What the American Public Wants in Health Care

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WHAT does the American public want in health care? This recurring question confronts every health official. However, because research in this area has been too limited to provide a scientific answer based on established fact, each health official must conjure up his own set of measuring devices. Based on his own experience and that of others in the field, and aided by a sizable portion of luck, he may be successful in reading the public's collective pulse.

But the health officer's responsibility extends much further than that of merely satisfying the wants of his public. And, indeed, he may often find that the public's wants are not always the same as its greatest needs. At this juncture the health official, with his personal popularity at stake, must take a stand to encourage the public to direct its energies to those programs requiring support, thereby assuming his responsibility to lead rather than merely to follow public preference.

Paradoxes

Factors influencing public response to health programs are varied and complex. Most people consider health a priceless possession and approve it in much the same spirit they endorse virtue and religion. Yet, the conflict between what people profess to believe and what they actually practice presents a number of interesting paradoxes. Frequently, issues considered of major importance by public health officials are not always recognized as serious by the public. As a result, the public is not sufficiently aroused to action.

A prime example of such conflict is the attitude of the general public toward accident prevention. Accidents claim more lives each year than most diseases. In fact, accidents rank as our fourth biggest killer among the population as a whole, and the leading cause of death among age groups from 1 through 34 years. The public health official regards these statistics with concern and warns the public of the need for certain safety precautions. Yet how many of us have safety belts in our automobiles?

Another interesting paradox is the interest which can be stimulated by certain types of diseases even though they may cause only a fraction of all deaths. Examples of such low-incidence, high-interest diseases are poliomyelitis and rabies. The national health spotlight was focused on poliomyelitis during the Roosevelt administration, and the fact that President Roosevelt was afflicted with the disease has been cited as one of the major reasons for this high level of interest. As for rabies, the high mortality rate among the relatively few persons who contract the disease is undoubtedly the reason for its dramatic impact.

Inconsistencies in attitude. The public is frequently inconsistent in its attitude toward certain health matters. Before an effective poliomyelitis vaccine was discovered, interest in the disease had reached such a peak that the National Society for Infantile Paralysis scored new highs every year during its fund-raising

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campaigns. Yet, despite the enthusiastic response to these drives, public health officials are still experiencing amazing difficulty in convincing certain segments of the public to be vaccinated.

Still another frustrating experience for health officials was the public reaction to Asian influenza during 1957–58. A five-city study showed that the great concern about an anticipated nationwide Asian influenza epidemic expressed by the Public Health Service and the American Medical Association was not generally shared by local communities. Yet, during the epidemic there was an excess of nearly 88,000 deaths, from all causes, above the number of deaths which normally would have been expected. Some 20,000 of these deaths were due to pneumonia. One-half of the total excess resulted from an increase in deaths from cardiovascular diseases.

Measuring rods. Why was there such public apathy to an illness expected to reach epidemic proportions? Investigators came up with several interesting observations, similar to findings resulting from other sociopsychological studies in the health field. Their observations may be useful measuring rods.

The three most important questions individuals apparently ask themselves before deciding whether to act on a health problem are: What are the chances of my being susceptible to a specific disease or health problem? How serious is the health problem in question? What are the benefits of taking some specified action?

These questions do not appear to have applied to the poliomyelitis experience, possibly because the few dramatic infections appear to have obscured the relatively low incidence of death or paralysis.

As for their pertinence to experience during the Asian influenza outbreak, beginning with the question of susceptibility, the vast majority of persons interviewed believed that they or their families were immune to the disease. As for the severity of Asian influenza, most people felt it was comparable to the common cold or grippe. And although public reactions to the benefits of vaccination were favorable, most people felt that the danger was not sufficiently serious to require precautionary measures.

No uniform motivation pattern. People are not uniformly motivated to prevent or control all health problems. Rather, they are motivated to deal only with those conditions to which they feel susceptible and which they regard as having potentially serious effects on their own lives. Even where there is indisputable medical evidence that a clear and serious health threat exists, most people will not act unless they relate it to themselves.

Why was the population as a whole less troubled than the public health officials by the possibility of an influenza epidemic? A study by the Public Health Service found that the reaction of the general public was more nearly like that of private practitioners than of public health personnel. In other words, local physicians did not share the concern of the epidemiologists, despite ample information in the public press. These differences reflect the orientation of the private physican and the public health official. For the public health official whose patient is the community, a highly prevalent disease may have serious community effects. For the private practitioner whose patient is the individual, the clinical severity of a disease and not its prevalence is the crucial factor. Thus, Asian influenza, widely heralded as a highly prevalent but low severity disease, caused a concern among public health people that was not shared by private practitioners.

