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MANAGEMENT OF HHS

Using the Office of the Secretary to Enhance Departmental Effectiveness

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To the President of the Senate and the
Speaker of the House of Representatives

This report on management of the Department of Health and Human Services (HHS) is one in a series of GAO management reviews of major departments and agencies. Our objective was to assess the Office of the Secretary's role and effectiveness in managing the Department and to identify ways in which departmental management processes and structures could be improved.

The report makes specific recommendations to the Secretary for improving management of the Department and helping it better prepare for the future. Implementation of many recommendations will require a sustained commitment from the current and future Secretaries of HHS, the Office of Management and Budget, and the Congress.

We are sending copies of this report to the Secretary of HHS; the Director, Office of Management and Budget; interested congressional committees and subcommittees; and individual members.

This report was prepared under the direction of J. William Gadsby, Director, Intergovernmental and Management Issues, who may be reached on (202) 275-8387. Other major contributors are listed in appendix VI.

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Executive Summary

Purpose

Secretaries of the Department of Health and Human Services (HHS) have shouldered tremendous responsibilities for budgets totaling several hundred billion dollars, for hundreds of programs, and for decisions that affect the health and welfare of millions of Americans. Some have been remarkably effective in executing their responsibilities. Others were less successful.

The responsibilities given to the Secretary of HHS cannot be executed by that person alone. The Secretary needs a cohesive management team operating together to carry out those responsibilities. The Office of the Secretary is the HHS component charged with assisting the Secretary in administering and overseeing the Department's organization, programs, and activities. Shortcomings in its organization or operations will impede the Secretary's ability to carry out his or her responsibilities. With this in mind, GAO reviewed the role and activities of the Office of the Secretary to assess its effectiveness and to identify ways in which its management processes and structures could be improved.

HHS Environment

HHS presents one of the more massive and complex management challenges in the federal government. Organized into five major operating divisions and the Office of the Secretary, the Department has an annual budget of $401 billion—the largest of any federal department—and a direct work force of 116,000. HHS is responsible for some 200 very different programs, having diverse designs, program delivery concepts, and purposes. Some programs are directly administered by HHS components; others, by HHS contractors; still others, by state and local governments, which often have substantial flexibility in designing the programs to suit their local needs. No fewer than 23 congressional committees have jurisdiction over HHS's programs and activities. (See pp. 12 to 15.)

The nature of the Secretary's management task has changed over the 36-year history of the Department. During the Department's formative years, the Congress gave the Secretary responsibility and staff to oversee common departmental administrative activities, such as personnel and financial matters, but kept program responsibility with component-level officials. As the Department grew, the Secretary gained greater responsibility for most HHS programs and policies. Staff were added to the Office of the Secretary to handle planning, evaluation, legislative, and public affairs functions. (See pp. 19 to 23.)

GAO's review of the Office of the Secretary's activities and operations spanned administrations dating from Secretary Gardner's through Secretary Bowen's. GAO interviewed current and former top-level Department officials; consulted with public policy experts and panels of former top-level HHS management officials; administered a questionnaire to current managers and senior staff to gain their perspectives on factors influencing the Office of the Secretary's effectiveness; and evaluated the office's management activities, operations, policies, and systems. (See pp. 16 to 18.)

Results in Brief

Secretaries of HHS are responsible for providing policy leadership and overseeing departmental administrative matters and programs. Some Secretaries have achieved successes with policy initiatives that personally interested them, but have been less successful in addressing other important issues confronting the Department and the nation.

GAO believes that Secretaries' capacity to effectively manage their tremendous responsibilities has been hampered by the lack of an effective management system within the Office of the Secretary. With such broad responsibilities and tenures averaging less than 2 years, Secretaries need a management system that structures the Department's activities and provides information on how well it is working.

Such a management system must help Secretaries understand and identify emerging policy and management issues, establish clear goals and objectives for these issues, and develop strategies to accomplish the goals and objectives. In addition, the system must include accountability dimensions that allow the Secretary to monitor and track the Department's progress in achieving its goals and objectives, oversee the operations of programs and activities that have been delegated to others, and provide feedback to and communicate with the Department's components.

Systems of various designs have been used effectively by certain past Secretaries, and elements of these systems, such as an executive clearance and decision-making process, remain in use today. Yet other important elements of an effective management system, such as departmental strategic planning and monitoring and oversight systems, are missing today. No secretarial management system has stayed intact long enough to provide stability to the Department's basic operations. Such a system needs to be comprehensive enough to enable the Secretary to fulfill the

broad responsibilities of the office, yet flexible enough so that successive Secretaries can adapt it to their own management styles.

Principal Findings

Establish the Strategic Planning Element of a Secretary's Management System

Departmental strategic planning is a key element missing from the Office of the Secretary's management system. A planning process helps the Secretary establish departmental goals and objectives, develop implementation strategies, monitor and track progress in achieving them, and communicate with and provide feedback to the Department. Without strategic planning, communications, coordination, and decision making in the Department can be handicapped. A majority of the HHS officials GAO surveyed believed that adding a strategic planning element would have a positive effect on the Department's activities and operations, such as crisis management, staff knowledge about future operations, and short-range decision making. (See pp. 27 to 36.)

Enhance the Decision-Making Element of a Secretary's Management System

HHS's decision-making processes tend to be slow, but when properly used they are generally effective in assuring that decision makers consider the right information, evaluate alternatives, and consult with appropriate parties. In reviewing a number of specific HHS decisions, however, GAO found that their quality or timeliness has suffered when the clearance process has been used inappropriately.

To manage the large volume of decisions that the Secretary must make, the Office of the Secretary has used a clearance process, designed to ensure that the Secretary obtains the knowledge and perspective of Department officials before making a decision. In some instances, when allowing officials to bypass the clearance process, Secretaries made decisions that they later reversed. In other cases, decisions were delayed because Secretaries did not act to resolve disputes that arose in the clearance process.

In one case GAO examined, a decision was delayed 4 years when departmental officials disagreed about whether to ban interstate sales of raw milk—a product that was known to cause illness and sometimes death. In this case, HHS was sued because of its inaction and finally acted under a court order. (See pp. 37 to 50.)

Establish Clear Lines of Authority and Accountability

Since 1981, Secretaries have appointed chiefs of staff to assist in managing the Department. The involvement of chiefs of staff in various departmental matters, such as major personnel and policy decisions, often has overlapped with and caused confusion over the formal duties and responsibilities of other senior officials within the Office of the Secretary. For example, GAO found redundant responsibilities and unclear lines of authority between the Under Secretary and the chief of staff. Chiefs of staff generally have had greater access to the Secretary than other senior officials, whose influence was thereby lessened. Also, the roles and responsibilities of some Office of the Secretary units do not match existing mission and function statements, further confusing the lines of authority within the office.

Secretaries typically have retained authority for policy activities and delegated authority for managing day-to-day administrative and program activities to others. In an organization with so many diverse activities and programs, decentralized management is appropriate as long as it is balanced with adequate accountability and control. The Secretary must hold those officials to whom authorities have been delegated accountable for results.

Recent Secretaries have used few formal or informal means to monitor delegated activities to assure themselves that programs and activities are being managed effectively and efficiently. HHS managers and senior staff reported that the Office of the Secretary's oversight of departmental activities and programs was weak. In addition, top-level management officials said they had limited access to the Secretary. (See pp. 51 to 60.)

Implement Strategic Work-Force Planning

HHS does not have a Department-wide, coordinated approach for systematically addressing its work-force problems. The Department is experiencing operational and program changes that have major implications for the size and skill needs of its work force. While some operating divisions have attempted to solve their own work-force problems, their initiatives have generally lacked the comprehensive perspective needed to match human resources to changing operational and program objectives. Secretaries and the Office of the Secretary have played a limited role in addressing departmental work-force issues. Strategic work-force planning could help the Department (1) ensure that personnel actions support program objectives and (2) address its work-force problems. (See pp. 62 to 71.)

Continue Strengthening Management of Information

Information management problems in many HHS programs have caused or contributed to difficulties in providing good service. For example, inaccurate and incomplete data on HHS's child support enforcement program made it difficult for the Department and the Congress to assess the program's performance. Before 1986, the Office of the Secretary's efforts to improve HHS's management of information were unsuccessful, because it had attempted to exert too much direct control over operating divisions' information management activities.

More recently, however, the Office of the Secretary adopted a more participatory management approach and initiated several measures to strengthen HHS's information management, including the hiring of staff with strong technical skills in top-level positions. The Office of the Secretary's actions are promising. But additional emphasis and sustained attention need to be given to several important information management activities, including planning, policy development, information resources management reviews, and skill development. (See pp. 72 to 81.)

Sustain Efforts to Improve Financial Management

HHS has had longstanding problems in establishing an effective departmental financial management system. Two past attempts to correct these problems were unsuccessful because of technical difficulties, cost constraints, and inadequate support from operating components. A promising new departmental effort to modernize financial management systems is underway. However, top-level support, adequate funding, and a skilled financial management staff will be needed to assure the success of this modernization effort. (See pp. 82 to 88.)

Recommendations

GAO's key recommendation to improve the management of HHS is that the Secretary establish a secretarial management system that would include

- a departmental strategic planning process to identify emerging policy and management issues, establish goals and objectives for the future of the Department's operations and the nation's health and human services programs, and develop alternative strategies to accomplish the stated goals and objectives and
- an accountability dimension that would monitor and track the Department's progress in achieving its goals and objectives, oversee the operation of departmental programs and administrative activities that have been delegated to others, and provide feedback to and communicate with the Department's components.

GAO also is recommending that the Secretary

- enhance the decision-making process by establishing means to resolve significant disputes promptly and preventing individuals from circumventing the process;
- clarify and formally communicate the authorities of key departmental leaders and adhere to such lines of authority;
- define the duties and responsibilities of a chief of staff, should the Secretary appoint one, so that they do not conflict with those of other high-level departmental officials;
- establish a departmental strategic work-force planning effort; and
- continue recent efforts to upgrade financial and information management within the Department. (See pp. 36, 50, 60, 71, 81, and 88.)

Agency Comments

In commenting on a draft of this report, HHS said the Secretary would give serious consideration to GAO's recommendations as he proceeds with his administration's management initiatives. HHS, however, did not specify any actions it plans to take to address GAO's recommendations for improving departmental management. HHS's general comments are included in this report as appendix V. HHS also provided technical comments, which GAO incorporated into the report as appropriate.

Contents

Abbreviations

AIDS	acquired immunodeficiency syndrome
ASMB	Office of the Assistant Secretary for Management and Budget
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPER	Office of the Assistant Secretary for Personnel Administration
CAMS	Cooperative Agency Management System
FDA	Food and Drug Administration
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IG	Office of the Inspector General
IRM	information resources management
OHDS	Office of Human Development Services
OIRM	Office of Information Resources Management
OMB	Office of Management and Budget
OS	Office of the Secretary
PHS	Public Health Service
PPBS	Planning, Programming, and Budgeting System
SSA	Social Security Administration

Introduction

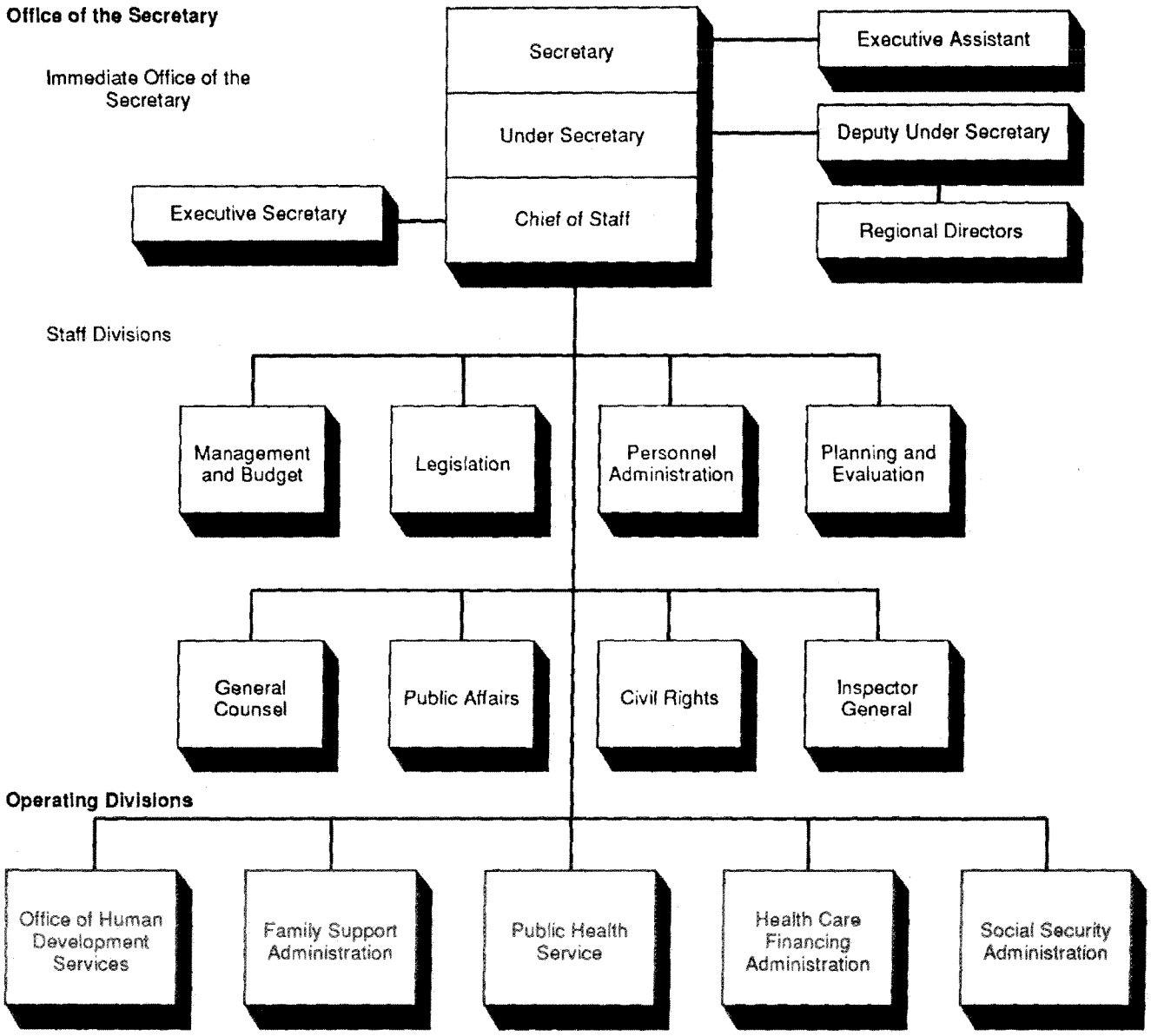
Picture a conglomerate overseeing hundreds of programs to aid the health and welfare of Americans, spending more than $1 billion a day. The conglomerate sends millions of pension checks to retirees; pays health care expenses for the aged, poor, and disabled; safeguards food and drugs from harmful agents; gives money to the aged, the disabled, and women and children to help them through difficult times; conducts research to advance the treatment of human diseases; helps immigrants and refugees to assimilate into a new culture; and offers health services for American Indians. This conglomerate is the Department of Health and Human Services (HHS).

HHS presents one of the more massive and complex management challenges in the federal government. Its expenditures for fiscal year 1989, estimated at $401 billion, account for about 35 percent of estimated federal expenditures and are the largest of any federal department or agency, including the Department of Defense. About 116,000 people are employed directly by HHS, and hundreds of thousands more work on its programs administered by the states, grantees, and contractors. The Department has about 200 programs that provide for the health and welfare of virtually every American citizen. No fewer than 23 congressional committees have jurisdiction over its programs and activities.

HHS History and Organization Structure

HHS has evolved from a series of consolidations and reorganizations of various federal departments and agencies. In 1939, health and human services programs were consolidated under the Federal Security Agency. This consolidation included the Office of Education, the Public Health Service (PHS), and the formerly independent Social Security Board. The Federal Security Agency was reorganized in 1953 as a cabinet-level department known as the Department of Health, Education, and Welfare. In 1980, the Department was redesignated HHS when Education became a separate entity. As illustrated in figure 1.1, HHS is made up of the Office of the Secretary (OS) and five operating divisions.

Figure 1.1: HHS's Organization Structure



Note: Also located administratively in HHS, but reporting to the President, is the Office of Consumer Affairs, which handles consumer-related policy and programs in the federal government.

OS Oversees Department Activities

OS, which employs about 4,300 people, consists of the Immediate Office of the Secretary and eight staff divisions. The Secretary is the chief executive of HHS. Legislation authorizes the appointment of key staff assistants to help the Secretary administer the Department's programs. The Under Secretary serves as Secretary in the incumbent's absence. Three Assistant Secretaries oversee offices—Planning and Evaluation (ASPE), Legislation, and Public Affairs—that deal with the Department's policy and communication activities. Two other Assistant Secretaries head staff offices—for Management and Budget (ASMB) and for Personnel Administration (ASPER)—that oversee the functions identified in their titles. Several other offices form the remaining staff divisions of OS. The Office of the General Counsel provides legal assistance to the Department, and the Office for Civil Rights enforces civil rights policies and investigates discrimination complaints against HHS grantees and contractors. In addition, the Office of the Inspector General (IG), which accounts for about 32 percent of OS staff, conducts audits and investigations of Department-funded activities.

Also, since 1981, Secretaries have appointed chiefs of staff, who have been assigned various duties at the Secretaries' discretion. Reporting to the chief of staff is the executive secretary, whose responsibilities include coordinating policy development activities and ensuring that offices affected by proposed actions or decisions are informed and given an opportunity to comment.

HHS also has 10 regional offices to help administer its programs throughout the nation and to provide closer contact with state and local governments. Heads of these field offices, called regional directors, are appointed by the Secretary to be his or her direct personal representative in the region. Within each region, there is a small office to handle central administrative responsibilities. Regional representatives of HHS's operating divisions are under the line direction of their parent organizations.

Five Operating Divisions Manage HHS Programs

HHS's five operating divisions are of very different character and size, providing a variety of services to the American public. PHS is the oldest. Authorized in 1798 to provide health services to merchant seamen, PHS, and its functions, were expanded as federal involvement in health activities grew. The Assistant Secretary for Health heads PHS and oversees its

numerous programs. Also, the Surgeon General, who heads the Commissioned Corps,[1] helps plan and direct the activities of PHS. PHS is also unique among the HHS components in that it employs many research scientists and medical professionals. With a staff of about 40,100, PHS also is involved in such diverse activities as basic health care, biomedical, and behavioral research; direct service delivery; grant programs; and public health surveillance and treatment. For fiscal year 1989, PHS will spend about $13 billion.

The Social Security Administration (SSA) is the Department's largest operating division, employing over 65,300 people and having estimated expenditures of $247 billion in 1989. SSA administers relatively few programs, including Old Age, Survivors, and Disability Benefits; Supplemental Security Income; and part of the Black Lung program. Nearly every household in America is affected by social security programs, either as a contributor or a beneficiary.

The Health Care Financing Administration (HCFA) was organized in 1977 to oversee the Medicare and Medicaid programs. While SSA does much of its benefits processing in house, HCFA uses contractors and states to administer Medicare and Medicaid. Together, these programs will spend about $121 billion in fiscal year 1989. HCFA directly employs about 4,000 staff. Both PHS and HCFA exert significant influence in the nation's health care matters.

Principally through the use of grants, the Office of Human Development Services (OHDS), created in 1973, provides social services for the aged, children, disabled, families, Native Americans, and youth. It employs about 1,000 people and will spend about $7 billion in fiscal year 1989.

The Family Support Administration is the newest HHS component, created in 1986 by Secretary Bowen to emphasize the family. This operating division administers welfare programs, such as Aid to Families With Dependent Children, Low Income Home Energy Assistance, Refugee and Entrant Assistance, and Child Support Enforcement. In fiscal year 1989, it had a staff of about 1,000 and estimated expenditures of $14 billion.

