Public Medical Care

PRINCIPLES AND PROBLEMS

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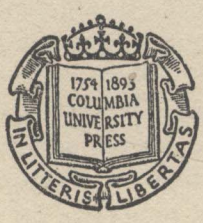

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PREFACE

ADEQUATE medical care is a fundamental human right. It is as much a necessity of life as food, shelter, clothing, or education. It is no less indispensable to the well-being of society than to the welfare of the individual. It is an essential component of any program for individual and social security.

In every civilized country efforts have been made to organize facilities and services necessary to prevent, cure, and mitigate illness and to reduce, if not prevent, disability, economic insecurity, and dependency. The development has advanced at widely varying rates of speed. On the whole, steady and impressive progress has been made, particularly during the last decades.

As a result of an arduous process of growth, often through trial and error, there have come into existence a large number and great variety of programs designed to distribute—nay, *democratize*—services for the sick. A systematic classification of all these efforts would be beset with the greatest difficulties were it not for the fact that two principal methods of finance have been used, namely, taxation and insurance. In general the combination of these two principles has been favored as the most promising approach to the goal of social security.

The actual situation differs greatly from country to country due to wide variations in needs and available resources and even more so in social philosophy. One group of countries have placed primary emphasis on the wide application of the contributory principle. They have made social insurance the backbone of their national health program, relegated tax-supported facilities and services to a secondary role, and relied on the efforts of voluntary organizations to provide for essential facilities and services not covered by compulsory insurance schemes.

A second group of countries have used the principle of taxation on a comparatively large scale, primarily for the construction, equipment, and improvement of all essential facilities needed by the population. The costs of operating these institutions, including the costs for personnel, and of services furnished by nongovernmental facilities and health professions in private practice are defrayed mainly

by programs of compulsory and voluntary health insurance and only to a smaller degree by tax funds.

A third group of countries have favored the allocation of tax funds for the establishment of selected institutional facilities and for payment of services rendered to designated groups in the population. They have left it largely to voluntary effort to provide certain facilities for the care of the sick, such as general hospitals and treatment centers, and to organize group prepayment plans for medical care. In many instances they have adopted compulsory insurance against industrial accidents as a first step toward an inclusive system of social insurance.

The operation of programs based on the insurance principle has been analyzed and evaluated often and thoroughly. In contrast, few studies have been made of the manner in which the principle of taxation has been applied to the organization of medical care. There are detailed descriptions of selected tax-supported services but there is no composite picture of the whole field.

This book deals with public medical care as a social movement. It is organized in two parts.

The first part attempts to analyze, interpret, and appraise public policy in providing, at public expense, facilities and services for the care of the sick. No effort has been made to present the events in strictly chronological sequence. Nor has the emphasis been placed on a factual review of selected programs of public medical care as they stand. Special needs, socio-economic conditions, and social philosophies in various communities differ too greatly to allow generalization of purely local experience. Instead, this presentation tries to follow those currents of thought which have left a deep mark; to find the common elements in the vast number of developments that have taken place when enthusiasm crystallized into programs; and to trace the guiding principles of organization and administration that have emerged in the process of a piecemeal and, often, haphazard growth.

The second part of this book takes up the problem of planning for clinics, hospitals, and related facilities; for organization of professional services; for payment; and for administration of medical care. It endeavors to show the relative merits of the method of taxation and its potential value to the development of broad programs of health and social security in the future, when the realization of freedom from want will tax the ingenuity of all democratic countries.

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FRANZ GOLDMANN

New Haven, Conn.
July, 1944

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If we could first know where we are and whither we are tending, we could better judge what to do and how to do it.
ABRAHAM LINCOLN

Part I: Haphazard Growth

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THE PATTERN OF PROGRESS

THE term "public medical care" denotes a special area of community health activities distinguished by two major features: taxation, general or special, is the method by which the funds are obtained; and an agency of government—local, state, or Federal—is responsible for the administration of the service.

