The Need for Medical Care Specialists in State and Local Health Departments

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THERE is a strange disparity between the enormous ferment in medical care organization throughout America and the very sparse staffing in this field among the local and State health departments across the nation. In the monthly "Employment Service" columns of the *American Journal of Public Health* one searches almost in vain for positions in the field of medical care organization or any of its variants, such as medical care administration, coordination, planning, research, or studies. Although the organizational tasks of medical care occasionally are camouflaged under seemingly less controversial phrases like "adult health services," or "health facilities and services," or other word combinations that leave some doubt as to their meaning, the apparent lack of demand for such personnel is not solely a question of terminology.

Background

The historical reasons for the meager concern of public health agencies for programs and social issues involving the treatment of the sick are well known. They include, on the positive side, the large challenge of epidemic disease, which properly absorbed the main attention of the early health departments, and the economic good sense of concentrating efforts on preventive services in the community. On the negative side, one must record the energy and initiative of other social entities (both governmental and voluntary)—like welfare departments, hospitals, or health insurance agencies—in organizing or financing medical care, as well as the fears and inhibitions of most public health officials about becoming involved in the controversial issues of "socialized medicine."

We now have come to a period when American health services are characterized by a vast jungle of organized programs for prevention or treatment of disease. There is no less diversity in organizations for underlying tasks like training health personnel, constructing facilities, performing research, or maintaining qualitative standards. There are scores of types of agencies and thousands of discrete organizations involved in all these functions (*1*). It has become trite to point out that coordination is desperately needed among them. Health departments, on the whole, are only small voices in this great and discordant chorus of American health activity.

We are not the first generation to call for an expansion of the role of the public health agency toward concern for comprehensive

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health services: that is, organized medical care as well as prevention. As early as 1800, when Johann Peter Frank propounded his "system of medical policy" in Germany, he included concern for the organization of hospitals and treatment of the sick, as well as for environmental sanitation, maternal protection, and other preventive measures, as the responsibility of a governmental health authority. Later, Edwin Chadwick with his Poor Law Commission in England (1834) and Lemuel Shattuck with his Massachusetts Sanitary Commission (1850) emphasized mass measures for disease prevention, which was appropriate in the great era of "sanitary awakening" (*2*). Yet this only partly explains why the health insurance and hospital movements in both Europe and America developed under auspices quite separate from the public health movement.

However, when the United States Conference of State and Territorial Health Authorities adopted a favorable report on "Health Insurance" in 1916, it discussed administration (*3*).

> There must be close connection of the administration of any health insurance system with the [public] health agencies of the country and with the medical profession. It is believed that this can be done in three ways: (1) by providing efficient staffs of medical officers in Federal and State health departments to carry into effect the regulations . . . ; (2) by providing a fair and sufficient incentive for the active cooperation of the medical profession; and (3) by providing for a close cooperation of the health insurance system with State, municipal, and local health departments and boards.

Moreover, in 1919, Hermann Biggs, health commissioner of New York State, conceived of public health as including administrative responsibility for hospitals and welfare medical care services (*4*).

Dr. Joseph Mountin of the Public Health Service advocated the same broad role for public health agencies in the 1930's and 1940's (*5*). The first major policy statement of the American Public Health Association on medical care, in 1944, called for administration of a nationwide health insurance program by the network of Federal, State, and local health departments (*6*). More recent APHA statements of the 1960's have espoused the same philosophy (*7*). On a world level—as reflected in reports of the World Health Organization and in scores of national studies and reports—the scope of public health agencies is seen to include coordination and planning, as well as direct administration, of both ambulatory medical care and hospitals (*8*).

A Health Department Role

All this history and advocacy seems somewhat theoretical in the light of current developments in the United States. The Medicare law of 1965—with its vast impact on patients and their families, hospitals, physicians, and others—is only the latest of the major developments which seem to have bypassed public health agencies or assigned them only a tangential role, while the central responsibilities are carried by social security agencies, welfare departments, and various fiscal intermediaries (*9*). The "heart disease, cancer, and stroke" amendment of 1965 to the Public Health Service Act heralds a new major movement for regionalization, in which power is being assigned to still other baliwicks, mainly schools of medicine.