[1]The Commissioned Corps, located within PHS, is a statutory uniformed service similar to the Army, Navy, and Air Force. It is composed of health professionals who are staff of PHS, are often used for civilian emergencies, and are available for defense emergencies.

Objective, Scope, and Methodology

Our objective for this management review was to examine the role and the operations of OS in managing HHS's diverse operations and suggest ways for improving its effectiveness and efficiency. We tried to gain a historical perspective of both HHS and OS not only to understand the Department's current strengths and weaknesses, but also to learn about past successes and failures. Our focus, consequently, was not on any particular administration's actions, but rather on the organization as it has functioned over time. We reviewed information dating from Secretary Gardner's administration, beginning in August 1965, through Secretary Bowen's, ending in January 1989.

We used a variety of techniques to evaluate OS's management of HHS. First, to gain an understanding of HHS's environment, history, operations, organization, and programs, we reviewed agency documents, budget material, consultant reports and studies, GAO and IG reports, legislation, literature on HHS (such as books written by former Department principals), regulations, and transcripts of congressional hearings on various aspects of the Department.

Second, we conducted structured interviews with current and former top-level managers of the Department to better understand the role of OS, the environment in which HHS operates, and the longstanding management strengths and weaknesses of OS and the Department. We interviewed 24 former top-level management officials, including 8 Secretaries (see app. I), 3 Under Secretaries, 2 chiefs of staff, 7 assistant secretaries, and 4 operating division heads. We also interviewed the incumbents of these positions, as well as the regional directors and program officials in four regions.

Third, we sent a questionnaire to 1,065 career and appointed HHS managers and senior staff to obtain their perceptions on the effectiveness of various Department management activities. Recipients included Department managers and senior staff at and above the GM/GS-15 level that worked in the Washington, D.C., and Baltimore metropolitan areas and at the Centers for Disease Control in Atlanta. Our response rate was 72 percent, based on an adjusted universe of 958. The questionnaire results and further details on its methodology are in appendix II.

As a result of our preliminary research, interviews, and questionnaire, we identified three major management areas to review—OS's role and organization; its evaluation, decision-making, and planning processes; and its management support activities. Specific methodology information for these management areas is detailed below.

Most of the information we obtained concerning OS's role and organization resulted from our interviews with current and former leaders, questionnaire results, and review of legislation. But we also reviewed mission and function statements for staff divisions and reports on departmental reorganizations to help us understand proposals that had been tried or considered in the past.

We reviewed the processes that Secretaries have used to manage planning and decision making.

- To evaluate planning, we reviewed operating components' current planning activities and researched the Department's past planning processes. In addition, we convened a panel—composed of former top-level HHS management officials, a planning expert, and the Department of Labor's Director of Personnel—to discuss the value of departmental planning and the role of OS in such planning.
- We also convened a panel of former top-level HHS management officials to discuss policy development and program evaluation activities within HHS. At this panel's suggestion, we choose a case study approach to review various decisions and decision-making processes used by the Department over the years.

Another focus of our review was an evaluation of OS's management of HHS's financial, human, and information resources. In each of these areas, we reviewed (1) reports issued by OS, GAO, and the IG and (2) current HHS procedures and policies. More specific evaluation steps taken for each of these areas are described below.

- In the financial management area, we interviewed key officials in ASMB responsible for this area and reviewed prior GAO and IG reports. We relied heavily on recent GAO work assessing HHS's financial management. In addition, we reviewed HHS's past and current efforts to develop a departmental financial management system.
- For information resources management (IRM), key officials in ASMB and the operating divisions briefed us on their IRM activities. In addition, we administered a structured questionnaire to these officials to obtain additional information about various management functions, such as staffing, planning, and budgeting, within their IRM organizations.
- In the human resources management area, we convened a panel of HHS's former top management officials, human resource management experts, and Labor's Director of Personnel to discuss work-force issues and planning activities. Our evaluation of HHS work-force planning activities focused on ASPER's role and the activities within HCFA, PHS, and SSA. In

addition, we examined Labor's work-force planning approach to assess its adaptability to HHS.

We also reviewed OS's evaluation activities. Our analyses of these activities, however, were inconclusive and are not discussed in this report. No more than 44 percent of the managers and senior staff responding to our survey indicated that they had an evaluation conducted of their program or functional area since 1985. A majority of these officials found the evaluations to be useful. However, the survey also indicated a belief among the staff that there was not enough evaluation occurring. Our analyses showed some relationship between staff who were dissatisfied with OS's performance of its evaluation functions and staff who had not received an evaluation of their activities since 1985. A useful evaluation component should be linked to a planning component. Because HHS lacks a departmental planning process, it was difficult to assess the effectiveness of OS's evaluation activities.

We performed the review in accordance with generally accepted government auditing standards. Our review was done at HHS headquarters in the Washington, D.C., and Baltimore metropolitan areas and its Atlanta, Chicago, New York, and San Francisco regional offices. We conducted our fieldwork between February 1987 and October 1988.

In August 1988, we briefed former Secretary Bowen and other top-level HHS management officials on our findings and preliminary conclusions and recommendations. HHS's written general comments on a draft of this report are included in the report as appendix V. HHS also provided technical comments, which we incorporated in the report as appropriate.

Chapter 2

Understanding the Role of the Secretary

Effective national health and welfare leadership is vital to the well-being of the American people. Getting a quick, appropriate response to a public health threat like product tampering can save lives. Conversely, responding slowly to an epidemic like acquired immunodeficiency syndrome (AIDS) can result in hundreds of avoidable deaths. The health and welfare issues that face the nation—AIDS, long-term care, homelessness, and abortion, to name a few—are both complicated and controversial. The nation looks to the Secretary of HHS to take the lead in addressing these challenges.

More than being managers who direct and control departmental activities, Secretaries need to be leaders, influencing others to support needed changes in the Department's activities. Secretaries of HHS have broad responsibility for federal health and welfare activities, but limited unilateral authority to change them. In addition, Secretaries find they cannot manage programs centrally. To have an impact on HHS, Secretaries have to lead. They must build consensus among varied interest groups and gain the cooperation of the Congress and other elements of the executive branch. Secretarial leadership is needed not only for policy and program development but also for institutional vitality. Through such leadership, HHS Secretaries can help assure that the Department maintains and builds its capacity to deliver programs effectively.

OS is the HHS component that assists the Secretary in executing his or her leadership responsibilities. Shortcomings in its organization or operations will impede the Secretary's ability to provide the quality leadership needed.

The Secretary Is Responsible for the Department[1]

Over time, the Secretary's responsibilities have evolved from increasing the Department's administrative efficiency to leading the national response to health and welfare problems. When the Department was formed in 1953, the Secretary had few resources and limited authority to direct and control its diverse activities. There were few central staff and numerous restrictions on secretarial authority. Departmental components were largely autonomous. The Secretary was in charge of departmental administration, such as personnel and financial matters; but by law, program decisions remained largely the responsibility of component officials.

[1]Much of the information in this section comes from George D. Greenberg, "Governing Hew: Problems of Management and Control at the Department of Health, Education and Welfare," Ph.D. Thesis, Harvard University, June 1972.

The Department grew in the 1960s and 1970s with the passage of major health and welfare legislation, and the Secretary gained increased programmatic responsibilities. Many legislative restrictions that had previously placed program responsibilities in the hands of component officials were removed. Specialized staff within OS, particularly in policy, budget, and legislative areas, also emerged during this time. Greater authority, combined with the resources to review and oversee programs, made OS more influential in health and welfare matters.

Today, the Secretary is responsible for providing health and welfare policy leadership to the nation and administrative leadership to the Department. To carry out the policy leadership role, OS performs a number of functions, such as planning, evaluation, budgeting, and congressional and public relations. To carry out its administrative leadership role, OS oversees various management support functions, such as financial, human, and information resources management, that are common throughout the Department.

Policy and Administrative Leadership—The Key Secretarial Roles

Former HHS Secretary Elliot Richardson offered a paradigm for understanding the management roles of a federal department or agency. In his view, the management role can be arrayed along three dimensions:

- Developing and refining policies and programs through planning, evaluation, and policy making.
- Managing day-to-day, routine activities, such as issuing Social Security checks.
- Responding to emerging situations and crises, such as public health epidemics and product tampering incidents.

Secretary Richardson observed that executives of federal departments and agencies place different emphasis on each of these dimensions in response to the unique mission and environment of their organization. For example, Department of State executives spend more time and energy responding to emerging situations compared to routine functions, such as issuing passports and visas. By contrast, the Internal Revenue Service Commissioner spends relatively more time and energy on day-to-day revenue collection than on crisis activities.

HHS's Secretaries concentrate OS activities on policy and program development and central administrative matters.[2] Typically, they delegate authority to manage day-to-day operations and programs to the heads of the operating divisions. While Secretaries must always be prepared to handle aspects of emerging crises, such as product tampering or unforeseen epidemics, this is not a routine role for them. HHS components, such as the Food and Drug Administration (FDA) or the Centers for Disease Control, often must assume primary responsibility for the response because of the technical nature of the incidents.

HHS's environment helps explain the principal reasons that Secretaries concentrate their efforts on policy and program development activities and central administrative functions. Secretaries of HHS face constraints to their authority that are more severe than those facing executives of many other departments and agencies because the Department's program goals are less unified and harder to measure. Such constraints discourage central management of routine program activities, but encourage Secretaries to lead through legislative and regulatory reform and through investments in the Department's administrative activities, such as making improvements to its financial and information management systems.

Several program and organizational factors have influenced the role chosen by HHS Secretaries. First, to manage centrally, Secretaries need single, clear operating goals that could help unify the Department's programs. Typically in HHS, program goals tend to be many, vague, and hard to implement. For example, health care programs have three simultaneous goals—assuring access to needed services, providing high-quality services, and controlling benefit costs. Such goals are interdependent and conflicting. In other words, needed services may be too costly to provide universally. Conversely, efforts to control costs may restrict access to certain providers or may result in lower quality services. Such conflicts are pervasive among HHS programs. No coherent strategy exists to resolve such conflicts. Furthermore, managers have difficulty developing refined measures for such goals as "quality health care."

The sheer number of diverse HHS programs having very different program designs magnifies the difficulty of goals that are multiple, vague, and hard to implement. Over 200 separate programs exist in very different lines of business. Social Security is a large-scale administrative and

[2]Much of the information that follows in this section comes from George D. Greenberg, "Constraints on Management and Secretarial Behavior at HEW," Polity, Vol. 13 (Fall 1980).

service delivery operation, while NIH is a large-scale scientific research facility. The mode of operations also varies dramatically by program. For some activities, administration is handled by federal personnel. For other activities, it is handled by outside entities—states, localities, or contractors—who often have flexibility in defining program details for their local setting.

In contrast to the vague, unclear goals of the many HHS programs, the expectations for HHS administrative activities are more uniform, allowing more central oversight by OS. As a federal organization, HHS must conform to laws and regulations governing federal administration. The Department is subject to civil service rules as well as to Office of Management and Budget (OMB) and General Services Administration guidelines covering administrative matters, such as financial management, information resources management, procurement, and grants management.

Another factor influencing the Secretary's role is the fragmentation of program authority and appropriations. Assuming that Secretaries developed coherent relationships among programs, they still would have limited ability to change program designs or funding without congressional approval. Certain programs, such as SSA's, operate under extremely detailed statutes. For such programs as welfare, Medicaid, and block grants, states have substantial flexibility in designing the benefits and eligibility to suit their local needs. Most of these programs are funded through formula grants, obliging HHS to fund authorized activities irrespective of the degree to which the Secretary may believe that they satisfy federal objectives.

Even budget authorities are narrowly constrained: About 96 percent of the 1990 HHS budget funded entitlement programs, such as Social Security, Medicare, and welfare activities, which must provide benefits to those who legally qualify. The discretionary budget is a very small part of HHS's total annual expenditures.

Another factor influencing the Secretary's role is the controversial nature of HHS issues. Issues such as abortion, homelessness, and welfare evoke widely divergent and strong views. Support as well as opposition comes from a variety of directions for many different reasons. The Secretary's role is to listen and consider the views of other influential parties. When national decisions are made about such issues and programs, they often involve compromise because there is usually significant disagreement on the type of services to be offered, how programs should be

designed and operated, and who should be served. Such a value-laden environment is vastly different from such federal activities as tax collection, which tends to be more technical or operational in nature.

These factors add up to a single reality for Secretaries of HHS. When Secretaries want to alter existing programs and policies, introduce new ones, or change departmental operations that affect program services, they must seek support from outsiders. Most significant changes to HHS activities require either legislative or regulatory action that directly involves the White House, OMB, or the Congress and indirectly involves interest groups representing different bodies of public opinion. Even changes that appear to be within the control of the Secretary—such as reorganizations and other operational decisions—often require endorsement by these outsiders to be successful because ultimately they may affect how services are delivered.

To operate successfully within this controversial environment, Secretaries define their role as one of providing leadership more than managing departmental affairs. Secretaries cannot achieve significant changes solely by executing their official authority. Rather, they must be able to move the various influential parties to a consensus for action. Sometimes such leadership is programmatic; at other times it is administrative. Through such leadership, Secretaries can create opportunities to influence the character and operations of health and welfare programs that they cannot unilaterally accomplish. John Gardner, Secretary of HHS during the Johnson administration, spoke about the challenge of having broad responsibilities without commensurate managerial authority, forcing HHS Secretaries into a role of influencing those inside and outside the Department:

"... you cannot manage the outside world; you lead. You cannot manage Congress: you can lead them. And you cannot manage the White House. You cannot manage the press. You cannot manage your big, professional constituencies .... The top person has that curious task of influencing the world over which the top person has no jurisdiction."

An Effective OS Management System Needs Certain Elements

Effective Secretarial leadership requires management systems to organize, guide, measure effectiveness, and readjust activities. Such systems should help Secretaries identify and pursue their goals and objectives and contribute to enhancing the Department's administrative efficiency.

To effectively support the current and future Secretaries in their leadership role, we believe OS should have a management system for the Secretary that has

- a departmental strategic planning process to assist the Secretary in establishing goals and objectives for the nation's health and human services programs, as well as developing strategies to accomplish the desired goals and objectives, and
- an accountability component to help the Secretary monitor and track the Department's progress in achieving its goals and objectives, oversee the operation of departmental administrative activities and programs that have been delegated to others to manage, and provide feedback to and communicate with the Department's components.

In addition, OS should have

- an effective decision-making system that gives the Secretary the information and knowledge needed to make informed policy decisions for the Department;
- a sound organization structure with clear lines of authority for key OS offices and leaders;
- components that give Secretaries advice and assistance with their policy agenda, such as legislative affairs, congressional relations, and public affairs activities; and
- the capacity to guide and assist the components in developing and improving the Department's management support activities, such as its financial, information, and human resources management systems.

GAO Assessed OS Management Activities

Our review assessed the overall effectiveness of OS's performance of its responsibilities before and during Secretary Bowen's term. Our survey of managers and senior staff throughout the Department indicated that OS carried out its responsibilities adequately or better. Some offices and activities were particularly highly regarded. For example, most officials believed the Office of the General Counsel and the IG were performing well to very well. Similarly certain activities carried out by OS to support

policy leadership—such as legislative affairs, various aspects of decision making, and certain characteristics of program evaluation—were viewed positively by senior managers throughout the Department.

Other OS activities were perceived to be working less effectively. The following sections of this report discuss our assessment of these less effective activities and make recommendations for establishing or improving them. Section I focuses on the need for a departmental strategic planning process, a well-managed decision-making system, and increased accountability and clear lines of authority for OS offices and leaders. Section II discusses the need to enhance OS's oversight and support of departmental administrative support activities.

Leading HHS

Changes in the nation's demographics—like the aging population—promise to bring about increased demands for health, social, and welfare services. As in the past, the nation will look to HHS to help meet these demands. It will be the Secretary's responsibility to take the lead in finding solutions.

The Secretary cannot tackle this leadership challenge alone. He or she needs to influence and gain the support of the White House, the Congress, the public, and others. In addition, the Secretary needs the experience and resources of HHS and its top political and career officials to help evaluate problems, examine alternative solutions, choose courses of action, and implement them.

To create a departmental team that works together cohesively, the Secretary needs to develop a plan so that the players have a clear understanding of where they are going. In addition, he or she needs an effective decision-making process so that the players can participate effectively in executing the plan and revise it when needed to meet changing national priorities. Last, the Secretary must establish clear lines of authority and foster accountability among the players, so that they understand what their role and responsibilities are and what is expected of them. In the next three chapters, we review these management areas within OS and make recommendations for improving them.

Departmental Planning Could Enhance HHS Leadership

Executives of large private and public organizations, operating in changing, complex environments such as HHS's, find planning processes to be an effective management tool in leading their organizations. HHS, however, lacks a strategic planning process to help establish departmental goals and objectives and to identify alternative strategies to accomplish them. During the late 1960s and most of the 1970s, HHS had such a process. More recently, in the absence of a departmental planning process, leaders of several HHS components have initiated planning efforts within their organizations. These planning processes have helped HHS leaders improve communications, coordination, and decision making. Some HHS managers and senior staff expressed skepticism about a departmental planning process. Many others believe it would be beneficial. We agree with the latter.

Planning: A Management Tool for Leading an Organization

Planning is the first step of a sound management system. It provides a rational and systematic way for an organization to visualize its future, set goals and objectives to achieve its vision, develop and evaluate alternative strategies to accomplish the goals and objectives, and choose a course of action. Accomplishing the planning goals and objectives is the primary purpose for the remaining functions of a management system—budgeting, budget execution and accounting, and evaluation.

Planning processes are usually tailored to meet the unique characteristics of the organization and managerial styles of the chief executive and other top management officials. There are two principal types of planning—strategic and operational. Strategic planning is an important activity conducted by top levels of management throughout the organization. Compared to operational planning, strategic planning focuses on broader policy questions facing an organization, covers a longer period of time and issues that are not well defined, and embraces all or a large part of an organization. Consequently, the goals, objectives, and strategies developed through such planning can and should be subject to change. Operational planning is more short range and is done principally from a functional or component point of view. It focuses on problems of implementing the broader goals and objectives established through strategic planning.

Management experts believe that several factors lead to successful planning. One is the direct participation by the organization's leader, because it gives the organization's managers and staff an opportunity to hear and be heard by the leader. Another is participation by key staff

throughout the organization, because it allows them to know and understand what they are expected to accomplish. Also, by having key staff participate in establishing the goals and objectives, the leader gains their commitment to achieving them. In this fashion, planning enhances a leader's ability to influence a broad spectrum of the organization and its activities.

As explained in chapter 2, the Secretary cannot directly control events but must lead in HHS's complex and political environment. Strategic planning can be a useful tool for the Secretary in leading HHS in the political world of health and welfare issues. It is in this context that we reviewed the Department's use of strategic planning processes over time.

HHS Lacks a Departmental Planning Process to Prepare for Future Challenges

HHS lacks a departmental planning process at the Secretary's level to help establish goals and objectives to address the challenges it faces moving into the 1990s. Some HHS managers and senior staff are skeptical about the value of instituting such a process, but many others believe it would improve their operations. Although an agenda of Secretary Bowen's priority issues was developed to help guide the Department through his term, few staff were guided or influenced by the agenda in managing their activities, operations, or programs.

No Departmental Planning Led by the Secretary

About 83 percent of the managers and senior staff responding to our survey were unaware of any comprehensive, Department-wide effort led or coordinated by OS to prepare for HHS's future. In addition, top-level management officials that we interviewed acknowledged the lack of a Department-wide planning effort.

