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TOWARD A NATIONAL HEALTH PROGRAM

Talk by Ruth L. Aikens
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Conservative, staid Fortune magazine, in January 1970, began the decade with a comprehensive statement concerning the state of this nation's health care system. In it, Fortune admitted that "American medicine, the pride of the nation for many years, stands now on the brink of chaos."1/ "To be sure," said Fortune, "our medical practitioners have their great moments of drama and triumph. But much of the U.S. medical care, particularly the everyday business of preventing and treating routine illnesses, is inferior in quality, wastefully dispensed, and inequitably financed. Medical manpower and facilities are so maldistributed that large segments of the population, especially the urban poor and those in rural areas, get virtually no care at all--even though their illnesses are most numerous and, in a medical sense, often easy to cure."

These sentiments have been echoed almost everywhere. Following in the footsteps of President Nixon, who has called attention to the "massive crisis"2/ in health care, the then Secretary of Health, Education and Welfare, Robert H. Finch, also agreed that "this nation is faced with a breakdown in the delivery of health care unless concerted action is taken.3/ Despite the rather clear statement of the problem from all sides, there is no national agreement, no national commitment, on what that "concerted action" should be. Bills and resolutions thus far introduced in the Senate and House of Representatives attempt to go in several directions at once. Sen. Walter F. Mondale of Minnesota proposed to the 90th Congress a 15 man temporary "National Commission on Health Science and Society" to study the situation and render a report. (Senate Resolution 145). Senator Jacob K. Javits proposed to that same session of Congress that a "Federal Council on Health" be established in the executive office of the President to conduct studies and set national health goals, (S. 1347). Senate Concurrent Resolution No. 69, introduced by Sen. Edward Kennedy of Massachusetts, would establish a 24 man congressional committee to review existing health legislation.

1/ Editorial, Fortune, 81:79, Jan., 1970.
2/ New York Times, July 11, 1969.
3/ "Report of the AMA Council on Medical Education," J.A.M.A. 210:1456, Nov. 24, 1969.

The 91st session of Congress came closer to dealing with the issue. Rep. Richard Fulton of Tennessee and Sen. Paul J.Fannin of Arizona introduced health insurance bills based on the "Medi-Credit" approach of the American Medical Association. Rep. Durward G. Hall of Missouri submitted a national health insurance plan that would replace Medicaid by voluntary health insurance covering 80% of health care costs and major illnesses when health care costs exceed a fixed percentage of the family's income. Rep. Martha Griffiths of Michigan introduced an AFL-CIO proposal that would replace Medicare and Medicaid with a program of comprehensive health benefits for all ages and income groups, financed by 3% employer, 1% employee Social Security tax and matching federal revenues. Sen. Abraham Ribicoff of Connecticut introduced a "Health Organization Act," (S. 2898) which would establish in the executive office of the President a council of health advisors to suggest policy and evaluate programs. Later, Senator Ribicoff called for an investigation of private health insurance plans.[4/] Senator Javits also introduced a national health insurance bill (S. 3711).

Widely publicized is the program developed by the United Auto Worker's Committee of 100 under the leadership of the late Walter Reuther and introduced as legislation by Senators Kennedy and Yarborough. Under this plan, national health insurance costs, estimated at $40 billion a year, would be financed by employer, employee, and government contributions and would provide comprehensive coverage. Yet nowhere in this legislation or in the myriad of bills, resolutions, or plans that have been advanced to date, is there any clear mandate to establish and implement with speed any coordinated national health system.

Medical care in the United States is a gigantic, expensive business dwarfed in cost only by the business of defense; (estimated expenditures for 1969: $85.2 billion).[5/] In 1969, medical care cost the people of this nation almost $63 billion, roughly 7% of the gross national product and more than we spend either on social security or the education of our children.[6/] Despite this huge investment, the United States ranks 17th among all nations in the life expectancy of women and 14th in the rate of infant mortality.[7/] Life expectancy is lower and infant mortality is even higher among the black and the poor. Despite this huge investment, most of our nation's 313,000 active physicians work alone as private entrepreneurs, largely responsible only to themselves and constituting "an army of pushcart vendors in an age of supermarkets."[6/] Clearly, our ailing medical care system--or non-system, to be more accurate--requires immediate and radical surgery. It is the purpose of this National Urban League position paper to explore closely the nature of the surgery necessary and to set forth principles and criteria against which specific proposals for the treatment of our medical care system can be evaluated.

4/ New York Times, June 1, 1970.
5/ New York Times Encyclopedic Almanac, 1970.
6/ Faltermeyer, E. K., "Better Care at Less Cost Without Miracles," Fortune 81:80, Jan. 1970.
7/ Medical Tribune, May 4, 1970.

