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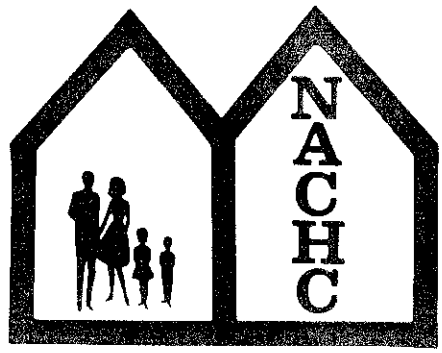


"NATIONAL HEALTH POLICY FOR PRIMARY CARE: 1980-82: ISSUES AND POLITICS"

POLICY ANALYSIS DEPARTMENT
1980

INTRODUCTION

This session is to re-emphasize health centers' need for serious concentrated involvement in public health policy decisions at the local, regional, state and national level.

The apparent lack of involvement was evidenced by NACHC staff recent visits to state health officials and legislatures in several key states. These officials (i.e. Senators, Congressmen, State Legislators, Heads of Health Depts.) lacked the basic knowledge about primary care centers in their state - the number and lecation of programs; who and how many persons they serve; their level of operation, and their needs. Unless this situation changes rapidly, the future of our centers is in serious question.

The purpose of this session will be to discuss methods in which we can more effectively affect public policy decisions which include:

- a systematic communications link with health center constituency - local, state, regional and national officials
- a basic understanding of key health policy issues
- a brief review of the legislative process and its importance
- building an organizational effort at the grass roots level which will impact upon public policy.

I. WHY THE GROWING NEED TO INFLUENCE AND PARTICIPATE NOW MORE THAN EVER?

1. Pressure brought about by budget cuts - state and federal - regardless of a Carter or Reagan Administration.
2. Competition has become fierce as resources are limited.
3. Growing opposition for influential groups - i.e. organized medicine.
4. "Health costs will triple in the next 10 years" - HCFA.
5. Greater roles for states in linking or controlling programs (ex.Mental Health,Distressed Hospitals, NHSC,Block Grant).
6. Growing pressure to eliminate consumer-majority governing boards because they are "unnessary" in running a "business" or conflict with public facility goverance laws/policies.
7. State Medicaid cutbacks (ex.Alabama, Tennessee, Illinois, Kentucky, New York - this year).
8. Restrictive state licensure or practice acts.
9. Shrinking federal monies for primary care programs evidenced in FY-80 Appropriations for health centers, NHSC, Family Planning, and related programs.
10. The need for dollars to support distressed hospitals as as a primary care effort.

From all indications above, there is a great need for coordination and organization to achieve public policy goals.

II. WHO SHOULD PARTICIPATE?

Although the health center movement is not as wealthy or long-established as other health related organizations (example: American Medical Association or American Hospital Association), we can influence public policy. Our stronghold rests with the vast numbers of people employed and served by health centers - in excess of 6 million people served and over 1200 primary care centers nationally. These people are voters, whether employees or consumers, we all have a vested interest in the well-being of "our" health center program as a whole, which will determine the fate of our individual centers and clinics.

III. KNOWLEDGE IS KEY

It is impossible to respond to a situation if you are not aware that it exists. The National Association of Community Health Centers' role through its Policy Analysis Department conducts research, analyzes data and presents its findings to Congress, Agencies, and the Public. However, the case must be made and reinforced from HOME. Our staff has so often been asked by Congressional Members and their staffs "WHY HAVEN'T I HEARD THIS FROM THE HEALTH CENTER PEOPLE IN MY DISTRICT OR STATE! They want to hear from you.

When NACHC staff visited state legislators and health department officials in a number of states, they were received warmly and there was genuine interest in our programs in most cases. They wanted to know all about the primary care programs and their political significance. People had different reasons for caring, but all showed an interest.

NACHC staff is not capable of making these contacts in each state - BUT YOU CAN. You must decide now that this is a priority and begin an on-going process to inform your local, state, and national representatives of your existence and needs.