Many current and former HHS management officials believe the Department would benefit from a planning process. At least 52 percent of the managers and senior staff responding to our survey believed that such a process would have a positive effect on the reduction of crisis management, staff knowledge about future operations, relations with other units, and short-range decision making. No more than 6 percent believed that a departmental planning process would have a negative effect on these operations. A former Under Secretary noted that a departmental planning process "not only enhances organizational effectiveness and efficiency of the Department, it greatly enhances the Secretary's ability to fundamentally steer and run it [the Department]." A senior manager responsible for one of HHS's management support areas said that the

absence of broad Department-wide planning makes "it slightly more difficult to formulate goals" in his specific area of responsibility.

While many believe departmental planning would be beneficial, others questioned its value. For example, one official said that there is no incentive for a Secretary to plan ahead because he or she will be given credit for only accomplishments made while in office. Some officials believed that such planning would be difficult because HHS components are so diverse. Others noted that such planning can be potentially embarrassing and problematic if major shortcomings in programs or management operations are identified and made public.

Bowen Agenda: Beginnings of a Departmental Planning Process

While many officials said HHS lacks a departmental planning process, others said the Bowen agenda was developed through such a process. The Bowen agenda did help communicate the Secretary's priorities, but few staff were guided or influenced by it in managing their activities, operations, or programs.

Early in Secretary Bowen's term, the Under Secretary led an effort to develop an agenda of the Secretary's priority issues. The Secretary had 20 policy items that he wanted to address. Through biweekly meetings of primarily the leaders of operating divisions and staff divisions, 4 priority initiatives and 23 sub-initiatives were developed. The initiatives focused on illegal drug use in America, improving the quality of health care, the future of the family, and AIDS. Individuals were designated to lead each sub-initiative, and time frames were established for accomplishing them. The Management Council, a senior level advisory body for significant Department-wide management issues, was assigned responsibility for reviewing the progress.

The Bowen agenda represents the beginnings of a departmental planning process. It was developed with the participation of the Department's operating division and staff division leaders and has helped communicate the Secretary's priorities. As evidenced by our survey, more than 80 percent of the managers and senior staff believed OS did an adequate or better job communicating the Secretary's priorities to the operating divisions. Also, the Management Council was designated to monitor the progress being made in accomplishing the goals and objectives.

While the agenda helped to communicate the Secretary's priorities, it appeared to have little effect or influence on staff in managing their

activities, operations, or programs. Our review and discussions with senior HHS officials indicated that clear, meaningful, and outcome-oriented objectives had not been established for many agenda initiatives. Thirty-three percent of the managers and senior staff responding to our survey said that they used the Bowen agenda as a principal source of planning guidance for their activities. Although three of the agenda's four major priorities focused on major national health issues, no more than 26 percent of the PHS officials responding to our survey said they used the agenda as a principal source of planning guidance. Also, a top-level PHS official said that the Bowen agenda is not being used to develop national health objectives for the year 2000, a major effort being led by PHS working with among others the National Academy of Sciences, state health departments, and national professional and voluntary organizations. In addition, few staff divisions were directly affected by the agenda, because it did not contain any initiatives in management support areas.

Planning Processes Not New to HHS

Although HHS currently does not have a systematic, rational planning process to establish departmental goals and objectives, such planning existed in the past. In the absence of departmental planning, several operating divisions recently engaged in such planning efforts (see pp. 31-32), which enhanced management within their organizations.

Departmental Planning Processes

During the late 1960s and most of the 1970s, various Department-wide planning processes existed in HHS. These processes were part of two different secretarial management systems—the Planning, Programming, and Budgeting System (PPBS) and the Cooperative Agency Management System (CAMS)—that were used in making budgetary decisions. Under both, the Secretary, his staff, and operating divisions participated in a systematic process to establish goals and objectives for the Department and to identify strategies to accomplish them.

PPBS was introduced during Secretary Gardner's term (1965-68). It provided a structured planning and programming process to help identify solutions to major long-term problems. Each year, operating divisions examined their mission and priorities for the future and submitted a 5-year plan to the Secretary. Based on the operating divisions' plans, analyses of the plans and suggestions by the Secretary's staff, and discussions with the operating divisions, the Secretary made decisions on program objectives for the 5 years. The 5-year plan served as a guideline for accepting or rejecting component budget requests. According to

Dr. Alice Rivlin, former Assistant Secretary for Planning and Evaluation, PPBS represented the first effort at the Secretary's level to look at the Department as a whole, to address alternatives and priorities, and to lay out a tentative program for the future.

Near the beginning of his term, Secretary Richardson introduced CAMS. It began with the Secretary communicating his priorities and other strategic guidance that operating divisions were to reflect in 5-year plans. As with PPBS, the Secretary, his staff, and operating divisions participated in a systematic cooperative and collaborative process of setting goals and objectives and developing strategies to accomplish them. HHS officials have attributed several important management successes to CAMS. For example, Secretary Richardson believed that in 1972 CAMS helped him to develop an integrated policy initiative, commonly known as the "Mega-Proposal," to restructure and reform departmental programs. Several major policy proposals of the Mega-Proposal ultimately formed the foundation for future legislation, such as block grants. The CAMS process was used into the late 1970s. Several former and current officials noted that it gradually fell into disuse because succeeding Secretaries were not active participants and too many issues were being managed through the process. For example, Hale Champion, the Under Secretary during 1977-79, said that "it became sort of a vast lint-picker . . . . anything that was really important was not in the major system."

Component Planning Processes

More recently, in the absence of a departmental planning effort, several HHS components have engaged in planning processes similar to PPBS and CAMS. As discussed on pages 32 and 33, these planning efforts enhanced coordination, communications, and decision making within these components. A brief explanation of these planning processes follows.

1. In 1984, OHDS held a symposium on "Social Services in the Year 2000." The symposium examined demographic, sociological, economic, and technological trends that were likely to influence society in the future and identified the social services likely to be needed by the year 2000. Outside groups and experts from business, government, academia, and the volunteer sector participated. Based on the symposium, OHDS established four overall goals—three programmatic and one management—and developed a 4-year plan of goal-related objectives. The four goals continue to be the guideposts against which OHDS program and staff offices develop their annual plans. OHDS systematically monitors the progress it is making toward accomplishing its goals and objectives.

2. In 1984, the Food and Drug Administration's new leadership and career employees engaged in an "Action Planning Process" to help smooth the transition of the new management team and to prepare the agency for the future. The Commissioner, top-level officials, mid-level staff, and outside groups participated in this strategic planning process. Through this process, FDA identified 10 goals and charted a broad course for policy and management directions in the years ahead. In addition, a system was developed to monitor the progress being made toward accomplishing the action plan's goals. FDA repeated this process in 1987.

3. In 1988, SSA issued a strategic plan for its organization, management, and operations to the year 2000. This was SSA's first effort to prepare a coherent, long-range strategic plan that established broad directions to guide how it will serve its clients. The process used to develop this plan entailed extensive collaboration among the Commissioner and SSA senior management officials, component involvement, and participation from external groups, such as congressional staff, the Council on Aging, and the American Association of Retired Persons. SSA has also established a system to monitor its progress in accomplishing its goals and objectives.

Departmental Planning Could Help HHS Address Management Concerns and Issues

A departmental planning process could help HHS address several management concerns and issues. Top-level management officials, managers, and senior staff have said that communications, coordination, and decision making could be improved. Planning processes have helped past and current Department management officials address these management concerns. Also, departmental planning has had a positive effect on management at the Department of Labor. This leads us to believe that HHS could benefit from such a process.

HHS Officials Identify Concerns and Issues

Through our interviews and survey, HHS management officials and senior staff identified several important management and leadership issues that they said needed to be addressed Department-wide. Among these were issues related to communications, coordination, and decision making. For example:

1. In response to a survey question to identify one problem in OS that they would like to resolve, at least 50 managers' and senior staff's comments focused on communications. One official said he would focus on "Developing better, more effective two-way communications (1) between the components of OS and the operating divisions and (2) among the operating divisions on matters of common interest."

2. About 32 percent of the survey respondents reported that OS did poorly or very poorly coordinating activities that required cooperation among operating divisions. In commenting on the number one problem to resolve in OS, one official wrote:

"I believe that as a senior level manager I should be more knowledgeable about OS initiatives, especially as they impact my organization. Lacking specific knowledge, I would say that OS could do a better job of tying the HHS family together in terms of broad common agenda and direction. I spend a good deal of my time as a manager 'drawing the big (named operating division) picture' for my staff to enable them to see where they fit in and how what they do adds to the common good. I'd like nothing better than to draw HHS into the tapestry. It lends itself to employee esteem, singularity of mission and purpose and achievement."

3. Managers and senior staff noted concern about decision making within the Department. About 30 percent of the respondents to our survey reported that OS did poorly or very poorly considering long-term effects of decisions when making major policy decisions.

Planning Processes Enhance Management

Each of the departmental and component planning processes previously discussed was structured to provide opportunities for improved coordination, communications, and decision making within the Department or a component. Through various planning meetings and memoranda, component leaders and staff were given opportunities to communicate their concerns, goals, and objectives to the Secretary, as well as hear the Secretary's. In addition, coordination was improved. For example, Dr. Laurence E. Lynn, Jr., former Assistant Secretary for Planning and Evaluation, noted that, through the CAMS process, the Secretary, his principal advisers, and component heads and staff worked together to develop a coherent approach to accomplishing goals and objectives. CAMS ensured that component officials with an interest in an issue had their say and thus reduced interoffice distrust and anxiety. Former Secretary Elliot Richardson saw the CAMS process as a basis to eliminate overlap, duplication, and turf battles.

Officials associated with HHS planning processes believe that having established departmental goals and objectives helped the Department with decision making. For example, Dr. Rivlin noted that the progress made under PPBS was clearly a start toward improved decision making. Also, Dr. Lynn noted that under CAMS, the quality of decisions improved by ensuring that relevant evidence was gathered and presented, alternative approaches considered, and opposing viewpoints heard.

Labor Finds Departmental Planning Beneficial

The Department of Labor has had positive results with its departmental planning process, and we believe such a process could also be beneficial to HHS. In our management review of Labor, we recommended that the Secretary institute a systematic Department-wide, long-range planning process.[1] The Secretary established a management system that included long-range planning to develop departmental goals. Our follow-up review showed that, after about 1 year of operation, most of the Department's managers believed the Secretary's management system had significantly improved management at Labor. For example, they believed that the Department's ability to identify unit goals and objectives and to establish top agency management commitments had improved. Also, they believed that the basic elements of the system should remain in place even when there is turnover of top Department officials.

Past Processes Provide Foundation for Departmental Planning

As evidenced by current and former HHS officials' comments, planning processes have enhanced departmental leadership, communications, coordination, and decision making. Based on our analyses of HHS's planning processes and discussions with a consultant panel,[2] we identified the following key elements for an effective departmental planning process:

- The Secretary should be an active participant.
- The Secretary should begin the process by communicating his or her goals and objectives. Components should consider those in the context of their own goals and objectives.
- The external environment should be reviewed to identify future sociological, technological, political, and economic issues and trends that may influence the direction or mission of operations and programs.
- External groups should be consulted to help identify the Department's future challenges and issues.
- Formal meetings between the Secretary and components' political and career staff should be held to discuss and reach agreement on a small number of primary goals and objectives for the Department. These meetings provide opportunities for the Secretary, his staff, and component leaders to hear what is important to each other.

[1] Strong Leadership Needed to Improve Management at the Department of Labor (GAO/HRD-86-12, Oct. 21, 1985).

[2] Our consultant panel consisted of former HHS top-level management officials, Labor's Director of Personnel, and a planning expert who helped SSA with its strategic plan.

- The outcome should be common management and program-oriented goals and objectives for the Department, as well as strategies to achieve them.
- The planning process should be integrated with the budget process.
- Everyone should gain something from the process. The components should get an orderly decision-making process, access to the Secretary, a better understanding of what is on the Secretary's mind, and more coordination among the Secretary's people. In turn, the Secretary should get cooperation, participation, and information from the components.
- The process should not be intrusive, onerous, demanding, or restrictive on those involved.
- The process should include a component to monitor the Department's progress in accomplishing the established goals and objectives.

Our review of HHS planning processes showed that CAMS contained many of the key elements discussed above and could serve as a model for developing a departmental planning process. In addition to having been used at HHS and being associated with various management successes, CAMS was used at the Department of the Interior—also with favorable results and reviews. In an article that he coauthored, Dr. Lynn commented that HHS and Interior staff greatly preferred CAMS to what went on before.[3] He said that "the success of CAMS depended on the credibility that only the department's most powerful executive can confer." In addition, he noted that "To ensure that bureaus and agencies took CAMS seriously, the master calendar of CAMS was coordinated with the budget process—the one management process taken seriously by all subordinate units." Appendix III provides a general description of how this planning process worked.

Conclusions

We believe that HHS and its leadership, management, and staff could benefit from instituting a departmental planning process. Such a process is a key element of an effective secretarial management system. A planning process led by the Secretary could help establish goals and objectives for the Department and develop strategies to accomplish them. Through the process, coordination, communications, and decision making among the Department's components could be strengthened.

[3]Laurence E. Lynn, Jr., and John M. Seidl, "'Bottom-Line' management for public agencies," Harvard Business Review, January-February 1977, pp. 144-153.

Recommendations

We recommend that the Secretary develop and institute a departmental planning process to

- establish goals and objectives for the future of the Department's operations and the nation's health and human services programs and
- develop alternative strategies to accomplish these departmental goals and objectives.

We also recommend that the Secretary establish some means to monitor and oversee the progress that the Department makes toward achieving desired goals and objectives.

Need to Maintain an Effective Secretarial Decision-Making System

Organizing and managing the OS decision-making process is a challenge that each Secretary has faced. It is difficult, because the Department is responsible for many varied issues that cannot be easily mastered by a single person. Furthermore, because many HHS decisions affect broad segments of the public, poorly conceived or implemented decisions may result in public outcry or embarrassment for the Department.

We evaluated HHS decision making from two perspectives—process and substance. We looked at the process used by Secretary Bowen and previous Secretaries to understand how the Department manages the large volume of decisions made by the Secretary. To help us understand how HHS ensures that the substantive details of decisions are adequately considered, we analyzed six policy decisions that confronted the Department during the past decade. These decisions were selected based on the suggestions of current and former HHS officials and our objective to obtain a balance of successful and less successful decisions. We reviewed these decisions to identify both strengths and weaknesses in the substantive information and analysis that formed the basis for policy choices. Our analyses of both the process and the substance of decision making were aimed at determining whether the Secretary or other key decision makers received appropriate information and analysis to make a reasonably prompt decision that would withstand public scrutiny.

In recent times, the Executive Secretary clearance process has been a principal vehicle for managing decision making. The clearance process collects the perspectives of various parties about a policy decision facing the Department. In general, the process has been effective, but Secretaries must work to avoid certain problems that can delay decisions or lead to less informed ones.

Our review showed that in making the six policy decisions, the Department generally has handled the substance of policy decisions well by considering pertinent information and a variety of alternatives. However, two steps could be taken to improve the substantive aspect of decision making—(1) ensuring that consultation with outside parties occurs and that it occurs in a timely manner and (2) pretesting the implementation strategies for policies involving public education.

Clearance Process Generally Works Well, but Several Problems Need Attention

At the core of decision making within HHS is the long-standing Executive Secretary clearance process. This process circulates policy proposals to various parties within the Department and solicits advice for the Secretary's consideration. The clearance process is an effective way to involve the appropriate parties in departmental decision making and get support for decisions. However, when misused, the clearance process has led to (1) decisionmakers' not receiving pertinent information available within the Department or (2) delayed decisions.

Clearance Process Helps Secretarial Decision Making

The Executive Secretary clearance process is designed to foster informed decisions that Department officials will support. First, it informs the Secretary by allowing officials throughout the Department to contribute their knowledge and perspective to a decision. Second, it garners the Department's acceptance of decisions by limiting the Executive Secretary to presenting an unbiased summary of the different viewpoints.

The Executive Secretary clearance process was developed when OS became increasingly involved in program decisions and has been used ever since. Secretary Richardson wanted to approve the issuance of regulations, which previously was the responsibility of the operating divisions. To do this, he needed a process to manage a large number of diverse decisions. The design of the clearance process mirrored Mr. Richardson's views on decision making:

"We did a lot to create this office and to me, it was an invaluable tool of communication. . . . We eventually worked out a pretty clear understanding of what kind of paper I needed to make clear what the issue was or issues were to be resolved, and it would have the backup material attached to it, with tabs. If I wanted to, I could go back to the underlying papers. And I used to read them quite a lot, not all of them, by any means, or all of any given one, but enough so that if I was bothered by some failure of coherence or sufficiency of the evidence to support a proposal or an option, I could look at it and raise questions about it. I would write in the margins and it had . . . an impact on people, that the Secretary read that paper, and asked what they knew was a good question. The other thing that it did was to create a vehicle whereby it became possible to see the opportunities for synergism, in the areas of overlap, or convergence."

The clearance process exposes the decision maker to different views and dimensions of an issue by allowing those with substantive expertise to contribute their knowledge and experience. When a policy proposal is

presented to the Executive Secretary for clearance, departmental officials with related responsibilities provide written comments. The Executive Secretary collects and summarizes them for the decision maker. Weighing the varying perspectives is the responsibility of the Secretary or other decision maker, not the Executive Secretary.

The clearance process attempts to represent the various views without prejudice—essentially becoming an "honest broker" of departmental perspectives. Making sure that views are presented fairly is critical to both informing the decision maker and gaining acceptance for the decision. Charles Bonser, a consultant to Secretary Bowen, described how the process should work:

> "In all large organizations, the danger exists that requests for information or action flowing either up or down can vanish into what often seems to be a 'black hole' in space. This can be extremely debilitating to both operations and morale. It is the responsibility of the Executive Secretary to make sure this doesn't happen.
>
> "As part of his organization, the Executive Secretary has several functional area specialists to facilitate dealing with the operating divisions in a knowledgeable manner. While this capability is necessary, the area specialists need to be sensitive to the fact that they are not there to make policy or management decisions for the operating divisions or the Secretary. They are there as expediters and information gatherers. They must also be careful not to over-filter the policy information reaching the Secretary."

Clearance Is Ineffective When Misused

The clearance process appears to be an effective tool for managing Secretarial decisions. However, we noted four problems that resulted in delayed decisions or decision makers not receiving pertinent information available within the Department:

- Using the process to force compromise between components.
- Allowing advisory bodies to make decisions without considering clearance comments.
- Using the clearance process very late in the policy development process.
- Allowing the process to be bypassed.

Clearance Process Generally Working Well

Senior managers of the Department generally perceive most aspects of decision making to be working well. About 86 percent believe that the Executive Secretary carries out its responsibilities adequately or better. When we asked their opinion about specific aspects of decision management, 83 percent said that OS generally involves the appropriate staff—the principal job of the clearance process. But senior managers reported

more dissatisfaction with the speed of decision making, with 36 percent in total reporting "poorly" or "very poorly" when asked to evaluate OS effectiveness at making decisions in a timely manner. Some delays appear to be caused by misuses of the clearance process, which are discussed below.

Forcing Compromise Delays Decisions

Effective use of the clearance process requires some means of resolving disputes. According to several HHS officials, disputes were rarely raised to the Secretary or the Under Secretary for resolution during the terms of Secretaries Heckler or Bowen. Instead, disputes were resolved at lower levels through extensive negotiations or repeated clearance until a compromise could be reached. In certain cases, compromise could not be reached and HHS action was delayed.

For example, action on an FDA regulation was delayed 14 months because components could not agree on the action to be taken. FDA had proposed several regulations to label drugs and foods that used sulfites, because this preservative appeared to be life-threatening to certain individuals. For one proposal to label drugs containing sulfites, ASPE said the scientific evidence was insufficient to warrant regulation. FDA believed there was sufficient evidence, citing reports in the medical literature that certain individuals were experiencing serious, often life-threatening reactions, such as respiratory arrest and coma, after ingesting food and drug products containing sulfites. Memos went back and forth outlining their differences. Eventually, the dispute was aired in a 1985 congressional hearing that portrayed FDA as a "sleeping government watchdog" and criticized ASPE for inappropriately involving itself in the scientific analysis.

