Medical Care Administration Confronts Public Health Practice

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WHEN President John Kennedy congratulated spacemaster John Glenn for his probe into the great unknown, the President said, "This is the new ocean and we must sail on it." Medical care administration is our new ocean and we must sail on it. So far, we in public health have probed about as much of our new ocean as the astronauts have of theirs. Why is this?

Old hands in public health will recall how in their training days their professors and mentors carefully admonished them to steer clear of medical care. They warned that if one opened that door even a crack the city fathers would flood him with so many clinical responsibilities that all his fine-laid plans for the "basic six" of public health would languish in dusty pigeonholes.

Our preoccupation with the "sacred six" has tended to insulate us from a full appreciation of great changes that have been occurring in the field of personal health services. Until the beginning of this century, personal health services in America required almost no administrative know-how. It was pretty much a matter of a doctor on one end of a stethoscope and a patient on the other. Hospitals were the end of the line, and prepaid medical service was hardly known outside the merchant marine.

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All that is changed. Personal health services have become an extremely complex interrelationship of contributions to patient care by a wide spectrum of professional disciplines under a bewildering variety of conditions and settings.

Haldeman has observed that governments characteristically participate in the provision of personal health services before they develop public health controls. This is particularly true of underdeveloped areas. Our country was no exception. Benjamin Franklin got that first grant-in-aid to build the first hospital in the colonies a hundred years before Shattuck dreamed up the idea of a State health department.

The nature of our national development, with its rapidly expanding frontier and almost completely decentralized form of government responsibility, limited these early sallies into medical care to a minor facet of our health care growth. From the middle of the 19th century until the Great Depression, public health was the predominant group activity in health care. With minor exceptions, programs were beamed at all the people: sanitate all the environment; protect all the water, all the milk, all the food; vaccinate all the people; record all the births, all the deaths. As late as 1952, Smillie could write in his textbook on preventive medicine and public health, "Only in recent years have we gained the concept that a healthy individual is a community asset. Contrariwise, a sick individual, or a man who dies prematurely, represents a community liability."

The change in emphasis that is occurring in

our local, State, and national health departments is largely the work of two forces pulling in opposite directions.

Changing Emphasis

The mass activities of most health departments have been gradually moving into an era of automation. The large amounts of administrative energy and time required to get these control programs rolling are not required to keep them going.

Meanwhile, a force like the cloud no bigger than a man's hand entered the health picture in 1912, when, on a wave of liberal legislation in this country and in England, Congress created a Children's Bureau in the Department of Labor. The women who took over the Children's Bureau did not neglect the mass aspects of their problems, but they quickly became interested in the problems of particular women and particular children. This interest resulted in public programs to promote and restore individual health. They brought administrative thinking to the problems of medical care.

Then, in the middle thirties, came Thomas Parran's heroic program to control syphilis. Here was a hybrid of communicable disease control and medical care. It was the first attempt in this country to control a deadly disease with an all-out therapy program through community organization. It brought more administrative thinking to the problems of personal health services than had yet been seen in this country.

Since then, the concept of community concern for individual health has gradually become established.

The emergence of chronic disease in an aging population as a major concern of Congress has resulted in increasing attention to the promotion and restoration of individual health through organized community effort. An important earnest of congressional intent in this area is the Community Health Services and Facilities Act of 1961. "Public health personnel and others in the field of health," said Senator Lister Hill in sponsoring the act, "are faced with the problem of most effectively and most economically ministering to the health needs of those afflicted with chronic disease."

This act contains an authorization for funds for project grants to explore new ways to bring administration thinking to the problems of personal health services. This is a wise provision. A great deal of exploration will be required before we reach Senator Hill's goal.

Cure and Consolation

At bottom, our goal in public health has been to increase and to equalize life expectancy for all the people. The bedside practitioner has this goal too, but he has another goal which for increasing numbers of his patients is even more important. It is to bring comfort, consolation, and capacity during those extended years. Curiously, this goal of the clinician has seemed to get less and less attention as the primary goal of life extension has been achieved by both the community health team and the clinicians. It has been said, perhaps a little facetiously, that the difference between medical care in 1900 and medical care in 1963 is that in 1900 physicians provided consolation without cure, and in 1963 they provide cure without consolation.

Why has consolation waned and what is this to you and me in public health? To answer the second part first, the wane of consolation in care is the most important single reason why we need a partnership of administrative and clinical medicine instead of the uneasy truce that has prevailed for so long. Why has consolation in care waned? There is no simple answer. Part of the reason is so deep and all pervading only a poet or a playwright can sense it. Partly, it is the pressure of technology. Certainly the limitation of time is one of the important factors. As one exasperated practitioner in Oregon put it, "I can hold your hand for 24 hours while you die of pneumonia or I can hold a syringe of penicillin on you for 24 seconds and cure you. Take your choice. Others are waiting." We can help the people get some of both.

Public health administrators are the group in the population best equipped by training and experience to help the clinical practitioner recapture the true meaning of "care." Our graduate degree is in health administration. We know the principles for action in this field and can do the job if we will, as we have demonstrated in venereal disease control and maternal and child health.