Is there any practicable way to reverse this trend? More positively, are there any practical steps that might be taken by public health agencies to give them a significant role in the vast machinery of organized medical care programs operating in every community of the nation?

I believe the answer is "yes," but it will depend on the initiative of the State and local health departments themselves. Many of the now widely accepted functions of public health agencies arose not from specific legislation, but by direct administrative decisions in the context of existing law. In terms of statutes, the authority of State and local health departments is very broad (*10*). Programs of community health education, for example, are seldom subjects of legislation: local health officers have simply decided to offer such services. Professional specialists in health education are hired, their salaries are included in the official budget, and the programs are launched. In like manner official public health agencies inaugurate most programs in nutrition, multiphasic screening, or occupational health (as distinguished

from factory inspection under departments of labor). Maternal and child health services, essentially preventive, have been supported of course by Federal financial grants, but, unlike services pertaining to sanitation or to control of communicable diseases, they have not depended on State or local laws and regulations.

In medical care today the pressing issues on which local leadership is needed are almost endless. So many agencies are involved, and so many problems must be faced—on the delivery of medical care, its reasonable financing, training of personnel, surveillance of quality, and promotion of more efficient and economical patterns—that the complexities may seem overwhelming (*11*). A feasible and immediate role for local health departments is to serve as the center for planning and coordinating the full range of curative and preventive health services in each community. Implicit in this role would be the promotion of new programs, if not their direct administration, necessary to fill the manifest gaps. Included also would be setting standards for and evaluating all organized health activities in a community.

To carry out such a role, health departments must recruit persons knowledgeable about the whole panorama of organized medical care. Half the job of the health education consultant on the health department staff, for example, is to understand the full range of resources for educating people about healthful living. The nutritionist, for example, must know about the diverse programs for achieving a balanced diet, whether these activities are sponsored by a school system, a women's club, a dozen different factories, or elsewhere. However, who in the local health department staff today is sophisticated about general hospitals, nursing homes, welfare departments, rehabilitation programs, health insurance agencies, group practice clinics, regional health councils, and all the other constituents of the medical care complex?

Conceivably the health officer, as director of the local health department, might be expected to have this knowledge. However, ramifications of medical care have become so intricate and far flung that he seldom can understand them all. Even if he has the knowledge, how can he be expected to find the time for the day-to-day tasks necessary to promote the appropriate coordination and planning? As in other sectors of the health services, a specialist has come to be needed—a specialist in medical care organization.

Medical Care Programs in the Community

To get a better idea of the range of problems that a medical care specialist in the local health department would be expected to encompass, some of the principal agencies and programs organized to treat the sick in most American communities may be listed. A few of these are now within the jurisdiction of health departments, but most are under other auspices.

Major providers of service:

1. General hospitals
2. Nursing homes and related facilities
3. Mental hospitals and clinics
4. Independent diagnostic laboratories
5. Group practice clinics
6. Medical societies
7. Dental societies
8. Organized home care programs
9. Rehabilitation centers
10. Pharmacies and prosthesis shops

Governmental programs:

1. Welfare programs for the needy
2. Workmen's compensation
3. Crippled children's services
4. Vocational rehabilitation
5. Veterans Administration medical program
6. Migrant family health services
7. School health services for treatment
8. Medical service programs for military personnel and their dependents
9. Professional licensure bodies
10. Food and drug control agencies
11. Mental health agencies
12. Office of Economic Opportunity (antipoverty programs)
13. Prison medical services
14. State hospital supervising agencies
15. Health insurance for the aged (Medicare)

Voluntary medical care programs:

1. Blue Cross plans
2. Blue Shield plans
3. Commercial health insurance carriers
4. Consumer-sponsored health insurance plans
5. Dental insurance plans
6. Labor-management health and welfare trust funds
7. Industrial inplant medical services
8. College student health services
9. Disease-specific voluntary agencies

10. Visiting nurse associations
11. Emergency services, such as the Red Cross or Salvation Army
12. Family social service agencies
13. Medical and other professional schools
14. Programs of civic agencies, such as women's clubs or businessmen's associations

Coordinating agencies:

1. Community health and welfare councils
2. Regional hospital councils
3. Special councils for the aged, for children, and other specific groups

This admittedly incomplete list of 42 types of agencies involved in some aspect of medical care may suggest the range of programs operating in nearly any community. Even if the agency is not headquartered in the locality, its operations have an impact on the local population. For some types, moreover, there may be dozens of local entities, such as hospitals, inplant medical services, or voluntary disease-specific organizations. Within each agency or program there are numerous well-defined organizational tasks in which the local health department could render assistance.

Organizational Tasks

The new Medicare legislation has brought some of these tasks into the limelight, but the listing should make clear that the needs and opportunities go beyond this scope. Relevant to Medicare (both titles XVIII and XIX) are these current tasks at the local level.

1. Assisting State health agencies in certifying "providers of service"
2. Advising on "utilization review" procedures in hospitals and extended care facilities
3. Facilitating "transfer agreements" between hospitals and nursing homes
4. Assisting extended care facilities in meeting official standards so that they can qualify for certification
5. Organizing "home health services" directly in health departments or encouraging their development by other agencies
6. Encouraging outpatient diagnostic services in hospitals which do not offer them
7. Establishing ambulatory care centers for physicians' services in both urban and rural slums, and thereby improving service to the indigent
8. Converting traditional child health conferences into comprehensive child care clinics
9. Offering emergency medical care in existing public health centers (with arrangement for referrals to nearby hospitals)
10. Upgrading independent laboratories

Aside from facilitating the Medicare program for the aged and the indigent, other challenges in medical care organization for local health departments are apparent.

1. Promoting various preventive services, such as immunizations, routine disease-detection tests, and health education in the general hospitals
2. Promoting inplant medical services in local industries
3. Developing organized diagnostic and treatment services for school children whose physical defects have not been corrected through private resources
4. Offering administrative assistance to physicians who wish to establish private group practice clinics
5. Arranging for impartial quality audits of medical care in local hospitals
6. Offering medical consultation (through health department engagement of physicians) to programs of vocational rehabilitation or for impartial testimony in workmen's compensation cases
7. Developing new medical care clinics in impoverished areas, as part of the Community Action Program of the Office of Economic Opportunity
8. Assisting State professional licensure bodies in protecting the public by identifying practitioners whose performance may be hazardous or harmful
9. Promoting regional hospital councils and other cooperative activities among general and special hospitals in an area
10. Advising consumer groups in the organization of comprehensive prepayment plans for medical care
11. Advising directors of labor-management trust funds on the purchase of health insurance policies which provide the best medical value per dollar
12. Fostering improvement of rehabilitation services in nursing homes and hospitals
13. Maintaining an inventory of all types of medical and paramedical personnel, so as to assist persons in obtaining care day or night
14. Organizing postgraduate educational programs in new aspects of clinical medicine for physicians and others
15. Conducting studies of difficulties identified in the local procurement of medical care and promoting legislative or other measures to correct them

These 25 functions that might be undertaken by local health departments illustrate the range of activities possible without new legislation. In State health departments the range of medical care functions would be even wider. Not that these tasks could be carried out by the current staffs at either State or local levels, but the necessary expertise could be hired in the same way that it has been hired to operate well child conferences, venereal disease clinics, or any of the now traditional public health serv-

ices. Nor could all the suggested functions be tackled at once; careful judgment and timing obviously would be necessary, as it always is in prudent community health leadership. Even to recognize the potentialities, however, would require a specialized staff member knowledgeable about and sensitive to the manifold content and issues in medical care.