Another dispute during Secretary Heckler's term resulted in a court finding that the Department had moved too slowly in acting on a perceived public health threat. In the spring of 1983, FDA proposed a ban of interstate sales of raw milk. A number of individuals had become ill and some had died after drinking raw milk. ASPE disputed the seriousness of the health risk and opposed the ban because interstate sales of raw milk were negligible. Two years passed while the Department debated the differences of opinion. Finally, a court order forced HHS to decide one way or the other, ruling that the Department had unreasonably delayed its decision on this matter. Ironically, HHS decided not to ban raw milk sales but was again sued. A second court ruled that the Department had acted capriciously and ordered the Department to promulgate a regulation banning interstate sales of raw milk. The final regulation was published in August 1987.

In both of these examples from Secretary Heckler's term, there were honest differences of opinion about the desirability of regulating. Such differences were not promptly arbitrated by the Secretary and resulted in decision delays.

During Secretary Bowen's term, differences of opinion on policy proposals continued to be negotiated or resolved through repeated clearance. Senior departmental officials commented that they would prefer the Secretary to be more involved in resolving departmental disputes. In commenting on the practice of repeated clearances under Bowen, one operating division manager said, "The OPDIV [operating division] must resolve conflicting comments provided by OS components and then Exec Sec [Executive Secretary] circulates the letter/regulation again. Only after everyone agrees can the package be sent to the Secretary." Another manager commented, "The Executive Secretary requires endless clearing and reclearing of reports to Congress . . . even when only minor changes are made."

Clearance Not Integrated With Advisory Bodies

The changes that Dr. Bowen made in the Secretarial decision-making process were not well integrated with the clearance process. As a result, his advisors did not consistently have access to a variety of perspectives when evaluating decision options.

Dr. Bowen established a structure that divided power between his Under Secretary and his chief of staff in order to integrate better the Department's activities and to reduce the number of issues that would come to his attention. The Under Secretary and the chief of staff chaired separate councils of staff division leaders—one for policy, the other for management. Dr. Bowen generally did not attend council meetings, but he did have daily joint meetings with the Under Secretary and the chief of staff to be advised on departmental matters.

One problem with the council structure was that members did not always have the benefit of clearance comments when deliberating issues. The issues brought before the councils often had not gone through clearance. Furthermore, council meetings were generally confined to senior staff members only, and staff that knew details about issues being discussed did not usually participate. As a result, the information presented to council members was sometimes incomplete. For example, one Assistant Secretary serving on the Management Council did not voice opposition to a proposed reorganization of one component's management structure discussed in a council session. When the same proposal went through clearance, he opposed it because he then

realized that increased costs were involved—a fact not disclosed at the council meeting but made apparent when his staff reviewed the clearance package.

Clearance Late in Regulatory Development Can Slow Decision Making

The clearance process can be used to give guidance for developing regulations or to review a proposed regulation after it has been developed. In recent times, OS has tended to use clearance to review a proposed regulation without having provided earlier guidance for its development. As a result, major disagreements have occurred late in regulatory development, causing delays that might have been avoided by earlier consultation.

Currently, OS gets its first detailed look at the content of most regulations when a proposal comes for clearance. Such a process works fine when there is agreement on the proposal, but when offices disagree, delays can result. For example, late intervention by OS contributed to delaying the tampon absorbency labeling regulation. FDA sent a draft proposal to OS after developing its position over 4 years. ASPE disagreed with FDA's approach, and 6 more months went by while the differences were negotiated. Had FDA had an earlier understanding of OS's policy preferences, the regulation might have been issued sooner.

However, even when it has tried to give early guidance, the Department still has had to resolve controversial policy issues late in development. For early guidance to speed action, the decision makers must understand the issues involved when they give direction. Decision makers may not, however, immediately understand all of the issues involved in a regulation being developed. When they do not, even early guidance may not help. For example, the Policy Council gave the Family Support Administration early direction on a regulation being developed to implement State Legalization Impact Assistance Grants. When the Policy Council met, it did not consider a key issue that ultimately would need to be decided—the distribution formula to be used to award grants to states. As a result, no guidance on this issue was given to the Family Support Administration, and differences had to be resolved by the Secretary late in policy development. The final regulation was issued more than 6 months after the program was to begin.

In 1988, the IG reviewed the development of HHS regulations and recommended earlier OS guidance to help speed the regulatory development process. It found that early OS involvement occurred in some high-priority regulations, but that there was no system to guarantee such involvement in important regulations. Past Secretaries, such as Richardson and

Weinberger, used the clearance process to provide guidance to operating divisions developing regulations. Secretary Califano used regularly scheduled meetings of key OS and operating division officials to provide earlier guidance. As one present operating division official said, "The agreements on what regulations are needed and why should be made before the regulation is written—not during the clearance process."

Allowing the System to Be Bypassed

On occasion, departmental officials have attempted to circumvent the clearance process to get a quick or favorable decision. Such end runs have caused implementation problems.

For example, Secretary Bowen expanded the responsibilities of HHS's regional directors for a brief time, then rescinded those responsibilities after realizing the initial policy proposal was incomplete. This initiative was sponsored by the Deputy Under Secretary, who went directly to the Secretary for a decision. It had not been considered by the Policy Council, the Management Council, or the clearance process. In studying the effects of the change after it had been in place for several months, the Management Council found the expanded authorities overlapped with authorities of regional operating division heads. Secretary Bowen rescinded the extra regional director responsibilities following the Management Council study.

Another decision during Secretary Bowen's term involved "revitalizing" the PHS Commissioned Corps. The Surgeon General proposed that the Corps report to him and that members be required to accept routine reassignment so HHS could deal more effectively with health crises. The proposal was adopted by HHS without going through clearance and before scheduled Management Council deliberations.

Implementation of the decision to revitalize the Corps resulted in problems because certain implications of the change were not well considered. For example, in recent years, certain features of the Commissioned Corps, such as early retirement, have been used as a way of making federal service more attractive to scientists. Changing Corps practices, without substituting another mechanism to attract and retain scientists, had the potential to weaken recruitment and retention, especially for the Centers for Disease Control, FDA, and the National Institutes of Health. Yet the proposal was not presented to the head of the Centers for Disease Control and went to the National Institutes of Health for comment just hours before it was officially adopted. When the Surgeon General began to make changes to the Corps—such as requesting resignations

from senior Corps officials eligible for retirement—he confronted serious opposition, particularly from the National Institutes for Health, which had 34 such officials serving as senior scientists or administrators.

Managing the Substance of Policy Decisions

A policy process can only be as good as the information and analysis that goes into it, which represents the substance of a decision. To better understand how HHS manages the substance of decision making, we reviewed six decisions that it made in the last decade.

Strengths of Decision Making

The decisions we studied showed that HHS has used a variety of techniques that strengthened substantive aspects of decision making, including (1) having secretarial involvement, (2) filling information voids, (3) considering a variety of alternatives, and (4) using staged decision making. As discussed below, these ingredients seemed to help the Department make speedier and better informed decisions.

First, the most sensitive and significant decisions typically get special treatment and sometimes personal involvement by the Secretary. Secretaries tend to convene special task forces or groups to manage the most significant or sensitive policy decisions. This special treatment or personal involvement by the Secretary seemed to speed decision making. For example, Secretary Schweiker, the HCFA Administrator, and the Assistant Secretary for Planning and Evaluation were directly involved in developing the Prospective Payment System Medicare legislation. The Secretary used several task forces to develop alternatives and to draft the final legislation. The Assistant Secretary and HCFA's Administrator worked intensively on developing the regulations. These complex regulations were developed within 6 months.

Second, our case studies showed that HHS officials were sensitive to the need to have as much information as practical in making their decisions. For example, uncertainty about the relationship between toxic shock syndrome and tampon absorbency prompted HHS to begin an active surveillance study to better understand it. Similarly, PHS has conducted or funded a series of epidemiological and medical studies to develop information to help control the spread of AIDS. Also, FDA asked an independent group to restudy sulfites as preservatives when FDA learned that

sulfites could be fatal to some people. In these cases, HHS officials identified the information voids that created uncertainty about the dimensions of a problem and tried to improve their information.

Third, senior managers generally believed that the Department considers reasonable alternatives before a final decision is made. About 38 percent said this aspect of decision making is done well to very well, and another 45 percent find it handled adequately. We agree. In each case we reviewed, except in the case of the Baby Doe regulation to be discussed later, reasonable alternatives were considered. For example, PHS considered several options to respond to the potential threat of the blood supply being contaminated by the human immunodeficiency virus, which causes AIDS. Their alternatives ranged from taking no action to requiring blood banks to test blood for other infectious agents that AIDS patients might have. PHS settled on an intermediate course and required blood banks to educate donors in high-risk groups to avoid donating their potentially contaminated blood. HHS rapidly implemented screening for the human immunodeficiency virus as soon as a test became available.

Fourth, when faced with uncertainties, departmental officials have tended to use staged decision making. More than 10 years ago, after reviewing the Department's response to a potential swine flu epidemic, we concluded that HHS could better manage situations of scientific uncertainty by separating decisions into components and systematically reevaluating what should be done as more information becomes available. Our current analysis of several cases—blood donor guidelines, sulfites, and tampon absorbency labeling—showed HHS applying such a strategy. For example, in 1980, HHS was confronted by a newly identified disease—Toxic Shock Syndrome—that was causing sudden death of healthy young people. Early indications showed that among young women the disease was linked to the use of tampons. There was limited scientific evidence that indicated the use of more absorbent tampons increased risk. FDA first required general warning labels on tampon boxes about the possible risk of Toxic Shock Syndrome. Further study confirmed the initial findings, so FDA later promulgated a second, more detailed regulation to prescribe (1) the scientific measure for tampon absorbency and (2) the package labeling that would allow consumers to compare absorbency among products.

Weaknesses in Substantive Decision Making

The decisions we studied showed that HHS made inappropriate or unnecessarily late decisions when it (1) did not effectively consult with external parties having interest in the policy under consideration and (2) designed policy proposals using public education strategies without pretesting their effectiveness.

Obtaining Timely Outside Consultation Crucial

Three of the decisions we examined illustrate the importance of obtaining outside consultation on proposed public policy decisions in HHS. In one case—Baby Doe—outside parties such as hospitals and physicians were not consulted, and they successfully overturned two versions of the Baby Doe regulations. In a second case—tampon absorbency labeling—HHS sought voluntary action on the part of tampon manufacturers. The effort led to a stalemate that FDA neither negotiated to settlement nor cut off. As a result, the regulation was delayed for several years. In the third case—the Prospective Payment System for Medicare—HHS effectively consulted with hospitals and the Congress and won support for its legislative proposal to revise Medicare payments.

HHS did not consult with outside parties on the Baby Doe case because it had clear marching orders from the White House. President Reagan reacted disapprovingly when he learned about an Indiana baby with Down's Syndrome who died after being denied life-saving surgery. Secretary Schweiker was directed to prevent further cases of handicapped newborns from being denied treatment. Citing the life-threatening circumstances, HHS issued an interim final regulation requiring hospitals to treat medically handicapped newborns. It used section 504 of the Rehabilitation Act of 1973, a civil rights law, as its legal basis for issuing the regulation. Organized hospital and medical groups were not consulted about the regulation.

The hospitals and medical groups found the regulation to be overbearing and objected to (1) posting of signs they considered to be offensive in newborn nurseries, (2) a federal telephone "hot-line" set up to solicit tips on infants being denied appropriate care that hospitals believed disgruntled employees would use to raise false charges, and (3) federal investigative teams that physicians believed could interfere with patient care. These groups successfully challenged the Department's failure to follow administrative procedures when it published the regulation in final rather than proposed form. HHS wrote another version, this time as a proposed regulation, which external groups continued to oppose. The Supreme Court overturned the second regulation, ruling that the Department lacked a statutory basis to regulate.

A policy to prevent medical neglect of infants was finally developed by the Congress and successfully implemented by HHS. Several congressmen and congressional committee staff consulted with interested groups to develop the Child Abuse Amendments of 1984. These amendments required that states receiving grant funds under the Child Abuse Prevention and Treatment Act must establish procedures to respond to reports of medical neglect of infants. HHS made more concerted efforts to elicit the viewpoints of hospitals, medical providers, and handicapped and right-to-life advocates to develop the implementing regulations for this law. According to an IG study, these amendments appear to have focused attention on the needs of severely disabled infants with life-threatening conditions.

In a second case, tampon absorbency labeling, FDA consulted with manufacturers and consumer representatives but set no limits on the amount of time to devote to external consultation; as a result, its rulemaking was seriously delayed. FDA was willing to abide by voluntary agreements reached by manufacturers and consumers as long as they met FDA's regulatory goals. Rather than begin rulemaking, FDA initiated a task force composed of manufacturers and consumer representatives in January 1982 to develop, among other things, a voluntary labeling scheme. Fundamental disagreements among the task force members surfaced within a year. Manufacturers could not agree on a labeling scheme that would be fair to all.

FDA started rulemaking in June 1984, after concluding that the voluntary effort had failed. In January 1986 correspondence to FDA, one major manufacturer proposed a labeling scheme it would use voluntarily. FDA stopped its rulemaking while it tried to get other manufacturers to accept this proposal and avoid regulation. They refused because they felt the proposal favored one manufacturer over others.

In December 1986, the Commissioner of FDA concluded that the second voluntary effort had failed, and rulemaking was restarted. FDA published its first proposed regulation in September 1988 and received comments that argued for standardizing or eliminating existing absorbency terms. As a result of these comments, FDA proposed a different regulation in June 1989, more than 7 years after the effort to label tampons for absorbency began. Had FDA set reasonable limits on the time allowed to achieve compromise, this regulation could have been issued sooner.

A third case—the Prospective Payment System—provides an example of effective consultation with outsiders improving decision making.

Through a task force and meetings with key interest groups, Secretary Schweiker brought outside ideas about Medicare prospective payment into the Department. Through these outside contacts, he became enthusiastic about the idea of using diagnosis related groups as a method of payment. Although this payment method had been developed through HCFA research grants, many of the HHS staff working on developing the Prospective Payment System proposals preferred other mechanisms to adjust hospital payments. Secretary Schweiker overruled them after having been convinced that this method met his goals. The prospective payment system proposed by HHS won widespread support, and legislation was enacted very quickly.

Pretesting Education Strategies Could Improve Effectiveness

In two cases where HHS chose a public education strategy, we believe pretesting the strategy could have improved the decision. Particularly for public health issues, HHS often needs to influence personal choice to improve health outcome. This may take the form of labeling a product or warning the public of a potential danger. In two cases in which HHS used warnings or labels—blood donor deferral guidelines and tampon absorbency labels—HHS did not pretest them for understandability.

1. HHS reacted quickly to protect the blood supply from AIDS, but we believe its action might have been improved by pretesting. HHS instituted an education process called donor deferral to request that potential blood donors avoid donating blood if they were members of groups at highest risk of the disease. Many respected members of the blood-banking industry questioned whether anything needed to be done at all when there appeared to be only a handful of cases that could possibly be traced to blood products. But the Centers for Disease Control team was convinced the disease was being transmitted through the blood supply. PHS issued guidelines for blood banks to use, outlining those groups being asked to defer their donations. However, these guidelines were not pretested.

Pretesting might have shown that the guidelines would be interpreted differently than intended. The initial donor deferral guidelines asked homosexuals who had "multiple" sexual partners to defer their donation. "Multiple" proved to have different meanings to different people. Furthermore, some men who had sex with other men did not consider themselves to be homosexual. As a result, some men engaging in high-risk behavior continued to donate blood. HHS recognized that the guidelines needed improvement and made them more specific 1-1/2 years later.

2. In September 1988, HHS proposed a rule that would require tampon manufacturers to label the absorbency level of their products. Since higher absorbency tampons are associated with greater risk of developing Toxic Shock Syndrome, FDA wanted tampon packages to be labeled in a way that would (1) inform consumers of the risk, (2) advise them to use the least absorbent tampon possible, and (3) enable them to compare the absorbency of different products. FDA considered several labeling alternatives, some of which were more burdensome to manufacturers than others. FDA did not pretest the alternative labeling schemes for consumer understandability and chose an alternative that would require at least one manufacturer to reformulate its product line. Comments that FDA received from consumers and manufacturers on this proposed regulation contended that the proposed labeling scheme would be confusing and could mislead consumers and argued that FDA should standardize or eliminate existing absorbency terms. FDA responded to these comments in June 1989 by issuing a different proposed regulation with a new labeling scheme. Thus, a result of not pretesting was that FDA chose an approach that consumers found confusing rather than informative and further delayed uniform tampon labeling.

Conclusions

The clearance process is a good design for making informed decisions that can withstand the test of time and legal challenge. But several steps need to be taken to improve its effectiveness: (1) have the Secretary resolve disputes that arise in clearance rather than forcing compromise, (2) integrate the clearance process with standing committees or other decision mechanisms that are used in the Department, (3) provide guidance early enough in decision making to avoid policy reversals late in the development stage, and (4) avoid bypassing the process.

Based on the decisions we reviewed, HHS generally makes good use of the information and analysis available to support its decisions. HHS's decision-making process has worked best when there has been high-level involvement, when the Department has worked to fill information voids, when it considered a range of alternatives, and when it used staged decision making to cope with uncertainties. The departmental decision-making process has not worked as well when (1) external parties have not been consulted effectively and (2) public education strategies have not been pretested.

Recommendations

We recommend that the Secretary use the Executive Secretary clearance process as the key vehicle for managing decisions and enhance its effectiveness by

- establishing some means to resolve significant disputes promptly, such as setting deadlines for when unresolved disputes will be referred to the Secretary;
- integrating the clearance process with standing councils or other decision mechanisms used in the Department;
- using the clearance process to provide early guidance on significant issues; and
- preventing individuals from circumventing the process.

We recommend also that the Secretary take steps to ensure that the Department consults in a timely manner with appropriate external parties having an interest in the policy being considered and pretests those policies that involve public education strategies.

Establish Clear Lines of Authority and Accountability

Effective leadership of HHS depends on departmental teamwork—the capacity of operating and staff divisions to work together in a supportive and cooperative environment—and adequate accountability. The Secretary can foster such teamwork by establishing clear lines of authority so that each member of the team knows his or her job and can promote accountability by monitoring and overseeing the performance of departmental programs and administrative activities that have been delegated to others to manage. In recent years, the lines of authority have been unclear and confusing to the Department's leadership team, and Secretaries have not given enough attention to overseeing and monitoring the performance of the Department's programs and administrative activities delegated to others to manage.

Key Organizational Ingredients of Effective Leadership

In the HHS environment effective leadership is easy to characterize but difficult to accomplish. To be effective, the Secretary needs to create teams within the organization. Former Secretary John Gardner put it succinctly: "The concept of a single leader is an illusion . . . . the really effective people are the folks that build their inner team . . ." Teamwork is essential because the Secretary can do little alone. By getting the Department working together, the Secretary can magnify his or her sphere of influence.

Creating loyal and supportive teams can be difficult for a Secretary who does not control the appointment process. In recent years, the Reagan White House held tight control over subcabinet appointments, sometimes making the political credentials of candidates a more important consideration than their potential to help build a leadership team and manage the Department. Sometimes, the political leanings of one appointee were offset by the differing views of another to create a certain political balance in the team. For example, "moderate," Eastern Secretaries Schweiker and Heckler were paired with "more conservative," Californian Under Secretaries Swoap and Svahn. However, the result of such pairings may be differences and even distrust among key departmental leaders. In this environment, the likelihood of creating well-matched leadership teams, even at the Secretary-Under Secretary level, is "a rare piece of serendipity," in the words of a former HHS chief of staff.

