Federal Government Interests in Group Health Practice

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BECAUSE the Federal Government seeks ways to bring comprehensive medical care to its citizens at a cost they can afford, the Department of Health, Education, and Welfare is vitally interested in prepaid group health practice plans and programs. Federal interest in the voluntary health insurance movement predates HEW departmental status. The Social Security Administration for years has collected enrollment and financial data about all independent health insurance plans. Among other things, such information has helped in determining trends in health protection available to the public from national organizations. The SSA studies also have made available a nationwide picture of the growth of prepaid group practice plans.

Studies by the Public Health Service of the Department also have helped in understanding the potential of organizing group practice services and the financing of those services. These studies, 10 years apart, were made to determine the number of group practices and the number of physicians who practice in groups. The Division of Dental Public Health and Resources initiated the first studies of prepaid dental programs. The Division of Occupational Health published one of the first descriptions of the various ways unions have organized direct service plans for their members.

Mr. Nestingen is Under Secretary of Health, Education, and Welfare. *This article is based on his talk to the Group Health Association of America at the 91st Annual Meeting of the American Public Health Association and Meetings of Related Organizations, Kansas City, Mo., November 13, 1963.*

In March 1961 the National Advisory Health Council published a report on the role of the Public Health Service in medical care in the United States. It stressed the need to improve the organization of services, to reduce the fragmentation of services, and, through better administrative and financial arrangements, to use resources more wisely. The report mentions prepaid group practice plans specifically.

It recommends that the Public Health Service "conduct a continuing program of intramural studies and technical assistance and a program of grants in support of extramural research, training, and demonstrations in the organization, administration, and financing of medical care."

Before discussing this recommendation, I would like to mention a few other activities of the Department that relate to prepayment groups.

Funds from the Hill-Burton program for hospital construction have provided facilities for several group practice plans. The Group Health Association of Puget Sound added outpatient facilities to its hospital with Hill-Burton funds. The AFL-CIO hospital that was dedicated in Philadelphia in October 1963 has relied on Hill-Burton funds for some of its financing.

In a health message to Congress on February 27, 1962, President Kennedy indicated his great interest in stimulating group practice by making funds available for construction of needed facilities. Future legislation also may give certain advantages to prepaid group practice plans.

The Federal Government has a health benefits program for its employees in which prepaid group practice plans participate. Our Depart-

ment's knowledge of such plans was exceedingly helpful to the Civil Service Commission when it embarked on the unfamiliar sea of administering the program.

At least two States, California and Hawaii, have used the Federal act as a basis of programs for State employees. A recent publication of the Public Health Service outlines all programs for State employees and calls attention to the multiple-choice plans (*1*). Contributory programs of health insurance for State employees have been stimulated by these examples. I have no doubt that other States in which prepaid group practice plans are used will follow the example of the Federal Government, New York, California, and Hawaii.

Why is the Department of Health, Education, and Welfare interested in prepaid group practice plans? I find the reasons of interest because they involve so many agencies of the Department. Let me touch on a few reasons.

Foremost at this time is our concern about an adequate supply of physicians, dentists, and other health personnel for an expanding population.

We find that group practice plans demonstrate an economical use of valuable personnel. If a doctor's time is organized to best advantage, 1 physician can care for 1,000 patients. The current average ranges from 848 to 1,354 in different regions of the country, indicating an oversupply in some areas and a shortage in others. These ratios are not confined to practicing physicians. The situation applies also to dentists. With all the evidence of an increasing shortage in the professions, wise use of doctors and dentists is imperative.

There is growing concern that our young physicians emerging from training are disease oriented rather than oriented toward the whole patient and his family. Some group practice plans provide the setting for teaching family medical care.

A program that is being developed in Cleveland holds promise of giving medical students a chance to see self-supporting, rather than indigent, patients in a setting more comparable to private medical practice. Wards and charity clinics of teaching institutions do not have typical patients.