This definition, used here in the interest of clear, functional designation of public activities, gives the term public medical care an exact and technical meaning. Not infrequently the word "public" is attached to any nonprofit program or institution offering medical care to groups of people with no regard to the source of funds and the administrative auspices. Such usage reflects the opinion that medical care in general and organized care of the sick in particular is essentially a public service because it benefits the community, serves the common good, and promotes the well-being of society. It visualizes ends to be attained but does not indicate the approach and the methods actually used to accomplish a specific task.

From a functional point of view public medical care, as defined here, includes all the facilities and services needed by a sick individual, not physicians' services alone. If there is one lesson that can be learned from the rapid advance of medical science and the practical application of scientific knowledge and skill, it is this: the various types of facilities and services necessary to meet adequately the needs of the sick are so closely related to one another and so interdependent, both professionally and economically, that they should be considered as an entity.

Public medical care in the United States has developed from hum-

ble beginnings in colonial times to a social movement steadily gaining in impetus. In spite of, and because of, its progress it has been, and continues to be, a controversial issue.

There is little dispute about the principle of public responsibility for adequate medical care. But there are wide differences of opinion as to the extent to which that principle should be applied and the form of organization that would best serve the purposes to be accomplished.

In the course of centuries a large number and bewildering variety of public facilities and services for the sick have evolved. They have grown piecemeal and haphazardly.

At first glance the picture of this development seems to be like a mosaic without any design. Closer study, however, reveals that there are definite patterns. The advance of public medical care has taken place in four principal directions at different rates of speed.

1. A public hospital system, including a large number and great variety of facilities for medical care, has been developed under the auspices of local, state, and Federal governments. It has grown from three main roots: "the pesthouse," the "insane asylum," and the "sick ward" in the workhouse or almshouse.

2. Various types of clinics have evolved out of the primitive dispensary distributing free drugs to the poor.

3. Organized programs, providing for home, office, clinic, hospital, and custodial care at public expense, have been set up for numerous socio-economic groups. They have superseded the old emergency provisions for a tiny segment of the population. In addition, separate programs, including complete medical care, have been established for the control of certain diseases and defects.

4. Responsibility for organization and administration of facilities and services for the care of the sick has been transferred from small to larger political units. Increasing emphasis has been placed on Federal-state and state-local cooperation so as to meet the needs for improvement of public medical care.

In many instances serious efforts have been made to substitute long-term strategy for the stopgap tactics typical of public policy in early times. The attainment of quantitative and qualitative adequacy of public medical care has been realized and accepted as a major task in contrast to the days when governments grudgingly granted a service that was too little, too late, and too poor. Some

beginning has been made to bring the public services for the sick into closer relation with the public provisions for the prevention of illness and promotion of good health and to coordinate them with nongovernmental activities. But the development has been fragmentary and far from uniform. Some of the policies and procedures adopted long ago have proved to possess a surprising longevity. They have remained substantially unchanged or have been but slightly modified —in spite of the rapid advance of scientific medicine and the profound social and economic changes that have taken place.

Details on the progress of public policy from the time of the emergence of community responsibility for medical care up to the turning point of the global war will be presented in subsequent chapters.

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THE GROWTH OF PUBLIC HOSPITALS

THE public hospital system in the United States has grown and expanded continuously. In 1942 the registered facilities controlled by local, state, and Federal governments provided 1,015,781 beds, or close to three fourths of all beds available in the country. They rendered service to nearly one third of all hospital admissions and to more than three fourths of the hospital population.[1] These figures are striking and impressive. They furnish conclusive evidence that there is an extensive program of hospital care under public auspices. They do not depict, however, the part played by the public hospital in the community health program. Actually, one in every four governmental hospitals and one in every five beds in them are, as a rule, not available for general use. They are restricted to designated groups of the population for whose care the Federal government has assumed responsibility.