Training of Medical Care Specialists

U.S. schools of public health for some time have been graduating persons who have majored in medical care administration and who could fill these positions. After only a handful per year were graduated before 1960, the support of the Special Purpose Traineeship Program of the Public Health Service has led to a national output now of about 75 such graduates per year, and this number certainly will increase.

Interest in graduate education in medical care organization has become so keen that there are now four national committees dealing with it. These committees are attached to the American Public Health Association, Association of Schools of Public Health, Association of Teachers of Preventive Medicine, and Association of University Programs of Hospital Administration.

The great majority of the medical care graduates are not physicians. Like hospital administrators or health educators, they come primarily from baccalaureate backgrounds in the social sciences, business administration, or sometimes nursing, pharmacy, or other paramedical fields. But one need not have a background in clinical medicine to deal effectively with the type of social and organizational problems I am discussing. This view, of course, is not always shared by some physicians who speak deprecatingly of "laymen" or "lay administrators." The fact is that the trained health administrator in medical care organization or other fields is a professional in this sphere; indeed, the average practicing physician is more properly the layman on matters of community organization or social policy.

Representatives of 10 schools of public health held a conference on education in medical care administration at Ann Arbor, Mich., in June 1965 (*12*), and there still is much discussion in the universities and elsewhere on the proper course of study to educate a specialist in medical care organization. As in any profession, of course, there are different levels of education appropriate for different levels of responsibility.

In small public health jurisdictions a person trained to a master's level (M.P.H.) may be adequate to do the planning and coordinating job outlined here. In larger local health departments, however, or in any State health agency, more educational depth and breadth are doubtless necessary. For this reason the school of public health at the University of California at Los Angeles and several others are increasing the emphasis on more thorough training of nonphysicians to the doctoral level (Dr.P.H. or Ph.D.) in medical care organization (*13*).

The policies advocated in this paper may strike some as unrealistic. How can one expect local health departments—which are so often weak sisters in the family of community agencies dominated by hospitals, medical societies, or health insurance agencies—to play such a significant role? Moreover, why does it matter?

The answer, I think, lies not in any parochial mission to advance the status of public health agencies. It lies rather in a vision of an effective, rational, and comprehensive health service for the population. It springs from the same realization that has led social and political leaders to call for more planning in nearly all sectors of modern life, not the least of which is health service (*14*). We see this in the final conclusions of the 5-year study by the National Commission on Community Health Services, in the new national legislative proposal (recently enacted) on grants to the States for "comprehensive health planning," in the whole concept of "creative federalism," and in the public-private agency partnership which is now so fashionable (*15*).

Such planning demands a center of leadership at the national level, which is now being increasingly assumed by the Federal Department of Health, Education, and Welfare. It also demands leadership at the State and local levels. Either wholly new health organizations must assume this role, which would only add to the complexities, or it will have to be assumed by vastly broadening the scope of

public health agencies. The specific proposal I advance for appointment of medical care specialists in local health departments is intended to move us a little further along on the path from the speculative challenge to a realistic coping with the need.

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Vision Test for 3–5-Year Olds

A simple hand card test may soon enable parents to screen preschool children visually in their own homes to determine early cases of amblyopia ex anopsia, a condition which results in loss of vision in one eye, and frequently causes crossing of both eyes or other types of squint.

The modified Sjogren hand card has been developed by the Illinois Chapter of the American Academy of Pediatrics, the Illinois Department of Public Health, and the Chicago Medical Society. It is intended for testing 3- to 5-year-old children.

The child is asked to point his hand in the same direction as the hand pictured on the card at a distance of 3 feet, and again at 12 feet, using both eyes, the right eye only, and finally the left eye only. If a child cannot identify the correct direction in at least four of six positions, he may have an early case of amblyopia ex anopsia. An ophthalmological examination would then be recommended.

Frequently these children see well with one eye. Poor vision in the other often is not detected until tested in school at 5–7 years of age. For many, detection at school age is too late for help.