NEEDED: A NATIONAL HEALTH SYSTEM

- National Financing Cannot Be Divorced from National Health Care.

To establish a nationwide health financing program without concurrently providing for the delivery of comprehensive health services under that program would be to perpetuate the existing system with all of its glaring deficiencies.

- Accordingly, To Be Considered Favorably, Any Proposals, Plans or Suggestions Must Make Specific Provision for Both To Be Coordinated into A National Health System.

- The National Health System Must Be Available To and Function Effectively for All Regardless of Age, Race, Sex, Location, Citizenship Status, or Income.

This is a vital requirement, particularly in view of the fact that some 24 million Americans under 65 now have no health insurance. Even those enrolled in insurance plans have significant gaps in their coverage and therefore cannot make extensive, prolonged use of the health care services currently available.[4] The present uneven and discriminatory pattern of health insurance coverage is illustrated by the following statistics: 85% of the people under 65 have some hospitalization insurance and about 78% are covered to some extent for surgeon's fees, only 51% have coverage for x-rays and lab tests outside the hospital, and only 40% for visits to the physicians office. From the differentials evident in this example between the percentage of persons covered by insurance for physicians and hospitalization, it may be easily inferred that the 3 major components of comprehensive health care services, prevention, early diagnosis, and treatment, are less likely to be available and utilized by those disadvantaged persons who need them most.

NEEDED: MORE HEALTH PROFESSIONALS

- A National Health System Must Provide A Tax Supported Public Health Professional Education and Training Program Which Is Free to Any Applicant able to Utilize the Training and Education Necessary to Fulfill a Wide Range of Health Professional Roles. The Recipient of Public Health Professional Education and Training Would Be Required to Fulfill a Five Year Service Commitment. Such an Educational System Must Be Non-Discriminatory and Genuinely Open to All.

The federal government is already in the business of educating physicians, social workers, and nurses. Most professional schools are highly subsidized by federal funding through research grants and a variety of matching grants. A public system would allow a more effective and nondiscriminatory utilization of the tax dollar. Through the Physician Augmentation Program, administered by the Department of Health, Education and Welfare and funded under the Special Project Grant section of the Health Manpower Act of 1968 (P.L. 90-490), schools are expected to increase their first year enrollments by 1,000 students per year, beginning in the fall of 1970.[3] In 1969, the American Medical Association

and the American Association of Medical Colleges (AAMC), in a joint statement on federal support of medical education, called upon the Nixon administration and the Congress to provide $117 million under the Health Manpower Act for support of operating costs of medical schools, $170 million for construction and renovation of health education facilities, and another $20 million for construction of health research facilities.9/ It is interesting to note that this joint statement reversed previous A.M.A. policy by calling for increased federal funding of loans to medical students for tuition and other expenses. Before, the A.M.A. had said that private loans were sufficient to meet the need. Comparable programs are available for nurses and social workers, but generally lacking for other health professionals.

Such efforts are at best feeble and inadequate to meet the needs. Seven states: Alaska, Delaware, Idaho, Maine, Montana, Nevada, and Wyoming, have no medical schools.10/ Of these, only Nevada has any expectation of starting a school as soon as the fall of 1971 and even then it is only expected to open with 64 first year students.3/

The number of MD's graduated each year did not exceed 8,000 until 1969. With the advent of the 1968-1969 academic year, the number of first year students in all medical schools totaled 9,863. The A.M.A. sees these figures as evidence that "the'tooling up' process in American medical education is beginning to show results in terms of more medical students and more graduates." Even the A.M.A. has had to admit that "the response of the system is painfully slow when considered in relation to the public demand for more physicians to provide more medical care."3/

As of the 1968-1969 academic year, there were 35,809 students enrolled in 98 U.S. medical schools. Of these, only 858 or 2.39% were black.11/ This is a slight improvement over the 1967-1968 figures of 2.28%.12/ Since the black population of the United States approximates between 11 and 12% of the total, the total admission of black students to medical school reflects the widespread denial of equal opportunity. Although there has been some progress in black student recruitment in the past few years, stimulated in part by the Macy Conference held in June, 1967,12/ the progress has been painfully slow. This is particularly true in view of the fact that two predominantly black schools--Howard and Meharry--enrolled 61.77% of all the future black physicians and 13 of the other 96 schools have no black students at all. It is revealing that 11 of the 13 schools with no black enrollment are supported by state tax revenues.11/

9/ "Joint AMA-AAMC Statement on Federal Support of Medical Education," July, 1969.

10/ Medical Economics, Dec. 22, 1969.

