Administration of Public Medical Service by Health Departments*

JOSEPH W. MOUNTIN, M.D., F.A.P.H.A.
United States Public Health Service, Washington, D. C.

TO persons not familiar with the varying points of view that obtain among members of the American Public Health Association it may seem odd that there should be any occasion for discussing the question at issue, namely: Who should administer tax-supported medical facilities and services? This is a simple question in governmental arrangement, and it is in no way concerned with current controversies relating to extension of public medical care or schemes of payment for professional services.

Substantial sums of money are now being made available through taxation for institutional care of the insane, the tuberculous, the physically handicapped, and for general medical service to the indigent and selected beneficiaries not in relief categories. Public officials, students of government, welfare workers, and practising physicians are in fairly substantial agreement to the effect that tax-supported functions that serve primarily health interests should be concentrated as far as possible in a single branch of government and be directed by a professional person of policy making rank. While not especially articulate on the point, the same groups perhaps would concede the health department to be the agency on whom administrative responsibility might appropriately rest. Public health workers, however, warily stand aside, fearful lest they be drafted for such duties. It is not uncommon for health officers, while admitting detached interest in medical affairs, to proclaim their lack of administrative competence. A few have gone so far as to appear before legislative bodies in opposition to the transfer of medical care services to health departments.

The matter of administrative responsibility for public medical service deserves most serious consideration, for on this decision may hinge the future welfare of the public health profession, and hence the preventive concept which it has espoused. Before a brief is presented supporting administration of medical services by health departments, some thought should be given to the inhibitions which deter health officers from accepting such responsibilities. Their attitude in large measure is closely related to the evolution of the public health program.

In former years, diseases accountable for most deaths gained wide prevalence either because of defects in scientific knowledge or disregard for personal and community hygiene of even the most elementary sort. Confronted with this state of affairs, it was incumbent on the health officer to give primary attention to such conditions as plague, typhus fever, yellow fever, malaria, typhoid

* Read at a General Session on Medical Care and the National Health Program of the American Public Health Association at the Sixty-eighth Annual Meeting in Pittsburgh, Pa., October 18, 1939.

fever, and the dysenteries; first, because these were major causes of death and, second, because their eradication was possible through rather simple procedures.

Striking conquests of disease during the past hundred years were readily attained by environmental control and mass education. There is a tendency to believe that maintenance of the ground gained is sufficient in the way of current accomplishment even though the maintenance of this static condition represents no particular effort. In this country at least, an esthetic sense and a desire for those conveniences commonly associated with sanitary devices serve automatically to insure continuance of measures necessary to hold in check most of the diseases previously mentioned. Furthermore, improvement in living conditions that usually goes with increased purchasing power among wage earners has brought about a lessening of the more serious nutritional disorders that arise out of privation.

It is the consensus of competent professional men today that the greatest opportunity for further improvement of the public health lies in the category of activity that is commonly classed as service to the individual. Of their own accord, the more progressive health departments for some time have been giving recognition to changing conditions as evidenced by their programs in immunization, diagnostic services for school children, care of the tuberculous, and hospitalization of persons with communicable diseases. More recently, largely through federal stimulation, attention has been focused on venereal diseases and the health problems associated with maternity and childhood. By and large, however, there has been no wide acceptance in public health circles of general medical care as a field for development. True, a few leaders of public health thought recognize the problem in an academic sort of way, but practical administrators as a group are disposed to regard the service as a commodity which the individual might purchase in proportion to his wishes and resources.

It is conceded even by those who are most reactionary that society has an obligation to meet the emergent needs of its dependent members. Health officers fear that a combination of public health services with medical care is certain to work to the detriment of the former. This of course is only speculation. There is no evidence to show that public health services of the traditional type fare better in departments without responsibility for medical service than in those with such encumbrances. Furthermore, the rapid growth of hospitals and medical services under welfare departments and separate commissions attests to the fact that action will be taken in these areas of social service irrespective of sponsorship. This development has taken place in response to a popular demand and often without adequate professional guidance, largely because the health authorities refuse the function of management.

As matters now stand it is the appropriating authorities that decide how much shall be allotted respectively to traditional public health services and how much shall be expended for medical care. According to all principles of organization the health department would be in better position to determine this apportionment if it had charge of the several functions of government designed to serve the health interest in its broader sense.

