The Linacre Quarterly

Volume 37 | Number 2 Article 19

May 1970

Persistent Problems in Medical Care

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With some anxiety, some humility, some modesty, I come before you this morning to talk about some persistent problems. What I am going to talk to you about was what I once gave as a course that took 16 hours, so I don't think you can expect me this morning to be able to cover all of those aspects. I am just going to pick out a few that you might find of some interest.

Of course, the first one has to do with the problem of medical manpower. There is no question in my mind that as we look ahead to the decade of the 70's, and perhaps even beyond, the most persistent problem is the shortage of manpower and womanpower in the health professions.

Wilbur Cohen, well known Secretary of Health, Education and Welfare under the administration of President Lyndon B. Johnson. Generally credited with being the author of many of the provisions of the "Medicare" legislation, Dean Cohen now is associated with the University of Michigan as a consultant in Health and Welfare and Dean of Education.

Last year when I addressed the Medical Association of Deans of Medical Schools, I wholeheartedly supported the AMA-AAMC position that in the course of the next decade we should double the freshman class in medical schools from about 9,000 at the present time to about 18,000.

The same thing is true regarding nurses and other medical personnel.

But I believe it is very, very important and it is very incumbent upon the medical profession, and all the medical and health professions in this area, to work together with government in the development and expansion of medical schools on the construction side, in the expansion of faculty and in the student financial aid as perhaps the number one problem.

RISING COSTS

Certainly, we all know that because of the problem of rising costs, it is obvious that if we have a continued shortage of professional personnel,

Mr. Cohen's article was originally published in the November, 1968 issue of the Indiana State Medical Journal. The editors have granted permission for The Linacre Quarterly to re-publish Mr. Cohen's essay.

prices will inevitably rise. There is no way to repeal the economic law of supply and demand. If supply is short and demand goes up which are the two things which will be happening during this decade, which has been happening the latter part of this decade, the problem will become even more intense.

As I speak later about the problem of extending the delivery of medical care to many people who don't have it, the problem of demand is going to become even more severe within the next ten years, and so, for that reason, I urge – I gently request and I suggest that the medical profession seek to work with government in the whole area of manpower.

It is absolutely essential, and I think there is very little controversy today as against ten years ago about the need for cooperation with government in the development of the financing of this important area.

Many millions of dollars are involved. I think if the medical profession were to work constructively with government, as I hope they will work with Dr. Egeberg, that it will be possible in the next few years to make a monumental impact on this problem, and no area of AMA-profession-government relationship has the possibility of greater constructive possibilities than were the medical profession now to enter wholeheartedly into this whole area. I think it will be possible. I am not pessimistic at all.

REVISION OF CURRICULUM

There is a second area that was discussed at that time that I think is important, and I do not feel competent to talk about it in detail but I read a good deal about it and that, I think, must involve a complete revie and possible revision of the medical hool curriculum.

I believe as I study the rious aspects of the medical school curriculum that it is now too long a l too complex and doesn't repres t an adaptation to current needs.

As a matter of fact, in my peech last November at Houston, I com-mended another Flexner Con ittee to completely review medical chool education.

There are a number of other atters that I could express some views n.

I think a review of the whole method of how we pay inter s and residents and whether the cost f that should be borne by hospita as a patient cost or should be born as an educational cost needs to b com-pletely reviewed.

But in this manpower area, think there is no reason that I can ee for continued conflict or contro rsy. I think that the medical profess n and those outside see eye to eye on eneral overall principles, and I would ertain-ly believe that during this com g four to eight years with Dr. Egebe g here, there is no reason why the edical school deans, the medical pro ession, those concerned about medic l costs and medical ideals couldn' work together constructively to deal more rapidly and more successfully with this particular problem.

ORGANIZATION OF MEDICAL CARE

Now I would like to turn to a question of the organization of medical care.

I happen to be one of those who have strongly believed over the years in pre-payment and group practice. I have myself been a member of the board of directors of a group practice plan for some years – a member of a group practice plan for some 27 years. I happen to be one of those who have been quite satisfied with the quality of medical care I received from the group practice plan.

Having been on the board of directors, I know something about the problems, both from the patient's standpoint and from the doctor's standpoint, and I recognized that there are a lot of doctors and a lot of patients for whom group practice is not applicable at the present time, but I do believe that it is necessary for those who believe in group practice, and those who do not, to begin to get together and to try to resolve this great conflict that has existed about group practice. The various states which still have restrictions against the use of group practice, particularly about consumer participation, I think are both unfair and unwise, and I think in addition it is a blot upon the integrity, or upon the professional integrity, of the medical profession, to have many people believe – whether it is true or not – that organized medicine does not support or encourage or stimulate group practice plans.