IV. ORGANIZATION + PLANNING GET RESULTS

Through organizations such as the National Association of Community Health Centers, public health policy is made and implemented. The key to influencing public health policy is a well-organized effort which has coordinated direction, a plan a good communications system, and follow-up. IS YOUR HEALTH CENTER ORGANIZED TO HANDLE HEALTH POLICY ISSUES? If so, how?

Please review the attached charts:

A. Shows required levels of on-going communication. If any of these links fail, the program as a whole will suffer.

B. NACHC Organizational Flow Chart for Public Policy also depicts how each link depends upon the other. Positions are developed from the grass roots.

V. LEVELS OF ORGANIZATION

A. National - exists and governed as established in by-laws. National office staff, Legislative and Health Policy Committees

B. Regional - exists as structured in by-laws of NACHC, now under revision. Should have staff and corresponding committees.

C. State - exist sparodically at differing levels of development, to be considered in NACHC by-laws revision. Should have staff and corresponding committees.

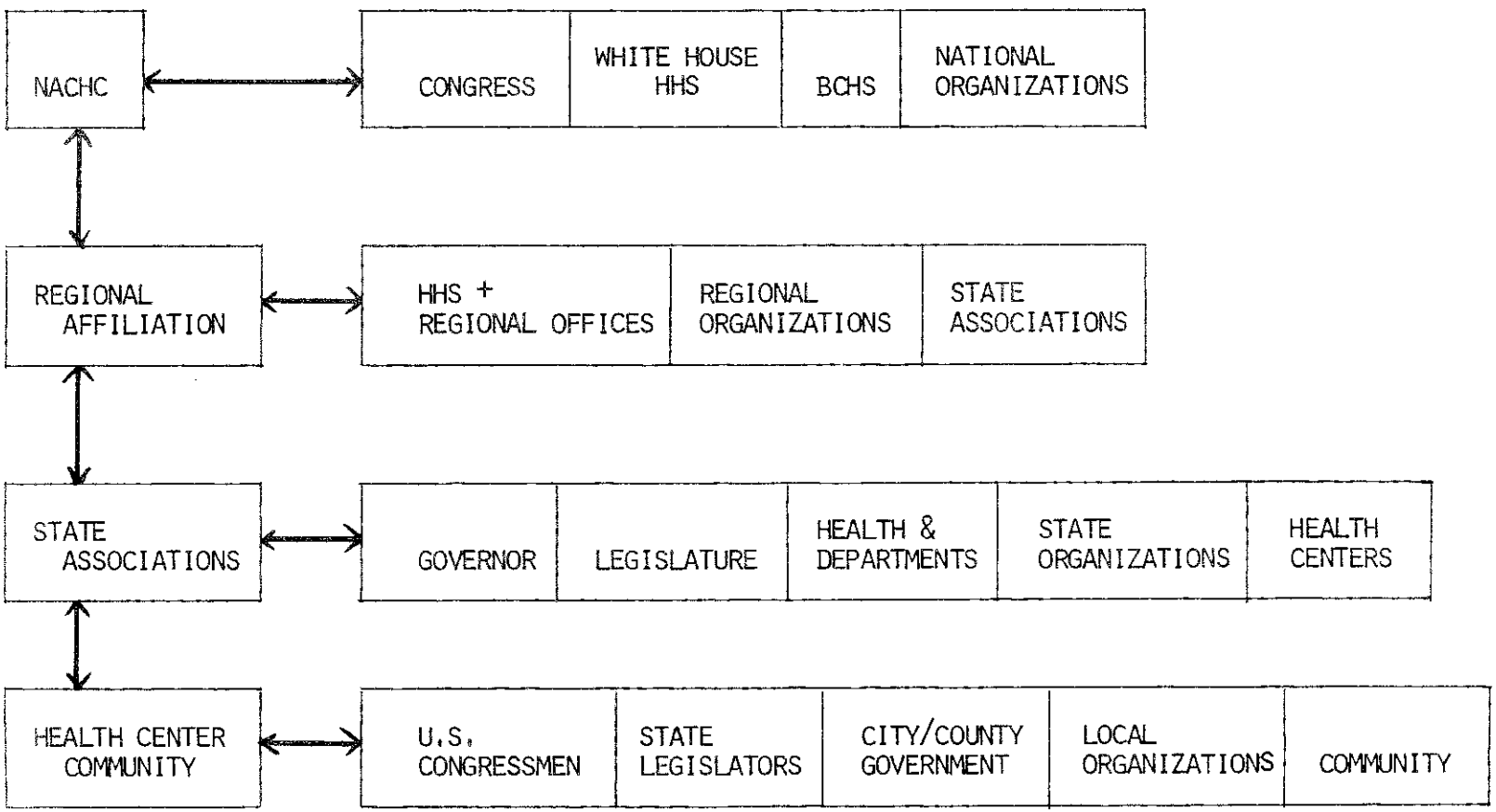
D. Centers - no formalized structure - yet a must if not the most critical stage. Should have staff assignees and corresponding committees.

