nical and financial support to build capacity. Agency funding supports (*a*) public-private health science centers to build provider capacity through health professions education, (*b*) State health agencies to assist States in strengthening their capacity to deliver maternal and child health services, (*c*) community and migrant health centers to deliver direct primary care services to medically indigent populations, and (*d*) the National Health Services Corps to increase the supply of appropriately trained health professionals to serve in areas where these providers are scarce. (It should also be noted that other public programs such as Medicaid and Medicare also fund primary care service delivery, as do private third party payers. Moreover, increases in the proportion of third-party reimbursement is a goal of HRSA's primary care service programs.)

The Agency's resources that are directed at filling gaps in the health system are redirected once the non-Federal parts of the system begin to fill them. Therefore, effective targeting of resources is critical to the Agency's mission in taking important measures to assure that existing weaknesses in the nation's health system are corrected, and that all are assured the benefits of public health.

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HRSA's Collaborative Efforts with National Organizations to Expand Primary Care for the Medically Underserved

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Synopsis

As the Federal agency that provides leadership in expanding access to primary health care, the Health Resources and Services Administration (HRSA) manages some 50 programs directed toward the delivery of services and strengthening the base of national health resources. An enabling element of the agency's strategy is the expansion of partnerships with national associations, private foundations, and other entities that share a concern for the health care of the medically underserved. Cooperative efforts with national organizations are intended to promote the integration of public and private resources and encourage adoption of efficient approaches to organizing and financing health care. Medical education in the primary care specialties, State programs for women and children, involvement of managed care organizations with low-income populations, and programs concerning the uninsured are the foci of some of these collaborative relationships.

ALTHOUGH THE U.S. HEALTH CARE SYSTEM has always been fundamentally private, the Federal Government has provided support for the care of special population groups as defined in law. Since the early 1900s, for example, there have been programs to serve mothers and children. Others eligible for federally supported care have included members of the Armed Forces and their dependents, veterans, and American Indians and Alaska Natives. With the advent of Medicaid and Medicare in 1966, the Federal Government began financing health services for the medically indigent and the elderly, thus affecting significantly larger numbers of the general population nationwide. Beginning at about this same time, the Federal role in health services delivery was expanded, primarily through the direct funding of State and local nonprofit public and private entities that provide primary care to underserved populations.

Since 1980, Federal policy has moved strongly toward strengthening the role of States in designing and implementing health programs for citizens who depend on public support for needed services. During the past several years, the Health Resources and Services Administration (HRSA) has pursued a strategy of expanding partnerships with States, national associations, private foundations, and other entities that share a concern for the underserved in addition to managing

grant programs designed to expand access to primary care. "Primary care" implies a range of preventive and outpatient diagnostic and treatment services provided or supervised by a physician who takes responsibility for the patient's health. Typically, these physicians are family practitioners, general internists, or general pediatricians, though obstetrician-gynecologists may also fill this role. By design, mid-level practitioners are involved in most of the health care delivery entities that HRSA funds. Increasingly, care coordination (often termed "case management") is a major focus of local and statewide projects and of Federal policy.

From the HRSA perspective, each of these new relationships has the potential to advance one or more of the following goals:

- to strengthen relationships between HRSA and HRSA grantees with (*a*) the private sector, (*b*) the States, and (*c*) public health officials at all levels;
- to facilitate more effective use of limited Federal funds by (*a*) promoting coordination among public and private providers; (*b*) encouraging adoption of efficient approaches to financing, organization, and management of care; and (*c*) increasing the proportion of HRSA funds going to technical assistance (as opposed to health services); and
- to share information with leaders of organizations outside the Department of Health and Human Services (DHHS) as to (*a*) health care needs of the medically underserved and (*b*) related programs of both entities.

The table lists some current collaborative efforts in relation to these agency goals. As described in the following sections, these initiatives include advocacy and marketing, dialogue with health industry officials, and participation in major demonstration programs of private health foundations.