Whether that is true or not we can debate for a long time, but speaking more in a public relations sense than in a substantive sense, I think it is time that we get together on this issue, and I believe it is significant that many of the younger students coming up from the medical schools today are much more in favor of group practice than probably those in this room, who are the seniors in the medical profession.

I am not trying to say that you individually, or that you collectively ought to endorse group practice, but I think for a sizable, perhaps still minority of professionals and patients, it represents a substantial area of possible adaptation to changing needs.

So, without trying to precipitate a result, I think we at least ought to open the dialogue about that, and I would hope with Dr. Egeberg's selection, this would be one of the items that would come up for discussion.

ECONOMY OF OPERATIONS

Thirdly, I think the most persistent problem that we are faced with today in medical care is from the standpoint, speaking now of perhaps the non-professional, is what I could call the interest, or renewed interest, in the efficiency and economy of operations in the medical care field.

I think that there must be a continued re-examination of new methods and new procedures to deal with problems of delivery of care. Certainly, the neighborhood health centers coming into the problems of the intercity struggle, with the problems of the ghetto – the whole fact that there are four million women, as we know from the various studies, in the fertility age group, from 15 to 44, who do not have family service plans available to them is something that certainly could be resolved.

For those of you who are concerned, John Rockefeller and I were co-chairmen on a committee for family planning last year, and we came up with a recommendation that in three years it will be possible in the United States to bring family planning

services to these four million women at a relative cost of about $120 million a year, or $30.00 per woman.

This is not an insuperable financial organizational question but it is one that certainly ought to be explored as another area of cooperation between the medical profession and other non-health groups in working in that area.

What I am trying to say is simply that we must not close our minds to new ways of working in the community with people outside the medical profession in the more effective organization and delivery of medical care.

The American Medical Association and various groups have expressed that health education and delivery of care is not solely a matter of concern or possible solution by the physician. Matters of malnutrition and hunger and family planning and lack of access and lack of understanding about medical care are all certainly the responsibility of other people in the community, and there must be new methods and new ways of looking at this.

I certainly agree that the whole matter of continued expansion of utilization review must continue.

There is no question on the point, it seems to me on reading the literature, that there are people in hospitals who do not need to be in hospitals. Some of them are there too long; some of them that are there do need to be there at a given moment, and certainly that indicates the need for much greater ap al of review and utilization review, a I think it also means considerati of many more alterna-ives to inst tional care.

Certainly, our Blue Cross a l our Blue Shield policies need to be dical-ly revised and extended to be su that home and office care are avail le as well as home health services an other types of services that will ep a person out of a day of hospit l care wherever medically indicated.

I believe one of the big prob ns we will see developed within the next couple of years is rather a strong revision of these Blue Shi l-Blue Cross commerical policies to e that comprehensive care, including ut-of-hospital, non-institutional care s part of the method of financing t s care. This certainly has been a key persis-tent problem, but certainly on that is now indicated on the part f the professionals and those co cerned with financing as well wit n our capacity to resolve.

THIRD PARTY PAYMENT

Now, the fourth persistent roblem is coverage of persons and serv ces not covered under health insurance

I would go back some 35 y ars ago when I started as a young ma in this field. How controversial th whole issue of third party paymen in the field of health insurance wa at that time!

I think one of the great experiences of our time is the way in which the medical profession and others in the community have built into this idea of insurance third party payments that has been relatively successful as a method of dealing with one of the great problems of our time.

However, we all know that there are very substantial groups – some 20 or 25% of our population in the United States – that are not covered under health insurance of any kind whatsoever. No Blue Cross – no Blue Shield – no commercial insurance – not a single penny or dime of coverage. Others among the other 70 or 75% of the population have minimal or only inadequate coverage.

Certainly, after these 35 years, we know now that the principle is sound. We know how to make it work.

I concur in the prediction that it will not be long in the coming, in this decade, when every single person in the United States will be insured under some health insurance policy for comprehensive care.

I think the great lesson of the Medicare controversy is that if the medical profession does not cooperate, sooner or later someone else will do what is needed without the co-operation of the medical profession.

In 1941-42, when I was working on the first legislation, I wrote a letter for one of the then important people extending an offer to the American Medical Association to cooperate in the advice on the first health insurance bill. That was turned down.