In this environment, the Secretary must do all that's possible to foster effective teamwork. Research shows that organizational leaders can be most effective when they (1) communicate the roles and responsibilities

of their subordinates and (2) extend trust, respect, and access to subordinates to enable them to carry out their duties. In discussions with us, Hale Champion, the Under Secretary to Secretary Califano, emphasized that he enjoyed substantial power and influence while at HHS because he had both the official position as the departmental deputy and the informal confidence, trust, and respect of the Secretary. In this case, Secretary Califano was allowed to pick his Under Secretary and the two were reputed to be among the best-matched and effective leadership team, maintaining close communication and coordination.

Just defining what is expected of those officials to whom authorities have been delegated is not enough. The Secretary must assure that the day-to-day practices of these officials also conform with established expectations. Consequently, the Secretary needs to have formal or informal ways to assure that departmental activities and programs being managed by subordinates are working effectively and efficiently.

In a 1987 article on management lessons of the Irangate scandal, Peter F. Drucker, a prominent management expert, commented on the importance of chief executives being informed. He said that former President Franklin D. Roosevelt was the greatest delegator in recent American political history and always stipulated when and how cabinet members were to report back. President Roosevelt demanded that his subordinates immediately inform him of the slightest deviation from plans. "He knew, as every chief executive officer learns sooner or later, that there are no 'pleasant surprises.'"

A former Secretary and Under Secretary of HHS also stressed this important concept of staying informed about ongoing activities. Former Secretary Gardner said that one of his key management strategies was to watch for the things that go wrong. He stressed that cabinet secretaries must view themselves as responsible for everything happening within the agency. In his words, "You [Cabinet Secretaries] are not getting all this prestige and status for nothing. You are getting it for keeping things like [embarrassing incidents] from happening." Former Under Secretary Champion also related his views about the need to oversee and monitor the ongoing Department's activities and programs rather than focusing exclusively on policies. He said he used to say to his top-level managers, "You've got just as much responsibility for the children already born [ongoing activities and programs] as the ones to come [policy initiatives]. And anybody who wants to manage HHS now ... has really got to understand that those are two equally important jobs."

Greater Accountability Needed for the Operation of Departmental Activities and Programs

Secretaries of HHS typically have retained authority for policy leadership matters and delegated authority to others for running departmental programs and administrative activities. Good management practices dictate that such delegation be accompanied by an accountability strategy to assure that both programs and administrative activities are managed efficiently and effectively. While some Secretaries before the 1980s used a variety of means to monitor and oversee activities that they delegated to others to manage, more recent Secretaries have used few formal or informal means to keep them informed about these matters.

Delegation Requires Accountability

In an organization with as many diverse activities and programs as HHS, no one person can do all the tasks necessary to accomplish the organization's mission. Consequently, the Secretary must share authority with his or her subordinates. This decentralization must be accompanied by adequate accountability, so that Secretaries can assure themselves that the Department's activities and programs delegated to others to manage are being managed efficiently and effectively. Such accountability could be formal—such as through routine reporting systems to monitor the performance of key programs and administrative activities. Or it could be informal—such as through routine one-on-one meetings with top-level operating and staff division officials, and meetings with key persons and organizations outside HHS, such as governors and public interest groups.

Little Accountability and Control of Delegated Authorities

Recent Secretaries have given insufficient attention to overseeing programs and administrative activities delegated to others to manage. Our survey of HHS's managers and senior staff, interviews with current and former high-level officials, and past studies of HHS indicate that OS's oversight of departmental activities and programs is weak and that few formal or informal means have been used to foster accountability.

HHS's managers and senior staff generally believed that OS's oversight was weak. At least 43 percent reported that OS did a poor or very poor job determining how well programs or functional areas were being managed, determining program effectiveness, identifying specific program strengths and weaknesses, and correcting identified program weaknesses. Nineteen percent believed OS was carrying out these responsibilities well or very well.

According to past studies of HHS and former and current high-level officials, OS has had few formal means to monitor and oversee departmental

programs and administrative activities. A former Under Secretary said that, for at least the last dozen years, it has been very unclear who within OS is to evaluate organizational efficiency. He said that it takes place a good deal less than it should. A 1976 internal study of the Department's organization reported that management control and accountability were not clearly distinguished or focused in OS's organization. The study concluded that the absence of clear accountability for managing cross-cutting issues was at the crux of the Department's management problems and needed to be more thoroughly addressed.

Also, the 1983 President's Private Sector Survey on Cost Control, otherwise known as the Grace Commission report, found a lack of accountability in HHS's organizational structure. The Commission recommended that an executive committee be established to, among other things, report problems, sensitivities, and achievements to the President and Secretary rapidly. More recently, a high-level official from Secretary Bowen's term said there was no way to measure progress or hold management accountable for the lack of progress. The official said that, although some former Secretaries had good agendas and a system to hold people accountable for achieving progress, the structure of OS precluded effective accountability and measurability.

In addition to having few formal accountability strategies, recent Secretaries have used few informal means to keep apprised of departmental matters. Secretary Bowen had meetings once a week with the Department's senior staff. However, an official attending these meetings said that controversial issues were seldom raised or openly discussed with the Secretary. The Secretary also had daily meetings with both the Under Secretary and chief of staff. Other high-level Department officials, however, did not have this opportunity. Several of these officials said that they and others did not have adequate access to the Secretary. Similar comments were made about access to Secretary Heckler. The Grace Commission also reported on the need for operating divisions to be brought closer to the Secretary and OS so that communication among key management officials was more direct, more personal, and not filtered or distorted by intervening staff.

At the beginning of Secretary Bowen's term, few means were available within OS for monitoring and overseeing how well key departmental programs and administrative activities were working. Early on, a "morning mail" system was developed to inform the Secretary and key officials about senior officials' schedules, upcoming Department activities, and

major developing issues. Later, a system for tracking the status of regulations and reports to the Congress had been established. In addition, the Office of the Inspector General was relied upon as a key source of information for program evaluation and compliance matters. The establishment and use of these techniques were a positive step toward helping the Secretary oversee and monitor the Department's programs and administrative activities. But more formal or informal means are needed within OS in order to provide effective accountability.

Ineffective Oversight Can Lead to Public Embarrassment

HHS has been lucky not to have been confronted with the problems and negative national attention that other federal entities recently have received as a result of insufficient oversight and monitoring. As noted in chapters 1 and 2, management of HHS's activities and programs is highly decentralized, with many programs being administered by state and local governments and third-party contractors. Without sufficient monitoring and oversight of its activities and programs, HHS is vulnerable to the types of problems experienced by the Department of Housing and Urban Development and the Internal Revenue Service. The following case provides one example within HHS of how poor management within one component and inadequate secretarial oversight can lead to undesirable and unnecessary consequences.

In 1986, because of poor performance and limited oversight of its activities, HHS's Office for Civil Rights was subjected to congressional investigation, media attention, and employee complaints. A congressional committee had found, among other things, excessive delays in the office's handling of discrimination complaints and violations of federal travel regulations and laws by the office's director. To correct these shortcomings, the committee recommended in April 1987 that the Office for Civil Rights establish a tracking system to routinely monitor the progress of discrimination cases and that OS establish controls over the domestic and foreign travel of its senior managers to eliminate the potential for fraud and abuse. This public scrutiny led to an internal management review of the Office for Civil Rights in 1987. The study identified several management weaknesses and made several recommendations, including implementing an effective performance monitoring system and strengthening secretarial oversight. Similar poor management within and oversight of the office's activities during the 1970s had led to a backlog of discrimination complaints, several lawsuits, and court-imposed time frames for investigating complaints and completing compliance reviews.

No Single Approach to Foster Accountability

There is no one way to foster accountability among HHS's leadership team, but to succeed, some conscious strategy must be followed. Past Secretaries have used various means to oversee and monitor the Department's activities and programs that they delegated to others to manage. For example, some Secretaries relied heavily on regular one-on-one or ad hoc meetings with key headquarters and regional officials to gain information on how efficiently and effectively programs were being conducted. Others relied on more formal means for monitoring the pulse of the Department. For example, Secretary Califano used service delivery assessments to determine how well certain programs were working. Other Secretaries established performance monitoring and reporting systems, such as the Planning, Program, and Budgeting System and Management-by-Objectives, to obtain key information about what programs were accomplishing. Under these systems, the Secretaries and their staff held periodic meetings with responsible managers to assess their progress in accomplishing departmental goals and objectives and held them accountable for specific accomplishments.

Unclear Lines of Authority Weaken Departmental Leadership

Unclear lines of authority have hampered the Secretary's ability to establish a strong leadership team that can work together to accomplish departmental goals. The introduction of a chief of staff into the leadership team has confused responsibilities among senior officials within the Department and deprived certain officials of access to the Secretary. In addition, the roles and responsibilities being exercised by the Department's senior officials do not match current mission and function statements, thereby confusing the assignments and responsibilities of various team members within the Department.

Chiefs of Staff Have Weakened HHS's Leadership Team

Since 1981, Secretaries of HHS have appointed chiefs of staff as informal deputies to help run the Department. The chief of staff has weakened the effectiveness of the HHS leadership team for two reasons. First, the chief of staff has become involved in a variety of departmental affairs, thereby confusing the assigned roles and responsibilities within the Department. Second, the chief of staff has decreased the accessibility of other departmental leaders to the Secretary, thereby diminishing (1) their opportunity to further their understanding of the Secretary's goals, which affects their success in achieving these goals, and (2) their ability to report back about potential problems.

The chief of staff position has been used by each Secretary since 1981. Secretary Schweiker initially appointed as his chief of staff a trusted

assistant with whom he had worked for years. His Under Secretary never gained the same degree of trust. Secretary Heckler continued the use of a chief of staff as a way of coping with an Under Secretary not of her choosing. Secretary Bowen was able to choose his Under Secretary, but he too appointed a trusted individual with whom he had previously worked as his chief of staff.

Compared to other high-level officials in the Department, the chief of staff position has little formal structure or specified duties. The position is not specified in statute, nor is the incumbent approved by the Senate. There is no mission and function statement formalizing the responsibilities of this office. The position description indicates that the incumbent reports directly to the Secretary and is assigned very broad duties and responsibilities in a wide range of departmental matters.

Despite the lack of formal structure to the position, chiefs of staff have had the trust and backing of the Secretary and have exerted extensive influence in an ad hoc way over departmental matters. Generally, each chief of staff has played a key role in filling departmental vacancies. Chiefs of staff have also been principal policy advisers, involved in top-level departmental discussions. Dr. Bowen's chief of staff also played an increasingly public role, giving speeches and testifying before congressional committees. One former chief of staff pointed out that he did not need formal structure because he had the unfailing backing of the Secretary should a dispute arise. Another said in retrospect he thought he had wielded too much power.

As chiefs of staff have involved themselves in an ad hoc way in departmental matters, the responsibilities of other departmental officials have been undercut. The actions of the chiefs of staff have impinged most directly on the Under Secretary, who is designated by law as the deputy of HHS. The chiefs of staff have reported to the Secretary but not through the Under Secretary, creating a de facto situation of two principal deputies in the department—one, the Under Secretary, whose position is specified by law; the other, the chief of staff, holding powerful influence by virtue of his relationship with the Secretary. Many of the Department's managers believe it is undesirable to have both an Under Secretary and a chief of staff, citing redundancy of responsibility, unclear lines of authority, and conflict between the incumbents.

Other key leaders have also found that the chief of staff's responsibilities have overlapped with their own. For example, during Secretary

Bowen's tenure, the chief of staff was assigned responsibility for coordinating departmental management, but the Assistant Secretary for Management and Budget had the official authority delegated from the Secretary to direct the Department's administrative and financial management. Similar overlapping responsibilities existed between the chief of staff and the Assistant Secretary for Planning and Evaluation and between the chief of staff and the Assistant Secretary for Personnel Administration.

In general, chiefs of staff also have had greater access to the Secretary than other top-level officials. Chiefs of staff met with the Secretary routinely. Yet, particularly during the terms of two recent Secretaries, senior staff of the Department had limited private access to the Secretary. For example, a top-level official from one administration told us that operating division staff did not feel close to the Secretary and did not have the direct contact with him that they believed was needed.

The ideal situation for a Secretary is to be able to select his or her own Under Secretary. However, should future Secretaries face constraints in choosing their Under Secretary and choose to use chiefs of staff, we believe the position should be structured with the objectives of (1) ensuring that the roles and responsibilities of the chief of staff do not interfere with those of high-level departmental officials and (2) ensuring adequate secretarial access for all departmental leaders. Structuring the position so that the responsibilities do not conflict with the formal authorities of other high-level officials is one alternative used in the past. For example, Elliot Richardson brought Jonathan Moore with him to HHS to help with the transition and to serve as a chief assistant. Joseph Califano, Jr., used Benjamin Heineman, Jr., as an executive assistant. These individuals, however, did not assume the responsibilities of principal Department officials.

Inadequate Mission and Function Statements Contribute to Role Confusion

Success in getting the Department's staff to work together as a team depends in part on the players knowing their roles. But Department officials have received confusing signals about the roles and responsibilities of various HHS offices. On the one hand, there is an administrative requirement for an official description of the duties of each office, but such descriptions have been vague, outdated, or sometimes nonexistent. On the other, there is actual practice, which can deviate from an official's formally prescribed responsibilities. In our opinion, confusions and breakdowns in cooperation within the Department could be lessened by the Secretary's clearly defining his or her organizational preferences

through revised mission and function statements and assuring that the actual practice conforms to the formal description.

Clear descriptions of the organization and its major procedures are required by HHS's administrative policy, which is based on the Administrative Procedure Act. But such mission and function statements are more than an administrative requirement. They are a vehicle for conveying to the public and officials within the Department a description of its mission, responsibilities, functions, and organization.

Mission and function statements are not serving the purpose of clarifying Secretarial preferences about operating practices and the roles and responsibilities of various offices. They are an amalgam of changes made by various Secretaries. Some are vague or outdated. Others are nonexistent. For example, no mission and function statement exists for the Office of the Chief of Staff or the Office of the Under Secretary to help clarify the relationships between them. The mission and function statement for the Executive Secretary dates from 1972. It was never updated to describe broader responsibilities exercised by the Executive Secretary under Secretaries Heckler and Schweiker. The mission and function statement for the Office of the Assistant Secretary for Legislation is 10 years old. The office's responsibilities have not been formally changed to reflect the reduced scope of its activities since its size was significantly reduced. Other mission and function statements discuss organizations whose names were changed years ago or still refer to HHS as the Department of Health, Education, and Welfare.

Conclusions

Insufficient secretarial oversight increases HHS's risk of fraud, waste, and abuse in its programs and administrative activities. In addition, insufficient oversight and unclear lines of authority among departmental leaders have weakened the effectiveness of the Department's leadership team.

We believe that given the size and complexity of the Department, it is appropriate for Secretaries to delegate to others the authority for running departmental programs and administrative activities. However, delegation does not end a Secretary's responsibility to be vigilant. Recent Secretaries have been too isolated from top-level officials to whom authorities have been delegated and have given insufficient attention to monitoring and overseeing the Department. With a decentralized management structure, HHS is highly vulnerable to fraud, waste, and abuse. Secretaries must have an accountability strategy to assure

that the Department's programs and administrative activities are operating well.

The use of a chief of staff and the lack of mission and function statements that conform to actual practice also have weakened departmental leadership. By using chiefs of staff, recent Secretaries have confused responsibilities within the Department and have lessened the influence of the Under Secretary and other high-level officials. Any future use of a chief of staff should ensure that his or her responsibilities do not conflict with those of other high-level departmental officials and that all such officials have adequate access to the Secretary. In addition, by neglecting mission and function statements, recent Secretaries have missed opportunities to convey their preferred organization and operating practices—a key element of effective leadership.

Recommendations

To help develop an effective leadership team and foster accountability within the Department, we recommend that the Secretary

- establish formal and/or informal means to oversee and monitor the performance of key departmental programs and administrative activities that are delegated to others to manage;
- should he or she choose to continue the use of the chief of staff position, define the duties and responsibilities of that position so that they do not conflict with the formal authorities assigned to other high-level departmental officials; and
- clarify early in his or her term the roles and authorities to be assigned to key Department leaders, formally communicate these roles and authorities through updated mission and function statements, and adhere to the assigned lines of authority.

Invest in HHS Management Support Systems

Too often, policy or program strategies go awry, not because they were ill-conceived, but because too little attention was paid to managing their implementation. Qualified and motivated employees, information on the results of program operations, and financial information to administer and control the taxpayer's investment are needed to effectively implement important policy and program proposals. However, budgetary constraints are forcing HHS managers to do more with less resources, thus requiring more effective and efficient management. Ineffective systems for managing the Department's people, financial activities, or information could contribute to failures in ongoing programs, frustrate new initiatives, and leave the Department vulnerable to public criticism. The following chapters address actions that could improve HHS's management support systems.

Enhance Work-Force Quality Through Improved Human Resources Management

A competent and effective work force is critical if HHS is to achieve its mission. Like other public and private entities, HHS is affected by work-force reductions and operational changes that affect work-force size and skill needs. HHS's components have taken steps to address these issues, but most of their initiatives have been short-term and do not represent effective solutions to work-force challenges. Human resources management within HHS could be enhanced if OS were to lead a strategic work-force planning process in the Department.

HHS Faces Major Work-Force Challenges

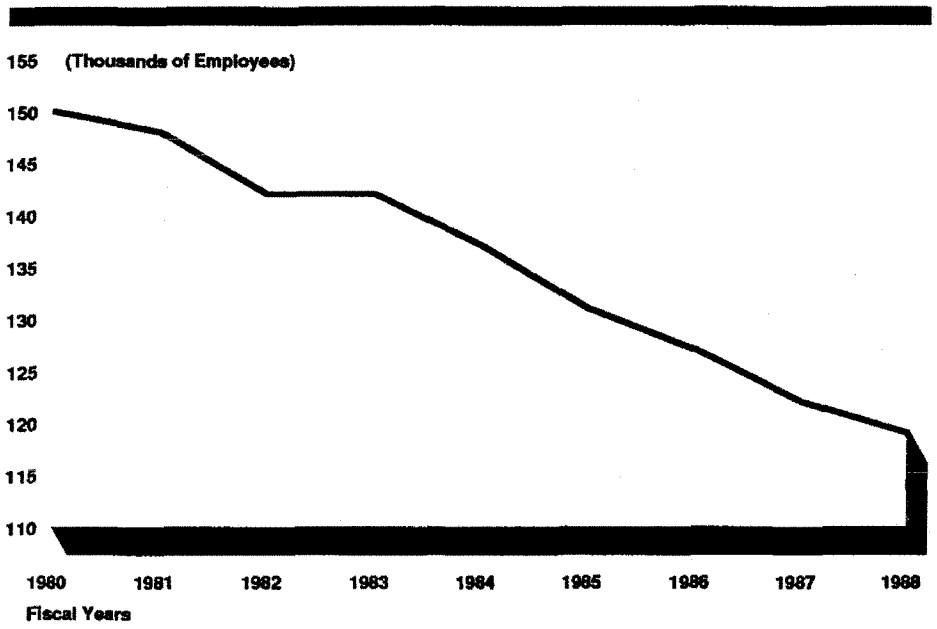
HHS's management faces two formidable challenges to managing its work force. First, the Department is experiencing significant reductions in the size of its work force. Second, environmental, operational, and program changes present major challenges to HHS's managers, who must find effective ways to adapt the work force to these changes.[1]

Work-Force Reductions

Since 1981, civilian employment in domestic agencies has declined by 59,400 employees. HHS experienced the largest share of this decrease, with a Department-wide loss of 20 percent—over 31,000—of its full-time equivalent positions. Each operating division underwent reductions: SSA by 17 percent, PHS by 18 percent, HCFA by 22 percent, the Family Support Administration by 25 percent, and OHDS by 46 percent. At SSA, reductions of 17,000 full-time equivalent positions were scheduled between 1985 and 1990. Also, OS lost 37 percent of its staff, mostly due to implementation of the President's Private Sector Survey on Cost Control (known as the Grace Commission) recommendations. Figure 6.1 illustrates HHS's staffing trend.