Further evidence that patients are influenced by their physicians' opinions was brought out in a recent study of progressive patient care in hospitals. Questions pertained to patients' acceptance of new procedures and their attitude toward being assigned to an intensive care unit rather than a private room. The study showed that the chances are excellent that if the patient's doctor favors progressive patient care, so will the patient. Moreover, studies show that patients do not choose their physicians because they happen to have staff privileges in a specific hospital. Instead, patients go to the hospitals chosen for them by their physicians.

Determining Public Wants

And now the big question. How might public health officials best determine what the public wants?

Opinion of legislators. One way to keep

abreast of popular opinion on health matters is by keeping tab on legislation approved or rejected by Congress and State legislators. I will not attempt an analysis of the complicated reasons behind congressional action. I have, however, made several observations during the many years I have appeared before appropriation and legislative committees on behalf of various public health programs. I found that long-needed programs, such as the Salk poliomyelitis vaccine program, basic medical research, and the Hill-Burton hospital construction program, not only have great popular appeal but also meet with congressional favor. Likewise, programs which have not "caught on" with the public will generally be viewed with reservations by legislators. An example is the program of general health grants to States, considered by many public health officials as one of our most useful financial contributions to State and local public health departments in terms of health purchased per dollar spent. Perhaps one reason for our inability, thus far, to win the desired support for general grants is the difficulty of dramatizing such a program as contrasted with the portrayal of an urgent need in one specific area.

Voluntary organizations. The public health official must consider the impetus for the establishment of voluntary organizations. The first such group, the National Tuberculosis Association, was organized in 1904 in response to a particular need. The organizations which flourished early in the century reflected the health conditions of that era when communicable diseases were the greatest public health menace. Now that chronic diseases present our greatest threat, interest has surged ahead in organizations concerned with such diseases as heart, cancer, diabetes, and arthritis. Thus, the formation of voluntary health agencies presents a rather accurate picture of health trends for our times.

Civic groups. The public health official must be alert to specific health projects sponsored by civic and community groups. And, indeed, such groups will generally call upon health departments for assistance. For example, a Lion's Club may require the services of a health official in carrying out its program for promoting better eyesight. A junior chamber of commerce may consult a health department sanitarian before beginning its annual Paint-up, Clean-up, Fix-up Week. A 20–30 club might call upon various public health disciplines to assist in staging its annual health fair.

Mass media. We have our press, television, radio, and other forms of mass communication whereby people can make their wants known. Many sounding boards are offered not only to groups but to individuals as well. If a private citizen wishes to register a complaint, he does not suffer from the lack of a vehicle conceived for just such a purpose. Instead, he might become somewhat frustrated trying to decide which, or how many, to use!

Mail box. The public health official's mail box is usually overflowing with letters apprising him of problems which range from relatively personal matters to those affecting the entire world. An example of the latter would be letters protesting nuclear tests. One of a more local nature with which I am personally acquainted came from a tourist from an eastern State who spent his vacation in a western State. Upon his return home, he wrote the health officer of the State he visited, complaining that a bedbug was found in a bed at a certain motel. He demanded an investigation. Enclosed in the letter was a small envelope with the partially decomposed remains of the bug.

Other public officials. Communication channels should be easily accessible to other public officials who by virtue of their office are being constantly informed of the health needs of the people. Such burning questions as inadequate nursing homes for our aged become political issues. Resolving these issues becomes the responsibility of health officials.

Statistics. When properly interpreted, statistics are excellent trend indicators. Numbers will sometimes tell us of problem areas in a much more striking and scientific fashion than will any other device. Thus, there is increasing emphasis being placed on systematic data collection on Federal, State, and local levels as a guide in program planning.

Personal observation. The public health official becomes aware of the community's wants through personal observation. His own personal needs and those of his family, neighbors,

and friends are very likely to be those of many other members of his community. A public health officer will not be effective if he operates in a vacuum. He must be an active member of society and this, perhaps, is one of the best ways for him to feel the public pulse.

What the Public Wants

The wants described below are limited to the field of medical facilities. In developing this list, I have had to rely on my 20-plus years of experience in the hospital and public health fields, and the measuring devices described above. These wants are not listed in the order of their importance; each is considered major.