In 1961, when I first came in as President Kennedy's Assistant Secretary, I wrote a letter for one of the secretaries, offering the American Medical Association the opportunity to comment on the various provisions of what was then the King-Anderson Bill, and eventually became the Medicare Bill. The opportunity was not accepted.

I think that was too bad. I think many of our problems in Medicare and Medicaid go back to that failure on the part of the medical profession not to have had an opportunity for consulation and participation.

Where the participation in the Medicare program after 1965 was substantial, as we offered it in 1965, there has been relatively good success. Where there has been lack of co-operation and understanding, the program has had certain failings.

And so I believe it will not be long, and I would predict by 1976 in this country, that every single one of the then 220 million people in this country will be covered under a comprehensive health insurance policy. The only question is how.

Now, I think in this next year we can find the formula to work together. First, I believe very strongly that the disabled ought to be covered under the Medicare program.

There are about one and a half million people under the age of 65 already drawing Social Security benefits who are exactly in the same situation as those over 65, and they ought to be brought into the Medicare program, just like senior citizens 65 or over.

Over half of any kind of voluntary health insurance policy holders – and most of them about six or eight months or a year after they are disabled – lose those policies because they are not able financially to keep up their private insurance.

I think it would be a boon to private insurance as well as to individuals to have them covered under Medicare, and I see no radical departure in the extension of that principle by covering people who are old among the group, who are old by chronological age and I would hope that rather than opposing

that feature when Congress begins to consider it this fall and next year, that the medical profession will show statesmanship in supporting it rather than opposing it.

I think this will be one of the first steps in the development of a co-operative relationship and working out the developments of that so that its administration will be successful.

PRESCRIPTIONS SHOULD BE INCLUDED

I believe that the coverage of prescription drugs under the Medicare program is also essential. I should say quite frankly that I view it with some hesitancy because the problem of the administration of a whole series of prescriptions which are in the millions is a very, very big administrative problem. I think our computers are not completely equipped yet to deal with this problem.

I would begin in a very limited way, taking only the most high cost long continuing drugs and not start in a comprehensive way, but for most of our senior citizens, who are living on rather small incomes, and particularly the four percent who have prescription drug bills of over $250 a year – I think we should insure those costs of prescription drugs under the Medicare program.

As I said to the drug businesses, the drug companies – as I have said to the pharmacists, and as I would say to you, the time to get into talking about the specifications and the administration of that is in the beginning rather than after it is the law of the land because certainly, as I stand before you, and whether you are for it or against it, I would predict that sooner or later it would be the law of the land.

PRENATAL CARE PROGRAM

It is a rather difficult thing in the United States to realize that we are only 14 or 15 in the world in our rate of infant mortality; that is, there are 14 or 15 other countries which have a lower infant mortality rate than we have.

Right here in New York there are places where the infant mortality rate is as high as 35 or 50 for every thousand live births, and other where it is as low as 15; there are other where it is as low as ten, and there are places in Intercity Chicago where they are as high as 40%.

We also happen to know that out of the 3½ million women who deliver a child each year, there are somewhere in the neighborhood of about five, six, or seven hundred thousand by sample studies that do not have comprehensive prenatal care at the present time. Most of these women, of course, are women in the low income groups, among the black members of our society, among the Appalachians, among those with low educational attainment with little health education, but the fact is they still produce 5, 6, 700,000 children a year, and without comprehensive prenatal and possibly even postnatal care.

I believe that part of the infant mortality, part of the maternal mortality, part of the lack of good access to the delivery of health care would be met if we were to develop a comprehensive prenatal care program.

But a Kiddie Care program, whether that should be handled through an insurance mechanism or through the prenatal and child health care program, is one of the questions on which the cooperation of the medical profession could be effective and meaningful if a new dialogue and a new discussion were to develop.

As I said, I believe that health insurance will be extended during the coming decade to all these millions who don't have it today, and on a policy or on a basis that will assure a rather comprehensive policy, including both hospital care and an incentive on keeping people out of high cost institutional care.

As a matter of fact, I think that if everybody is covered, we might even include in that kind of a program giving every physician in the country a minimal mal-practice insurance coverage.

I think, as a matter of fact, that if we could sit down in a room and discuss how that could all be worked out, you would find there were many advantages to the profession.

However, whether it is done by asking people to sign up under Blue Cross or Blue Shield or commerical insurance, or Medicare, in my mind remains one of the big open questions of our time, and again, I say now is the time for the health professions and others to sit down and explore that question, because if it is not explored, it still is going to be answered sooner or later.