[1] Recruitment and retention of scientists, a serious work-force challenge to HHS, is not addressed in this report. Our recommendations for work-force planning, presented on page 71, would not resolve this problem.

Figure 6.1: HHS Full-Time Equivalent Employment (FY 1980-88)



Environmental and Operational Changes

The employee skills needed to accomplish the variety of HHS activities change over time. Such factors as new or revised legislation, demographic changes, incidence of disease, or the need to modernize operations often require new skills. Environmental and operational changes at SSA and HCFA illustrate this.

The skills SSA will need in the future are expected to be significantly different as paper processes become electronic and the need for face-to-face service diminishes. SSA recently started a national centralized telephone inquiry system, continues to implement a direct data entry system to eliminate paperwork when applying for benefits, and is modernizing its primary computer network. It envisions other innovations in the future, such as "smart" (multifunctional) social security cards and interactive transactions between recipients and data terminals over the telephone. These innovations have substantial implications for work-force size, employee selection and retention, skill needs, training, and retraining. Most of SSA's work force for the year 2000 is already employed by the agency. Its work force has the skills needed for paper-intensive clerical processes and face-to-face service delivery. They will need to master new skills as jobs change; otherwise, service to the public could deteriorate.

At HCFA, implementation of recent catastrophic health care legislation provides another example of work-force challenges brought about by a changing federal program. Expansion in Medicare benefits created the need for additional staff with a new array of analytical skills and for professionals who are not easily attracted to federal employment, such as physicians, pharmacists, and nurses.

HHS Has Responded in Different Ways to Work-Force Challenges

HHS has resorted to several different approaches, some more effective than others, in addressing the Department's major work-force challenges—downsizing and program changes. Usually, its managers turn to conventional, short-term measures, mostly because of rigid federal personnel procedures. In some cases, however, managers adopted more systematic, pro-active solutions. The Secretary and ASPER have played limited roles in supporting these efforts to address the Department's work-force challenges.

Conventional Approaches to Address Work-Force Challenges

HHS managers have generally used conventional approaches, such as across-the-board staff reductions, hiring freezes, or reductions by attrition, to deal with its work-force challenges. These approaches offer little or no managerial control over the resultant inventory of work-force skills. As a result, HHS components often have been left with a work force not well suited to accomplish their missions effectively. Following are two examples of HHS's use of conventional approaches.

1. SSA's top management encouraged "voluntary redeployment"—relocation of headquarters personnel to field offices—as a means to reduce staffing at SSA headquarters. The relocations frequently eliminated the already limited advancement opportunities in field offices and adversely affected employee morale. Also, this voluntary redeployment did little to alleviate chronic staff shortages at inner-city offices, which the volunteers avoided. Consequently, SSA's long-term operational interests were not well served, and the Commissioner rescinded this option.

2. Managing staff cuts through hiring freezes and attrition has hampered HHS program operations, according to many regional program managers. For example, some regional officials reported difficulty responding to changes in HHS's relationship with state and local entities when block grant procedures shifted the role of HHS regional offices from service delivery to compliance monitoring of third-party grantees. The use of hiring freezes and attrition to manage directed staff reductions left HHS with staff who often lacked the skills needed to carry out

this new role. Many regional program managers we spoke with identified work-force quality as the Department's chief management challenge.

Some of the reasons that experts cite for the limited success of conventional federal personnel approaches include the following:[2]

- Responsibility for personnel issues and actions belong to personnel specialists, not line managers.
- The frequent perception by program and line managers that personnel rules are obstacles to obtaining needed human resources.
- Failure to link decisions affecting the numbers, skills, and management of people to program objectives.
- The separation of personnel planning and decision making from budget planning.
- Lack of attention to personnel management issues by agency heads.

All of these factors were present at HHS. Its managers have tended to rely on conventional measures to contend with staff reductions or operational changes. Their responses (1) have lacked a long-term focus and were not always linked to program objectives, (2) did not involve line and personnel specialists in collaborative efforts to identify and solve problems, or (3) were carried out on a project management basis and were sometimes led by personnel staff, who generally received little cooperation from line managers.

Pro-Active Approaches to Address Work-Force Challenges

While conventional measures tended to predominate, some HHS component managers have responded to changing work-force needs in more innovative ways. Some work-force initiatives resulted from componentwide planning efforts. Other innovative solutions came about when managers and staff engaged in constructive, pro-active problem solving, framed issues in broad terms, and considered the long-term effects on the work force.

[2]Improving the Management of Human Resources in the Federal Government Through a Private-Public Partnership, The President's Council on Management Improvement (Washington, D.C.: 1987), Volume I.

A Study of Private Sector/State and Local Government Personnel Operations, McManis Associates, Inc. (Washington, D.C.: 1985).

Revitalizing Federal Management: Managers and Their Overburdened Systems, National Academy of Public Administration (Washington, D.C.: 1983), Chapter 1, 2, and 5.

Managers who had engaged in componentwide planning efforts, such as those discussed in chapter 3, were better informed about current and future work-force needs. Componentwide planning assisted work-force management because it clarified organizational goals, identified objectives, and underscored the importance of improved human resources management. FDA and SSA managers were able to propose innovative work-force initiatives that were tied to organizational and program needs, as highlighted below.

1. FDA's action planning process represents a sustained effort, initiated by the agency head and involving management and staff personnel, to identify operational problems, develop solutions to these problems, and track their resolution. As a result of this process, FDA identified several human resources management initiatives intended to enhance recruiting, training, and motivating its work force.

2. Even though SSA managers initially responded to work-force downsizing and program modernization with stopgap measures, the Commissioner soon recognized that the agency needed comprehensive, long-term planning to guide the agency to the year 2000. Like FDA, SSA began its planning process by obtaining extensive input from its field and headquarters managers and experts in and out of the agency. The result was a long-range strategic plan that is intended to guide the modernization of agency operations. The strategic plan identifies long-range work-force goals. SSA has identified and begun to implement specific steps to develop a work force with the skills needed for a more electronic, streamlined agency.

We found additional examples of other innovative approaches to addressing HHS's work-force challenges. Although not the product of systematic planning efforts, these examples illustrate pro-active, planning-oriented approaches to personnel management:

1. When the Congress authorized an additional 40 positions for FDA's effort to deal with the Tylenol tampering episode, rather than permitting the immediate hiring of assorted scientists, Commissioner Young insisted that FDA managers first clearly identify a new forensic role for the agency. FDA then tied requests for specific occupational skills to the new program objectives. As a result of the commissioner's involvement, the agency acquired a more permanent capability rather than only a short-term means to deal with a single crisis.

2. When passage of catastrophic health care legislation seemed likely, managers within the HCFA bureau responsible for its implementation began identifying the employee skills needed for new program requirements. The managers also brainstormed recruiting strategies, concluding that HCFA could best obtain certain technical skills on a contract basis. More conventional analytical skills could be obtained quickly by use of special hiring authority already obtained through the collaboration of HCFA's personnel office, ASPER, and the Office of Personnel Management. As a result of pro-active management involvement and planning, needed skills were quickly and effectively brought on line.

Current Role of ASPER and OS

ASPER and HHS Secretaries have had a limited role in the creation of strategies to solve departmental work-force issues. ASPER's activities have focused largely on administering federal personnel regulations, and HHS Secretaries have not been strong proponents of comprehensive human resources management improvement efforts. A high-level operating division official noted that the Department lacks an agenda for urgent human resources issues.

ASPER devotes about 90 percent of its effort to administering the HHS personnel system. However, it has sponsored a number of human resources management initiatives, including (1) software packages to analyze management effectiveness, (2) an employee assistance program, and (3) a management development seminar for Senior Executive Service personnel.

ASPER has not received a clear mandate from past Secretaries to devote more attention to improving work-force management practices. Without strong secretarial support, ASPER has had little ability to persuade operating division managers to participate actively in its human resources initiatives. ASPER staff and operating division managers informed us that operating divisions rarely seek or willingly accept ASPER's assistance on most operating division work-force problems. Several operating division managers commented that some ASPER initiatives were unrelated to their operating needs.

HHS's Management Efforts Could Be Enhanced by Work-Force Planning

Federal managers and task forces, such as the National Commission on the Public Service, the National Academy for Public Administration, and the President's Council on Management Improvement, have advocated a better balance between traditional merit system procedures and increased personnel management flexibility. Many corporations and at least one federal agency have recognized that effective management of people is crucial to the attainment of organizational goals and have adopted pro-active, employee-oriented personnel management approaches. A key element in pro-active personnel management is strategic work-force planning, which is a systematic process that more effectively matches human resources decision making to operational objectives.

The five central characteristics of strategic work-force planning are (1) analysis of an organization's environment and implications for the work force, (2) identification of key management concerns that involve human resources issues, (3) development of strategies to address major human resources issues, (4) assurance that human resources initiatives are consistent with internal procedures and goals, and (5) the regular development of strategic work-force plans to implement human resources initiatives. Work-force planning promotes collaboration between line managers and personnel specialists in identifying the employee skills and resources needed to attain organizational goals.

Strategic work-force planning in the federal sector has been dismissed as a concept with theoretical appeal, but little real world relevance. Yet such planning was successfully implemented at the Department of Labor in 1986 to better manage a diverse and changing work force that had experienced several years of reductions in force. Managers at Labor sought to avoid human resources imbalances by effectively managing the hiring, use, and attrition of employees and by ensuring that officials at all levels analyzed, planned, and managed human resources effectively.

The following factors were critical to Labor's success:

- Secretarial and top-level support that promoted a new organizational culture of mutual support and goal-oriented working relationships, especially between staff offices and operational units.
- Organization of both budget and personnel offices under an Assistant Secretary for Administration and Management, which eliminated much of the "turf guarding" that commonly exists between personnel and budget staffs and facilitated cooperation and integrated planning.

- Personnel staff providing technical support and service to Labor managers in a way that helped introduce improved management practices and accomplish effective implementation of strategic work-force planning.

After 2 years of experience with strategic work-force planning at Labor, the President's Council on Management Improvement reported that resource allocation is more rational, training is much more focused on actual program needs, communication and data sharing between staff and operating divisions are better, and cooperation between units has increased. Labor managers, including the Director of Personnel, believe that their work-force planning system is sufficiently flexible to allow it to be adapted to other federal agencies.

Organizational Changes Needed to Implement Strategic Work-Force Planning

Strategic work-force planning could enhance HHS's ability to address its work-force problems on an ongoing basis. However, secretarial leadership will be necessary to ensure that (1) cooperative relationships are built and maintained between managers and personnel specialists, (2) budget and personnel functions are integrated, and (3) ASPER's role is refocused to include increased support for improving human resources management throughout the Department.

Develop Cooperation Between Line and Personnel Staff

The Secretary's leadership will be needed to overcome the reluctance to engage in work-force planning in the Department. New partnerships will be needed between and among components, key staff divisions, personnel specialists, and line managers to develop systematic approaches and remedies to HHS's work-force challenges.

Coordinate Budget and Personnel Functions

To implement work-force planning, plans must be linked to the budget. A high-level manager in one operating division stated that for human resources planning to become an institutionalized practice at HHS, the Secretary would have to require HHS agencies to identify their occupational skill needs during the budget process. Such a requirement would allow the operating divisions to design their own solutions to their unique work-force problems. It also would help ensure the systematic analysis of work-force needs since the budget process is an ongoing, annual activity that is led by OS.

During the past decade, personnel management in HHS has been driven by budgetary decisions focused largely on controlling the size of its work force. Both personnel specialists and line managers, however, need a

voice in work-force decisions made through the budget process to ensure that appropriate attention is given to the skill mix of the work force, as well as its size.

At HHS, effective cooperation between personnel and budget staffs has been difficult to accomplish because ASPER and ASMB share responsibility for managing personnel resources. While ASMB controls the work-force size through the budget, ASPER and operating divisions address work-force skills. Strategic work-force planning will need the Secretary to find ways to integrate work-force size and skill mix decisions.

Refocus ASPER Activities

Its responsibility for enforcing personnel rules places ASPER in a regulatory and potentially punitive role. Operating division managers are sometimes wary of ASPER's work-force initiatives. It will be difficult for operating division managers to enter meaningful partnerships with ASPER as long as ASPER's role remains largely confined to traditional personnel administration. ASPER should continue to oversee personnel activities, but should also be responsive to and supportive of operating division managers' and operational needs. Personnel actions, such as recruiting, executive development, and training, should be directly related to operating division program and operating objectives.

Secretarially led work-force planning in HHS would require ASPER's role to be expanded to include providing support for work-force planning, such as personnel data and work-force planning guidance. Operating divisions could be surveyed to determine their work-force information needs, and upon request, ASPER could review operating division plans for addressing work-force problems. In addition, ASPER could become more of a resource for sharing work-force planning expertise among the operating divisions and promoting human resources initiatives in the Department. ASPER could also be responsible for supporting the work-force planning activities of the staff divisions, OHDS, and the Family Support Administration, which it services. Chapters 7 and 8 discuss employee skill needs in HHS's information resources management and financial management functions that could be addressed by work-force planning.

Conclusions

HHS faces major challenges in maintaining a competent and effective work force. Although HHS components have attempted to address their work-force problems, HHS needs a Department-wide, coordinated approach for systematically anticipating and solving its human

resources problems. We believe that, with new and changing work situations arising throughout HHS, strategic work-force planning should become an ongoing process that could (1) integrate human resources planning with other planning and budget functions and (2) help ensure that personnel actions support program objectives.

To accomplish the goals of strategic work-force planning, secretarial leadership will be needed to forge cooperation between line and staff managers, to integrate budget and personnel functions so that work-force size and skill mix can be determined together, and to support an enhanced leadership role for ASPER in human resources management within the Department.

Recommendation

We recommend that the Secretary establish and lead a departmental strategic work-force planning effort. Successful accomplishment of such planning will require

- integration of budget and personnel functions to consider both work-force size and skill needs,
- cooperation between line and staff managers, and
- a new leadership role for ASPER to guide and support human resources management efforts throughout the Department.

Improving Information Resources Management

OS has had difficulty developing an IRM program that effectively supports HHS's missions. An IRM program should ensure that the data, equipment, and people used to produce information and the information itself are well managed. Before 1986, HHS's IRM program was focused largely on ensuring that the procurement and use of computer equipment and systems were being managed effectively. ASMB, which is responsible for overseeing the Department's IRM activities, had centrally controlled the development of the IRM program, seeking little input from the operating divisions. Also during this period, OS offices had received little technical assistance in developing modern computer technology to help their managers carry out their responsibilities.

In 1987, ASMB revised its overall approach to managing and overseeing the Department's IRM activities. It expanded the focus of the IRM program by recognizing the importance of managing information and people as well as equipment and systems. To increase its chances of success with this expanded effort, ASMB began involving the operating divisions in developing new initiatives to improve IRM throughout the Department. In addition, ASMB increased its focus on developing effective computer systems for OS. This new approach and the improvements we recommend in this chapter, if properly implemented, should enhance HHS's management and use of its information resources. Because effective IRM contributes to accomplishing HHS's missions, the Secretary should continue the investment in this management area.

Responsibilities for IRM

IRM responsibility is shared by OS and the operating divisions. OS, through ASMB, provides IRM leadership by establishing policies, administering a Department-wide strategic IRM plan, overseeing operating division activities, and developing management information systems for the staff divisions. Recently, ASMB has begun to play a greater role in helping OS and the staff divisions carry out day-to-day IRM implementation, such as planning for information needs, acquiring technology, and assessing internal performance. In contrast, implementation of IRM in the operating divisions is left to those divisions.

The Assistant Secretary for Management and Budget is the Department's senior IRM official. Within his office, the Office of Information Resources Management (OIRM), which was created in 1987 and now has a staff of about 40 people, consolidates all IRM-related activities and sponsors IRM initiatives that cut across the entire Department. In this way, OIRM carries out the IRM leadership function.

IRM Problems Experienced Department-Wide

Poor information management can undermine HHS's ability to provide services to the public. It can reduce mission effectiveness, delay needed mission improvements, increase information-processing costs, endanger human safety, and jeopardize the assessment of program performance. Past GAO reports show that IRM problems have occurred in many important programs and caused or contributed to difficulties in providing good service. For example:

- One of HCFA's responsibilities is to manage Medicare—the health insurance program for the nation's elderly. But neither its existing central data systems nor the information generated by its review systems provided representative information on quality of care problems in the United States.[1]
- The Family Support Administration manages the Child Support Enforcement Program, which requires states to enforce support obligations owed by absent parents to their children. Inaccurate and incomplete data from the states made it difficult for HHS and the Congress to assess the program's performance.[2]
- The quality and timeliness of SSA's service in administering the nation's social insurance program depend largely on the accessibility and accuracy of information in its computer systems. SSA encountered many difficulties in modernizing its systems. As a result, much of its workload and management information had to be processed manually, which was slower, more expensive, and more error-prone.[3]

Past OS Efforts to Improve IRM Had Little Success

Effective information resources management could help to minimize the occurrence and impact of the types of problems discussed above. OS attempts to improve information management were unsuccessful before 1986. It developed a strategic planning process that lasted only 1 year; it introduced an IRM manual that was not expanded as originally intended; and it created an IRM Advisory Board that was not often used.

While a number of factors contributed to the collapse of these efforts, the key factor was ASMB's attempt to exert too much control over operating division IRM activities. In short, the operating divisions felt that ASMB was inflexible in managing IRM. As evidence, they cited the excessive

[1]Medicare: Improving Quality of Care Assessment and Assurance (GAO/PEMD-88-10, May 2, 1988).

[2]Child Support: Need to Improve Efforts to Identify Fathers and Obtain Support Orders (GAO/HRD-87-37, Apr. 30, 1987).

[3]Social Security Administration: Stable Leadership and Better Management Needed to Improve Effectiveness (GAO/HRD-87-39, Mar. 18, 1987).

detail required in the strategic planning process and ASMB's practice of establishing IRM policies without considering the unique needs of each operating division. In addition, an internal HHS study reported that operating division officials felt that ASMB did not give the operating divisions sufficient discretion in purchasing equipment. Before 1987, ASMB reviewed all requests for purchasing equipment that cost more than $150,000. This approach created feelings of resentment toward ASMB, and as a result, OS was unable to gain the support it needed to implement IRM initiatives.

New OS Philosophy Toward IRM

In 1987, ASMB placed increased emphasis on the need for OS to provide departmental leadership—but less direct control—over IRM. First, it placed staff with strong technical skills in OIRM's three top positions. Second, it issued a revised mission and function statement for OIRM that specified roles and responsibilities. In addition, it began several initiatives—including an IRM planning process and a project to develop an effective communications network for OS.

The Assistant Secretary for Management and Budget recognized the importance of obtaining operating division support and participation in formulating and implementing improvements. Accordingly, OIRM adopted a more participative management style in addressing IRM issues that affect the operating divisions. As a result, the operating divisions have more responsibility and accountability for their IRM activities, and managers have a more positive attitude toward the new approach.