Long-term care facilities. Only a few nursing homes existed prior to the thirties. In 1935, with the enactment of the Social Security Act, Federal funds were made available to the needy aged. At that time, proprietary boarding and nursing homes for the elderly began to flourish and public almshouses subsequently declined. It was not until 1939, however, that the first known count of nursing homes indicated that there were about 1,200 nursing, convalescent, and rest homes, with approximately 25,000 beds. Since that time the growth of nursing homes has been phenomenal; yet they have not kept up with the demand. We haven't begun to scratch the surface from the standpoint of meeting the nation's needs.

At the beginning of 1961, according to Hill-Burton State plans, the nation had 382,000 long-term care beds: 56,000 beds in chronic disease hospitals and 326,000 beds in skilled nursing homes. According to standards established by the States, only 231,000 of these beds, or 60 percent, are acceptable.

In relation to our aged population, the nation has about 23 long-term care beds per every 1,000 persons aged 65 and over. There are great disparities among the States in meeting long-term care needs. As of July 1961, the group of five States with the highest ratios of total long-term care beds available per 1,000 population aged 65 and over have about five and one-half times as many beds for their aged as the group of five States with the lowest ratios. These two groups of States have approximately the same number of aged.

Although the seriousness of the long-term bed shortage is unquestionable, the problem will not be resolved by simply meeting the bed needs. Of major concern is the need to better integrate long-term care facilities with short-term hospital facilities. The demands are such that forward-looking communities, planning future hospital care, must organize their facilities, services, and staff to provide effective continuous care for the aged ill. This means providing continuity of care for patients between the various medical and paramedical institutions involved. Within a hospital there are mechanisms for providing interdepartmental transfer of patients, patient records, and information concerning the patient's condition. The mechanisms for accomplishing transfers between institutions, unless the patient's physician is a staff member of both institutions, are not as clearly defined. In fact, we lack the most elementary means of providing continuity of care between the various types of institutions and programs. There is need, therefore, for a total system of long-term care at the community level.

The needs of the long-term care patient cover the entire spectrum of medical facilities. Some require only a hotel-type arrangement where medical treatment and nursing care might be nearby when needed. Chronic illnesses do not tend to strike suddenly and terminate rapidly. There are acute phases calling for definitive treatment and later phases calling for continuing definitive treatment of a convalescent and restorative nature. But with increasing age, the patient's condition frequently becomes stabilized. At this point, he should be transferred to an institution providing varying levels of nursing service and medical supervision along with a homelike atmosphere. Many chronically ill patients are ambulatory. Others, with some help, can become partially independent. This might be accomplished through medical rehabilitation and physical medicine, through corrective surgery, geriatrics, or even through services such as help in walking, getting in and out of bed, and with dressing and bathing.

Since not all aged, disabled, and chronically ill need hospital or nursing home care, it becomes increasingly important that efforts be intensified to develop more out-of-hospital community health services, such as coordinated

home care programs, homemaker services, and home nursing services.

The major problems facing us as a result of shortages in long-term care facilities are now being studied by an ad hoc committee appointed jointly by the American Hospital Association and the Public Health Service. The 17-member committee is presently developing principles and recommendations on planning for facilities for long-term patient care.

Replacement of obsolete facilities. The public is now recognizing the need to replace or modernize our older hospitals. While financially this need is mainly in the metropolitan areas, it does not stop there. Rather, any hospital which has been in existence for a number of years may find itself in need of a capital construction program because of changes brought about by medical and technical advances, improved social and economic conditions, and difference in the character of the population served.

Spiraling hospital costs. The public is demanding that unwarranted increases in hospital costs be forestalled. These complaints are equaled only by those of the hospitals themselves. Volumes have been written on this subject. However, I must limit my remarks to only a few of the possible ways of attacking this problem. Skyrocketing hospital costs was one of the major issues considered at four regional conferences held in 1959 under the joint sponsorship of the American Hospital Association and the Public Health Service. Among the most significant principles developed at those meetings was the need for the general hospital of the future to be as interested in providing outpatient care as it is currently in providing inpatient care. Moreover, the hospital should be concerned with (*a*) caring for the long-term patient (including the mentally and chronically ill); (*b*) extending good medical and hospital care to the home by assisting the physician in the care of the patient at home; (*c*) providing continuity of care for patients being transferred to paramedical institutions, and (*d*) offering preventive services and teaching health care. This is in keeping with the progressive patient care concept which envisions the general hospital of the future as a community health center.