Of the beds in Federal hospitals in 1942, more than three fourths were in general, about one fifth in mental, about one fiftieth in tuberculosis, and an insignificant fraction in other hospitals.

In contrast, about three fourths of the beds maintained by local and state governments were in facilities designated for patients with mental deviations, while about one seventh were in general, about one twelfth in tuberculosis, and a small proportion in various other types of hospitals.

Evidently the course followed by the various public agencies has been quite dissimilar. For selected groups general hospital facilities have been provided in relatively large numbers. For community service, on the other hand, the special hospitals for mental deviations have been the principal facilities established at public expense, while general hospitals have been made available on a relatively very small scale.

The development of hospital facilities under the auspices of local and state agencies has been decisively influenced by the interpretation of government's obligations in this field. Traditionally, provision for selected services—but not the creation of a balanced hospital system—has been considered a public concern.

In early times assumption of community responsibility for insti-

tutions was motivated by fear, the need of self-preservation, and the desire to be sparing with expenditures for the maintenance of "paupers." The main objectives of social action were to prevent danger to the community and to salvage human flotsam. In line with this concept facilities were established for the segregation of patients suffering from the diseases most feared, the contagious and mental, and for the accommodation of the destitute sick. They were the first manifestations of public responsibility for institutions. For a long time "the State [closed] its eyes to all illnesses which did not fit the crude conception which identified the sick person with the criminal and removed him for the while from society, not for his reformation, but for the public good." [2] This comment, made by J. H. Harley Williams on the social philosophy prevailing in Great Britain up to the turn of the nineteenth century, can be applied to many a country.

The old public institutions were designed and equipped to give custodial care only, and that at a minimum expense to the taxpayer. Shocking defects in building, equipment, and care were frequent; time and again they aroused public indignation. But the niggardly attitude of official agencies toward their institutions for the sick prevented radical improvements. The reasons for this attitude were anything but obscure. The diseases recognized as requiring institutionalization at public expense were those which were believed to demand nothing but custodial care. The carefully restricted group of the sick admitted, the destitute, were regarded as an inevitable burden to the taxpayer and were provided only with the minimum of care.

No respectable citizen would descend to such depths as to apply for admission to a public institution if he could help it.

In the course of the nineteenth century, particularly towards the end, the picture began to change. Scientific and technical progress made it possible to transform the old institution for the sick from a center of danger into a center of usefulness. Four developments combined to make the modern hospital. They were: improvement of sanitary conditions; progress in architectural design and construction; advance in diagnosis, treatment, and medical technique; and introduction of organized professional services by physicians, nurses, and medical social workers. It must be noted that "medical social service in hospitals" in the modern sense is a product of the twentieth century.

The functions of a hospital could be redefined. Around the middle

of the nineteenth century the institution for bed patients was still generally believed to serve three major purposes. Rudolf Virchow described them as follows: to furnish custodial care for the sick; to provide for the professional education of medical and nursing students; and to carry out medical research. A generation later it had become clear that the modern hospital could make another, and highly important, contribution to society as well as to the individual: namely, organizing and providing adequate and competent diagnostic and treatment service. Restoration of health, working ability, and earning capacity became a new and increasingly stressed objective of hospitalization.

The contemporary concept of a hospital is well expressed in the following definition:

> [A hospital is] a community organization which provides facilities and personnel for rendering the highest possible grade of health services to patients, professional groups and the community; for educating the community to demand and support adequate health services and sound health policies, for educating additional personnel and professional groups in technical fields and in co-operative endeavor; and for advancing our knowledge of disease and its prevention through technical research and appropriate organization.[3]

Huge was the task faced by communities anxious to keep pace with scientific and technological progress. There were new opportunities to improve the situation in the hospital field. But there arose also a big problem. Should tax funds be raised and allotted only to reorganize, modernize, and increase such services as were traditionally supported by local and state governments or should a broader policy be adopted? The decision fell in favor of a new approach. Since the end of the nineteenth century public policy in regard to hospitals has changed markedly.

