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PUBLIC HEALTH REPORTS

Address correspondence to Executive Editor

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ABRAHAM RIBICOFF, *Secretary*

PUBLIC HEALTH SERVICE

LUTHER L. TERRY, *Surgeon General*

New Directions in Medical Care

Several decades ago, Benjamin R. Cardozo said: "The law of our day faces a twofold need. The first is the need of some restatement that will bring certainty and order out of the wilderness of precedent. . . . The second is the need of a philosophy that will mediate between the conflicting claims of stability and progress, and supply a principle of growth."

A "wilderness of precedent." That fairly describes our system of providing medical care today—a philosophy that mediates between the claims of stability and progress and offers "a principle of growth." Isn't this what we're in search of?

Crusty precedent once dictated that the responsibility for preventing illness and for curing it be divided, public health for the former, private medicine for the latter. But that fallacy has been shattered, first by various official utterances of both groups and, second, by scattered but highly successful working arrangements which successfully merged the two goals functionally. Today no one seriously argues that there is any remaining advantage in making prevention and cure separate functions. And yet the physical and modal residue of that original distinction still bedevils our efforts at fusing these two great tasks of medicine.

Where we seem to be bogged down today is not in the mutual recognition of this oneness. We seem most stumped by the question: "Who shall assume leadership if we merge our functions?" And there we stop. We lack, as Cardozo put it, "a principle of growth."

Planning for medical care can only begin when you know two things—the characteristics of the population to receive the care plus reliable projections of population characteristics and trends. The goal should be to provide the best care possible, when and where it is needed and at a price that families can afford. Some people can afford nothing and we need to know who they are and where they are. Others can pay on a spreadout prepayment or postcare basis. . . .

Public financing of medical care to selected groups in the population has gone ahead in an orderly way. We now give care to the handicapped, the tuberculous, the mentally ill, and the chronically ill. A new class of eligibles, the aged, is being added.

This adding on of new groups of the sick to programs of public medical care has resulted in piecemeal and patchwork administration. And patchwork organization has become an expensive luxury in an age of high-cost medical care. This is why the demand has become more insistent for efficient and economical statewide organization of our medical services.

So let's look for a beginning point somewhere, "a principle of growth." Perhaps the obvious place to begin is in government health services. If we can bring discipline to this huge beast, if we can domesticate him to the complex job of insuring good medical care and get him pulling in one direction, we will have made the kind of beginning that will get us somewhere. Maybe if we can succeed in bringing order to the vast monolithic structure of government health services, then the patterns we develop and the insights we gain will serve us as a point of reliable reference for the bigger job of insuring sound health care to everyone, everywhere.

The biological and social factors affecting the health of our people are changing at a tremendous pace. There is so little time left to get on top of our medical care problems before they overwhelm us.

This is a time to plan, to act, and to evaluate. To those who might think otherwise, I commend this final thought: It is exciting to be part of a vast evolutionary process; it is tragic not to realize it.—HERMAN E. HILLEBOE, M.D., *State health commissioner of New York.*

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