11/ Crowley, A.F., and Nicholson, E.C., "The Education of Negroes for Medicine," J. of the National Medical Assn., 61

12/ Cogan, L., Negroes for Medicine, the Johns Hopkins Press, Baltimore, 1968.

NATIONAL MEDICAL ASSOCIATION MEMBERSHIP BY SPECIALTY AND SPECIALTY BOARD CERTIFICATION — 1967

	Total NMA Members (100%)	Board Certified	% Board Certified	Not Board Certified
Total Physicians	4805	1074	22.4	3731
Allergy	4	0	0.0	4
Anesthesiology	79	27	34.2	52
Aerospace (Aviation) Medicine	9	0	0.0	9
Cardiovascular Diseases	14	3	21.4	11
Child Psychiatry	25	8	32.0	17
Colon and Rectal Surgery	1	1	100.0	0
Diagnostic Roentgenology	1	1	100.0	0
Dermatology	49	22	44.9	27
Gastroenterology	8	2	25.0	6
General Practice	1867	16	0.9	1851
General Preventive Medicine	10	6	60.0	4
General Surgery	479	206	43.0	273
Internal Medicine	540	110	20.4	430
Neurological Surgery	15	3	20.0	12
Neurology	22	5	22.7	17
Obstetrics and Gynecology	425	152	35.8	273
Occupational Medicine	10	3	30.0	7
Ophthalmology	78	38	48.7	40
Orthopedic Surgery	65	16	24.6	49
Otolaryngology	33	10	30.3	23
Pathology	56	31	55.4	25
Pediatrics	280	143	51.1	137
Pediatric Allergy	1	0	0.0	1
Pediatric Cardiology	2	2	100.0	0
Physician Medicine & Rehabilitation	22	7	31.8	15
Plastic Surgery	6	3	50.0	3
Psychiatry	275	81	29.5	194
Public Health	19	7	36.8	12
Pulmonary Disease	8	0	0.0	8
Radiology	109	74	67.9	35
Thoraic Surgery	14	12	85.7	2
Urology	78	40	51.3	38
Not Recognized (1)	65	34	52.3	31
Unspecified	136	11	8.1	125

(1) includes 55 Administrative Medicine

PREDOMINATELY WHITE MEDICAL SCHOOLS RESPONSIBLE FOR TRAINING MORE THAN 20 BLACK GRADUATES

University of Illinois College of Medicine	57
University of Michigan Medical School	48
Wayne State University School of Medicine	38
Indiana University School of Medicine	35
Ohio State University School of Medicine	30
New York University School of Medicine	27
Harvard Medical School	23
Northwestern University School of Medicine	22
Loma Linda University School of Medicine	22
Chicago Medical School	21

A task force of the AAMC recently recommended that minority group students in medical degree programs be increased to 12% of the total enrollment by 1975-1976.[13] The task force suggested that increases in the number of places available in medical schools, more student loans and special counseling would make the goals possible. Nevertheless, based on projections of the current rate of the current rate of growth by the Public Health Service, there will be 13,000 first year medical students in 1975-1976.[10] If the goal of the AAMC task force is attained, this would mean that only 1,560 of those students entering medical school in 1975 would be black. And this would still not begin to meet the needs of the black community. If successful the AAMC Task Force efforts will not materially change the 1967 fact that among white American citizens, one in 560 becomes a doctor, whereas among black citizens the ratio is 1 in 3,800.[12]

The thrust of this discussion has been on physicians only because the shortage of doctors is most dramatically acute. Further, the medical profession has the longest and most complex professional training period. There could be, however, a comparable discussion relative to each of the health professions.

ENROLLMENT AND GRADUATES OF U.S. MEDICAL SCHOOLS
1968-69

Enrollment 1968-1969	98 Schools	96 Schools*
Total	35,809	35,236
Black	858	328
% Black	2.39	.93
Class of 1968		
Total	7,930	7,778
Black	155	47
% Black	1.95	.60
Class of 1969		
Total	8,168	8,037
Black	167	60
% Black	2.04	.75
Class of 1970		
Total	8,596	8,450
Black	196	34
% Black	2.28	.40
Class of 1971		
Total	9,403	9,212
Black	217	70
% Black	2.31	.76
Class of 1972		
Total	9,717	9,545
Black	278	130
% Black	2.87	1.37
% Change	.92	.77

* excluding the two predominately black schools, Howard University and Meharry Medical College.

- Any Law Establishing a National Health System Must Clearly and Unequivocably Commit This Nation to the Principles of Non-Discrimination and to the Training of Sufficient Numbers of Health Professionals--including Doctors, Dentists, Pharmacists, Occupational Therapists, Administrators, and Others--to Meet the Increasing Needs of an Expanding Population and Economy.