More Effort Needed to Strengthen IRM

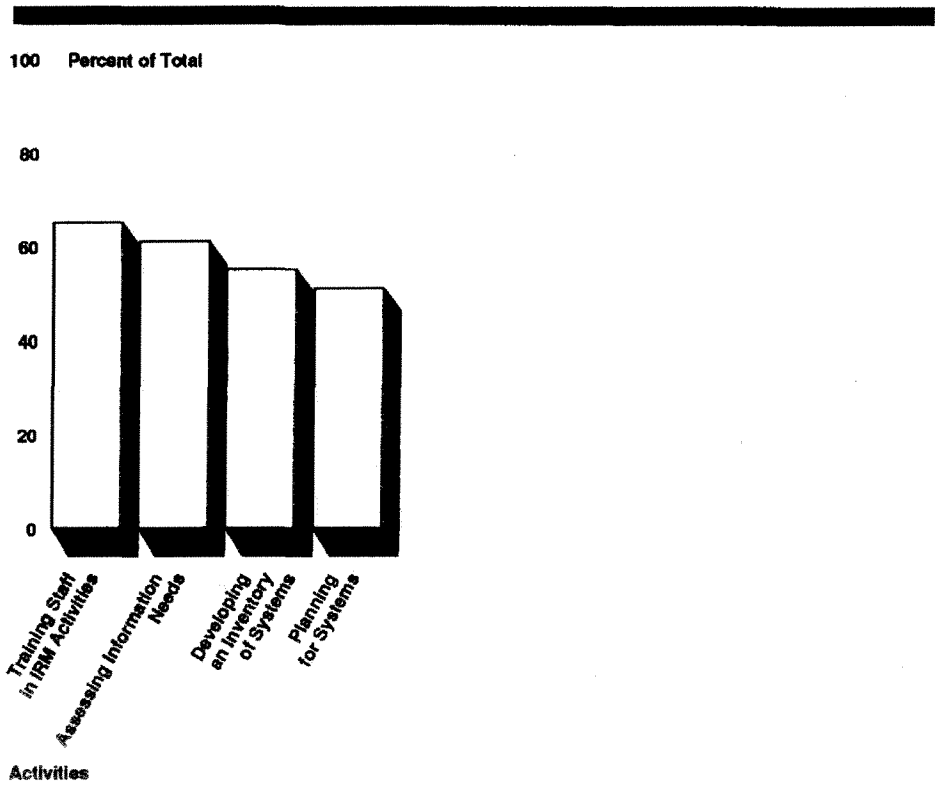
Over the past 2 years, ASMB has devoted considerable attention to strengthening IRM. Although the efforts are still in their formative stages, we believe that the path ASMB has identified has the potential to develop a strong program. However, we identified five areas—policy development, planning, IRM reviews, skill development, and technical support—that need more focus and sustained attention. As discussed below, progress across these areas has not been uniform over the past 2 years. OIRM has placed much emphasis on strategic planning and improving technical support of OS, but less on developing thorough IRM policies or reviewing operating division IRM activities. Each of these areas contributes to improving IRM and deserves management's attention.

IRM Policy Manual Is Not an Effective Management Tool

HHS issued an IRM policy manual in 1985 to give program managers and IRM officials a clear and complete understanding of Department IRM policies. However, it was not a successful tool for communicating those policies.

Although program officials are ultimately responsible for making sure that information and information resources supporting their programs are used effectively and efficiently, responses to our survey showed that only about 20 percent of HHS's program officials have seen the manual. Further, a large percentage of these managers felt that it was not particularly useful in several categories. (See fig. 7.1.)

Figure 7.1: HHS Managers Who Feel the IRM Manual Is Not Particularly Useful for Certain Activities



OMB Circular A-130 cites policies that apply to the information activities of all federal agencies. In comparing the circular and HHS's manual, we found that the manual does not provide guidance to managers in several areas. Two subjects that OS originally planned to add to the manual—office automation and IRM reviews and evaluation—have not been

addressed. In addition, guidance in several policy areas identified by OMB's circular has not been included. For example, the manual does not discuss training staff in IRM, disseminating information, identifying and correcting IRM problems, and avoiding unnecessary information.

Little has been done to improve the completeness and quality of the IRM manual since it was issued in 1985. However, OIRM is now updating the information systems security portion because of changes in technology, legislation, and regulations. Also, in 1987, OIRM established a work group to determine what improvements needed to be made to the manual.

IRM Planning Process Needs More Focus on Information

IRM planning is important because it helps HHS assure that the information needed to accomplish its missions will be available. After 2 years without a departmental IRM planning process, OIRM introduced a new one in 1988. Past processes required the operating divisions and staff divisions to include plans only for technology. Now they have to include plans for their information needs as well as technology.

The following example illustrates the need for improved Department-wide IRM planning. ASPER is in the fourth year of developing a new automated personnel and payroll system for HHS. The system—known as IMPACT—is estimated to cost nearly $17 million dollars and is the largest single OS computer system to reach the implementation stage. A recent independent study of the system found no discernable link between IMPACT's plans and the budget process. At the same time, at least one operating division is developing a new computer system that contains functions that may duplicate IMPACT's features and information. One goal of good IRM planning is to prevent such problems.

OIRM's new approach is to encourage the operating divisions and staff divisions first to identify their information needs and then to determine the appropriate technology to support those needs. Under the new information planning approach, OIRM has requested the operating divisions and staff divisions to describe their data bases; identify initiatives that require the recurrent collection of information from external organizations; and describe major information plans—such as plans for forms management, records management, and desk-top publishing. In addition, the IRM plans are to be linked to the Department's budget to ensure that funding will be available.

This represents a good start to information planning, and the increased focus on information should help to improve the process. We identified

32 IRM actions that we believed would enhance information planning at HHS. The list included (1) developing information quality requirements, (2) identifying the sensitivity of information, (3) developing techniques to periodically assess the need for particular information, (4) developing information-retention requirements, and (5) developing procedures for correcting information problems. While acknowledging the value of each of the actions we identified, the head of OIRM said that staff limitations preclude their immediate inclusion in HHS's planning process.

It is too early to tell if HHS will be able to successfully implement information planning. OIRM let the operating divisions and staff divisions submit either an information plan or a traditional technology plan in the first year—1988. After assessing the submissions—one from each operating division and a consolidated plan from the staff divisions—OIRM determined that one of the six was information based and most of the others contained elements of information planning. In December 1988, OIRM issued its request for second year submissions and did not provide the option of submitting technology-only plans.

OIRM Needs to Review IRM Offices

By law, HHS must periodically review its IRM activities to ensure that they effectively support its missions. Before 1987, ASMB focused its reviews primarily on the acquisition and use of technology rather than on how well the operating and staff divisions carried out their overall information management responsibilities. These reviews gave OS little knowledge of the divisions' capability to manage information activities. In 1987, OS developed a broader review approach that could provide this knowledge, but had not implemented it at the time of our review.

Until 1987, ASMB used three methods to review IRM operations. First, ASMB and IG staff conducted management reviews to assess operating division and staff division compliance with federal acquisition regulations and policies. Three rounds of these reviews have been conducted, the last for procurements awarded between April 1985 and September 1986.

Second, ASMB reviewed all procurement requests for technology that cost more than $150,000. The level was generally determined by the results of the acquisition reviews discussed above. The former Assistant Secretary told us that he kept the level at $150,000 because he was concerned that the operating divisions were spending large sums on technology without evaluating whether the investments were cost effective. By

reviewing proposed procurements, OS had some assurance that HHS was getting a good return on its investments in technology.

Third, to meet a requirement of the Paperwork Reduction Act and OMB Circular A-130 (known as Triennial Reviews), operating divisions and staff divisions reviewed selected computer system development and redesign efforts. ASMB played a small role in this process, serving primarily as the focal point for reviewing the results.

In 1987, ASMB changed its approach to overseeing IRM. First, because the most recent acquisition management review showed adequate procurement capabilities in many operating divisions, the Assistant Secretary raised the level of equipment procurement reviews from $150,000 to $2 million for most operating divisions. In making this change, both the Assistant Secretary and the head of OIRM felt that the $150,000 level provided little incentive for the operating divisions to develop competent IRM organizations. Their objective was to provide this incentive.

Second, in conjunction with the procurement authority increase, and to monitor development of operating division IRM capabilities, OIRM planned to conduct broad reviews of the operating division IRM offices to assess their proficiency in all phases of information management. As of January 1989, OIRM had not started the intended broad IRM reviews. An OIRM official cited staff limitations and other efforts—such as the time required by the planning process—as reasons for the delay.

Finally, concerning the Triennial Reviews, OIRM will continue to serve as the focal point but will provide more guidance to the operating and staff divisions on how to adopt a broader IRM perspective in conducting their reviews.

More Attention to IRM Skills Is Needed

IRM organizations are in the business of helping to meet the information needs of officials who operate complex and changing programs that serve the needs of the American public. To accomplish this, they require staff skilled in a variety of technical and managerial disciplines. Although the Department's IRM officials are aware of their current staff's skill levels, they do not conduct periodic assessments of the number, type, and qualifications of IRM personnel that they need. Moreover, HHS has no policy on the type of skills needed to improve IRM.

To assist the Department in assessing its current and future staffing requirements for IRM, we assembled a list of IRM skills that we believe

would be useful for an effective IRM program. In developing this list, we obtained input from officials who teach IRM and modified our list based on their comments. Our list of skills include (1) needs assessment skills to ensure that the IRM objective of maximizing information usefulness is achieved, (2) costing skills to determine and evaluate the cost of information processing operations, and (3) management information system skills to identify and extract important management information from operational information systems. The list of skills and their applications is in appendix IV.

The head of OIRM agreed that many of the skills would be valuable to HHS and that upgrading the skill mix is important. He considers our list a positive starting point for identifying needed skills. While indicating that many of these skills are already available to his office, he added that some are not available in sufficient numbers to accomplish a wide range of information activities. He told us that OIRM intends to create a policy addressing needed skills.

ASMB Needs to Improve Technical Support to OS

OS offices have had difficulty in developing and using modern computer technology. This has occurred, in part, because most offices have not had access to technical assistance. As a result, many OS computer systems are antiquated, problem-ridden, and unreliable. OIRM has recognized this problem over the past year and has taken steps to improve it.

The current head of OIRM's Office of Systems Management said that OS had been underserved for many years and that modern systems and equipment were almost nonexistent. He sees this situation as the most serious IRM problem facing OS. A 1987 internal HHS management review also observed that OS officials expressed the need for assistance in acquiring computer systems and appropriate technical training. Respondents to our questionnaire confirmed this. For example:

- "Several years ago the Office of the General Counsel [OGC] contracted for an automated precedent retrieval system. . . It didn't work and had to be abandoned. Later OGC contracted . . . for an automated Litigation Tracking System—ALTS. The computer program was so bad they had to have a programmer rewrite it . . . The system doesn't generate accurate reports and is user hostile."
- "OGC's procurement of word processing equipment and Personal Computers has been uncoordinated and inefficient. OGC equipment is incompatible with client agencies and with other parts of OGC."

- "[It is a problem] getting information from personnel systems to respond to EEO [Equal Employment Opportunity] lawsuits and to manage the HHS Ethics in Government program."
- "I have had a minor system acquisition problem which is related more to insufficient technical staff being available to . . . modify existing frail systems or . . . to develop state-of-the-art systems."
- "[I] could not find the central source—if there is one—knowledgeable of systems in use and available throughout HHS. This would have saved about 3 to 4 manweeks of planning a concept . . ."

ASMB took action to improve assistance and support to the staff divisions when it created the Office of Systems Management in 1987. To help improve OS's systems, this office is leading an initiative to acquire and electronically link personal computers to facilitate message and document transfer. The office also provides technical support and training to staff within OS and has already had some impact in helping develop systems. So far, it has developed about six new computer applications requested by the heads of several staff divisions and has hired a contractor to train and assist staff division personnel in using personal computers. In developing new systems, its goal is to assure that systems serving OS are compatible. If staff divisions take advantage of OIRM's technical assistance, OS could improve its use of modern technology.

Conclusions

Good IRM is critical at HHS because the Department's programs affect the health and welfare of virtually every American citizen. Over the past 2 years ASMB has devoted considerable attention to strengthening IRM. We believe it is on the right path in its efforts to encourage the creation of strong, competent IRM offices throughout the Department and its recognition of the need for HHS to begin managing its information as well as its technology.

Although the approach is sound, ASMB's progress in implementing it has not been uniform across five key areas—policies, planning, review, skills, and support. If improvements are not made in these areas, progress to date could be undermined. A shortage of skilled staff to carry out improvements in each of these areas has precluded the Department from realizing the benefits that effective IRM can provide.

Recommendations

We recommend that the Secretary continue the Department's investment in HHS's IRM program by ensuring that resources are available to

- develop needed IRM policies;
- implement ASMB's IRM strategic planning process, focusing on information planning and extending the process to include steps discussed in this report;
- start and continue ASMB's broad reviews of operating division IRM offices;
- assess HHS's IRM skill needs; and
- continue to provide technical support to OS.

Need to Sustain Efforts to Improve HHS's Financial Systems

In 1987, the Department, together with its operating components, renewed its commitment to strengthening its financial management environment and developed a new plan aimed at modernizing its outdated financial management systems. Known as Phoenix, the plan constructively addresses the factors that hindered past modernization efforts. In our opinion, the plan is properly focused and is a good foundation for actions to improve HHS's financial management.

While the Phoenix plan provides a solid base upon which to build a modern set of financial systems for the Department, successful implementation of the plan will require top-level support, adequate funding, and a skilled financial management staff. These investments are essential for the success of the plan and the improvement of the Department's financial management environment.

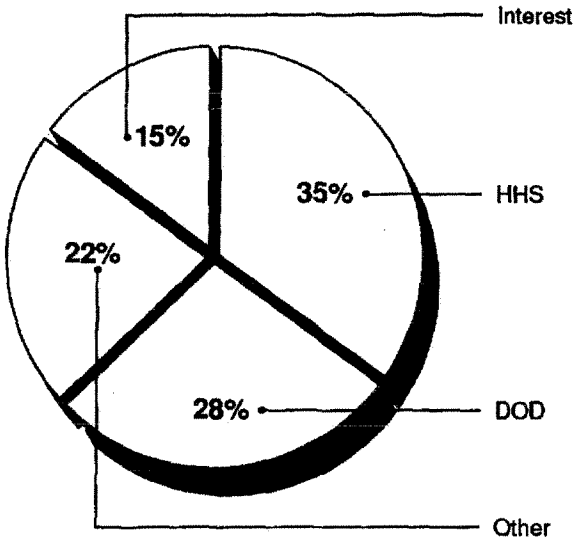
HHS Has a Complex Financial Management Environment

The high volume of annual expenditures, the large number of complex programs, and the variety of methods used to finance and make payments create a highly complex financial environment for HHS. The difficulties in this environment are compounded by HHS's use of outdated automated systems to account for and control the billions of dollars used to carry out its programs.

Environmental Complexities

A total of 121 appropriations and four trust funds are used to finance about 220 HHS programs. As illustrated in figure 8.1, estimates show that HHS will make about 35 percent of all federal expenditures (about $401 billion) in fiscal year 1989. About 95 percent of HHS's payments are for Social Security, Medicare, Medicaid, and other smaller entitlement programs. The other 5 percent are for a wide variety of social welfare and medical programs.

Figure 8.1: Composition of Estimated FY 1989 Federal Expenditures



Estimated FY 1989 Federal Expenditures = $1,102 Billion

HHS uses several methods to disburse funds to a wide spectrum of recipients of its entitlement, public assistance, and medical programs. For example, SSA makes benefit payments to about 43 million retired and disabled individuals, their dependents, and their survivors by either mailing checks directly to them or depositing moneys directly in their bank accounts through electronic fund transfers. Also, HHS uses letters of credit to transfer funds to contractors, grantees, and states administering HHS programs. The recipients provide the letters of credit to their banks and draw down against them as funds are needed to administer programs.

Financial Management Structure

To develop and maintain the financial information necessary to effectively manage and control HHS's missions and programs, HHS operates 13 major financial management systems—7 primary accounting systems, 3 Department-wide subsidiary systems, and 3 programmatic systems. In addition, the Department's components operate numerous financial and administrative management subsystems, which feed data to the seven primary systems. Contractors and grantees operate systems outside the Department that are used to make payments under various programs, such as Medicare and Medicaid.

The primary systems are used to (1) record and control appropriated funds and other financial resources; (2) record summary information on the financial results of program and administrative operations; and (3) prepare financial reports for HHS managers, the Congress, and other public officials. The subsidiary systems are used to carry out payroll operations, pay grants, and support HHS's consolidated regional accounting operations. Program systems help managers carry out unique program and operating functions, such as payment of social security entitlements and management of the processes used to collect money owed the government.

Long-Standing Problems in HHS Accounting Systems

Most of the Department's primary accounting systems are 15 to 20 years old, and they often use manual or outdated automated processes to enter, transfer, or reuse data. Such processes increase the possibility of error, preclude the implementation of effective controls, are generally labor intensive, and often store information in central accounting files located far from managers. Because of the difficulty in gaining access to data in the central files, Department managers develop their own "informal files," which are duplicative and sometimes inconsistent.

Because of these weaknesses, some of the Department's accounting systems do not provide timely, complete, and accurate information on the results of program and administrative operations. For example, HHS does not always properly account for advances made to grant recipients and property for which it is responsible. These types of system problems hinder HHS's ability to establish effective fund control and manage grants and property.[1]

Past Systems Enhancement Efforts Unsuccessful

The Department has long recognized the above problems, but past corrective actions have not succeeded because of inadequate support from HHS's operating components, technical difficulties, and cost constraints. Two previous attempts—the Standard Accounting System in 1978 and the Financial/Administrative Integrated Management System in 1984—tried to develop a single standard Department-wide financial management system. HHS terminated both of these projects in large part because some operating divisions did not support them and resisted implementation. The operating divisions believed that the Standard Accounting System would have been more cumbersome and costly to operate than the

[1]See Financial Management: Continued Top Management Support Needed to Improve HHS's Accounting Systems (GAO/AFMD-88-37, Sept. 29, 1988).

systems then in place. Similarly, they did not support the Financial/Administrative Integrated Management System because of the complexities required to have a single automated accounting system to account for the wide spectrum of programs carried out by different operating divisions. Operating division officials also told us that they did not consider themselves part of the decision-making process and the project was forced on them.

Efforts in 1986 to implement the Financial/Administrative Integrated Management System were also set back because of a contractor bid protest. HHS had made changes to the functional requirements for the software that were not permissible under procurement regulations.

Phoenix Plan Addresses Problems in HHS's Primary Accounting Systems

In May 1987, HHS began developing the Phoenix plan to address the problems in the Department's primary accounting systems. In developing the plan, HHS applied the lessons learned from past efforts. It established effective overall direction and leadership for the project and gained the support of the operating divisions.

Objective of the Phoenix Plan

The plan's objective is to obtain a set of modern financial systems that will meet both program and management needs as well as departmental financial information requirements. The overall thrust of Phoenix is to ensure that the Department's future accounting systems include

- reliable and meaningful information,
- less redundant and labor-intensive operations,
- standardized financial processes,
- interchangeable software, and
- an integrated information flow among systems.

Unlike the prior two efforts, Phoenix does not attempt to prescribe a single accounting system for the entire Department but does establish compatibility standards that each component's automated system must meet.

Actions to Refocus Accounting Systems Improvement Efforts

HHS's Assistant Secretary for Management and Budget and Deputy Assistant Secretary for Finance developed a participatory management approach to gain acceptance of needed accounting system improvements. While retaining responsibility for overall direction on all accounting and financial matters, these individuals established a financial/accounting/systems development group. The group consists of the operating divisions' financial management officers and their systems staff and is chaired by the Deputy Assistant Secretary for Finance. Their goal was to develop guidelines for the Phoenix plan and monitor project implementation. The plan, which was completed in fiscal year 1988, included guidelines and standards for acquiring and implementing replacement systems for the seven aging primary accounting systems. Monitoring responsibilities include approving each operating component's plan, assuring that the plans are updated as needed, coordinating the project, and reporting to OMB on implementation status.

