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Content and Administration of a Medical Care Program

A Brief of the Report on Medical Care in a National Health Program *

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BEFORE a professional body such as the American Public Health Association, there is little purpose in belaboring the point that the great unsolved problem in public health is one of making available to every American citizen the full benefits of good medical care. The very fact that this problem has already taken on the status of a political issue is a more convincing indication of its importance than any argument or body of statistics that could be adduced. The intemperate support of limited remedial measures by partisan groups, as well as the blind opposition to any change in the *status quo* encountered from other sources, clearly indicate the need for responsible agencies to give technical direction to the public movement for better medical care. The American Public Health Association should be peculiarly fitted to give such direction, since its members are familiar with the intimate character of medical service and can see the problem from the point of view of both those who receive and those who provide health services.

Mindful of the urgency in this matter, the Committee on Administrative Practice at its meeting in November, 1943, directed its Subcommittee on Medical Care to draft a set of principles which would describe the content of a suitable medical care program and methods of administration. Inasmuch as a great wealth of material had already been accumulated through basic studies and as a result of practical experience in the operation of limited medical care programs, it was decided that the first job for the subcommittee to undertake should be to analyze these findings rather than engage on additional research studies. The subcommittee was fortunate in having as members individuals who had participated in former studies, others who

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were familiar with the experience gained in various organized methods for distributing medical care, and still others responsible for medical care programs now in operation—in brief, its composition included both students of the problem and practical administrators.

The subcommittee met several times during the past twelve months. After exploring in detail many of the problems involved in the design of a national medical care program, the group felt that its thinking had reached the stage at which a statement of principles could be formulated. A preliminary report setting forth these principles has been released. It was published in the September, 1944, issue of the *American Journal of Public Health*, with the thought that the entire membership of the Association might have ample opportunity to study the proposals in advance of formal action. After some modification, this report was accepted by the Committee on Administrative Practice and passed on to the Governing Council with suggestion that it be considered as an expression of Association policy. There follows a brief summary of the report, together with a few of the underlying considerations.

The objective of a national medical care program should be to make available to the entire population, regardless of the financial means of the individual, the family, or the community, all essential medical services. Such services must be of high standard and rendered under conditions acceptable to the public and the professions concerned. In scope they should include hospital care, the services of physicians, laboratory and diagnostic services, nursing care, essential dental services, and prescribed drugs. Because of inadequacies of personnel and facilities, all of these measures cannot be provided immediately to the whole population, but their complete development within ten years may be taken as a goal. Regardless of temporary shortcomings, a beginning should be made now in the provision of services to the extent that available personnel, facilities, and administrative technics make possible. Later, but as rapidly as possible, the program should be expanded to the intended scope.

An achievement of the objectives of a national medical care program, the subcommittee thought, would require simultaneous attack on five main fronts; namely, distribution of costs, development of administrative organization to provide the service, training of personnel, construction of facilities, and improvement of knowledge.

The basic problem in providing more and better medical care for persons of all circumstances is that of distributing costs over the entire population in proportion to ability to pay. Already the phenomenal success of non-profit voluntary insurance against hospitalization costs makes it quite apparent that the people desire a convenient way of paying for medical care, and especially a way that will give protection against the risk of heavy bills. Despite such achievements, there is ample reason for believing that voluntary insurance unaided will not be able to include the whole population for all of its medical needs.

The subcommittee therefore came to the conclusion that health services must be financed by compulsory social insurance contributions supplemented by general taxation, or by general taxation alone. Financing through social insurance contribution alone might result in the exclusion of farmers or self-employed persons, or still other occupational groups, who need the advantages of prepayment as much as industrial and commercial employees. Certain of the long-term disabling conditions, such as mental disorders and tuberculosis, had better be financed for the present at least, as

they now are, out of general revenue separate from the provisions for general illness.

The subcommittee was unwilling to compromise the principle that service should be of high quality and available to all persons regardless of economic circumstances or geographic location. It also recognized the desirability of decentralized operation, with participation by state and local authorities. Because of the great mobility of our population and the wide variation in economic resources among the several states and their political subdivisions, an unrelated series of state or local plans cannot assure a suitable service national in scope. Only the federal government through its broad powers of taxation can compensate for those differences in income which exist among individuals and among the lesser units of government.