Another and perhaps the most compelling cause for hesitancy on the part of health officers to accept responsibility in the field of medical care is fear of being stigmatized by association with so-called socialized medicine. The contention of health officers that public health service is for all the people carries with it the implication that medical

service, if operated by health departments, would at once be made free to every citizen. Such thinking obviously is not realistic. It is the low-income and dependent classes of the population that now form the clientele of health department clinics. Essentially the same group now constitutes the beneficiaries of public medical facilities.

One type or another of public health or medical provision may predominate according as the facilities are developed in particular communities. The notion that indigency must be the qualification necessary for participation in benefits where physicians are employed still prevails and there is little likelihood of either type of service being expanded to include self-sustaining groups of the population without a direct mandate from the people. In that event the beneficiaries will be defined through legal enactment rather than through any discretionary authority that may be exercised at the admitting office, thus removing eligibility from the field of controversy.

Even if one granted that all of the foregoing disadvantages might accrue to health departments from having accepted responsibility for the administration of medical care, the inherent opportunities for enlarged service to the community far outweigh any other consideration. In this way only can a health officer exploit all the possibilities for health promotion. It is understood that prevention of illness would be the first concern in a health program regardless of its content. As a second objective, those unfortunate individuals on whom sickness falls should be afforded every opportunity for recovery and restoration to former health. These purposes certainly are more easily accomplished when the health officer has at his command technics and facilities for performing service suited to the individual's requirements than under the present dispersion of authority.

As stated at the outset, this paper is not concerned with the wider distribution of good medical care, a subject on which the public is becoming especially articulate. Rather an attempt is being made to present the opportunities for bringing to recognized beneficiaries better service from existing facilities through operation by health departments. Good medical service has a preventive content of another type from that exhibited by immunization, for example. This perhaps is expressed best in a negative way. A poorly handled fracture may cause a worker to lose employment in an occupation for which he is especially prepared. An eye injury, unless treated promptly and skillfully, may cause loss of vision and reliance on pension for the blind as a source of income. Neglect of a circulatory disturbance or failure to recognize the condition in its incipiency often results in early disability, unemployment, and finally dependency.

Cancer is not a disease confined to senility as often supposed. A large percentage of deaths occur at a time of life when social and economic obligations of the individual are at a maximum. Especially is this statement true of cancer among women. Children thus deprived of their mothers often become dependent and therefore a direct burden on society. No longer may the health officers find refuge in the old dodge: "Our function is to prevent disease, not to cure it." As stated, disease prevention, even to the point of eradication, should always remain the goal of public health enterprise, but prevention today has many connotations. Now it is expected that disability both temporary and permanent should be lessened by any device which society can command.

Some of the apologists for limiting activities of health departments to programs of traditional content make the point that a complete job is not being done at the present time even within

this narrow range. As opposed to this viewpoint, evidence could easily be adduced to show that concentration of forces against these limited objectives is attained by neglecting other opportunities for greater achievement. The 10 major causes [1] of death in the order of occurrence are as follows:

- Heart diseases
- Cancer, all forms
- Cerebral hemorrhage, arteriosclerosis, and high blood pressure
- Pneumonia, all forms
- Accidents
- Nephritis, acute and chronic
- Tuberculosis, all forms
- Malformations and diseases of early infancy
- Influenza
- Diabetes mellitus

Only tuberculosis and the disorders associated with early infancy are recognized in health department programs of orthodox type. The causes of disability as measured by days absent from work or usual occupation are quite different from the causes of mortality. Again, if one should arbitrarily select 10 major causes [2] for inspection, the array in descending order of importance would be

- Colds and bronchitis
- Influenza and grippe
- Accidents and injuries
- Tonsillitis and laryngitis
- Indigestion and other stomach disorders
- Rheumatic disease
- Confinement and miscarriages
- Diseases of generative organs (nonvenereal)
- Ear and mastoid diseases
- Diarrhea and enteritis

For many years health department programs skirted this group except diarrhea and enteritis. Largely through stimulation by the U. S. Children's Bureau, the hitherto neglected field of maternity seems destined to receive more and more attention. One must readily concede that many facts remain to be established before our knowledge can be considered satisfactory in respect to the causes of mortality and morbidity previously enumerated. On the other hand, measures for combating cancer, pneumonia, heart disease, and accidents, for example, are perhaps more effective than those now used against whooping cough, measles, poliomyelitis, and several other conditions on which a very large part of public health effort is spent.