Primary Care Medical Education Conferences

In March 1988, HRSA sponsored an invitational conference to consider the nation's current and future needs for primary health care and the implications of these needs for public policies regarding medical education. The conference was planned with representatives of medical specialty groups and chaired by Dr. Leighton Cluff, then president of the Robert Wood Johnson Foundation (RWJ). Conferees drafted recommendations for future directions in both undergraduate curricula and residency training. Attendees included medical faculty members, practicing physicians, and representatives of medical associations such as the American Academy of Pediatrics and the American Academy of Family Physicians. The proceedings were distributed throughout the public policy and medical education communities (*1*).

Co-sponsored by the RWJ, the Second HRSA Primary Care Conference took place March 21-23, 1990, in Columbia, MD, to discuss ways to improve access to care for underserved populations. Four separate work groups developed recommendations concerning recruitment and retention, educational reform, linkages between education and community settings for the delivery of care, and primary care research. The proceedings include commissioned papers concerning the linkages between medical education and the delivery of primary care (*2*).

NGA: State MCH Programs

The National Governors' Association (NGA) cooperative project, managed jointly by HRSA's Bureau of Health Care Delivery and Assistance and its Office of Maternal and Child Health (now the Maternal and Child Health Bureau, MCHB), was inspired largely by the expansion of Medicaid coverage in the Omnibus Budget Reconciliation Act of 1986. This collaborative project was designed to assist States by disseminating information about practical and innovative approaches and identifying opportunities for collaboration at the State level between programs funded by HRSA and by the Health Care Financing Administration (HCFA).

An early "product" of this project was a January 1988 workshop on physician participation in public programs. In addition, the following reports have been widely distributed: "Increasing Provider Participation (*3*)," Estimating Medicaid-Eligible Pregnant Women and Children Living Below 185% of Poverty (*4*)," and "Reaching Women Who Need Prenatal Care (*5*)." More recent reports concern State-level program coordination (*6*), program evaluation strategies (*7*), or enhancing the scope of services (*8*).

The final major event under the current agreement was a national conference on March 29–31, 1989, in San Antonio, TX, for State, local, and Federal officials as well as others involved in health care delivery. As described in the conference proceedings, one purpose was to assess progress and encourage further improvements in prenatal, child, and adolescent health services (*9*).

GHAA: HMOs and Low-Income Populations

Since the fall of 1987, HRSA representatives have been meeting with senior staff members of the Group Health Association of America (GHAA) about the possibility of expanding the role of member plans in serving low-income populations. Officials of about 30 plans

Collaborative relationships and goals of the Health Resources and Services Administration

Collaborative efforts	Strengthen relationships			Increase effectiveness of limited funds			
	Private sector	States	Public health entities	Coordinate providers	Improve financing, management	Increase emphasis on technical assistance	Share information with outside groups
Conferences on primary care and medical education	X	X					X
State programs for women and children		X	X	X	X	X	
HMOs and low-income populations	X	X		X	X	X	X
Corporate sector relationships	X						X
Health care for the uninsured	X		X	X		X	X
Healthy Generations	X	X					X
Health promotion program	X	X	X				X
Public health associations		X	X			X	X

attended a meeting in January 1988, convened by James F. Doherty, President and Chief Executive of GHAA. Attendees endorsed the idea of a continuing dialogue among HRSA, HCFA, and GHAA. In connection with the Group Health Institute in June 1988, there was a special session on HMOs and low-income populations. A paper commissioned by the association identified six problem areas based on the June meeting and prior discussions: eligibility and enrollment, rate setting, patient care delivery, data systems and administrative issues, mandatory versus voluntary systems, and the uninsured (*10*).

Subsequently, the association convened several work groups that identified such corrective actions as changes in the Medicaid law, model State regulations for managed care organizations to use in contracting for care of Medicaid eligibles, and approaches to improve communication among providers, payors, and government at the State and local levels.

