The Responsibility of Public Health for Medical Care of the Aged

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DURING the last century more and more aspects of man's needs for health protection and health care have been met through social organization. The physical environment, which can so readily contribute to the causation of disease, has been brought under increasingly systematic control. Health services for both prevention and treatment have become organized in a hundred ways; both their financial support and their technical provision have become increasingly systematized. The training of personnel and the construction of facilities have been subjected to more and more social planning. Research to advance knowledge of disease and how to control it has become a feature of national and even international public policy.

A medical Rip Van Winkle of a century ago, waking up in the United States of 1963, would be astonished not only by medicine's technical achievements but by its social developments as well. Let me list a few of the organized health programs he would see.

1. Environmental sanitation, with elaborate laws and procedures protecting the water and food on which life depends.
2. Programs of mass immunization against a number of serious communicable diseases.
3. Organized clinics to help maintain the health of babies and pregnant women.
4. Dental clinics for children and, in some communities, a fluoridated water system to prevent dental caries.
5. Far-flung health education activities on a vast number of problems, such as accidents, proper diet, and mental hygiene.
6. An occasional assembly line in which adults are getting laboratory or X-ray tests for early detection of various chronic diseases.
7. Widespread research on the epidemiologic factors in cancer and heart disease or on the hazards of new environmental pollutants such as smog or radiation.

These and certain other organized activities our Rip Van Winkle would find emanating from a great network of local, State, and Federal entities known as public health agencies. But he would also observe an array of other organized health programs with even broader impact on the people than those just mentioned. He would see these.

1. Great public hospitals providing care to hundreds of thousands of patients with mental illness.
2. A vast network of general hospitals (more than 6,000 in the United States) in which people with all sorts of serious illness are treated and where most of the physicians in the community are engaged in supervising complex diagnoses and therapies.
3. Organized general medical care for the poor, with elaborate arrangements for ambulatory medical, dental, and nursing service, drugs, and bed care in various types of short-stay or long-stay institutions.
4. A system of governmental insurance for

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meeting the costs—both in wage loss and medical care—of injuries and illnesses incurred during a person's employment, known as workmen's compensation.

5. Diverse forms of insurance to help meet the costs of expensive hospital care and services by physicians in the office, home, and hospital, many of these growing out of collective bargaining in industry.

6. For adults with serious physical handicaps, an organized plan for corrective medical service, retraining, and job placement, known as vocational rehabilitation.

7. Laws, regulations, and agencies for the examination and licensure of physicians, dentists, nurses, technicians, and other health personnel.

8. A bewildering variety of special nongovernmental agencies focusing attention on particular maladies, such as cancer, tuberculosis, heart disease, poliomyelitis, and cerebral palsy, through promotion of research, extension of education, and sometimes direct patient services.

9. Local agencies providing bedside nursing services to persons at home needing such care or organized home care involving many medical and ancillary modalities.

10. Highly organized institutions of higher learning for training health personnel of all types and elaborate centers for research in all the myriad aspects of the diagnosis and therapy of disease.

11. Surveillance agencies to guard the safety of food and drugs, to prevent harm to people through misleading claims or sale of untested products, and to prevent narcotic addiction or the misuse of dangerous medications.

12. Associations or councils of hospitals designed to promote efficiency in operation and integrated service to patients in geographic regions.

13. Organized teams of physicians of various specialties working together in ambulatory care centers, known as group practice clinics.

14. Specialized systems of preventive and limited therapeutic service in factories, mines, railroads, and other places of work.

15. A vast system of comprehensive health services for members of the Armed Forces of the nation, not only on the field of battle but also at military posts in peacetime and specified care for their dependents, supplemented by a special system of medical care for veterans.

16. An endless variety of other organized arrangements for providing first aid in emergencies, human blood (through special banks), hearing aids, eyeglasses and other visual aids, instruction in reading Braille, counseling for marital or emotional problems, guidance on finding a suitable nursing home, assistance in getting a physician at night, loan of a wheelchair or a pair of crutches, and dozens of other special services for coping with man's many ailments.

The second list of organized health activities that our Rip Van Winkle would observe in most U.S. communities is long enough, I suspect, to clarify my point that, objectively viewed, the great bulk of community health services in the United States are being provided or sponsored by agencies other than the health department.

I am not speaking of private medical or dental care or the private purchase of drugs and appliances but only of those services that in our society, because of technical complexity, cost, or human importance, have come to be provided in some organized rather than individualistic manner. Yet the public agency that we like to think is "the key health organization" in any State or community has little or nothing to do with the vast majority of these organized health programs.