- A National Health System Must Also Provide for and Encourage the Continuing Formal Education of Physicians, Nurses, Administrators, Technicians, and Other Personnel without Loss of Income.

This should be considered an integral part of the system's thrust for greater efficiency, productivity, and higher quality care. The health professional needs both the encouragement and the opportunity to attend post-graduate courses, seminars, and professional meetings without financial loss. In 1968-1969, 71 medical schools reported 127,377 registrations in regular continuing education courses.[3] Since physicians who do enroll in post-graduate courses tend to enroll in more than one, the probability is that no more than 63,688 or only 20% of the nation's active doctors actually participate in medical school programs. While radio and television courses attract another 24,658 registrants, this experience cannot compare with the participation with peers in an intellectually stimulating, productive, and more conducive learning environment. Health professionals would participate in continuing education if courses were readily available, if they were assured of being able to participate without financial loss and if there is provision for adequate care of their patients during periods of absence. Further, participation in post-graduate courses could be encouraged by special income incentives for salaried health professionals or income tax incentives for the self-employed.

- A National Health System, As Part of Its Thrust to Improve the Quality of Medical Care, Should also Encourage Physicians to Seek Certification by the Specialty Board in the Field in Which They Are Working.

As of 1967, only 38% of all physicians in internal medicine were board certified, only 36% in psychiatry, 46% in obstetrics, and 68% in radiology.[14]

PERCENTAGE OF BLACK SPECIALISTS WHO ARE BOARD CERTIFIED
1967

	% Board Certified (Black)	% Board Certified (U. S.)
Internal Medicine	20	38
Psychiatry	30	36
Obstetrics & Gynecology	36	46
General Surgery	43	48
Pediatrics	51	57
Radiology	68	68

14/ Haynes, M. A., "The Distribution of Black Physicians in the United States: 1967," J. of the National Medical Assn. 61:470, Nov. 1969.

Board certification is no guarantee of quality care, but it is the only objective measure beyond mere licensure that the consumer has for determining clinical competence. Since, with the exception of those in radiology, black physicians have not been granted sufficient opportunities for advanced study leading to board certification, a non-discriminatory national health system could eliminate this problem.

NEEDED: BETTER DISTRIBUTION

- A National Health System Must Assure That Comprehensive and Specialized Health Care Services Are Distributed Evenly Throughout the Nation by Area and in Accordance with the Needs of the Populace.

With proper planning, health professionals may be encouraged to serve in the rural and poverty areas of the nation where the need is most apparent. This could be accomplished by requiring, in return for government financed training, a minimum five year period of service, or other incentives in assigned areas. Precedents for this approach may be cited from the experiences such as Puerto Rico, Mexico, and some European countries.

Contrary to widespread belief, the second major barrier to health care in the United States, after its high cost, is not physical distance from hospitals. Hospital facilities of 25 beds or more are now within 25 miles of all but 2% of the population, and within 10 miles of any urban area.15/ Rather than in distance, the problem lies in fear, distrust, denial of treatment, or the inaccessibility of care to the poor, the black and the isolated.

While more is involved in the supply of medical services than the number of physicians available, their number is crucial. When the National Advisory Commission of Health Manpower issued its report in 1967, the Commission cited three problems patients characteristically face: difficulty of reaching a physician at nights or on weekends, except through emergency rooms of local hospitals; long delays in obtaining appointments for routine care; hurried and impersonal attention even after long hours wasted in waiting rooms.15/ These indicators pointing to the kind of service the nation receives is tied to the critical shortage of treating physicians since the physician is an integral part of the health team and usually is its leader.

Since 1950, the number of physicians has grown some 25% faster than the general population. By 1967, there were 277,729 active physicians--doctors of medicine or osteopathy--outside of the federal services, roughly 135 per 100,000 population. (The Department of Health, Education, and Welfare estimates that at present rates of growth, there will be 361,500 active physicians in 1975, a ratio of 160 per 100,000 population.) It must be noted, however, that such overall statistics tend to obscure the actual situation. About a third of all

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15/ Report of the National Commission on Health Manpower, Vol. I, U.S. Government Printing Office, Washington, D.C.

active physicians are in research, public health, hospital administration, industry, or teaching. The actual doctor-patient ratio including specialists is closer to 92 per 100,000.17/ If just those physicians providing day-to-day family care are considered--the general practitioners, internists and pediatricians--then the ratio is down to 50 per 100,000.17/ This is the heart of the problem. It is through just these practitioners that the first treatment of illness is sought.