Communities became cognizant of needs hitherto disregarded. Many abandoned the time-honored concept that the establishment of facilities for communicable diseases and mental deviations and the provision of free service for the poor were the standard and only functions of government in the field of hospitalization. More diseases and special conditions were added to the list of those warranting hospital care at public expense. Among them, physical handicaps and malignant tumors received primary consideration. Determined

efforts were made to substitute general hospitals meeting modern standards for institutions of the poorhouse type.

New principles of organizing facilities for the care of the sick emerged. In the first place, differentiation of service according to special needs was emphasized. A variety of special hospitals were established and gradually subdivided into units designated and equipped to perform particular functions. General hospitals were departmentalized, often to a high degree. Unfortunately, the principle of specialized service has not been carried far enough. Chronic disease and convalescent hospitals have been sadly neglected. Secondly, concentration of highly specialized personnel, equipment, and physical plants was stressed in the interest of optimum and economical utilization of all resources. Hospitals of moderate or large size have been built in preference to small ones that cannot be equipped and staffed adequately and still be operated economically.

In general, the special hospitals under government control, such as tuberculosis and mental hospitals, have been staffed with salaried physicians. On the other hand, most of the general hospitals have only a skeleton staff of full-time physicians and rely for professional services largely on physicians practicing in the community.

In short, the public hospital system, once comprising a few types of special facilities, began to expand along all fronts. What is even more significant, many of the governmental hospitals reached a high standard, chiefly as a result of harmonious cooperation between public agencies and the American College of Surgeons. Others, however, continued to be ugly ducklings among local facilities.

Increasingly the services of hospitals controlled by local and state governments were made available to the public at large rather than merely to the needy. Such opportunity was first offered to patients with communicable or mental diseases and gradually, although not uniformly, extended to others regardless of the type of disease. The long-standing distinction between these special hospitals for all of the people and general hospitals for the poor became less sharp; in some parts of the country it has disappeared. Particularly in small towns and sparsely populated areas has the governmental hospital become a true community hospital providing medical care for all economic groups.

In hundreds of communities a service once disliked, if not despised, by all has won a high place in public esteem and is used by people

from all walks of life. Yet, there are instances where governmental facilities demonstrated an old truth to be valid: evil reputations cannot be lost in decades, while good reputations can be lost over night. In some large cities the municipal general hospital, deservedly or not, has remained separated from the community by a wall of distrust.

A similar change took place in Great Britain, once called "the home of the voluntary hospital." [4] Prior to 1929, only infectious disease, mental, and poor-law hospitals were supported out of tax funds. Since the early thirties public general hospitals for community use have been provided on the basis of a carefully drawn plan. They have grown in number, improved in quality, and won the confidence of the people.

FACILITIES FOR PATIENTS WITH COMMUNICABLE DISEASES

Community responsibility for establishment of institutional facilities for communicable diseases dates far back. It has advanced particularly since the Middle Ages when severe epidemics struck many European countries and created problems of tremendous gravity and magnitude. *Visis effectibus*, after the effect of epidemics had been seen, communities tried to prevent the recurrence of devastating visitations from a disease that *communicat multitudini*. The two principal methods employed were maritime quarantine, that is, the detention for a fixed period of all vessels coming from an infected port, and isolation of the infectious sick in special institutions established for this purpose.

American policy followed the same path. Public responsibility for maintenance of isolation facilities was increasingly accepted in the eighteenth century. Stirred by the staggering toll in human lives and the havoc wrought to business by "contagious" diseases, public opinion strongly demanded and unreservedly endorsed the allocation of tax funds so as to eliminate the danger to public health. One community after another adopted statutes authorizing or requiring the maintenance of special institutions, such as pesthouses, lazarettos, or smallpox hospitals. These institutions became the favorite places for exiling the sick from the rest of the community. They were complemented by facilities at seaports for the detention of passengers and crews suspected of "a contagious distemper," as the quarantine law enacted by the colonial legislature of New York in 1758 put it. Objectives other than these were temporarily attained with the intro-

duction of inoculation hospitals designed to provide for inoculation against smallpox.

