHI from their current parent agencies.

3. NEED FOR A COMBINED APPROACH.

As the preceding analysis demonstrates, there are disadvantages inherent in each of the four organizational options that were developed. While the first option, for instance, appears preferable according to most of the criteria, it would be the most disruptive to implement.

In addition, any of the options containing a separate health resources agency and a health insurance agency have two inherent problems. They would require considerable policy coordination between the service resource programs and the financing policy development activities in order to facilitate the conversion of service delivery activities to support through financing mechanisms other than grants. The health resources agency would place all current resource activities that are scheduled for termination or conversion to other forms of support in an agency that would retain no articulated long-term responsibility for health resources. Although many of the present grant-supported service delivery activities and the resource development activities are scheduled to be severely curtailed or redirected, there will be a continuing need for a capability to address the status of health care resources in the U.S. in order to provide responsive leadership and develop effective federal policies, including those related to the financing system.

Upon reexamining the options, it appeared desirable to combine the strong features of the four options, and to redefine the role with respect to health resources. The organizational recommendation, therefore, represents a combination and a reshaping of elements from the four options as they were originally developed.