We need not dwell on the historical reasons for this state of affairs, although they are not far to seek. Health needs permeate our whole social structure; they concern industry, education, military action, care of the poor. They are of interest in the political arena, in religion and private charity, and, obviously, in the ranks of the health professions. They are of concern to labor unions, women's clubs, farmers' leagues, and governmental agencies oriented to commerce, agriculture, mines, railroads, or children. All of these sources of power and initiative have reason to generate actions to meet certain health needs, especially in the absence of a clear concentration of health authority around any one administrative center.

The reasons for this lack of a clear center for organized health authority in the U.S. community are not only the very multiplicity of social

interests in health, but also a deliberate policy by most public health agencies. The organized health services that were reviewed sketchily did not all come about smoothly and easily. Most were associated with bitter controversy along the way. The contentions about health insurance are fresh in everyone's mind today, but do not forget the earlier struggles preceding the food and drug control laws, full-time medical faculties, workmen's compensation, organized welfare medical services, veterans' programs, or even blood banks. These controversies could be handled by special interest groups in and out of government which had a single battle to fight, especially when that battle was tangential to some larger goals in another field. But for the health department, these controversies would be difficult to bear. Having a number of health programs to conduct and complex relationships to maintain with the health professions, health departments have been apprehensive about the bruises and brickbats of blazing new trails.

Whatever may be the total explanation, public health agencies have only exceptionally assumed responsibility for any of the wide variety of organized health services outside the classic sphere of preventive medicine. It is true that a few health departments administer medical care for the indigent. A handful of health departments operate hospitals. A few State public health agencies license medical and related personnel. The whole health insurance field, with its vast impact on the quantity and quality of medical care throughout the nation and especially on the problems of chronic illness, is quite outside the public health arena, except for two or three States where the insurance commissioner is supposed to consult with the State health officer before approving of health policies. The chief function beyond prevention in which health departments are active is probably the Hill-Burton hospital construction program, and this was assigned to them largely through the Federal leadership of the Public Health Service, by special act of Congress.

The result of all this fragmentation of health service administration is not merely a messy organization chart. It means duplications which waste precious resources and gaps in service that are not filled. It means competition for personnel and money when cooperation could channel these according to objectively determined priorities. It means inefficient use of skilled manpower and expensive equipment. It means endless waste in the administrative process and confusion for patients and health professionals. It means the failure to apply certain techniques where they are needed because it is awkward or inconvenient to do so. It means the failure to see the health situation whole on the level of the community or the family and the individual person, so that the potentialities of science are simply not realized.

The public health agencies of the United States have developed a rich tradition of service and professionalization. Some 12 university schools have evolved in this country to train personnel largely for public health employment. The American Public Health Association has provided a forum for the development of a score of technical subdivisions of the field. But all this competence and merit have been confined to relatively limited segments of the total world of organized health service.

After examining the steady expansion of this total world, it is probably fair to say that the share being supervised by public health agencies is actually contracting. Measured by the dollar share of organized expenditures (via taxation, insurance, philanthropy, and industry) coming under the wing of public health, it is certainly declining. It is not that public health is doing less than in the past but that the other agencies, governmental and voluntary, are doing so much more. The net result is that, relatively speaking, the voice of public health agencies in the larger national debates about health and medical care is simply not strong.

One striking indication of this is the role assigned to public health agencies in the number one health issue today in the United States, the health care of the aged. No health issue in the last decade has had wider public debate and more legislative adventures. A series of bills have been launched in Congress, both by the administration in power and by its political opposition. One bill, the Kerr-Mills Law for care of the medically indigent aged, was enacted in 1960. There is little doubt, in my opinion,

that further legislation of much more sweeping character will be enacted in the next year or two.

Yet in all these important proposals, as well as in the law that was enacted, the public health agencies play a minor part. There is a provision, of course, that hospitals in which aged persons would be served are to be licensed by a State agency which is usually, though not always, the health department. But this is conventional practice now. In my own view, there is, indeed, a demonstrated need for paid-up insurance to meet the costs of hospital and nursing home care for old people, as advocated by the APHA Governing Council in 1961. But the need is not merely financial; there is also need for competent guidance. Funds on the order of magnitude of $1 to $2 billion a year exclusively for health services have been recommended for administration by essentially fiscal agencies of government. This amount of money for medical care will dwarf all other organized health programs operating under either public health or other governmental agencies in the United States. Yet the public health agencies, as these funds are conceived, would sit on the sidelines.

Consider the opportunities for positive health services for the aged if adequate funds became available under proper leadership. Consider the possibilities for encouraging primary prevention through balanced nutrition or hygienic exercise, for early casefinding through multiple screening programs, or promotion of periodic examinations in physicians' offices. Consider the possibilities of encouraging hospitals to develop sound geriatric practices or regimens of graded service for the entire range of acute, chronic, or convalescent conditions, for progressive patient care. There are vast gaps in the development of organized home care under the auspices of hospitals, nursing agencies, or health departments. Carefully planned home-help services could significantly affect the use of hospitals and nursing homes. Other components of positive health services to consider are sheltered workshops and properly operated nursing homes and chronic disease hospitals. The whole concept of rehabilitation through general hospitals, long-term facilities, and special centers demands attention. It is not to be expected that this positive approach to the health care of the aged would be taken by a pure insurance agency, whether public or private, that is set up essentially to pay bills.

