The Public Health Service Role in Medical Care Administration

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THE PROVISION of medical care has a long history, and social, economic, and scientific forces have all intimately influenced its evolution. In Western Europe and the United States, this process took a dramatic turn in the 18th century, with the employment of the steam engine, mass production techniques, the development of a worldwide trading system, the rise of urban population, and assertion of the scientific attitude, at least with respect to technology.

In these circumstances, effective medical care increased both as a potentiality and as a necessity. The epidemiology of the 18th and 19th centuries demonstrated that a single infection was often a threat to an entire community. At the same time, individual families, impoverished and in congested quarters, lacked capacity to cope with illness.

Empirical forms of sanitation as a public protection are known to have been applied since the days of Imhotep. But individual medical services did not promise a great deal until recent times. Although the "little beasties" of Leeuwenhoek blazed an early trail, the highway did not open until Pasteur, Koch, Jenner, Semmelweis, Van Auenbrugger, Laennec, and other great pioneers had done their work. The potential available today in current knowledge about antimicrobial pharmaceuticals, immunization, biochemistry, and environmental stress gives hope, almost too much hope, that new peaks in human vigor and vitality lie at hand.

Today health services are included in the top rank of necessities that individuals and communities seek. The rapidly expanding field of knowledge and the complex technology which now characterize the practice of medicine must be recognized as mixed blessings, because they also create mischief. The provision of scientific medical service requires increasing specialization of the professions and their facilities and increased institutionalization of patients. Organization of services and facilities is complex. The costs of medical care therefore have of necessity increased, quite apart from increased demand.

Another important issue relating to medical care administration is the character of and methods for distribution of services traditionally used in our country. A quick review of our social concepts and the activities undertaken through public and private effort makes it abundantly clear that this is a complex problem.

Economic and social forces over the past two centuries have created a set of circumstances which simultaneously increase the threat of illness and reduce the individual family's ability to cope with it. At the same time medicine's capability to serve essential human need with scientific precision and predictability has established health along with food and shelter as an essential element of life. Under such conditions of threat, on the one hand, and aspiration, on the other, the group and not the individual reacts. Therefore, today we see communities building hospitals, unions bargaining for health services, and legislative calendars filled with health bills.

The first Federal legislation in our country, to my knowledge, which provided public medical care was the act passed by Congress in 1798 which created the progenitor of the Public

Health Service, the Marine Hospital system for the care of merchant seamen. During the 19th century, State and local governments began to assume responsibility for the mentally ill, patients with acute communicable diseases, and tuberculosis. Prior to World War I, various States began to pass workmen's compensation laws. Following World War I came medical care for veterans with service-connected conditions. In 1921, the Sheppard-Towner Act was passed, a grant-in-aid program with components which provided medical and social services for mothers and children. Beginning in 1933 the Federal Emergency Relief Administration began to provide limited medical, dental, and nursing services to recipients. The Social Security Act passed in 1935 provided, under title IV, Federal grants for general public health. In 1943 came the emergency maternity and infant care program, and following World War II, the Veterans Administration's expanded medical care program. The Social Security Amendments of 1950 broadened the public assistance title by authorizing matching of payments for medical services for five categories of beneficiaries. "Medicare" was provided for the dependents of the uniformed services; health insurance for civil servants; and expanded health programs for the Indians and Alaskan natives. And the Kerr-Mills Act of 1960, financing medical assistance for the aged, brings this history up to date.

Since early 1930, our country has experienced an extremely rapid growth of insurance coverage for medical services. Blue Cross and Blue Shield, private insurance, prepaid group practice, and union medical care programs have all developed. The size of their enrollments attests to the public's interest in this form of collective action. Approximately 132 million Americans now have some form of health insurance, and their coverage pays about 26 percent of the Nation's private medical bill.

This history of official and voluntary action in the field of health care is not merely an anthology of action; it is an extremely important indication of what may be expected in the future. Our entire history shows a consistent public policy that finds government, either Federal, State, or local, assuming responsibility for the health care of certain groups in peculiar positions of unusual need. The major segment of the population meanwhile remains in the sector of individual or group nongovernmental programs of care. Here then is our social history and tradition and to me it has the following meaning:

1. There has been, is now, and will continue to be a sharing of responsibility for personal health services among private and public systems. At the present time, out of the $26-billion-plus of all expenditures for medical care services, slightly more than $6 billion is from public funds. Public expenditures as a percentage of total expenditures, with the exception of the rise during the World War II years, has increased only from 20.8 percent in 1934–35 to 23.5 percent in 1959–60 (*1*).

2. Public assumption of responsibility for high-risk or high-cost segments of the population removes them from the community group which otherwise must absorb their excess costs. It follows that, relieved of such adverse experience, community-rated health benefit programs can expand benefits to better serve the medical needs of their subscribers.

3. The many differences in both public and private programs create difficulty in organizing services to insure the best possible medical care with the most efficient use of facilities and personnel.

4. All the programs are of such size and importance to the public health that the Public Health Service in recognition of consumer interests and in cooperation with official and professional groups concerned must prepare itself to give consultation and technical assistance on administrative, fiscal, and organizational aspects and on the quality features of the services being provided or purchased.

5. The professional, technical, and other services provided by the Public Health Service in such an undertaking will respond to the program needs and interests of both the public and private sectors of medical care administration.