In addition to the physician shortage in general, the supply of those available is extremely uneven geographically. The District of Columbia leads the nation with 318 non-federal physicians providing patient care per 100,000. New York State is second with 199 per 100,000. Colorado ranks third (168/100,000); Connecticut, fourth (164/100,000); and California, fifth (161/100,000). At the bottom of the scale, Mississippi and Alaska have but 69, and Puerto Rico only 68. Even in states in favorable positions, distortions in distribution are common. Private physicians tend to settle in prosperous, predominantly white, middle class urban neighborhoods or suburban areas.17/ Ohio, for example, had in 1967, 129 non-federal physicians providing care per 100,000 population. But a

DISTRIBUTION OF NMA PHYSICIANS BY REGION AND STATE 1967

Division State	Total NMA Members	Division State	Total NMA Members
New England	93	Virginia	138
Connecticut	41	West Virginia	12
Maine	3	East South Central	275
Massachusetts	43	Alabama	61
New Hampshire	0	Kentucky	37
Rhode Island	6	Mississippi	44
Vermont	0	Tennessee	133
Middle Atlantic	976	West South Central	244
New Jersey	178	Arkansas	17
New York	562	Louisiana	62
Pennsylvania	236	Oklahoma	30
East North Central	921	Texas	135
Illinois	265	Mountain	29
Indiana	99	Arizona	12
Michigan	270	Colorado	8
Ohio	256	Idaho	0
Wisconsin	31	Montana	0
West North Central	197	Nevada	3
Iowa	12	New Mexico	5
Kansas	23	Utah	0
Minnesota	19	Wyoming	1
Missouri	135	Pacific	598
Nebraska	7	Alaska	0
North Dakota	1	California	574
South Dakota	0	Hawaii	4
South Atlantic	1084	Oregon	6
Delaware	11	Washington	14
D. of Columbia	417	Possessions	22
Florida	82	Puerto Rican	11
Georgia	86	Virgin Islands	11
Maryland	163	Address Unknown	84
North Carolina	130	Overseas	262
South Carolina	45	Foreign Countries	20

Total Physicians: 4,805

17/ Cordtz, D.D., "Change Begins in the Doctor's Office," Fortune, 81:84, Jan. 1970.

survey in Cleveland found only .45 physicians per 1,000 in poverty neighborhoods, but more than double that frequency in non-poverty areas (1.13 per 1,000).[18]

Like their white counterparts, black physicians tend to gravitate towards the better neighborhoods in New York, California, and the District of Columbia. A 1967 study by the National Medical Association, a predominantly black professional organization, found that of its 4,805 members, 574 were in California, 562 in New York, and 417 in Washington, D.C.[14]

If the distribution of physicians is considered by medical specialty, the situation appears particularly uneven. Recent attempts to attract more students to general practice or family medicine have not been notably successful. As of the 1968-69 academic year, only 20 programs in these fields have been established, only 713 interns, residents, or fellows were on duty in these programs and 43% of the internships and residencies offered went vacant.[3] Such efforts will not materially alter the fact that only 22% of all physicians[3] and 38% of black physicians are in general or family practice, the point of contact through which most patients enter medical care.

At present the most attractive specialties among all physicians are, in rank order, internal medicine (14%), surgery (10%), and psychiatry, obstetrics-gynecology and pediatrics (6%). Preferences among black physicians follow a similar pattern.

However, the gravity of the specialty problem shows up most clearly on close examination of the distribution of any one specialty group. For example, even in favored New York, there are only 25 psychiatrists per 100,000 population. Rural states suffer even greater lack of psychiatric treatment: Maine, Kentucky, Indiana, North Dakota, New Mexico have only 4 psychiatrists per 100,000. Poorer states such as Alabama and Mississippi have only 3 per 100,000.

NUMBER AND PERCENTAGE OF BLACK SPECIALISTS OF CERTAIN CATEGORIES

	U.S. Physicians 1967	Black Physicians 1967	Per Cent
Internal Medicine	42,325	540	1
General Surgery	29,687	479	2
Psychiatry	19,749	275	1
Obstetrics and Gynecology	17,964	425	1
Pediatrics	17,614	280	2
Radiology	10,877	109	1

- A National Health System Could Alleviate the Shortages of Particular Specialties by Making Residencies in This Field Particularly Attractive Financially or Through the Use of Other Incentives.

18/ Report of the National Advisory Commission on Civil Disorders, U.S. Govt. Printing Office, Washington, D. C. 1968.