The exclusion of public health agencies from any significant role in the proposed health insurance programs does not spring from malice. I suspect it stems from two other factors. One is that the proponents see the issue of medical care for the aged as primarily a financial one, even as it was assumed that labor ministries should govern the early health insurance programs of Europe, rather than health ministries. The other factor is probably that public health leaders themselves have offered insufficient guidance to clarify the needs and recommend corrective actions.

If a huge program of medical care for the aged is administered by Federal or State agencies other than the health departments, I am afraid that the public health movement in this country will suffer an impairment from which it will not soon recover. Twenty years ago I had the privilege of working under the direction of one of America's most imaginative public health leaders, Dr. Joseph W. Mountin of the Public Health Service. It was Mountin's dream that public health agencies would one day become the true centers of all organized health service planning and administration in every community. The task, as he saw it, was not simply to cope with the handful of preventable diseases but to administer effectively all health programs involving social action whether preventive or curative, ambulatory or institutional, physical or mental, operational or supervisory.

In the intervening years it is not apparent that health agencies have moved vigorously toward the realization of Mountin's dream. There have been small advances here and there, largely under the theme of chronic disease control, but the center of gravity of health services in most U.S. communities has probably shifted more toward the community hospital and the health insurance plan. In 1950 the Surgeon General of the Public Health Service predicted that "The dominant organizations in public health service of the future will be those who are ready and willing to plan and administer

adequate medical programs as part of the community's total health program."

Since then, public health agencies have even suffered some setbacks. The mental health movement, which for a while seemed to be growing under the public health umbrella, has now swung away under separate psychiatric jurisdictions in several of the most populous States. In one western State, the medical care program for the indigent, which had been transferred from the welfare to the health department, was shifted back after a short interval. In one of our most industrialized States the occupational health program, which had been moved from the labor department to public health, was returned to the labor department a few years later.

I do not mean to belittle one bit the great achievements of public health agencies in the last 100 years. In the sphere of prevention, especially primary prevention, the accomplishments have been magnificent. But the task of the future is the better organization of medical and hospital care for our longer-living population; secondary prevention, if you will, of the great chronic diseases. If public health agencies are to play the leadership and coordinating role that is urgently needed, I believe that they must become far more deeply involved in the administration of medical care in all its ramifications for different population groups, different illnesses, and different modalities of service. The current national issue on medical care for the aged is really only the latest in a series of such issues, but it is of such proportions that I fear it may be the critical turning point.

Fortunately there are signs that the public health leadership of the nation is beginning to respond to the challenge. The Community Health Services and Facilities Act of 1961 has stimulated a galaxy of local programs in health departments to improve out-of-hospital services for the chronically ill and aging. The Public Health Service has established a Medical Care Branch in its Division of Community Health Services. The new National Commission on Community Health Services, chaired by Marion Folsom, is examining the whole question of coordination of health service administration at the local level. Through the American Public Health Association the health officers of this country have shown increasing interest in the technical aspects of medical care programs. Our schools of public health have been faced with increasing demands for instruction and research in the broad tasks of medical care. It is not too late for public health agencies to halt the trend to fragmentation and assume their responsibilities as centers of comprehensive health service organization.

It is not a parochial attachment to the public health profession that leads me to make this plea, but rather a conviction that all health services in the United States can be most effectively provided for people if they are organized, coordinated, and administered by agencies that are motivated by a philosophy of prevention and are in a position to see the total human need without bias or vested interest. More than any other branch of government, public health agencies are in the strategic position to play this role. It remains to be seen if they will.

Conference Calendar

November 14, 1963: Technical Conference on Air Pollution from Incinerators, Air Pollution Control Subcommittee, American Society of Mechanical Engineers, United Engineering Center, 345 E. 47th St., New York, N.Y., 7 p.m. Details available from Leo P. Flood, Department of Air Pollution Control, 15 Park Row, New York, N.Y., 10038.

November 20–23, 1963: National Association of Mental Health annual meeting and mental health assembly, at Sheraton-Park Hotel, Washington, D.C. Details in September issue of *NAMH Reporter*, 10 Columbus Circle, New York, N.Y.

May 25–27, 1964: American Thoracic Society (medical section of the National Tuberculosis Association), New York City. Membership not prerequisite to participation. Abstracts of papers to Robert Oseasohn, M.D., Chairman, Medical Sessions Committee, American Thoracic Society, 1790 Broadway, New York, N.Y., before January 6, 1964.