E. Proposal for Center Organization

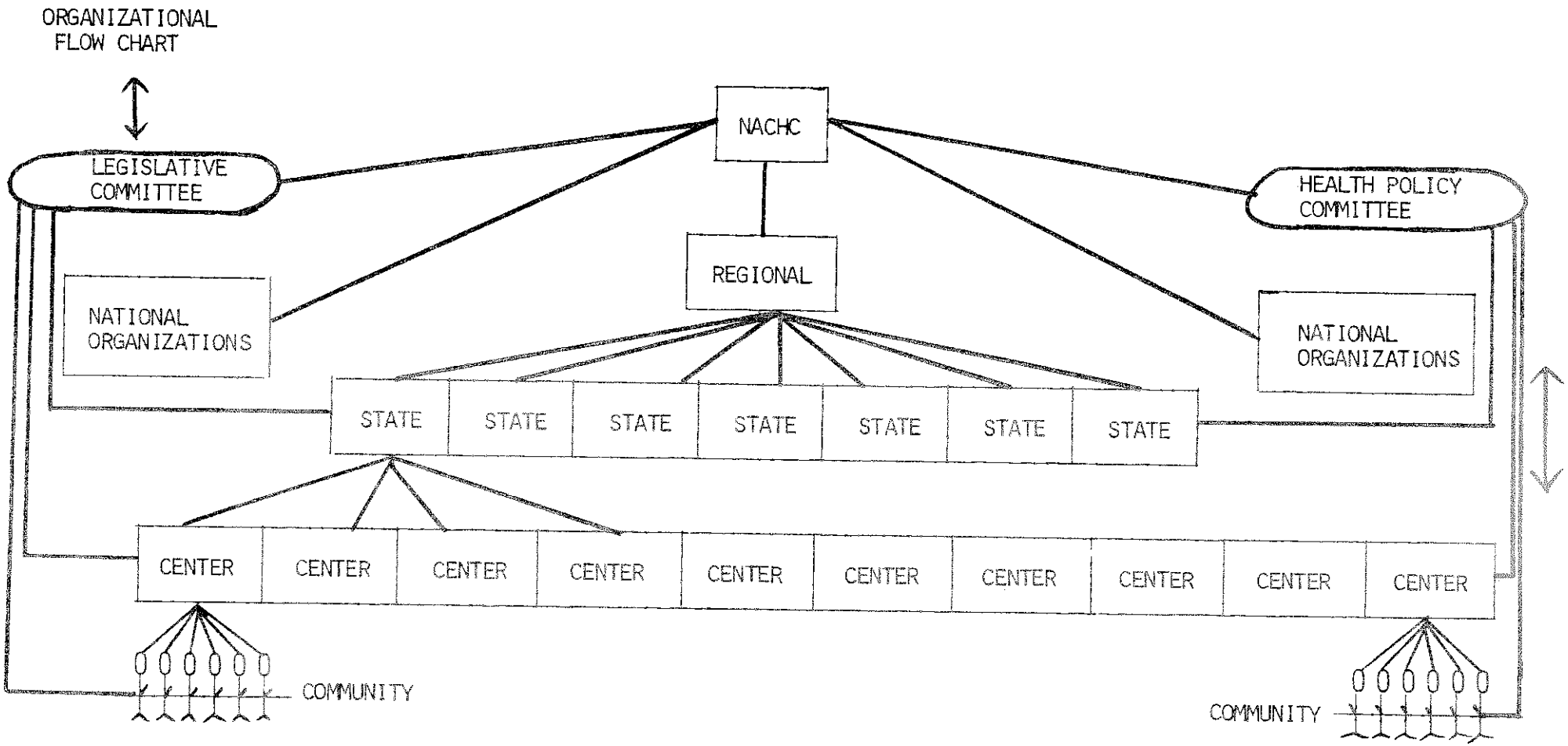
The basic mission at each level is to:

1. Gather pertinent information about the program
2. Disseminate information to appropriate public/private individuals and organizations
3. Foster relationships and develop contacts
4. Secure support on needed objectives
5. Give support as desired
6. Maintain an on-going effort.

REQUIRED LEVELS OF INTERACTION: ON-GOING



NACHC ORGANIZATIONAL CHART FOR PUBLIC POLICY



VI. COMMUNICATIONS - The Critical Link

NACHC uses several methods of communication which includes:

Policy and Issues Guidebook - outlines major issues to be address during upcoming calendar year and their priority of importance.

Legislative Status Report - outlines major health issues affecting primary care centers and the community. This bi-monthly publication keeps one abreast of major health issues and laws whether pending action or action completed.

Action Memo - a document requiring immediate attention. When an issue of extreme urgency is about to affect the well-being of primary care centers, this document is prepared and transmitted as quickly as possible to the centers and board chairpersons. It spells out in simple everyday language the

- Issue at hand, who to contact, suggested methods
- Who to contact
- suggested methods of contact (letters, phone calls,etc.)
- Length of time required to respond.

This document is distributed on an as needed basis.

At a minimum, an individual membership should be held by at least three (3) persons representing the health center - the Executive Director, Board Chairperson, and the Chairperson of the legislative body of the center. These timely documents can be mailed to your home address.

In addition to these communication tools, others that are available to persons holding membership include:

Newsletter, Clearinghouse News, Clinical Management Bulletin.

SOME SUGGESTIONS OF WHAT YOU CAN DO

Basic information should be disseminated to state, local, regional, and national representatives during a personal visit at some time during the year.

Legislators and state officials are not project directors, staff or patients of health centers. They do not know the details of your center and rarely will seek answers. IT IS YOUR DUTY TO KEEP THEM INFORMED. Assume they know little or nothing of the program.

A brief fact sheet about your health center should be done and could include:

1. Name and location of health center
2. Number of persons served
3. Types of services offered
4. Length of time in existence
5. Number of NHSC personnel (if any)

LEGISLATION

Legislation is clearly divided into two basic types. In this section, we will outline and define those two activities in such a manner that their role in the legislative process is clearly recognized.

Authorization (Ex. PL 95-626)

The first process is the creation of an AUTHORIZATION. This measure, bill or law creates or renews a program or activity. It would:

A. Authorize, by law, the maximum amount of money to be spent to carry out a program.

B. Stipulate components and requirements of a program.

C. Spells out definitions of activities and conditions for grant or contract support.

D. Generally sets a time period for which a program is authorized.

It is, however, important to note that the authorization process itself does not provide funds, only the level up to which the program can be funded.

Appropriations (Ex. fiscal 1980 Appropriations for the Departments of Labor and Health, Education and Welfare PL 95-

The second process sets the amount of money which will actually be made available for expenditures to carry out a program or activity.

In almost all cases, an appropriation is required each year. Funds for primary care centers are appropriated on a yearly basis. In addition, a program must be authorized before an appropriation can be made. If an authorization is late in being passed, the program may not be part of the regular appropriation legislation and would have to depend on a supplemental appropriation or continuing resolution in order to exist for the next fiscal year.