NEEDED: NEW WAYS TO SERVE

Clearly, health manpower in all categories is and will remain in critically short supply unless creative solutions are conceived. In view of the increased demand for improved and more readily accessible services, the problem will never be solved merely by recruiting more people into traditional training programs, however expanded and attractive such programs become. Rather, the key to the improvement of medical care lies in a bold re-ordering of priorities, careful re-definition of previous roles and realistic evaluation of the amount of formal education necessary to carry out new responsibilities successfully and efficiently.

In many areas of medical care, innovative approaches have already begun to point the way. Faced with impossible shortages of care-giving personnel, institutions all over the nation are finding new avenues of more effective service in the "paraprofessional," the warm, empathetic person who not only relates more easily and more personally to the patient in distress but who also carries a significant and substantial part of the work load previously reserved for professionals with lengthy and expensive training. In less than a week, for example, hospitals in New York have trained aides, most of whom are black and not formally educated beyond ninth grade, to take and record temperatures and blood pressures, routines that at one time were thought to require a full nursing education. In North Philadelphia ghetto as well as rural Iowa, psychiatrists have discovered that local housewives and others without high school diplomas can, after only a brief period of "on the job" training, serve effectively in helping most families and individuals in emotional crises.

In many instances, programs that began strictly as manpower production schemes have found that by tapping new human resources, the quality of care is improving substantially. In what started out as merely an attempt to assist its over-burdened professional psychiatric staff, not long ago the U.S. Army began to produce "social work/psychology specialists" in a ten-week training program. Needless to say, the enlisted men often find these "specialists" easier to talk and confide in than the Army psychiatrists who are all of officer rank. Similar situations prevail in civilian life, especially in rural or disadvantaged urban communities where differences in status or race tend to act as barriers to communication between the highly trained, middle class professional and the patient in need of his services. In such instances, the use of the paraprofessional aides may be essential to the delivery and maintenance of high quality, dignified and comprehensive care.

- A National Health System Must Be Committed to the Flexibility Necessary to Discover and Implement New Ways to Raise Standards of Care Through the Recruitment and Training of Paraprofessional Personnel and to the Establishment of "Career Ladders" Which Enable Advancement to Higher Levels of Service.

NEEDED: PUBLIC EDUCATION

- A National Health Care System Must Emphasize Case-Finding and Public Education as Part of Its Preventive and Treatment Efforts.

It is not enough for a concerned health system to sit back and wait for patients to present themselves. Experience has shown that many patients will neglect themselves out of ignorance or fear or mistrust. To be effective, the national health service must reach out beyond institutional doors. One imaginative approach is the project undertaken at Hunters Point ghetto of San Francisco. "The program is unique in that it doesn't include the usual charity clinic concept and no stigma is attached to the recipients," Edwin T. Johnson, M.D., reported in the Journal of the National Medical Association.19/ "Backed by government financing and sponsored by a local medical society, a program has begun in which teams of social workers, nurses, and health aides go into neighborhoods, often knocking on doors and surveying the health needs of the community block by block. These teams assist people to the proper entrance into the medical field. They instruct the community about their health needs; they inform them of proper facilities available; they return patients to their own physicians or clincs and inform them of indigenous private physicians if they have no doctor." A similar effort by the University of Rochester Department of Preventive Medicine and Community Health uncovered 10,000 residents 65 or over in need of some specific treatment other than for senility. Of the 10,000, only 41% were receiving the care they needed.19/

Community surveys have long been part of the routine among workers in public health. Many hospitals, community health centers and medical school Departments of Community Medicine have reached out into the community in similar ways, thereby making themselves better known and more acceptable in the communities involved. By utilizing indigenous professional and paraprofessional personnel, such pilot programs have to a great extent begun to overcome the resistance and distrust in disadvantaged areas. Successful programs can serve as models for national health system procedures.

Similarly, the model of the National Institute of Mental Health in its use of television, radio, and other mass media for public education purposes, can be utilized to promote health education programs on a nation-wide basis.

NEEDED: A SINGLE HEALTH AGENCY

- To Be Effective, A National Health System Must Be Administered by A Single Agency under Community Influence and Control and Have a Secretary of Health at Its Head.

It should be organized in such a way as to take under its wing all civilian health, mental health, and environmental activities now conducted by a variety of separate federal, state, and local government agencies. The organization of this agency must provide for influential consumer participation at all levels of its functioning and assure community control of those facilities and programs which provide direct services.

19/ Johnson, E.T., "The Delivery of Health Care in the Ghetto," J. of the National Medical Assn. 61:263, May, 1969.