As health administrators we need to turn

our attention increasingly to developing ways to help the practitioner improve his ability to coordinate the many disciplines contributing to his patients' care. We must learn to use our administrative know-how to create and maintain the administrative machinery which will assist, and will always be in tune with, the doctor-patient relationship and which will make the time demands of management as small as possible for the practitioner. In our country, the development of this kind of partnership is in its infancy. We will need all the cooperation, understanding, and good will there is in us to make it succeed.

It is urgent that we do make it succeed, for this cooperative relationship between medical administrators and practitioners is the only apparent way the patient can get the full measure of comforting consolation and confident cure at a price within reason. It is the only way that the healing arts can accept the full burden of medical management under our system. And unless we accept the full responsibility of management throughout the entire spectrum of health services from the promotion of health to the rehabilitation of the convalescent, we face an era in which people will look to others who care but not wisely, an era with gradual debasement of diagnosis, fragmentation of therapy, and a decrease in the prestige of our healing professions.

How can we as health administrators meet this challenge? By scrapping our "sacred six"? By mounting our bucking budgets and riding off in all directions? By telling the practitioners they need our help? No. In this field we simply don't know enough to justify such actions. The most important part of the Community Health Services and Facilities Act appropriation is that part appropriated for project grants. If we use wisely the project grants funds, we will find our way to a working partnership with practitioners, to more satisfactory and economical solutions to health care problems.

Starting the Partnership

Two ways are readily at hand by which any health department can begin to meet its increasing responsibilities in medical care administration.

During the past 25 years, as we have noted, health maintenance and health restoration have become extremely complicated not only in their techniques but also in the distribution of resources. Thirty years ago it was pretty much the doctor, dentist, nurse, hospital, and the patients' ability to pay, plus a little more. Now we have, in increasing abundance, health departments, laboratories, special clinics, outpatient departments, group practice, widespread specialization, rehabilitation centers, hospitals for special diseases, chronic disease hospitals, nursing homes, Blue Cross-Blue Shield, a vast array of commercial insurance, labor contract benefits, workmen's compensation, foundation benefits, veterans' benefits, public assistance medical care, OASDI benefits, Vocational Rehabilitation Administration funds, research funds, the Clinical Center of the National Institutes of Health, and many more. At present, in most communities, there is no single source from which a person can get information on every health resource available to the people of that area. Health departments have traditionally considered their responsibility limited to those resources concerned with mass prevention of disease. It is doubtful if anything would increase our feeling of involvement in the total health care program of our communities so much as to become the communications hub through which anyone in the community could find the health resource he needs to meet his problem.

For instance, how many health departments know such basic facts as all the professional qualifications of every person practicing the healing arts in their community? How many even know for certain that every doctor, dentist, nurse, physical therapist, occupational therapist, and other regulated healer has a valid license to practice? How many know the postgraduate training, specialty certification, hospital connections, and professional society memberships each has?

How many health departments are prepared to give accurate information on the eligibility rules for every health resource available to citizens in their area? In this land where 70 percent of the people live in metropolitan areas and where one-fifth move every year, this kind of service is of particular importance.

At least one State has made a good start on this as far as licensing is concerned. Some local health departments do act as a clearinghouse on information about organized health resources in the community, but how many consider themselves as the clearinghouse for detailed information on every health resource available to their citizens? This is a new dimension of our duties as the only continuing legally constituted health resource for all the people.

Becoming a communications hub would not be a simple matter of creating a catalog with a good index. It would mean a thorough knowledge by the health department of the limits of each resource. It would mean a continuing relationship between health departments and these resources.

This kind of information flow is as important in the study and improvement of personal health services as the reports of births, deaths, and disease have been in our traditional role. Out of it might even come the "new and challenging image of community health services" Mattison and Richman are calling for.

And finally, any health department looking for a handle by which to grab hold of the problem of chronic disease should consider rehabilitation. Every State has a vocational rehabilitation service. In the nation as a whole, more than $100 million a year is spent on this program. Nearly half of the case service money spent in this program goes for medical care. In many southern States, it is considerably more than half. In only one State, Washington, is there a statewide program of participation of local health directors in the rehabilitation service. Each client of the vocational rehabilitation service requires an evaluation of his rehabilitation program to assure the soundness of the proposed medical restoration procedures. This review should be made by someone who knows what good medical practice is, who knows about all the resources available to fulfill the client's needs, and who is in a position to be objective in his judgments. In the Washington State program, the vocational counselor meets with the local health director once each week to discuss the medical problems of each new client.

Rehabilitation is a program that is popular with practicing physicians. It deals with chronic illness. It has a built-in need for medical administrative thinking. It is waiting.

Summary

Medical administration is the "new ocean" for public health. We have the know-how and the resources for experiment to make a vital contribution to the solution of one of the vexing problems of medical care through a partnership with practitioners. The changing nature of health problems requires that we make this contribution. One basic way in which health departments can strengthen their position in this field is to become the encyclopedia of information on all health needs and resources in their communities. They should also recognize that vocational rehabilitation is an established program of publicly financed health service in which local health directors can readily establish constructive working relationships with practicing physicians.