It would indeed be folly to suggest a pat answer for resolving our hospital financial difficulties. Instead, I would like to suggest some overall principles which may be universally applicable. First, a critical review should be undertaken of hospital operations to isolate areas where potential savings can be made without sacrificing quality of care. Our best hope lies in systematic study of such areas and application of the results of hospital research to the development of more efficient methods of patient care, better techniques of administration, improved design of physical plant, and better coordination of community health facilities. As suggested in the principle referred to earlier, we should plan tomorrow's hospital as the focal point of community health services in a planned hospital system. This plan should be developed by a local hospital planning agency broadly representative of the public to assure a coordinated hospital system. To be effective, the type or types of leverage needed to implement the plan must be determined. Just what form the leverage should take is a question uppermost in the deliberations of all thoughtful areawide hospital and health facility planners.

The many problems revolving around areawide hospital planning and some recommendations for their solution are presented in a report of findings of an ad hoc committee jointly sponsored by the American Hospital Association and the Public Health Service. This report, Public Health Service Publication No. 855, is entitled "Areawide Planning for Hospitals and Related Health Facilities."

Mental health. The public is seeking more adequate facilities for the mentally ill. The need to resolve the crucial bed shortage for mental patients is both compelling and perplexing. It is compelling because of its magnitude. It is perplexing because the answer is not merely a matter of obtaining more beds. Instead, greater emphasis should be placed on the need for a wide spectrum of community-based mental health facilities such as psychiatric units in general hospitals, outpatient clinics, community mental health clinics, day hospitals, halfway houses, and rehabilitation workshops. Much groundwork still needs to be done before broadscale decisions are made concerning physical facilities needed for a comprehensive pro-

gram of treatment and care. Some helpful considerations are presented in the Public Health Service Publication No. 808, "Planning of Facilities for Mental Health Service," recently published by the Surgeon General's ad hoc committee appointed to develop principles for such planning.

General hospitals. The public wants additional general hospital facilities in certain areas. While great progress has been made in providing needed general hospital facilities and services during the past 15 years, many people still live in areas which have no acceptable hospital beds. Furthermore, our population is increasing by approximately 3 million people each year. In recognition of these factors, emphasis must continue to be given to the construction of general hospitals in areas with a backlog of need and to meet the demands for such facilities and services resulting from the continuing growth of our population.

Hospital research. The public wants an intensification of hospital research aimed at:

1. Improving the operating efficiency of the hospital as an organization, so that the optimum can be obtained from the medical staff, administration, and other personnel.

2. Improving the functional design of the hospital structure, placing special emphasis on flexibility. The hospital should be designed so that it will be adaptable to further scientific and technological discoveries.

3. Improving the coordination of community health facilities with hospitals serving as the focal point of the coordinated hospital system. The community and individual would thereby be assured of continuity of quality patient care at the lowest possible cost.

4. Improving the efficiency of patient care organization so that levels of nursing skill and care would be related more realistically to the specific needs of the individual patient. The action taken by the 87th Congress reflects its interest in greater activity in these areas. Whereas in the past our appropriation in hospital research has been limited to the expenditure of only $1.5 million, we now have $10 million to be allocated for such purposes.

In summary, the public has these wants in medical facilities: first, additional long-term care facilities and nursing homes; second, replacement or modernization of structurally or functionally obsolete hospitals; third, forestalling of unwarranted increases in hospital costs; fourth, improved planning of the nation's mental health facilities; fifth, additional general hospital facilities in certain areas; and finally, acceleration of the hospital research program in an attempt to improve operating efficiency, functional design, coordination of community health facilities, and patient care.

These, we feel, are not only the wants but also the musts. Each of these wants can be fully justified, and hopefully, in time, they will all be realized.

Cancer Investigations

To avoid any possible misunderstanding, the Public Health Service states that there is no relationship between the Florida screening project for uterine cancer, which was reported by James E. Fulghum, M.D., and Robert J. Klein, M.D., in the February 1962 issue of *Public Health Reports*, and the activities of the Cancer Cytology Foundation of America. The Public Health Service has not made a grant to support any part of the work of the Cancer Cytology Foundation. The note describing the foundation's screening projects, published in conjunction with the article on the "Community Cancer Demonstration Project in Dade County, Florida," was not intended to imply a connection, which does not exist, between the Dade County screening project and the activities of the foundation.