After the fund has been collected through social insurance or taxation, arrangements must be made whereby the institutions and professions rendering service may be paid for their efforts. The great bulk of service in this country today is performed by voluntary hospitals and private practitioners; they need to be brought into the scheme. Methods of paying hospitals for their services have been developed under extensive voluntary insurance plans; these methods can be readily adapted to the requirements of a national health program. The problem of compensation for professional service is more complex. Inasmuch as fee-for-service has been a tradition, this with suitable controls may have to be accepted as one of the methods; however, the inherent defects in fee-for-service should be faced, and it should be recognized from the beginning that unsatisfactory experience may in time force more extensive utilization of other methods.

The subcommittee believes that the principle of free choice must be preserved for the public, the professions, and the institutions; namely, that patients shall be at liberty to select their physicians from among all who participate, subject to acceptance by the physicians; and to select their hospitals, subject to the practices and the staff arrangements of the hospitals; and that all qualified physicians and hospitals shall be eligible to participate in the program. This principle should apply to group as well as to individual action.

At the present time public medical care functions are being discharged through a host of agencies at all levels of government. The effective operation of a national program requires that at each level of government—federal, state, and local—administration, or the supervision of administration, should be by a single responsible agency. Because of their strategic position in the framework of government, their record of successful administrative experience, and their interest in prevention as well as cure of disease, health agencies are believed best fitted to discharge the responsibilities incident to administration of a nation-wide medical care program. However, any agency that expects to carry major responsibilities in a program of such magnitude and complexity should begin preparing itself now for the position it intends to occupy. When the public comes to consider where administrative responsibilities for a national health service shall be lodged, it will be influenced in large measure by the readiness for such duties displayed by the agency, by the initiative taken in fitting itself for the task, and by the eagerness shown in wanting to accept these responsibilities.

Perhaps of more interest to the members of this Association than the operation of a plan at the national level is its management locally. It is here where the program functions in relation to the needs of the people and where

the true measure of satisfaction is determined. Irrespective of whether the national program be a federal scheme or federally aided state schemes, it must operate through units of control that are in direct contact with the people who receive the service, and with the facilities and personnel through which the service is delivered.

The subcommittee gave thought to the proper size of jurisdiction for local service and to the relative advantages and disadvantages of state administrative districts as compared with districts composed of one or more existing political units. If, as the subcommittee believes, local health agencies should take a prominent part in the administration of medical care, it is difficult to escape the conclusion that material modification in the boundaries of local health jurisdictions must be effected in most, if not all, of the states. For the most part health agencies are built upon a foundation of law enforcement. Consequently, health jurisdictions conform, in the main, to local political boundaries. Many of these areas are too limited in population for efficient administration and their resources are so limited as to make it difficult for them to make any substantial contribution to a program, such as medical care, which involves large sums of money. Furthermore, neither hospitals nor physicians have been accustomed to draw their clientele from within the confines of existing local political subdivisions. In other words, medical service must continue to follow the natural lines of trade areas. Health officers are rapidly coming to the belief that public health jurisdictions also must be reshaped in similar fashion. Whether these areas be made administrative districts of the state, or become new political entities with considerable degree of local autonomy, must be left for determination by the state and local authorities concerned. In reality a decision either way is not of great importance from the standpoint of developing a suitable framework for medical service.

Under an acceptable plan of medical care the hospital must occupy a central position. In addition to providing beds for the more serious cases of illness, its facilities should be generally available for diagnosis and treatment of ambulatory patients and for appraisals of physical status. Before these purposes can be accomplished, it will be necessary to construct additional hospital accommodations in many rural areas where such facilities are nonexistent or wholly inadequate. Even in the larger centers of population a high proportion of present hospitals are in need of extensive alteration, or replacement by more modern structures.

When bringing the total bed capacity of hospitals throughout the country up to actual requirements, a concerted effort should be made to replace the individual and haphazard arrangement that has characterized hospital evolution to date by a planned development under national and state guidance. The scope of service in existing and proposed hospitals should be arranged so as to meet the needs of the localities in which they are situated and fit into both the state and the regional scheme of hospitalization. Under such a plan the modern medical center as well as the outpost first aid station will have its place.