WE MUST COOPERATE

Fifth, one of the big persistent problems in my opinion is cooperation between public groups or consumers and the professions.

As I see the problem, looking back to 1938 when the first Wagner Bills were introduced – that is a good sort of marking point – there was a period of time in 1938 when the American Medical Association and medical groups evidenced an interest in co-operation with consumers and government.

By 1939 that had broken, and roughly you might say that from 1940 to 1965, some 25 years later, there was a complete separation, because there wasn't a really effective opportunity for dialogue and exchange of views.

It is my opinion that with the passage of Medicare and Medicaid, an opportunity for an era of dialogue and constructive communication is now possible. The appointment of groups like "Help Back the Health Insurance Committee," with representatives on it from a host of other bodies, advisers from Medicare, and so on and so forth, that now enable us to communicate, there ought to be more effective dialogue, but I believe it does mean that there has to be this common understanding, which I think has been most difficult, and that is that consumers of medical care have a right to express their views and their concern about the quality of medical care, the method of financing, and the method of organization.

It is not possible, ladies and gentlemen, for 300,000 physicians in this country, with 200 million population, to completely determine all of the terms and conditions that go into the complex question of medical care, medical schools, medical education and delivery of care, access to care and Blue Cross and Blue Shield and Medicare.

I think the whole 200 million, including the 300,000 physicians and 650,000 nurses – in fact, all three

million of the people working in the health industries, have to be brought together in a new kind of working relationship. I believe that one of the most important suggestions that I can make is that the health professions and the physicians generally seek out consumers of medical care and attempt to work with them in some kind of a cooperative relationship.

I would recommend that in every county medical society, every state medical society, there be set up a joint consumer medical committee to deal with these new and – I shouldn't say "new" – but with the current problems of pricing and costs and relationships with the medical profession.

There is no question in my mind that prices and costs in medical care are going to continue to rise. You and I can look upon that with some degree of criticism, or some degree of unwillingness, but the fact of the matter is if you look at the next ten years of hospital costs, if you look at matters relating to equipment, if you look at the demand for medical care, there is no other way but for the total expenditures in this country for medical care to go up, and in my opinion they will probably go up something in the nature of about five billion dollars a year.

We are spending 55 billion dollars a year now for all aspects of health costs in this country, and by that I mean Blue Cross, Blue Shield, out-of-pocket payments to doctors and hospitals, the construction of hospitals, and other facilities, and nursing homes, and medical education.

If you take the whole ball of wax of what you nd I and every one of the 200 millio people in this country paid, it is 55 billion dollars, little over six percent of the gross n tional product, and it is going up in ollars, and percents, faster than p bably other items in the general cost living index.

So it behooves all of us, ether you are a physician, whether y are a nurse, whether you are an ec omist, whether you are a consumer, ether you are a politician – for t con- sumer, and the politician, d the physician, to begin to get toget er.

I don't think this thing can b solved by the consumer unilaterally or the physician unilaterally, and it n't be solved by the politicians uni erally. If there is some way we ca find a mechanism that every one of e three thousand counties in every or of the 50 states, that consumers an physi- cians in other medical groups vere to work together, continually st dy and bring in information to the p blic on what is happening on demand n cost, doing a kind of self-polic g, and showing the responsibility t t is in- volved, I think it could well c nge the situation.

For instance, let me give y just an illustration in the Medcaid pr blem. In the administration of the Medicaid program, most of the state agencies that administer that program are state welfare agencies – not sta e health agencies.

Why is this? Because the st te health agencies have not in the ast been particularly consumer- rien ted because in the past it ha been an adaptation of the welfare program, and because the welfare agencies whatever else their failings were, and whatever else their non-rel tionships to the medical profession are, at leas sought out other people in the community who paid the tax bill, who were concerned about access and delivery of medical care.

I myself favored the transfer of the responsibility of administering the Medicaid program to the state health departments from the state welfare departments, but is is not possible in many states until there is a major reorganization and reorientation of the role of the state health department and its relationship to people outside of the health industry and to the effective consumer participation, where tax funds are being paid. I believe that this is certainly an area of concern.

A TIME OF UPHEAVAL

Let me say in closing, there are lots of changes going on in our society at the present time. The changes that are occurring are not merely changes in medical care but, if you sat down yourselves and put down a list and said what is happening in our total society, I am sure many things happening are distressing to you, as they are to me, but it is clear to me that vast changes are under way.