Relationships with the Corporate Sector

At HRSA's request, the American Enterprise Institute created a small working group that met in October 1986 to evaluate the potential of private initiatives for meeting more of the health care needs of the medically indigent. Building on these preliminary steps, HRSA and the Robert Wood Johnson Foundation cosponsored an invitational seminar in July 1988 in Columbia, MD. Participants included senior staff members of HRSA, the Office of the Secretary, HCFA, and RWJ, health policy researchers, and selected members of the foundation's National Advisory Committee for the Uninsured Program. The report on the seminar reflects multiple views and recommendations to improve the complementarity of public and private health services financing and delivery policies (*11*).

In the spring of 1990, HRSA asked the Washington Business Group on Health (WBGH) to assist the Agency in exploring potential roles for the private sector in strengthening the primary care public health system. On May 9, representatives of government, business, and business coalitions came together to discuss current public-private relationships, lessons learned from these, barriers to further public-private collaboration, and new opportunities for public-private relationships. WBGH then interviewed some 60 persons about public-private partnerships and developed a report presenting options for working with HRSA grantees, with national business or voluntary organizations, and with local business or voluntary organizations (*12*).

As an initial step in furthering new partnerships with the private sector, an invitational symposium may be convened in the Washington area during the spring or summer of 1991 to discuss more specific opportunities with corporate representatives.

RWJ: Health Care for the Uninsured

In November 1985, the foundation announced a program to demonstrate ways of improving access for uninsured populations by modifying financing and delivery arrangements. The foundation funded 15 projects, including several that involve community health centers (CHCs). The following three projects, for example, are developing or using insurance products for small firms or individuals:

• *Tennessee Primary Care Association.* The Tennessee Primary Care Association has designed a comprehensive health benefit plan, called MedTrust, which is being offered to uninsured employers and employees. Costs have been reduced through substantial discounts from participating hospitals, a major feature of this demonstration. Enrollees will select a primary care physician from among those participating in the Tennessee Primary Care Network, a nonprofit HMO which is the carrier for the MedTrust plan. The plan became avail-

able in the Memphis area in March 1989; 209 firms had enrolled (covering 806 persons) as of September 1, 1990.

• *Utah Community Health Plan.* This project is developing and testing an insurance plan for low-income employees of very small businesses and their dependents. HRSA-funded CHCs form part of a subsidized ambulatory care network which, with participating hospitals offering discounts, is organized as an HMO. Marketing began in September 1989 for coverage to be effective October 1, 1990. As of September 1, 211 firms were enrolled, and they were insuring 1,190 persons.

• *Washington Basic Health Plan.* With funding from the Robert Wood Johnson Foundation, Health Systems Resources developed managed care networks that include CHCs in some locations. Organization into managed care systems has enabled these entities to submit bids to serve enrollees of the State-sponsored Washington Basic Health Plan for the uninsured. As of October 1, 1990, a total of 13,528 people were enrolled under the plan, including all providers.

The HRSA-funded health centers have played an important role in developing provider networks for these insurance plans in Salt Lake City and Memphis. In addition to grantee involvement, the Administrator and an Associate Administrator of HRSA serve on the National Advisory Committee for the program.

RWJ: Healthy Generations

The Office of Maternal and Child Health (now MCHB) and the Robert Wood Johnson Foundation have developed collaborative initiatives to promote improved maternal and infant health in areas with high infant mortality. This MCHB initiative, entitled "Healthy Generations," supports the development and implementation of

• effective approaches and financing arrangements that will improve access, content, and quality of health services;
• coordinated systems to assure that the overall health needs of pregnant women and infants are assessed and the full range of services provided; and
• policies for strengthening the capacity for outreach, case management, and enhanced services that address medical as well as social and behavioral needs of pregnant women and infants.