Definite as the interest in community responsibility was, it occurred in waves, gaining momentum with a new outbreak and slowing down with the disappearance of an epidemic. Action was taken only if and when an emergency arose. Temporary arrangements and makeshift solutions were the rule. Facilities were maintained "for the duration" and discontinued when the scare subsided. Simple expedients were employed, such as the conversion of refuges, almshouses, inns, or doctors' homes into temporary isolation facilities or the use of hastily erected barracks or camps. As late as 1897, Kern County in California saw only one way out of the dilemma created by a smallpox epidemic: to isolate the patients in tents out on the plains and have them watched by an armed guard to prevent their escape.[5]

Isolation facilities were mainly for patients who were recognized as affected with a highly communicable disease. Wards in workhouses or poorhouses accommodated many destitute patients in an infectious stage whose condition was not noticed at all or believed to warrant no special attention. In the absence of any provision for isolation these "fever cases" made the institutions into centers from which infection spread. Most of the hospitals, primarily those of the proprietary and nonprofit voluntary type, for reasons of self-protection refused to admit any patients with an infectious disease or transferred them immediately after the diagnosis was established. Significantly, in the French capital in 1893, the general hospitals La Pitié with 766 beds and La Charité with 520 beds had but five and three isolation rooms respectively. The dangerous conditions prevailing in the hospitals of many countries by the end of the nineteenth century were summed up by M. L. Davis at the International Congress of Charities, Correction, and Philanthropy held in Chicago in 1893 in the following words: "The labors of sanitarians have been directed almost exclusively towards preventing the spread of disease from the sick to the well—no attempt being made to protect those already ill from receiving more of the disease germs and, thereby, aggravating each individual case." [6]

A new phase of development began late in the nineteenth century. Permanent programs emphasizing adequate and competent treatment to render infectious patients noninfectious superseded temporary arrangements for the segregation of such patients as were

highly contagious. The scientific basis for the turn to new objectives was provided by the rapid progress in the knowledge of causation and modes of transmission of infection; the adoption of new principles of hospital building; the vast improvement in the technique of care of infectious patients; and, last but not least, the introduction of new and effective treatment methods. All these advances made it possible to build up an entirely different system of hospital care.

The old isolation facilities had served "contagious" patients without distinction as to type of disease, although there had been some exceptions to the rule. Particularly notable are the special institutions for syphilitic patients maintained by a number of cities on the European continent as early as the end of the fifteenth century and the smallpox hospitals established later in many countries.

The new policy was based on the principle of organizing special services to meet the special needs resulting from specific diseases.

Four main types of facilities for patients with communicable diseases have come into use: (1) special hospitals designed exclusively for the treatment and care of a large variety of acute infectious diseases; (2) special hospitals accepting exclusively patients with a distinct type of infection such as tuberculosis or venereal disease; (3) general hospitals and special facilities, such as mental or children's hospitals, equipped with units for service to a variety of infectious patients; and (4) special institutions designed primarily for long isolation of patients with conditions such as leprosy or advanced tuberculosis in a chronic stage.

These facilities are distinguished by their functions as well as by the type of disease admitted. The first three groups emphasize treatment, including that of complicated conditions, and, to a varying extent, observation for the establishment of diagnosis. Isolation remains, of course, an important objective. The fourth group places the main emphasis on segregation so as to prevent danger to the community but also makes provisions for medical supervision and such treatment as may be needed. It includes a variety of institutions ranging from simple homelike facilities to elaborate settlement-like organizations.

In organizing treatment services for patients with communicable diseases other than tuberculosis (and, sometimes, venereal disease)