The whole presence of the Peace Corps and Vista and the Teacher Corps, in affecting idealism and experience of young people in recent years, is a significant thing.

I don't need to tell you about the vast effect that student participation in colleges is having, and I predict we will have significant changes in medical schools as well during this coming decade, so that when you gentlemen go back to your medical schools, five or six years from now, you will see a vastly different study body than when you went to school, with vastly different attitudes on the part of the young people coming into medical school, and certainly freshman classes doubled in medical schools.

You will find more black people in the medical schools – more women. You will find more people with different social attitudes than those of us who came up in education in the thirties, forties and fifties.

Let me say I just finished making a study of student participation in high school, and I met with a group of people who were telling me what kind of student unrest is going on in the elementary school, which was rather devastating to me.

All I want to say is there is a lot of change in attitude coming up. Don't think that those who talk about changes in medical care are just picking on the medical profession. They are not. It is pervasive throughout our society.

You look at the black militancy that is occurring, and when you see collective bargaining about teachers in the profession, and when you see movement of people out of cities and into the suburbs, when you see industries moving into the South, changing the kinds of relationships there, when you see the kinds of political realignments going on in this country, where old conventional attitudes about conservatism and liberalism are changing, when you see Republican, Democrat or Independent – what this is going to be doing in the next eight years in our body politic – I only say to you that

these tremendous social changes that are going on are not merely limited to the United States of America, must inevitably have equally an impact upon physicians and on medical care.

Seven years from now, I think I am right, is the 200th anniversary of the Declaration of Independence of the United States, in 1976. I think when 1976 comes you are going to see a vastly different America from the one that was 1876, 1926 or 1956.

I might say that it is only about ten years since Sputnik came about, and in my opinion, when you look back and try to trace some of these changes, the appearance of the Russian Sputnik was one of the most intensive factors in changing our lives.

Why? Because it showed that the United States of America no longer had the exclusive scientific leadership in the world, that other countries were able to compete with us.

If we in the United States want to retain our leadership, as I hope we shall, retain our freedom and our independence, a new era of constructive dialogue, constructive working together, must occur.

And as one who was Secretary of Health and Welfare in the last administration, I hope all of you will give constructive aid to Secretary Finch and to Dr. Egeberg in the development of health policies.

I regret that it has taken six or seven months to appoint a new Assistant Secretary of Health. Twenty billion dollars in health affairs have been spent during that time while there was no leader in our nation's capital in this area. We have got to make up for lost time.

It is extremely important that nder Dr. Egeberg and Secretary F ich's leadership we explore every p sible way to develop a new type co- operation, a new era of good f lings and an opportunity for the plor- ation of any idea, no matte how controversial, no matter ho de- batable, so that we can still ve a system of medical care on th one hand that uses the talents an the abilities of free men and free omen but at the same time accom lishes that objective which I think has ways been the objective of the dical profession, which is that every an or woman who needs medical ca will get the highest quality of medi l care without regard to race, without egard to religion, and without reg d to income at the time that they ne l that medical care.

Editorial Comment

There are certain areas in Mr. Cohen's reprinted talk and previously published paper that are not strictly pertinent to our current problem, e.g., his discussion of the medical school curriculum. The paper is reprinted in full, however, in order to maintain the continuity of Mr. Cohen's thought.

It is obvious from Mr. Cohen's comments that he believes strongly that every person should have health care coverage. He does not discuss this specifically as "a right" with or without reciprocal obligations on the part of the recipient or the provider (the physician). For those unable to provide health services from their own income, he anticipates government financing. It is realistic to assume that this would derive from general revenue. Assumedly, those able to finance their own plan would do so.

Very important to this discussion is the statement by Mr. Cohen that he believes provision of medical health care is not solely the concern of the physician, it is the concern of the people themselves and government as well. (See the epilogue).

Unfortunately in this article he does express his thoughts concerning the reciprocal rights of the physician, perhaps on the assumption that the physician and the profession as a whole are capable of providing their own built in safe guards both against personal and professional abuses. The obligation of the physician to provide health care services to a non-selected population seems, however, to be assured. It would have been interesting however to have had his thinking on these aspects of the problem.

Throughout the essay he stresses "cooperation" and certainly it is fair to state that he strongly believes that providers, consumer groups and politicians would have to meet in a spirit of cooperation in order to provide a just distribution of available health care services. One cannot quibble with the importance of the physician and his related organizations joining in dialogue with those concerned with the health problem. "Cooperation" is a point that needs stressing.

V.H.P.