The nature of ill health and its underlying causes might be pursued, but this is not the occasion for a lengthy discussion of the consequences of neglected illness or the humanitarian considerations which impel some provision for the relief of human suffering. Only a few generalizations can be made concerning the extent of tax-supported facilities and services now available, the opportunities for promoting public health through a better arrangement of available resources, and the suitability of health agencies for administering organized programs that serve the public health.

If health departments are to enlarge their interests in medical administration, the obvious first step is to assume greater participation in the management of functions now accepted as within the scope of public responsibility. Institutional care of the mentally afflicted is for all practical purposes a monopoly of government. Among nearly 600,000 beds of mental institutions in the Continental United States more than 500,000 are operated by federal, state, and local governments.[3] While field services in the interest of mental hygiene have not as yet attained significant proportions, mental institutions seem destined to be the centers from which such programs should develop. Health departments have not been identified to any appreciable extent with either the administration of mental institutions or the mental hygiene program. It seems doubtful if health departments can attain any stature in mental hygiene without first taking charge of the mental institutions.

While tuberculosis control was initiated by voluntary organizations, health departments at an early date recognized some responsibility in respect to case finding and field control measures. In contrast, however, a high proportion of sanatorium beds are not under direct control of health departments despite the fact that 80 per cent of such beds are in tax-supported institutions. As a result of this divided responsibility, it is difficult to bring about a proper integration of institutional and field services.

Relatively few people appreciate the fact that a very large medical service for self-supporting people has grown up through workmen's compensation. The insurance principle is used for spreading wage loss and the costs of medical care. While the benefits are geared for the most part to accidents arising out of employment the aggregate amount of care represents a money value of significant proportions. This social development occurred without intimate medical guidance and entirely beyond the ken of public health authorities. It requires no great amount of insight to appreciate the possibilities for promoting the health of workers through a closer association between health departments and compensation commissions than now exists.

The figures compiled annually by the American Medical Association show a steady and substantial increase in the number of general hospital beds under the control of state and local governments. These units of government operate nearly one-fourth of the beds in general hospitals. In addition to maintaining hospitals, governments contribute $32,000,000, or about 9.5 per cent of the income reported by voluntary hospitals.[4] While the number of out-patient departments attached to governmental hospitals is not so great as the number operating under voluntary auspices, proportionately more of the public hospitals operate such facilities. Like the sponsoring hospitals, governmentally operated out-patient departments tend to be larger than their voluntary counterparts. A study conducted by the U. S. Public Health Service in 1936 showed that 9,500,000, or 44 per cent, of the visits were made that year to out-patient departments of tax-supported general hospitals, as contrasted with 13,500,000, or 56 per cent, of the visits made to those under voluntary control.[5]

The volume of tax-supported medical service supplied directly by physicians in their offices and in the homes is difficult to express since the service is administered under a variety of auspices. Furthermore there is no regular provision for reporting to a central agency. The estimated public expenditure of $25,000,000 per annum for care of patients outside of hospitals [6] shows very clearly that such service is of sufficient magnitude to arrest the attention of groups who should be interested in seeing that public services operate under competent professional direction. Despite the fact that medical care of needy persons has been recognized as a function of local governments since colonial days, the service as a rule is inadequate and poorly administered. The deplorable state of the home and office component may be attributed in large measure to the fact that tax-supported medical service usually operates without professional direction by a responsible public official. Meager though the sums appropriated by individual localities for such care may be, yet in the aggregate the expenditures for the nation as a whole represent a substantial amount. It is quite likely that appropriating authorities would be disposed toward greater liberality if good administration could be assured. Practising physicians no doubt would welcome impartial management by full-time health officers.