Some indication of the extent of the fragmentation and duplication of health matters in government is shown in the recent experience of the Joint Commission on the Mental Health of Children. Dr. Reginald Lourie, the Commission's President, has stated that his staff found more than 70 separate, distinct, and uncoordinated federal programs directly related to childhood mental health and these programs were spread over more than 40 different government agencies and bureaus. Another example is the Environmental Science Services Administration which is now in the Commerce Department while other environmental matters are covered by the Public Health Service. Still another example is the problem of air pollution which is now a responsibility of the Public Health Service, while water pollution is in the hands of the Department of the Interior.[20]

A well-coordinated single agency could bring together and thereby maximize the effectiveness of similar efforts. In 1969, while the Department of Health, Education, and Welfare was spending $122 million for the construction of private hospitals and another $74 million on health research and education, the Veteran's Administration was spending $1,582 million on its own hospitals and medical care.[21] All such facilities could be merged into the national health system, thereby making them available to all instead of to selected segments of the population. Veterans could still be entitled to special benefits, but their treatment would often be more convenient in hospitals or other facilities closer to their homes and an emphasis on outpatient care would discourage dependency and chronicity.

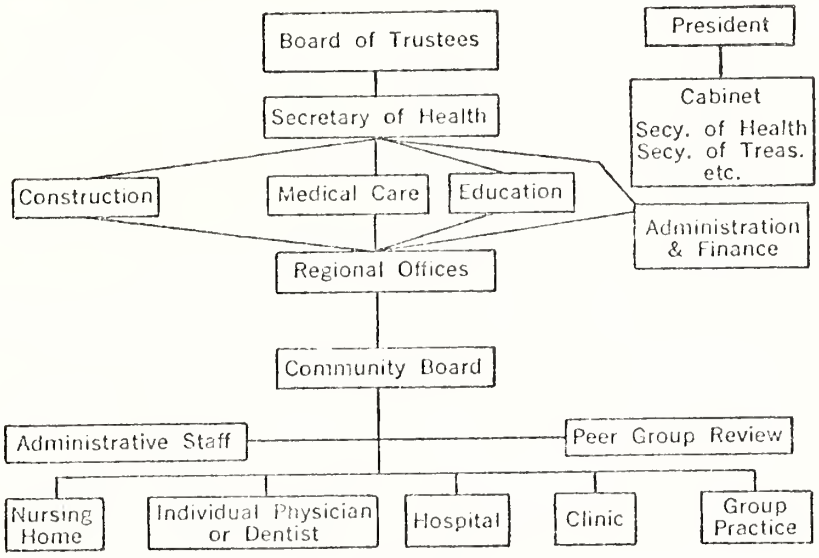
The nucleus of an agency capable of operating a national health system already exists in the U.S. Public Health Service and its supporting structures, the Consumer Protection and Environmental Health Service, the Health Services and Mental Health Administration, and the National Institutes of Health.[20] Reorganization to provide consumer participation in policy making and planning at all levels from national office to local neighborhood would be necessary.

Starting at the top, a broadly representative (including consumer and community representation), Council of Health Advisors should help set national standards for health care and environmental protection, provide for national licensing of health workers in all categories, determine other specific policies and guide the implementation of these policies. Long range planning on a national scale should be the responsibility of a central office in Washington with divisions headed and manned by career civil servants rather than political appointees. Funds should be allocated to representative regional boards for regional planning, establishment of regional medical centers for specialized care, and for distribution to community boards concerned mainly with providing and elevating the quality of care in their own localities. Community boards finding themselves with similar problems and needs could associate themselves on an area basis. Essential to effective operation and elevation of standards of care would be review panels to check on the quality of care being rendered and to act on consumer complaints.

20/ U.S. Government Manual, General Services Administration, U.S. Gov't. Printing Office, Washington, D.C., 1969.

21/ Statistical Abstract of the United States, Bureau of the Census, U.S. Gov't. Printing Office, Washington, D.C., 1968.

ORGANIZATION OF A NATIONAL HEALTH SERVICE



THE COMMUNITY
Approximately 25,000 families)

To provide and extend the facilities of the existing federal hospitals system, regional and community boards could enter into contractual agreements with county, state, or municipal hospital systems, private hospitals and clinics, individual physicians or physicians in group practice.

FINANCING THE NATIONAL HEALTH SYSTEM

- To Avoid the Pitfalls of Dependence on Annual Appropriations, Funds for the National Health System Must Be Considered As "Trust Funds" in Much the Same Way that the Social Security Revenues Are Considered Now.

The general revenue should be the major source. It is feasible for adequate resources for the education of physicians and other health workers, for public education, for administration, for the construction of treatment, training, and research facilities and other phases of the system could come from the general federal tax revenues, employer-employee contributory taxes, or a surtax on income marked for this purpose. Such revenues could be reviewed and revised by Congress every five years, and supplemented if necessary on an annual basis.