Another reason for our interest, associated with the first, and of vital concern to our Department, is group practice stress on preventive medicine, which is woven into the fabric of prepaid group practice plans. Preventive medicine saves lives, lessens disability, and produces a productive citizenry: Children are able to attend school, adults are able to stay on the job, old people have fewer chronic conditions. Surely, with illness less prevalent, physicians can care for more people, and costs of medical care can be better contained. Think for a minute what the polio vaccine program has accomplished.

A third important aspect of prepaid group practice plans is removal of the financial barrier to seeking care, which promotes the opportunity to practice preventive medicine or to see patients early in an illness.

Our Department, through the Hill-Burton program, is vitally interested in all phases of hospital care. Therefore, we look with great interest on hospital utilization in the prepaid group practice plans. While the evidence is not clear cut, it appears that where services are available outside of the hospital and continuing care can be provided, the number of hospital days used by a given population are reduced. There is also some evidence that surgical rates are lower.

Prepaid group practice plans serve defined population groups. Therefore, the age and sex composition of the membership can be determined and the services provided can be related to membership characteristics. These data are valuable to a number of HEW programs. The Public Health Service recognized this when they made a grant to the Group Health Association of America to develop a system of compiling data from member plans. A major concern of our programs is the volume of services required by a population outside of the hospital. Populations having access to such services without a financial barrier are ideal laboratories for studies.

Concerned as we are with health care of the aged, we need to anticipate a level of diagnostic services. Through grants, the Public Health Service is aiding the testing of multiphasic screening techniques and the planning of a health maintenance program for older persons.

Our Welfare Administration is watching with interest a health insurance plan—New York City welfare experiment in providing the recipients of old-age assistance with care, coordinated through one of their centers.

The Division of Occupational Health is interested in the records of some of the prepaid group practice plans because of the possibilities of relating a man's occupation to his health status, and following a patient's history through the medical services he receives.

These areas of mutual concern will continue, but I foresee still other ways that the Department will be looking for cooperation from group practice plans. At the same time, the Department may be able to help the groups with pilot programs to test the feasibility of broadening benefits.

The President's Mental Health Program is becoming a reality through legislation providing $150 million for 3 years, beginning July 1, 1964, for formula grants to States. One-third to two-thirds of the costs of constructing community mental health centers will be paid by the Federal Government, and funds will be allotted for construction of research centers and for various activities relating to the mentally retarded or deaf.

Group practice plans have shown interest in the fight against mental illness in concrete ways: improved benefits to cover some aspects in the care of mental illness, studies in cooperation with the National Institute of Mental Health on the incidence of mental disorders in insured groups, and studies of the extent to which physicians, other than psychiatrists, are managing psychoneurotic conditions. Family counseling is offered by a number of the plans as an adjunct and aid to the physician faced by a patient with an illness of psychogenic origin.

Group practice case records on the complete history of medical care given to patients could be a potential source for examining the effects of X-ray on the body.

Our concern with the chronically ill and the aged has increased our interest in what it means to provide services outside of the hospital, both for economic and health reasons. The prepaid group practice plans can add to our knowledge of ways to organize and finance home health services, including visiting nurses, homemakers, physiotherapists, and dietitians. The same is true of nursing-home and convalescent facilities.

The high cost of drugs, particularly for the aged and chronically ill, makes prepaid drug benefits, through group practice, of value to the national effort in appraising the costs and volume of use of medications.

In the discussion stage in Washington are several potential programs that may engage the Federal Government in purchasing medical and hospital services or insurance coverage for other groups. Since these programs would probably provide for services both in and out of the hospital, conceivably they might be patterned on the Federal Employees' Health Benefits Act. This could mean additional enrollment in group plans through contracts such as those arranged with the Civil Service Commission.

REFERENCE

(*1*) U.S. Public Health Service: State employees' health benefits program. PHS Publication No. 947–2 (Health Economic Series No. 2). U.S. Government Printing Office, Washington, D.C. 1963.