While the inadequacy of public pro-

visions for medical service of all types has become the theme for much discussion within recent years, strangely it is the magnitude of the expenditure for such service that causes health officers to avoid operating control. The estimated amount $130,000,000, used for the support of old-line public health service is dwarfed by $400,000,000 of tax money that now goes for the support of medical service including the care of persons in institutions.[6]

Arguments for and against participation by health departments in administration of medical care services could be pursued and perhaps with profit to the end that our views on the subject might be clarified. In a forum such as this, interest would perhaps hinge on the convenience of the health officer or the effect which the inclusion of medical care would have on his present program. From the standpoint of public administration such attitudes do not merit consideration. Those responsible for the arrangement of functions within the structure of government are concerned only with placement of responsibility where it can be discharged most satisfactorily to the interests of the taxpayer and of the beneficiary.

In closing, let us try to visualize a very practical situation that confronts public officials of a local political unit containing for example 50,000 inhabitants. The area maintains a small health department headed by a full-time medical officer. As assistants, there are employed another physician or two; a chief of sanitation, who may be an engineer, and several inspectors; a corps of public health nurses; one or more laboratory technicians; and the usual clerical force. The same community may operate a small tax-supported hospital; or, more than likely, care is purchased at local hospitals under voluntary control. Both the county physician system and a fee-for-service scheme have been tried for rendering home and office care to the indigent sick but neither plan has proved satisfactory. Altogether the area under consideration spends $50,000 of tax money or possibly more on public medical service of one type or another, in addition to the cost of maintaining clinics operated by the health department and persons in state institutions. Part of this fund is administered by the welfare department, another fraction directly by the county commissioner or city council, a substantial sum by a hospital board, and perhaps the county medical society has a mechanism for dividing among its members the amount paid for professional services. Neither the sponsors nor the consumers of service are exactly satisfied with the system or what might better be termed lack of system. Public officials, welfare authorities, and practitioners of the healing arts see the needs of sick people that remain unsatisfied and the wish to do more.

For an enlarged program they might find support among taxpayers if assurance could be given that the service and its administration would be made reasonably satisfactory. Under no circumstance, however, would the volume of such service be sufficient to justify the maintenance of a medical organization exclusively for its administration. In this area, please remember, there is a health department of average size and reasonable competence. It is the only publicly supported group of workers with medical and administrative experience; its leadership would be acceptable to public officials, welfare workers, the medical profession, and to the general public.

Public health workers in attendance at this convention, and especially those residing in places away from large urban centers, will recognize immediately that the situation described is typical of many areas even where an honest effort is being made to supply some reasonable measure of care. In those areas what

should the local health department do about administration of accepted tax-supported medical care? Does this Association have any advice to offer? It should be emphasized again that the question relates to "administration" of the medical care program and not actual care of patients by the executive health officer. Attempting to place responsibility on the doorstep of the county medical society is a subterfuge not deserving to be classed as artful side-stepping. It puts the onus for the present disorganized state of public medical service on a loosely knit society formed to serve the scientific and professional interests of its members. The acceptance of this challenge by the society would be equivalent to management of a public service by a guild with a vested interest. This of course would be contrary to recognized principles of public administration and is not likely to achieve any wide acceptance in our democratic society.

If the American Public Health Association and other professional groups have no further suggestions to offer, decision must be referred back to the people and their political leaders. We may rest assured that rather simple and direct steps will be taken, and it is entirely possible that the particular interests represented by the membership of this Association may become a subordinate consideration in a broad social program that features other issues.

REFERENCES

1. Bureau of the Census, Department of Commerce. *Vital Statistics—Special Reports,* 6, 51 (Apr. 29), 1939.

2. Collins, Selwyn D. The Sickness Survey: Types, History, and Some Results. To be published in revised edition of *Nelson's Loose-Leaf Preventive Medicine.*

3. Hospital Number, *J.A.M.A.*, 112, 10 (Mar. 11), 1939.

4. Pennell, Elliott H., Mountin, Joseph W., Pearson, Kay. Business Census of Hospitals, 1935, General Report. *Supp. No. 154, Pub. Health Rep.*, U. S. Public Health Service.

5. Plumley, Margaret Lovelle. General Out-Patient Departments the Important Element in Organized Out-Patient Care. *Hospitals,* 11, 9 (Sept.), 1937.

6. *Proceedings of the National Health Conference,* July 18, 19, 20, 1938, Washington, D. C. U. S. Government Printing Office.