The experience under provisions of the Medicaid law as compared to Medicare, suggests that the national health system should operate without financial participation or "Matching grants" from the states. To date, because of the optional nature of Medicaid, the people of Alabama, Alaska, Arizona, Arkansas, Florida, Indiana, Mississippi, New Jersey, North Carolina, and Tennessee are without Medicaid coverage, although these states are known to have sizable "medically indigent" populations.[22/] Further, after it had been in existence

22/ Medical Tribune, July 14, 1969.

for only about a year, the New York State Legislature, frightened by the $461 million Medicaid was costing, raised the standard for participation, thereby reducing the number of people who could be served.[23] A similar attempt, which would have cut "Medi-Cal" expenditures by some 25% was blocked by the California Supreme Court.[24]

KEEPING COSTS DOWN

- A National Health Financing System Must Also Operate to Control, Rather than Inflate the Cost of Medical Care.

One important factor in the rising health costs of the recent past is the growing use of increasingly expensive hospitalization.[6] The effective use of preventive medicine, early diagnosis and increased emphasis on the treatment of disease on an outpatient basis and in its initial rather than acute phases, would reduce the need for hospitalization. Further, the present "piece work" or fee for service method of billing for medical care--separate for lab tests, x-rays, hospital room and board, visits to the doctor, surgery, anesthesia, etc.--has in the past few years made the costs of medical care soar above those of other costs of living. In addition, by insuring hospitalization and not health, existing private insurance plans as well as Medicare and Medicaid have encouraged unnecessary hospitalization. By using a cost-plus formula of reimbursing hospitals after fees are incurred, these programs have further served to inflate the nation's health bill. Medicare and Medicaid provisions for the payment of "usual and customary" fees have encouraged physicians to raise the level of fees for all.

- A National Health Financing System Must Be on a Pre-Paid Rather Than "Reimbursement" Basis. It must Encourage Preventive and Outpatient Care Where Possible and Promote Efficiency and Effectiveness in Hospital Management. This Places the Emphasis of a National Financing System on the Maintenance of Health Rather than on Care of Disease.

SUMMARY

To be effective, a national health program must be sufficiently comprehensive to make specific provision for the delivery of health services, financing, education, and training. It must:

be administered by a single agency under community influence and control;

have a Secretary of Health at its head and be manned primarily by career civil servants;

encompass all civilian health, mental health, and environmental activities now covered by a variety of separate agencies; and

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23/ Medical Tribune, Dec. 19, 1967.
24/ Medical Tribune, Dec. 28, 1967.

hold and control its own funds in trust for those it serves.

The primary goal of a national health system is to provide high quality, comprehensive, dignified medical, dental, and mental health care and environmental protection for all people in the United States regardless of race, sex, location, citizenship status or income. To attain this goal, the national health system must:

take responsibility for the accessibility and even distribution of quality comprehensive health services and appropriate health professionals to meet the needs of the nation as a whole and poverty and rural areas in particular;

devise a system of public tax-supported education and training for health professionals with a required service commitment; such a system would be void of all forms of discrimination;

provide for and encourage the continuing formal education of all health professional personnel without loss of salary; to encourage physicians to seek specialty board certifications; practitioners of specialties must be encouraged to achieve appropriate certification and accreditation;

emphasize and promote research, case-finding, and public education in health; and

provide for national certification or licensure of health workers in all categories.

Through regional and community boards, the national health service may contract with existing private or public facilities, individuals or groups to provide needed services. However, to control the cost of care, such contracts shall require payment on a per capita or other basis, taking into consideration area needs, and shall not provide for payment on a reimbursement or "fee for service" basis. Further, such contracts shall in all cases provide for local review of the quality of service rendered.

Funds to support the national health system may be drawn from many sources. The most promising approach would be the utilization of the general tax revenues, but other methods such as contributory taxes from employers and employees or a surtax on income earmarked for this purpose may be alternatives. In any event, health systems funds should be organized in a trust fund plan to assure program stability.

The nucleus of an agency capable of operating a national health system already exists in the U.S. Public Health Service and its supporting structures: the Consumer Protection and Environmental Health Service; the Health Services and Mental Health Administration; and the National Institutes of Health.

The United States is the only so-called "developed" nation in the world that does not now have a national health system. As a people we are pledged not only to provide for the common defense but also to promote the general welfare. In the past, as demonstrated by Social Security and Medicare, our nation has responded to a nationwide problem on a nationwide, federal basis. The time has come to do the same with medical care. The World Health Organization defines health as a state of complete physical, mental, and social well-being--not merely the absence of infirmity or disease. American can do no less.