These approaches have shown promise in improving outcomes for women at risk due to low income or poor access to care. MCHB has awarded grants to five States for 4 years and to American Samoa for 3 years. Under a similar initiative (called Healthy Futures: A Program to Improve Maternal and Infant Care in the South), the foundation has awarded grants to five other southern States and to Puerto Rico. The foundation's program builds on the work of the Southern Governors' Association Regional Task Force on Infant Mortality.

"'Primary care' implies a range of preventive and outpatient diagnostic and treatment services provided or supervised by a physician who takes responsibility for the patient's health. Typically, these physicians are family practitioners, general internists, or general pediatricians, though obstetrician-gynecologists may also fill this role.'

Other Maternal and Child Health Activities

The agency is working with a variety of entities outside the Federal Government to improve services to mothers and children. Following are some of these collaborative arrangements:

• The Healthy Mothers, Healthy Babies Coalition, with support from MCHB, develops and distributes to the general public and to providers educational materials directed toward pregnant women to promote healthy habits for themselves and their families. The coalition, which has an emphasis on low-income women, also develops networks for sharing information among groups concerned about improving the health of mothers and babies.
• MCHB and HCFA staff and representatives from State Maternal and Child Health (MCH) and Medicaid agencies are working together through the Medicaid MCH Technical Advisory Group. This group has compiled and reviewed perinatal care guidelines and model practice relationships between State agencies to improve quality and coordination of services for pregnant women and children in the Medicaid-eligible population throughout the United States.
• The interest and cooperation of the corporate sector was the focus of a 1½ day seminar during October 1989 on maternal and child health. Jointly sponsored by HRSA and the Washington Business Group on Health, the seminar concerned such issues as prenatal care,

infant care, parental leave, and day care. MCHB has subsequently funded WBGH to carry out additional collaborative activities such as a Business Advisory Board on Maternal and Child Health, development of public-private strategies and systems to improve MCH services, and dissemination of information about MCH programs and issues to corporations, small business, and national business organizations.

Other cooperative initiatives involve professional organizations, such as the American College of Obstetricians and Gynecologists; other agencies, such as the Department of Agriculture (Special Supplemental Food Program for Women, Infants, and Children); and voluntary organizations, including the March of Dimes/ Birth Defects Foundation.

KFF: the Health Promotion Program

In April 1986, the Henry J. Kaiser Family Foundation (KFF) began a 10-year program to reduce the incidence and prevalence of five major preventable causes of morbidity and mortality: cardiovascular disease, cancer, substance abuse, unintentional injuries, and adolescent pregnancy. The program involves other foundations and additional partnerships with universities, governments, business, labor, minority organizations, and public interest groups. Implementation is sequential, by region, and has begun in 13 States in the West and in the 16 southern States. The Northeast (9 States) and the Midwest (12 States) will follow. The program includes seven related components: community health promotion grants, health promotion resource centers, public awareness and education, health policy, research and development, evaluation, and collaborative relationships and funding partnerships.

HRSA and KFF have executed a broadly worded memorandum of understanding to create a framework for cooperative arrangements involving HRSA programs. Initial efforts are being designed around community health centers, some of which have received a KFF grant. HRSA and KFF staff are planning an evaluation of rural health promotion programs under various types of sponsorship, including CHCs.

Associations of State and Local Health Officials

The Administrator of HRSA has begun a series of quarterly meetings with leaders of three associations: the Association of State and Territorial Health Officials, the National Association of County Health Officials, and the U.S. Conference of Local Health Officers. During the first meeting, on March 27, 1990, association and HRSA officials presented priorities and concerns and planned cooperative activities to strengthen collaboration at all levels, especially in rural health, minority health, and relationships between health departments and the National Health Service Corps. As a basis for a variety of cooperative arrangements, a memorandum of understanding with each association was signed on October 1, 1990. Grants have also been awarded to fund specific activities.

Conclusion

The collaborative efforts described in this paper offer one way to enhance the productivity of both public and private resources while maintaining a health system that reflects the pluralistic American society. These types of partnerships will continue to be a focus for the agency during the next few years, with an increasingly dominant role for States and public health organizations.

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