Under the Phoenix plan, each of the Department's operating divisions, working through the development group, is responsible for developing and implementing its own system enhancement plan. Officials said that this was a desirable approach because the divisions are most familiar with the areas needing improvement. As a result of their participation, financial managers in the operating divisions view Phoenix positively. They are involved in setting the priority and the specifics of corrective actions to be taken to solve their own accounting systems problems.

Substantial Investments Required to Complete Financial Management Improvements

While the Phoenix plan is a promising start toward modernizing HHS's financial management environment, substantial and continuing investments will be needed to complete, operate, and maintain it. The Deputy Assistant Secretary for Finance advised us that as of September 1989, the plan was on schedule, initial implementation of the seven new primary accounting systems should take place between July 1989 and September 1990, and all systems should be fully operational by the end of fiscal year 1991.

HHS estimates that it will cost about $134 million to develop, operate, and maintain the new primary accounting systems for fiscal years 1990-93. HHS top financial management officials advised us that in the past they have had difficulty maintaining the necessary funding levels to operate and maintain effective financial systems. They pointed out that it has been difficult to compete with programs for funds in HHS's budgetary process. While we agree that program funding is important, we also believe that investments in modern financial systems are important to

provide the adequate, timely financial information necessary to make decisions that will enable HHS to carry out its programs cost-effectively. Moreover, Phoenix is essential to HHS's efforts to comply with governmentwide initiatives under OMB Circular A-127 on financial systems and meet requirements to implement the governmentwide standard general ledger.

Investment in Human Resources for Financial Management Needed

HHS's accounting systems should be able to give managers the financial data they need to adequately account for public funds. Such data can help managers plan and control operations, safeguard assets, and use resources effectively. Enough qualified financial staff are needed to work with the Department's program staff to assure that data are useful and accurate and that the integrity of financial systems is maintained.

During the 1980s, the financial management staff was subject to the same budget-driven staff cuts as the rest of HHS (see ch. 6). As we pointed out in an earlier report (see footnote 1, p. 84), lack of staff was one of the reasons that HHS was not reconciling data in financial systems with financial reports to assure that they were accurate. HHS advised us that it was taking some actions to correct this problem, but the problem will not be fully corrected until Phoenix is completed.

A number of HHS financial management officials told us that the Department needs to improve its ability to attract and retain a high-quality financial management work force. For example:

- The Deputy Assistant Secretary for Finance stated that, given the restrictions on hiring and the limited computer skills of the current accounting staff, HHS faces a major challenge in obtaining staff qualified to operate and maintain the proposed new automated accounting systems.
- A former Director of OHDS's Office of Management Services stated that HHS lacks a career path for its financial management staff. As a result, financial management personnel have become stagnant and have limited financial management skills. The Budget and Financial Management Division Director in the same office pointed out that he recently trained two paraprofessionals for positions in his budget shop, but once trained, they obtained positions with higher salaries at another federal agency.

As the Assistant Secretary for Management and Budget pointed out, given continuing budget pressure, retaining qualified staff will be one of HHS's major challenges over the next decade. The use of a work-force

plan could help HHS deal with the problem. Staffing needs could be identified, alternative strategies (such as a career path for financial personnel) could be developed, and training needs for the Phoenix system could be developed. The work-force plan for HHS's financial management staff should be developed as part of the comprehensive work-force planning effort we are recommending in chapter 6.

Conclusions

The Department has developed a plan—the Phoenix plan—aimed at correcting its accounting systems weaknesses through long-term systems enhancement efforts. The plan, which has the support of managers in HHS operating components, is an important first step. When implemented, the Phoenix plan should help HHS (1) bring about improvements in its accounting systems, (2) maintain an effective financial management environment consistent with governmentwide efforts to improve financial reporting, and (3) improve compliance with accounting standards and internal control requirements. However, continuing investments in systems components and financial management staff will be needed to complete the plan.

Recommendation

We recommend that Secretary support the goals and objectives of the Phoenix plan by providing

- adequate funding for the upgraded systems and
- enough qualified staff to operate and maintain the modern systems.

Secretaries of HHS

Incumbent	Term
Oveta Culp Hobby	Apr. 1953 to July 1955
Marion B. Folsom	Aug. 1955 to July 1958
Arthur S. Flemming[a]	Aug. 1958 to Jan. 1961
Abraham Ribicoff	Jan. 1961 to July 1962
Anthony J. Celebrezze	July 1962 to Aug. 1965
John W. Gardner[a]	Aug. 1965 to Mar. 1968
Wilbur J. Cohen[a]	Mar. 1968 to Jan. 1969
Robert H. Finch	Jan. 1969 to June 1970
Elliot L. Richardson[a]	June 1970 to Jan. 1973
Caspar W. Weinberger	Feb. 1973 to Aug. 1975
F. David Mathews[a]	Aug. 1975 to Jan. 1977
Joseph A. Califano, Jr.[a]	Jan. 1977 to Aug. 1979
Patricia Roberts Harris	Aug. 1979 to Jan. 1981
Richard S. Schweiker[a]	Jan. 1981 to Feb. 1983
Thomas R. Donnelly, Jr.[a,b]	Feb. 1983 to Mar. 1983
Margaret M. Heckler[a]	Mar. 1983 to Dec. 1985
Otis R. Bowen[a]	Dec. 1985 to Jan. 1989
Don M. Newman[a,b]	Jan. 1989 to Mar. 1989
Louis W. Sullivan	Mar. 1989 to Present

[a]Contributed to this study.

[b]Acting.

Methodology for Questionnaire Administered to HHS Managers and Senior Staff

We sent a questionnaire to HHS managers and senior staff (1) to obtain their perspectives on OS's management of HHS and (2) to assist us in identifying management areas that they believed were most in need of attention. We asked them questions concerning OS's leadership and management of personnel, legislative, planning, program evaluation, information resources, and financial activities.

Pretesting the Questionnaire

During June and September 1987, we pretested a draft of our questionnaire with 14 civil service, political appointee, and commissioned corps managers and senior staff of HHS's headquarters and regional components. These officials included 2 from HHS staff divisions, 10 from operating divisions, and 2 from regional offices. We also provided a copy of the draft questionnaire to the Executive Assistant to the Chief of Staff and the Deputy Surgeon General of the Commissioned Corps for review and comment. Based on the results of the pretests and comments, we revised the questionnaire to improve the relevance and clarity of the questions and to minimize design flaws that could introduce bias or error into the study results. The responses to the pretest questionnaire are included in the final results for questionnaire recipients who asked us to use their pretest responses.

We concluded from our pretesting that the questionnaire should be sent to HHS managers and senior staff at or equivalent to the GM/GS-15 and above levels located in the Washington, D.C., and Baltimore metropolitan areas and the Centers for Disease Control headquarters in Atlanta. Officials below the GM/GS-15 level and from the regions indicated they had no basis to answer many of the questions about OS. Additionally, we chose not to mail the questionnaire to top-level management officials, such as the heads of the operating divisions and staff divisions, because we interviewed these individuals.

Identification of HHS Managers and Senior Staff With Management Responsibilities

We worked with ASPER staff and PHS's Division of Commissioned Personnel to identify the universe of HHS management officials. Using ASPER's personnel information system, we identified 1,012 civil servants and political appointees at or above the GM/GS-15 grade level having management responsibilities within HHS's headquarters in the Washington, D.C., and Baltimore metropolitan areas and the Centers for Disease Control headquarters in Atlanta. These officials included Senior Executive Service staff and political appointees. In addition, through PHS's Commissioned Corps personnel information system, we identified 53 Corps

officers that were equivalent to HHS's civil servants and political appointees having managerial responsibilities and located in the same geographical areas.

Administration of the Questionnaire

In August and October 1987, we mailed the questionnaire to the 1,065 managers and senior staff identified in our universe. If we did not receive a response from these officials, we sent up to two letters encouraging them to return a completed questionnaire. As a final measure, we telephoned nonrespondents encouraging them to respond. In December 1987, we concluded our efforts to obtain responses. We edited the completed questionnaires for consistency and verified the accuracy of our computer data.

To help obtain managers' candid opinions and insights about OS's management of HHS, we pledged confidentiality to the questionnaire recipients. We assured them that their answers would be held in strict confidence and that no individual would be identified with his or her response in any material reported outside of GAO. In addition, we assured them that the responses would be combined with those of other HHS managers in our report.

Questionnaire Response Rate

A total of 690 managers had responded to our questionnaire by January 1988, when we conducted our final analysis of the questionnaire results. Questionnaires received after that time are not included in the results. Based on an adjusted universe, as explained below, the overall response rate for the questionnaire was 72 percent. Table II.1 shows the original and adjusted universes and response rate to the questionnaire.

Table II.1: GM/GS-15 and Above Managers and Senior Staff Questionnaire Response Rate

Personnel system	Original universe	Adjusted universe	Respondents	
			Number	Percent
Civil service and political appointees	1,012	905	657	73
Commissioned corps	53	53	33	62
Total	**1,065**	**958**	**690**	**72**

As a result of the questionnaire responses and further investigation of nonresponses, we adjusted the original universe of 1,012 civil service employees and political appointees. Adjustments were made to account for staff who either had less than 1 year of HHS service, had retired, had died, had departed the agency, were not in a management position, or

should not otherwise have been included (e.g., managers who worked at St. Elizabeths Hospital and became District of Columbia employees on Oct. 1, 1987). No adjustment to the universe of Commissioned Corps managers and senior staff was necessary.

CAMS: A Planning Model for HHS

Our review of HHS planning processes revealed that the Cooperative Agency Management System established by Secretary Richardson contained many of the key elements needed for an effective departmental planning process. We believe that CAMS could serve as a model that HHS could adapt to begin developing such a process. An article coauthored by Dr. Laurence E. Lynn, Jr., former HHS Assistant Secretary for Planning and Evaluation, explained that the planning phase of CAMS worked as follows.[1]

CAMS began in February of each year with the Secretary issuing a planning guidance memorandum to the Department's components, directing them to develop plans and tentative budget allocations for their organizations. The memorandum communicated the priorities and issues that the Secretary wanted each component to consider in developing its annual policy, legislation, and budget proposals, as well as the assumptions and constraints that should be considered. Also, the memorandum provided strategic guidance on presidential and secretarial policies that were to be reflected in the plans; general fiscal guidance for the upcoming fiscal year and targets for the 4 years beyond; guidance concerning the selection of program objectives; and other guidance related to legislation, program planning, and evaluation.

Using the guidance provided in the Secretary's memorandum, the components developed their plans for the upcoming fiscal year and 4 years beyond. These plans contained the components' goals and objectives, as well as strategies for accomplishing them. In addition, the plans were to include an allocation of the budget target for the upcoming budget year and cost implications of the allocations for 5 years. Legislative and regulatory initiatives and other proposed actions for the upcoming budget and subsequent years were to be included.

Between May and June, after the submission of the components' plans, teams of the Secretary's staff offices reviewed the plans and prepared "issue papers" for the Secretary on their respective areas. These teams were formed around program areas, such as health or social services. The issue papers, which were jointly prepared by the Secretary's and the component's staff, described the major issues, identified disagreements between the secretarial staff and the components, and outlined alternatives for the Secretary. The papers focused attention on the

[1]Laurence E. Lynn, Jr., and John M. Seidl, "'Bottom-Line' management for public agencies," Harvard Business Review, January-February 1977, pp. 144-153.

future implications of current decisions so that an overall strategy aimed at departmental long-range goals could be fashioned.

In addition to the issue papers, an overview memorandum was prepared for the Secretary by a separate team. This memorandum described the issues and alternatives facing the Department as a whole and placing the components' proposals in an overall organizational context. The memorandum gave the Secretary "a conceptual and analytical framework" within which to consider crucial decisions that he had to make in directing the affairs of the Department, in both the short and longer run. It described the overall financial situation of the Department, reviewed the total of the program managers' requests, and suggested alternative strategies to guide the Department's activities in the next 5 years.

After the issue and overview memoranda were completed, the Secretary presided over a series of top-level meetings. These meetings were among the Secretary and his key staff advisers and program managers and their top advisers. The sessions gave these officials a comprehensive picture of current and likely future departmental activities. Top officials from all areas were encouraged to attend each program area meeting. The Secretary used these meetings to hear the arguments and evidence in support of various alternatives in all program areas before deciding exactly how to allocate budgetary and legislative costs. He used the meetings as a means to solicit information, indicate priorities, evaluate program operations, and speculate about the future. The meetings provided a forum to put his personal imprint on the Department.

By August, the Secretary communicated to the components tentative program, budget, and legislative decisions made on the basis of his consideration of issues and arguments presented in the meetings and subsequent overview memorandum. This end of the planning phase started the final budget and legislative drafting.

In late November or early December, the Secretary and key line and staff officials met to review the management team's effectiveness in managing the Department. At this meeting, the Secretary's long-range goals were discussed, budgetary and legislative successes and failures in support of these goals were identified, issues that needed study before the next series of meetings were assigned, and the focus and tone of the planning memorandum to be published in February were decided.

Skills Useful for Effective IRM and Some Potential Applications

We analyzed the Paperwork Reduction Act (P.L. 96-511), OMB Circular A-130, and recent research performed for the General Services Administration and the National Academy of Public Administration to identify skills that we believe would be useful for an effective IRM program. We also identified IRM activities (applications) that we believe relate to each skill. We shared our preliminary list of skills and applications with IRM instructors from the Department of Defense Computer Institute, the General Services Administration Training Center, and the U.S. Department of Agriculture Graduate School and revised our material, where appropriate, based on their comments.

Skill Application

Management	To perform and evaluate necessary management functions of planning, organizing, directing, training, budgeting, costing, and controlling information, information resources, information processing, and other information activities.
Information Management	To manage information. Skills involve evaluating information utility and uses, determining continuing needs, and assessing mission effects of poor quality or unavailable information (e.g., overpayments or excess payments). Involves evaluating the quality of data sources and establishing data quality standards and goals based on information importance. Evaluates resources needed for data error correction. Also involves developing data standards for system integration and identifying sharing opportunities to avoid duplication. Determines or evaluates appropriate information dissemination requirements and other information life cycle attributes (e.g., timing and frequencies). Identifies privacy and security requirements for appropriate information protection. Uses or evaluates use of effectiveness measures, audit trails, data inventories and dictionaries, quality standards, and error rates to help ensure maximum utility of information in meeting agency missions, goals, and objectives.
Information Technology Management	To keep abreast of the most appropriate technology management for producing needed, useful information. Participates in decisions about technology considerations in systems development and modernization

	projects. Evaluates management of technology using tools and techniques that identify efficiency, capacity, and throughput limitations. Evaluates backlog information (e.g., software maintenance schedules) to ensure problem prioritization and correction. Ensures user notification of uncorrected problems. Maintains or evaluates use of inventories to promote information technology sharing, standardization, and integration, where appropriate. Assists users in personal computers and workstations.
Needs Assessment and Reassessment	To work with user organizations in identifying resources and technology needs for producing needed and useful mission-related information efficiently.
System Development and Acquisition Management	To apply acquisition justification methodology, system development approaches, contracting rules and regulations, General Services Administration and OMB requirements, etc.
Telecommunications Management	To review approaches for networking local and wide areas, distributed data processing, and personal computer integration with central, distributed, and local data bases.
Management Information Systems Development	To identify, and extract from operational systems, key information needed by executive and top management officials. Applies skills in assessing the degree of success in meeting organizational missions, goals, and objectives effectively and efficiently.
Security	To ensure that appropriate consideration is given to protecting information and systems against threats and risks. Knowledgeable of security considerations in system development phases, risk management approaches, testing and certification, security management, and various mixes of technical, administrative, and physical safeguards and controls.
Manual Information Processing Evaluation	To apply skills involving forms, records, library management, and other manual information processing procedures. Includes evaluating manual processing in an automated environment.

Costing	To determine (or estimate) and evaluate costs of current and planned information-processing operations. Provide advice on problem correction, its prioritizations, and costs. Costs also used as measurement to (1) determine significance of an information problem, (2) justify alternative actions in acquisition and systems development, (3) make return-on-investment and cost-benefit decisions, (4) balance decisions between operational systems performance and security in and around the system (risk analyses), and (5) charge fees for services.
Productivity and Efficiency Evaluation	To assess the productivity and efficiency of information-processing activities and information use, where appropriate. Capability to apply and interpret input and output measures, output per direct labor hour or other time measures, cost per unit and other measures used to evaluate the productivity and efficiency of information processing operations. Useful in identifying information bottlenecks, excessive manual processing, and difficulties in information access and use.
Statistical Analysis	To determine correlations and trends in information quality and its relationship to mission effectiveness and costs. Identification of problematic data sources. Interpreting results and effects of information and information-related problems.
Auditor/Evaluator	To troubleshoot information processing and other information activities for identifying significant problems that increase costs and/or impede mission effectiveness. Uses such methods as reviewing correspondence and complaint files and performing data-flow analysis to assess whether the prime objectives of IRM are being achieved and to identify problems that need priority attention.
Consultants	To supplement needed skills that may not be resident in the agency in sufficient numbers for effective IRM. Also, a source of independent opinion on the state of IRM in an organization.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of the Secretary

Washington, D.C. 20201

NOV 24 1989

Mr. Lawrence H. Thompson
Assistant Comptroller General
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

I am responding on behalf of the Department to the draft General Accounting Office report on "Management of HHS: Using the Office of the Secretary to Enhance Departmental Effectiveness". These comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received. We appreciate greatly the time and effort GAO staff spent in developing this information.

The draft report offers valuable insights and data about the historical role of the Office of the Secretary from the tenure of Secretary Gardner through Secretary Bowen's administration. Secretary Sullivan will give serious consideration to the broad recommendations in the draft report as he proceeds with his administration's management initiatives. In fact, the issuance of the draft report reasonably early in the tenure of Secretary Sullivan makes it especially useful as a fresh look is being taken at the Department's priorities and organizational and management strategies. There is no question of the key role which the Office of the Secretary (OS) must play to help direct and manage numerous programs, not to mention staff resources, of this large Federal enterprise. The report reflects a strong appreciation of this role.

The success of the Office of the Secretary in managing the Department is certainly dependent on leadership from the top. The Administration has established a Governmentwide set of management objectives through a process of challenges and negotiations with the Federal agencies. Concurrent with that being established, Secretary Sullivan set forth a list of goals and priorities to guide the policies and programs of HHS in the years ahead, and HHS agencies have developed plans to implement them. As the report suggests, such goals, objectives and milestones are vital ingredients to the success of managing this Department.

Prior to and since the receipt of the GAO draft report, we in the Office of the Secretary, together with the Operating Divisions, have been working to improve the management of the Department of Health and Human Services (HHS) and the overall effectiveness and efficiency in achieving the Administration's and Secretary's priorities and goals. The GAO draft report provides an excellent summary reference of some of HHS' past managerial strategies, their achievements and shortcomings.

Page 2 - Lawrence H. Thompson

The report discusses principles concerning the need for clear lines of authority and the desirability of streamlining decision-making processes. Making changes in these areas can be achieved through formal as well as informal means, and often can depend on the nature and style of persons in key positions.

The report highlights the need to continue to make improvements in the financial and information systems throughout HHS. Much progress has been made in these areas and, without question, more needs to be and will be done.

As we develop plans to manage HHS better for the immediate and more distant future, we will consider fully the insights and background which the GAO report brings to this dynamic forum. In the course of bringing about management improvements, we will continue to survey, assess and consult with our managers and their staffs, with the Office of Management and Budget and Congress, and with key external agencies such as the General Accounting Office.

Following are technical comments on the draft report which should be of assistance in GAO's editing and preparation of the final report, and we look forward to the receipt of the final report. This office will ensure that the insights and recommendations which it contains are systematically considered and reported to the Secretary. The Office of Inspector General is highly appreciative of GAO's acknowledgement of departmental innovations and progress toward quality top level management as well.

Sincerely yours,

Kevin E. Moley
Assistant Secretary for
Management and Budget

Enclosure

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