The Public Health Service plays a direct role in medical care through the provision of clinic and hospital services for seamen and other legal beneficiaries of the U.S. Government. Since 1955, the Service also has administered a program of comprehensive health care for American Indians and Alaskan natives. Specifically,

the program includes home, clinic, and hospital care; preventive, curative, rehabilitative, and environmental services.

The Public Health Service also plays a role in medical care for the general population and although indirect it is quite important. During the past 15 years in particular, Public Health Service cooperation with public and private organizations in fields related to medical care has increased substantially. The Hill-Burton program, for example, has augmented a primary resource for medical care throughout the country; namely the nation's hospitals, nursing homes, rehabilitation and other medical facilities. Limited programs of aid to health professional education have been established in the Public Health Service. Various other programs have expanded, focusing increasingly on the organization of community services related to medical care, such as disease detection, home care of long-term patients, and improvement of nursing home services and community services for the mentally ill. In the same period, the Public Health Service has initiated and continued important studies of health manpower, utilization of health personnel, hospital administration, and health economics. Underlying all these activities, Public Health Service programs for the support and conduct of medical research have contributed tremendously to the scientific and technological changes affecting medical care.

These recent developments have increased the responsibilities of the Public Health Service in medical care fields. All but a few of our operating programs have activities related to medical care, ranging from direct provision of personal health services to research, consultation, and technical and financial assistance.

These and other issues involved in medical care were analyzed in 1960 by the National Advisory Health Council and its Medical Care Committee. The council's report issued in 1961 (*2*) emphasized the nationwide significance of medical care administration and made important recommendations on the role of the Public Health Service in this field. Taking this report and our statutory authorities into account, and recognizing present and future developments, the following objectives were formulated by the Public Health Service:

1. In collaboration with the professional groups and agencies involved, assist in defining acceptable standards of medical care services and promote their widespread use; provide technical assistance to health insurers, State insurance commissioners, State departments of health, Federal agencies, and others concerned with standards of medical care services.
2. Expand its activities and increase its emphasis on cooperative planning and development of comprehensive health care services among hospitals, group practice clinics, outpatient departments, nursing homes, home care programs, rehabilitation centers, homemaker services, and other health professional groups or individuals providing patient services.
3. Establish and conduct a continuing program of studies, technical assistance, and grants in support of research, training, and demonstration in the organization, administration, delivery, measurement, and improvement of quality and methods of financing of medical care.
4. Exercise vigorous leadership in recruiting and training all types of health personnel and encourage and support specialized training in the skills necessary to meet the changing demands of modern medical care.
5. Continue to promote research necessary to provide the knowledge essential to meet the medical care needs of the nation.
6. Expand its efforts to appraise the effectiveness of promising new developments, to disseminate related information, and to make available resource materials relating to programs in medical care administration.
7. Continue to promote the effective organization and delivery of high-quality medical services to its beneficiaries in its own facilities.

In order that the Public Health Service might have greater technical and professional capability to function effectively in this field, a new Division of Community Health Services has been established. It has been delegated responsibility for both public health and medical care administration. In addition to on-going programs in support of public health practice, it will be concerned with the development of acceptable standards, consultation, and support in the field of medical care administration. Aspects of health economics such as systems of

financing, methods of payment, and costs of services will be studied.

In taking this step to develop a more unified capability in medical care administration, there are several facts that deserve special mention:

1. Proper organization and quality of service are essential ingredients of medical care required by any patient young or old, acutely or chronically ill. Long-term care has created new and difficult problems; however, planning for personal health services must recognize all patient needs.

2. The approach to payment for service in this country has resulted in a multiple system rather than a uniform method of reimbursement. Therefore, professional knowledge and technical skill encompassing all methods of payment—whether it be fee-for-service, salary, capitation charges, per diem, or some other form—are necessary if each system is to fulfill its capability.

The implications of this effort for the medical services received by our people and the responsibilities to be assumed by health agencies impose a solemn obligation. Social, economic, and scientific development will continue to influence the character of this problem. The ability of health professions and agencies to give leadership and meet successfully changes as they occur must be maintained.

Summary

The history of medical care in the United States offers some insight as to the nature of the current need. It appears clear that social and public policy relating to medical care have been evolving over a long period. The decision for an active program and the Public Health Service objectives in medical care are a response to the growing need. The obligations to recognize trends and characteristics of the problem and their implications on program must be recognized in the present effort and future plans.

REFERENCES

(1) Merriam, I. C.: Social welfare expenditures, 1959–60. Social Security Bull. 24: 3–11, November 1961.

(2) U.S. Public Health Service: Medical care in the United States. The role of the Public Health Service. PHS Publication No. 862. U.S. Government Printing Office, Washington, D.C., 1961.

Killed Virus Measles Vaccine

Killed virus measles vaccine and live virus vaccine are being tested in field trials begun in December 1961 by five local health departments in cooperation with the Communicable Disease Center, Public Health Service.

Some 5,000 children in De Kalb County, Ga.; Cincinnati, Ohio; Seattle, Wash.; and Rochester and Buffalo, N.Y., were divided into three groups. The first group received three injections of killed virus vaccine; the second, two of killed vaccine and one of live vaccine; and the third, three of placebos.