Closely related to the location of hospitals is the placement of physicians and other medical personnel. A hospital without a competent medical staff is of questionable value, but on the other hand experience has shown repeatedly that a community cannot expect to attract and retain qualified physicians in sufficient numbers unless opportunities for hospital practice are afforded. A large part of the maldistribution of physicians could be corrected in short order if advantage

should be taken of the unusual opportunities that will attend demobilization of the armed forces for placing physicians where they are most needed. The presence of hospital facilities, together with the assurance that funds are available for the payment of medical bills, will go a long way toward effecting a permanent distribution of physicians in proportion to the population. For the more remote and sparsely settled areas some measure of direct aid in addition to the foregoing broad provisions may be necessary. Such instances should not be numerous and neither should the costs entailed be burdensome.

Under an expanded medical care program shortages of personnel no doubt will be experienced for most categories of service. This is likely to occur especially if the present pattern of practice is carried over into a national program. Dentistry perhaps represents the most critical situation. While this general subject of personnel requirements and methods for meeting probable needs deserves further study, the subcommittee pursued the matter far enough to be impressed with wastages of resources which normally occur. The average physician in private practice does not reach his maximum performance until age 40 and, after a period of about 5 years, a falling-off in output begins. The time of nurses consumed in maid and clerical services has been a subject of study and unfavorable comment for years. Now it would appear that many of the operations done by dentists could be assigned to persons of less training than that prescribed for graduation from dental schools. Much more work needs to be done in the way of job analyses before precise statements can be made regarding the extent to which subsidiary personnel can be used to lessen the demands for those in higher educational brackets. Likewise, a great amount of thought needs to be given to the training of auxiliary personnel themselves, and their certification for prescribed types of work. At present this whole matter is in a chaotic state. Until the entire subject of auxiliary workers has been fully explored it will be difficult to make calculations as to the needs for personnel with more extensive preparation.

Of all the groups that contribute to medical service the basic professional education of physicians seems to have been fairly well stabilized at sufficiently high level to assure good quality of medical graduates. If used to full capacity the present number of medical schools, or possibly with moderate increase, should be able to satisfy the normal needs for physicians by the population of the continental United States. The great unsolved problem in medical education is that of keeping physicians abreast of scientific and technical advances subsequent to completion of their formal education. This deficiency is especially apparent among physicians who, because of location or lack of hospital connections, become isolated from their fellow practitioners. The mere provision of additional hospitals and clinic facilities alone will not solve this problem. A continued educational influence must be infused into the system. This influence should emanate from teaching nuclei which may be located in medical schools or medical centers to which satellite institutions of the surrounding areas are related. In addition, individual physicians must be encouraged to pursue specialized courses so that the particular needs of each locality may be properly satisfied. Within reasonable limits these and other measures necessary for maintaining quality of service should be regarded as appropriate for public support, but should not be charges against the medical care fund proper.

From the very outset there should be a frank recognition of the fact that

any medical care program is certain to deteriorate unless research goes hand in hand with the provision of service. Hence the support of research, like the support of personnel training, must be accepted as a legitimate and necessary item in the over-all cost of medical care. When selecting topics for basic research, it would seem appropriate that primary consideration be given to conditions such as mental disorders and chronic disabling disease of advancing years, which tend to overburden any comprehensive program of medical care. In the normal course of operating a medical care program endless opportunities will arise for improving service and reducing costs; such matters constitute appropriate subjects for the administrative type of research. There will also be need for the pilot-plant type of installation in which new procedures are tested and perfected prior to full-scale application.

In the foregoing discussion an attempt has been made to set out the circumstances which prompted the preparation of the report of the Subcommittee on Medical Care, the subject matter considered, and the factors which determined the conclusions. Each of the problems under discussion has many facets. Papers that follow in this symposium represent attempts to describe in more detail the underlying factors which have precipitated out medical care as a national issue, and the corrective measures that seem applicable, together with appropriate methods of administration.